September 23, 2024

Nevada Medicaid Web Announcement 3448

Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for August 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 August 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.
1008	1508	Billing Prov is not a Grp/Performing is a Grp Prov	Providers should review claims to ensure that a Group National Provider Identifier (NPI) is listed as the billing NPI and that an individual NPI is listed as the rendering or performing provider.
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.
2017	0038	Client Services Covered by HMO Plan	Provider will need to submit the claim to the appropriate Nevada Medicaid 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.

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
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
1010	3110	Rendering Prov not Member of Billing Prov Group	Provider should ensure that the rendering provider is enrolled with Nevada Medicaid for the dates of service as well as verify linkage information to determine if the rendering provider was linked to the Group at the time the service was rendered. Providers should log in to the EVS and access their “Affiliated Providers” page to see current linkage information. See Web Announcement 2982 for more information. If the rendering National Provider Identifier (NPI) is not linked, the provider should submit an update requesting linkage.
676	841	DOS Exceeds Timely Filing Edit	For in-state providers, to be considered timely, claims must be received by the fiscal agent within 180 days from the date of service or the date of eligibility decision, whichever is later. For out-of-state providers or when a third-party resource exists, the timely filing period is 365 days. Please review the Billing Manual for more information.
4223	0325	Medical Review for Procedure Coverage Rule	The client only has an Emergency Medicaid Only (EMO) benefit for the date of service. Provider should provide appropriate clinical documentation supporting that the emergency criteria were met. If documentation is attached, the additional medical documentation does not meet the criteria for emergency medical services covered by Nevada Medicaid for non-U.S. citizens with EMO coverage. Please reference the Emergency Medicaid Only (EMO) Billing Instructions for more information.