Nevada Medicaid and Nevada Check Up News

Volume 21, Issue 3
Third Quarter 2024

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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,542,482,173.87 in claims during the three-month period of April, May and June 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.

Children's Behavioral Health: Working Group Kickoff

Nevada Medicaid is tackling major reforms to improve our children's behavioral health system. Over the next two years, we are investing more than $200 million to support over 20,000 children and their biological or foster care families. These new and improved services will include:

- **Therapies** for children and families
- **Parenting support** for caregivers
- **Life skills training** for youth
- **Peer support**, connecting children and families with community members with similar experiences and needs
- **Respite care** to give caregivers short-term relief
- **Transportation** to medical appointments
- **Psychiatric care** and medication management
- **Mobile crisis services**, whenever and wherever needed
- **A "Wraparound" program** to help children and families achieve a multi-disciplinary care plan and get the support they need to thrive in their communities

Nevada Medicaid anticipates that many of these services will be running early next year. The agency is also working to establish a specialized health plan designed to support eligible children in 2027. All these efforts require stakeholder and community input and involvement, so please join the effort and provide your feedback by completing this form. To learn more, please review this flyer. Updates will be posted on the Behavioral Health Services page of the Division of Health Care Financing and Policy website.
Email ChildrensBH@dhcfp.nv.gov to receive more information.

Medicaid Coming for Justice Involved Individuals

Nevada is undertaking two initiatives that provide targeted healthcare services to better support youth and adults transitioning from incarceration. Under the federal Consolidated Appropriations Act of 2023 (CAA, 2023), beginning January 1, 2025, states are required to provide pre- and post-release case management as well as screening and diagnostic services for Medicaid and Children's Health Insurance Program (CHIP)-eligible youth who are under age 21 or former foster youth up to age 26 who are post-disposition for 30 days prior to their release. Additionally, Assembly Bill (AB) 389, which was passed in June 2023, directs the Nevada Division of Health Care Financing and Policy (DHCFP) to pursue a Section 1115 waiver to provide a targeted set of services to Medicaid-eligible incarcerated individuals, including youth, for up to 90 days prior to their release.

To learn more, please visit the Justice Involved Individuals Re-Entry Program page.

You can also subscribe to receive emails about progress, meetings and more by clicking this link and sending the email.

Have specific questions or want to learn more about getting involved, please email the team at 1115waivers@dhcfp.nv.gov.

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.

Always use the current Nevada Medicaid version. Billing guides are updated when policy changes are implemented or to clarify information.

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

Change is coming! A new enrollment solution for Nevada Medicaid Providers is coming in early 2025.

Provider Flex

Intuitive Attachment Process
Integrative solutions for ensuring all required attachments are included to reduce returns.

Streamlined Processes
A simplified process for ownership and disclosure, NPI verification, and application navigation.

Simplified Checklist
Integrated checklist for clarity and ease of access.

DocuSign
New security and integrative signing solutions ensure authorized electronic signatures.

Integrated Licensure & Certification
Integrated license verification.

More information on this exciting change coming soon!

Attention All Providers: Top Prior Authorization Denial Reasons

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.

Denial Reason Description	Suggested Action to Avoid Future Denials
Request does not meet the medical necessity criteria **OR** Requested service does not meet DHCFP policy criteria for reimbursement	Providers should review their Provider Type Medicaid Services Manual Policy Chapter as well as their Provider Type Billing Guidelines and generally accepted standards of care. Providers must document all relevant clinical aspects that should be considered when reviewing the request for medical necessity.
Additional information requested not received; preauthorization request rejected	Providers **must** review their prior authorization requests in the Electronic Verification System (EVS) portal. Providers should check the portal frequently; if a PA is in a "Pending" status please review the notes to determine if additional information has been requested. Providers can review Chapter 4: Prior Authorization of the EVS User Manual in order to learn about how to review the status of a PA as well as additional information regarding submitting additional documents that are requested by Nevada Medicaid.
Recipient is no longer eligible for coverage **OR** Recipient not eligible on requested dates of service	Providers should review the recipient's eligibility information prior to PA submission. This is done through the EVS portal. Review Chapter 2: Eligibility Benefit Verification of the EVS User Manual for more information.
Late notification: prior authorization timelines not met	Prior authorization was submitted outside of timely filing rules and Nevada Medicaid is unable to accept any requests that are not within the appropriate time frame. Providers should review Chapter 4 of the Nevada Medicaid Billing Manual for prior authorization timely filing information.
Invalid preauthorization request form submitted, resubmit request with a current form	Providers should review their Provider Type Billing Guidelines for more information regarding which form should be submitted. Providers must also review the Forms Page to determine that the most current version of a form is being used.

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
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.
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.
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.
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.

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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
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.
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.
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.
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.

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. 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.