# Nevada Medicaid and Nevada Check Up News

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## Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,127,888,269.05 in claims during the three-month period of October, November and December 2019. Nearly 100 percent of current claims continue to be adjudicated within 30 days. Thank you for participating in Nevada Medicaid and Nevada Check Up.

# Nevada Medicaid Novel Coronavirus (COVID-19) Webpage and Information Resources

The Division of Health Care Financing and Policy (DHCFP) created a Novel Coronavirus (COVID-19) information webpage at http://dhcfp.nv.gov/covid19/. The Division created this webpage to answer frequently asked questions and to share information and resources pertaining to the current status of COVID-19 and its impact on Nevada Medicaid recipients and providers.

The webpage provides the Nevada Medicaid Response to the Novel Coronavirus (COVID-19), as well as useful links for recipients and providers. The Recipients section contains links to English and Spanish FAQs, guidance for those being monitored and links to Nevada's Managed Care Organization (MCO) websites. The Providers section includes links to a Healthcare Planning Checklist and Telehealth guidelines. The Nevada Links section connects providers to health agencies. The Federal Resource Links section provides access to the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS) and Medicaid.gov websites.

In addition to the DHCFP webpage, multiple web announcements have been posted on the provider website (www.medicaid.nv.gov) to keep providers informed. Following are some of the published web announcements:

Web Announcement 2137: Pharmacy "Refill Too Soon Waiver" Implemented in Response to Coronavirus Disease (COVID-19) Threat

Web Announcement 2140: Attention Provider Types 12 (Hospital, Outpatient) and 43 (Laboratory, Pathology Clinical): Novel Coronavirus Testing and Diagnosis Procedure Codes

Web Announcement 2141: COVID-19 Nevada Telehealth Memo and Resource Guide

Web Announcement 2142: Nevada Telehealth Memo Update Effective March 19, 2020

Web Announcement 2145: Directives Regarding Provider Enrollment

Web Announcement 2146: Attention Prescribers and Pharmacies: Emergency Regulation on Prescribing and Dispensing Hydroxychloroquine and Chloroquine during Novel Coronavirus (COVID-19) Pandemic

Web Announcement 2149: Telehealth Billing Guidelines

Web Announcement 2151: Nevada Telehealth Memo - March 27, 2020 Update

# Frequently Asked Questions (FAQs) for the Electronic Verification System (EVS)

A Frequently Asked Questions (FAQ) reference has been created to assist providers with questions regarding the Electronic Verification System (EVS) secure Provider Web Portal. The EVS FAQ is available on the Provider Training webpage under Workshop Materials, the EVS User Manual webpage or by clicking on EVS FAQ.

The EVS FAQ contains questions and answers regarding the following topics:

- General Questions
- Delegates
- Recipient Eligibility
- Claims
- Prior Authorization/Care Management
- File Exchange
- Secure Correspondence
- Member Focused Viewing
- Payment History and Remittance Advice
- Revalidation/Change
- Pre-Admission Screening and Resident Review (PASRR)
- Electronic Health Records (EHR) Incentive Program
- Presumptive Eligibility

Examples of questions and answers included in the FAQ are:

**Question:** Do I need to call Nevada Medicaid to reset my password?

**Answer:** In most cases, the user can reset their own password by selecting the "Forgot Password" link located on the Site Token and Password screen.

**Question:** How can I grant access to a delegate?

**Answer:** For more information on how to grant or revoke access for a delegate, users can review Chapter 1: Getting Started of the EVS User Manual for a step-by-step process: https://www.medicaid.nv.gov/providers/evsusermanual.aspx

**Question:** Where can I locate instructions on how to review recipient eligibility on the EVS portal?

**Answer:** Step-by-step instructions can be located on the EVS User Manual page located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx. The user should review Chapter 2: Eligibility Benefit Verification for more information regarding how to search for recipient eligibility, as well as view more information regarding each available benefit plan.

Please review the EVS FAQ for additional helpful answers to questions you may have.

## Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact the Nevada Medicaid Provider Customer Service Center by calling (877) 638-3472, press Option 2 for providers, then Option 0 and then Option 2 for claim status. If you have a question regarding prior authorizations, please call (800) 525-2395.

If you have a question about Medicaid Service Policy, you can go to the DHCFP website at http://dhcfp.nv.gov. Select "Resources" and then select "Telephone Directory" for the telephone number of the Administration Office you would like to contact.

# Top Enrollment Return Reasons and Resolutions

The Division of Health Care Financing and Policy and the Nevada Medicaid Fiscal Agent review all Enrollment submissions and compile a list of the top 10 reasons for which Enrollment documents have been returned to providers. The table below lists the current top 10 reasons for the returns along with the instructions on how to resolve the returns.

**Note:** Several provider enrollment training resources are located on the Provider Enrollment webpage and on the Provider Training webpage under "Provider Enrollment and Revalidation Instruction Materials."

| Document Return Description | Resolution |
|---|---|
| Ownership information is not listed correctly or in its entirety | Users must review the Chapter 2 Addendum: Ownership & Relationships Example for more information regarding the information that must be listed on the application. |
| License information is being input into fields incorrectly | Information that is input into the documents must match the information from the physical license.<br>Users must review the physical license and confirm the information that is populated matches the information on the physical license.<br>User must verify that when inputting the updated Secretary of State information that the information populated in the License Number field must also match the information populated into the Nevada Business ID field, as well as input the correct License Effective and End Dates.<br>A physical copy of the license must also be included. |
| Individual providers are listing tax information pertaining to a Group | When an Individual is enrolling with Nevada Medicaid and linking to a Group, Individuals cannot list a Group's Federal Tax ID.<br>Individuals should only list their own Social Security Number (SSN) and the Federal Tax ID field should be left blank. |
| Enrollment checklist is not being attached | Depending on the Provider Type being selected, the Enrollment Checklist may be required to be uploaded.<br>Users should review the Enrollment Checklist to determine if the checklist is a required document.<br>Example: The Provider Type 14, Specialty 305 checklist contains the following: "This checklist must be completed and submitted with the attachments listed below," which indicates the checklist is required. |
| Documents that are required on the enrollment checklist are not being attached | Users should re-review their Enrollment Checklist to verify that all documents being requested are uploaded and attached to the application. Be sure to view the most current checklists at Enrollment Checklists. |
| Provider does not have the correct qualifications for the provider type and/or specialty code that they are enrolling for | Providers should re-review the Enrollment Checklists, the Billing Information webpage and their Medicaid Policy chapter to determine if the correct credentials are present.<br>If their credentials are not associated with the current Provider Type being enrolled in, the user will want to review the other Provider Types and related information to determine the best Provider Type to be enrolled with. |
| Quality Assurance Policies for Behavioral Health Providers are insufficient | Providers must re-read their Medicaid Policy chapter to determine the guidelines for their Quality Assurance Policy. |
| Non-authorized users are attempting to sign documents on behalf of a provider | Only Owners or Authorized Users can sign off on documentation.<br>Non-Authorized Users are unable to sign or make changes.<br>Verify that the person listed in the Ownership & Disclosure section under the "Change Authorization Information" is correct. |
| Provider Type 17 (Special Clinics) are attempting to link individual providers to the Group NPI | Provider Type 17 cannot link Individual providers to their Group National Provider Identifier (NPI).<br>The Individual providers should complete the Ordering, Prescribing and Referring Enrollment Application as the Individual will not be submitting claims. Only the Group will be submitting claims. |
| Provider is attempting to enroll an already enrolled provider and the provider being enrolled is not up for revalidation | A provider that is already enrolled with Nevada Medicaid cannot enroll under the same NPI and Provider Type twice.<br>Verify on the Revalidation Report when the provider is due to revalidate their contract.<br>If a provider is attempting to make changes to their profile, when in the Electronic Verification System (EVS) / Provider Web Portal, select Revalidate-Update and then select Update Provider. |

# Top 10 Claim Denial Reasons and Resolutions and/or Workarounds

The Division of Health Care Financing and Policy and the Nevada Medicaid fiscal agent review all claim submissions and have compiled a list of the top 10 reasons for which 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 |
|---|---|---|---|
| 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.<br>Provider will need to verify that the NDC is a payable and covered code. NDC information can be located at:<br>https://www.medicaid.nv.gov/providers/ndc.aspx<br>Providers may also reach out to the Pharmacy Benefits Manager at: 866-244-8554 (Pharmacy Help Desk). |
| 451 | 0452 | No Crossover Coinsurance or Deductible Due | Provider will need to submit a new claim using the regular Fee-for-Service claim along with the Medicare denial reason.<br>See Web Announcement 1776 for more information. |
| 3347 | 0609 | No Payable Accommodation Code | Error code 3347 will typically post as a denial along with additional denial code(s).<br>Providers must review their submitted claim and open the Adjudication Errors panel. |
| 1070 | 1464 | Procedure Missing on Outpatient Claim | Provider must enter a valid procedure code on the detail level of the claim and submit a new claim. |
| 1011 | 1011 | Contract could not be determined – HDR (header level) | Provider must verify that the National Provider Identifier (NPI) being listed is under contract with Nevada Medicaid for the dates of service indicated on the claim. |
| 708 | 0039 | HCPCS Procedure Requires a Valid NDC | Verify that the Healthcare Common Procedure Coding System (HCPCS) code is accompanied by a valid and payable NDC. |
| 3959 | 1178 | No Reimb (Reimbursement) Rule for Rev (Revenue) Code | Review the claim for any additional adjudication errors and make any necessary changes.<br>Also review the recipient's dates of eligibility and Benefit Plans.<br>Verify the dates of service associated with the claim. |
| 2003 | 3006 | Client ineligible on DTL DOS (detail level date of service) | Verify that the code being billed is a payable code by Nevada Medicaid.<br>User should review the Search Fee Schedule for more information. |
| 4801 | 0116 | No Billing Rule for Procedure | Verify that the code being billed is a payable code by Nevada Medicaid.<br>User should review the Search Fee Schedule for more information. |
| 3001 | 0192 | Prior Authorization not Found | Verify that a prior authorization request has been submitted and approved.<br>Verify the correct authorization number has been placed on the claim.<br>Provider will also need to verify that the Dates of Service (DOS) match the time span of an approved authorization and that those DOS match the dates billed on the claim.<br>Provider will also need to verify that the authorization number corresponds with the correct NPI and recipient ID before resubmitting the claim. |

# Reminders Regarding Submitting Claim Appeals

All providers have the right to appeal a claim that has been denied. Below are some helpful reminders for providers who are interested in appealing a denied claim.

- Appeals must be submitted electronically.
- **Appeals must be submitted within 30 calendar days from the date on the remittance advice. Any claim appeals submitted after those 30 calendar days will be rejected by Nevada Medicaid.**
- An FA-90 Formal Claim Appeal Request form must be filled out in its entirety and accompany the claim appeal. Each appeal must be submitted with its own FA-90 form.
- **Appeal requests for subsequent same service claim submissions will be rejected.**

The Division of Health Care Financing and Policy and the Nevada Medicaid Provider Training team offer monthly training sessions covering Claim Appeals, Adjustments and Voids. Providers interested in attending a training session may review the Training Calendar for dates and times and register by visiting the 2020 Provider Training Registration Website. Please note that these training sessions are only intended to discuss Claim Appeals, Adjustments or Voids and all other concerns should be directed to NevadaProviderTraining@dxc.com.

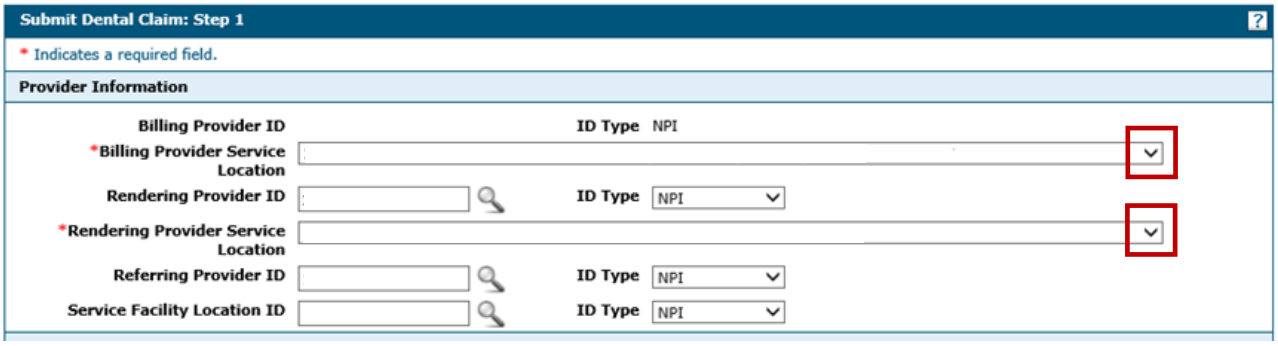
Other resources available for providers are the training presentation Claims Appeals, Adjustments and Voids, the Claims Appeals Tip Sheet and the Medicaid Services Manual (MSM) Chapters 100 and 3100.

# Prior Authorization System Updated to Allow Providers to Choose Service Location

Effective March 3, 2020, the online prior authorization system was updated to allow providers to select their service location when creating a prior authorization.

- For Medical prior authorizations, the Requesting Provider Information panel and Service Provider Information panel will now display a Service Location drop-down list for the correct service location to be selected.
- For Dental prior authorizations, the Requesting Provider Information panel and Rendering Provider Information panel will now display a Service Location drop-down list for the correct service location to be selected. (shown in the example below)

Please refer to the Electronic Verification System (EVS) User Manual Chapter 4: Prior Authorization for more information and instructions.




## *Instructions to Avoid Prior Authorization Requests Denied for Overlapping Services*

Nevada Medicaid providers must submit a Prior Authorization Data Correction Form (FA-29) to end services on a prior authorization (PA) if the recipient terminates services or discharges prior to the end date on the PA. If the FA-29 form is not submitted and the recipient seeks treatment elsewhere, the new PA may be denied due to overlapping services and cause delays in the recipient getting the needed services.