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Nevada Medicaid Web Announcement 3424

Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for July 2024 Professional Claims

The Division of Health Care Financing and Policy and the Nevada Medicaid fiscal agent have reviewed all claim submissions for the month of July 2024 and have compiled a list of the top 10 reasons for which professional claims have denied. The table below lists the top 10 error codes along with the Explanation of Benefits (EOB) code that appears on the remittance advice for the claim denials, the error code descriptions and instructions to providers on how to resolve the claim denials.

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
452	452	No Medicare Coinsurance, Deductible or Copay Due	Provider will need to verify the co-insurance, deductible or co-pay amount in the Medicare crossover details fields. See the Submitting Secondary Claims to Nevada Medicaid Training Video for more billing information when Third-Party Liability (TPL) is present.
3001	0192	Prior Authorization not Found	Provider is advised to proceed with the following steps: • Verify that the prior authorization request has been submitted and approved. • Verify the correct authorization number has been placed on the claim. • Verify that the Dates of Service (DOS) billed on the claim match the time span of the approved authorization. • Verify that the authorization number corresponds with the correct National Provider Identifier (NPI) and recipient ID before resubmitting the claim. • Verify that units are available on the approved authorization.
3340	3340	Service not covered by NV Medicaid	Provider should verify that the code being billed is a payable code by Nevada Medicaid for the specific dates of service. Review the Search Fee Schedule for more information.
4021	0698	No CVG (Coverage) Rule for Procedure	Provider should verify that the code being billed is a payable code by Nevada Medicaid for the specific dates of service. Review the Search Fee Schedule for more information.
2003	3006	Client ineligible on DTL DOS (detail level date of service)	Provider will need to verify that the recipient is eligible for the dates of service and has the appropriate Benefit Plan. This may be completed in the Electronic Verification System (EVS) by reviewing the Member Eligibility tab, or by utilizing Gabby™ by calling the Customer Service Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511.

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
2017	0038	Client Services Covered by HMO Plan	Provider will need to submit the claim to the appropriate Nevada Medicaid Health Maintenance Organization (HMO)/Managed Care Organization (MCO) for processing. Client eligibility can be verified within the EVS by reviewing the Member Eligibility tab, or by utilizing Gabby™ by calling the Customer Service Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511.
908	0908	PAD (Physician Administered Drug) Detail Denied by PBM (Pharmacy Benefits Manager)	The National Drug Code (NDC) on the Physician Administered Drug claim was denied by the Pharmacy Benefit Manager. Provider will need to verify that the NDC is a payable and covered code. Providers may reach out to the Pharmacy Benefits Manager at (800) 695-5526 or visit https://nevadamedicaid.magellanrx.com/home
7215	7215	Procedure Code is Incidental	The procedure code is incidental, or considered inclusive, to another billed line and is not separately payable. Providers should review the recipient's benefit plan to ensure that the code being billed is a code covered by the recipient's benefit plan and has not already been billed and paid.
4801	116	No Billing Rule for Procedure	If no active billing rules exist for the procedure, provider should verify that the code being billed is a payable code by Nevada Medicaid for the specific dates of service. Review the Search Fee Schedule for more information.
5035	5035	Exact Duplicate: Practitioner to Practitioner	Claim is an exact duplicate of a previously paid claim. Provider will need to review claim history and submit an adjustment or void the claim if changes are needed. This may be completed in the EVS. Please review the EVS User Manual Chapter 3: Claims and for further instruction.