July 16, 2025

Nevada Medicaid Web Announcement 3675

Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for June 2025 Professional Claims

Nevada Medicaid and its fiscal agent have reviewed all claim submissions for the month of June 2025 and have compiled a list of the top reasons for which professional claims have denied. The table below lists the top 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	Providers 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.
2003	3006	Client ineligible on DTL DOS (detail level date of service)	Providers 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 Provider Web Portal (PWP) by reviewing the Member Eligibility tab, or by utilizing Gabby™ by calling the Gainwell Technologies Contact Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511.
2017	0038	Client Services Covered by HMO Plan	Providers 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 PWP by reviewing the Member Eligibility tab, or by utilizing Gabby™ by calling the Gainwell Technologies Contact Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511.
4021	0698	No CVG (Coverage) Rule for Procedure	Providers 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.
1009	1009	Contract Could not be Determined	Review billing provider contract dates to verify provider is contracted with Nevada Medicaid for the dates of service listed on the claim. Provider may need to submit a new enrollment application to Nevada Medicaid via the Provider Flex tool to be able to bill for dates of service. Visit the Provider Enrollment webpage for more information.

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
3001	0192	Prior Authorization not Found	Providers are 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 NPI and recipient ID before resubmitting the claim. • Verify that units are available on the approved authorization.
5035	5035	Exact Duplicate: Practitioner to Practitioner	Claim is an exact duplicate of a previously paid claim. Providers will need to review claim history and submit an adjustment or void the claim if changes are needed. This may be completed in the PWP. Please review the PWP User Manual Chapter 3: Claims and for further instruction.
3340	3340	Service not covered by NV Medicaid	Providers 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.
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.
4371	1379	Claim Type Restriction on Proc Cvg Rule	Providers will need to review the claim type that was submitted to Nevada Medicaid and ensure that the correct claim type was used. Please visit PWP User Manual Chapter 3: Claims for more information. For recipients with Qualified Medicare Beneficiary (QMB) only coverage, ensure the claim type is listed as a Crossover as applicable. For additional information, please refer to Web Announcement 2901.