Nevada Medicaid and Nevada Check Up News

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Second Quarter 2024

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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,313,774,828.41 in claims during the three-month period of January, February and March 2024. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

Thank you for participating in Nevada Medicaid and Nevada Check Up.

Provider Training Sessions Scheduled Each Month

The Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid Provider Training team would like to remind all providers, delegates and staff that several provider training sessions are offered each month. Training is free of charge and billing staff, billing agencies, direct practitioners/health care providers, office managers, admitting and front-desk staff, etc., are encouraged to attend.

Nevada Medicaid moved to a new training registration platform effective January 2024. If you have not yet registered for the new training platform, please see the LMS Training Portal Tip Sheet for instructions or reach out to the Nevada Medicaid Provider Training team at nevadaprovidertraining@gainwelltechnologies.com for assistance.

Monthly web announcements listing upcoming training sessions provide the link to the new Provider Training Registration Website. The link to the registration website is also posted on the Provider Training webpage and the Provider Enrollment webpage.

If you have any questions about the registration tool, please send an email to: nevadaprovidertraining@gainwelltechnologies.com.

Attention All Providers:

Inactive Providers May Be Subject to Termination

The Division of Health Care Financing and Policy (DHCFP) systematically reviews Nevada Medicaid/Nevada Check Up provider files to purge inactive providers. Providers who have not submitted a claim or rendered any services to Nevada Medicaid/Nevada Check Up recipients within the past 24 months may be subject to termination.

Providers who are identified as eligible for termination will receive a Notice of Intent letter notifying them of the decision. The letter will contain instructions for providers who would like to request an extension of their termination date.

Attention Inpatient Hospital and Nursing Facility Providers:

Reminders for Submission of Pre-Admission Screening Resident Review (PASRR) and Level of Care (LOC) Requests

The following reminders for inpatient hospital and nursing facility providers will help Nevada Medicaid process Pre-Admission Screening Resident Review (PASRR) and Level of Care (LOC) requests.

PASRR Requests:

- Retroactive PASRRs are not allowed and requests for retroactive PASRRs will not be processed.
- When listing medications, please only include psychiatric medications; it is not necessary to list other medications.

LOC Requests:

- When the provider is requesting a retroactive LOC, the recipient must show retroactive eligibility in the Electronic Verification System (EVS) under the retro-eligibility tab.
- Please put the recipient's admission date to the Skilled Nursing Facility (SNF) in the "Justification" field on the last page of the LOC form.
- When requesting a Vent LOC, the patient must be on a vent mode for a minimum 6 hours per day. The flowsheets must be filled in completely with vent mode. The recipient can be on a continuous positive airway pressure (CPAP) trial, but flowsheets must show that the recipient is on a vent mode for at least 6 hours per day also.
- Page 3 of the LOC screening form is for pediatric requests only; do not use page 3 for requests for adults.

Resources:

- The "PASRR and Nursing Facility LOC Frequently Asked Questions" provides answers to commonly asked questions regarding submitting PASRR and Nursing Facility LOC requests.
- The "Nevada Medicaid PASRR, LOC & Nursing Facility Provider Training" document provides details regarding EVS access, and Nursing Facility and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Tracking Information.

Reminder to Review Provider Type Specific Billing Guides

The Division of Health Care Financing and Policy (DHCFP) and Nevada Medicaid would like to remind all providers, delegates and staff that provider type specific billing guides are available to help ensure that your claims are submitted properly.

The provider type specific billing guides may include some of the following information:

- Policy Information
- Rates Information
- Prior Authorization Requirements
- Covered and Non-Covered Services
- Special Billing Instructions, if applicable

All persons submitting claims to Nevada Medicaid should be familiar with their provider type specific guides, as understanding this information may reduce claim denials, claim appeals and the need to contact Nevada Medicaid.

Billing guides by provider type are posted on the Providers/Claims Billing Information webpage.

Provider Documentation Reminders

The following reminders will assist providers in adhering to the documentation responsibilities required of each Nevada Medicaid/Nevada Check Up provider.

- It is the provider's responsibility to keep patient records that adhere to basic standards of practice in accordance with the Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual (MSM), and state and federal statutes and regulations at a minimum of six years from the date of payment for the specified services. Providers are required to keep any records necessary to disclose the extent of services the provider furnished to recipients and to provide these records upon request to the DHCFP, Nevada Department of Health and Human Services, or the state Medicaid Fraud Control Unit.
- It is the provider's responsibility to submit accurate, complete and legible claims and supporting documentation upon request.
- Requested documentation must be provided within time frames specified by the DHCFP, other state and/or federal officials, or their authorized agents for the purpose of determining the validity of claims and the reasonableness and necessity of all services billed to and paid by the DHCFP.
- It is the provider's responsibility to adhere to program and provider type specific documentation requirements in the MSM, the Billing Manual and the Billing Guidelines for each provider type.

Please review the provider responsibilities specified in the MSM Chapter 100 (Medicaid Program), MSM Chapter 3300 (Program Integrity), and the chapters related to the services you provide. The MSM is located at: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/.

The Billing Manual and Billing Guidelines are located on the Providers Billing Information webpage at: https://www.medicaid.nv.gov/providers/BillingInfo.aspx.

Attention All Providers: Top Enrollment Return Reasons and Resolutions

The Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid Fiscal Agent review provider enrollment submissions and have compiled a list of the top reasons for which enrollment documents have been returned to providers. The table below lists some of the top reasons for the returns and instructions on how to resolve the returns. Note: Several provider enrollment training resources are located on the Provider Enrollment webpage and on the Nevada Medicaid YouTube Channel.

Group Enrollments	
Return Reason	**Resolution**
The Nevada Secretary of State (SOS) license is required to be attached	Obtain the most up-to-date copy of your Nevada SOS license and verify it is attached to your enrollment application.
EFT Authorization form is required to be attached	Ensure that the required Electronic Funds Transfer (EFT) Authorization Form is completed and attached to your enrollment application. This can be found within the application or via the Electronic Funds Transfer (EFT) Authorization Form.
License issue/end date listed on the application does not match attached NV SOS licensure	Ensure that the issue and end dates on the application match the formation/annual report due date on the Nevada Secretary of State website.

Individual Enrollments	
Return Reason	**Resolution**
Signature in the "Terms of Agreement" is not an authorized signer	The signature in the "Terms of Agreement" section of the application is required to be that of the provider, managing employee, or authorized user.
License issue/end date listed on the application does not match licensing board website	Verify that the issue and end dates listed on the applicable state board website match the dates on your enrollment application.
Attached license does not match enrollment	Ensure that any attached licensure is for the provider enrolling and that the name, license number, and the beginning and ending dates of the license match the information entered on the online enrollment.

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Top Prior Authorization Denial Reasons… *Continued from page 3*

Ordering, Prescribing and/or Referring (OPR) Provider Enrollments	
Return Reason	**Resolution**
Signature in the "Terms of Agreement" is not an authorized signer	The "Provider or Authorized Representative Signature" in the application needs to be that of the provider. The signature of the Managing Employee or Authorized User on an OPR application is not acceptable.
License issue/end date listed on the application does not match licensing board website	Verify that the issue and end dates listed on the applicable state board website match the dates on your enrollment application.

Urgent/Emergent Enrollments	
Return Reason	**Resolution**
EFT Authorization form is required to be attached	Ensure that the required EFT Authorization form is completed and attached to your enrollment application. This can be found within the application or via the Electronic Funds Transfer (EFT) Authorization Form.
Per the checklist, please attach a "Letter of Intent"	When submitting your urgent/emergent enrollment application, a "Letter of Intent" including information on the recipient, such as name, Nevada Medicaid ID number, dates of service, procedure/revenue codes, etc., is required. Verify the enrollment checklist associated with the provider type you are enrolling as it may provide additional details and/or requirements for your application.
Proof of Medicaid Enrollment in home state required	Proof of Medicaid enrollment in your home state is required to be attached to your enrollment application. Acceptable documentation includes copies of a welcome letter/ revalidation letter or remittance advice. Documentation must show that the provider was enrolled with their home state Medicaid for the requested date of enrollment.

Professional Claim Denial Reasons and Corresponding Resolutions/Workarounds

The Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid fiscal agent review claim submissions to monitor the common reasons for professional claim denials. The table below lists some of the error codes providers have been receiving recently for their denied professional claims. For each error code, the table also lists the corresponding 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
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.
1047	0205	Provider Terminated – DTL Performing	Providers should ensure that the performing National Provider Identifier (NPI) is enrolled with Nevada Medicaid for the dates of service. Providers should check their status via the Online Provider Enrollment (OPE) tool. If not contracted, you will need to submit a new application to Nevada Medicaid. Visit the Provider Enrollment webpage for more information.

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Professional Claim Denial Reasons… *Continued from page 4*

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
1048	0025	Provider Terminated – DTL DOS (detail level date of service)	Indicates that the provider is not contracted with Nevada Medicaid for the dates of service listed on the claim. Providers should check their status via the OPE tool. If not contracted, you will need to submit a new enrollment application to Nevada Medicaid. Visit the Provider Enrollment webpage for more information.
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.
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, by calling (877) 638-3472 and utilizing Gabby™ or by utilizing the Automated Response System (ARS) at (800) 942-6511.
1076	1012	Prov Contract not Valid on DOS – DTL (detail level date of service)	Indicates that the provider is not contracted with Nevada Medicaid for the dates of service listed on the claim. Providers should check their status via the OPE tool. If not contracted, you will need to submit a new application to Nevada Medicaid. Visit the Provider Enrollment webpage 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.
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
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.

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, and press Option 2 for providers. 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 the "Resources" drop-down list, then select "Telephone Directory" and look for the telephone number of the Administration Office you would like to contact.