Nevada Medicaid and Nevada Check Up News

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Inside This Issue:

A New Provider Enrollment Solution is Coming Soon!

The Division of Health Care Financing and Policy (DHCFP) and our fiscal agent, Gainwell Technologies, are excited to announce Provider Flex, our streamlined, intuitive, integrity-based provider enrollment solution.

Provider Flex will be available soon, and here is a sneak peek at a few of the features:

- Streamlined document attachment
- Checklists integrated with the application
- DocuSign digital signing solution

Training sessions will be offered every business day, starting Monday, April 7, 2025. To register for training sessions, please visit the Provider Training Registration Website. If you have not yet registered for our training platform, please see our LMS Training Portal Tip Sheet for instructions.

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,669,586,561.12 in claims during the three-month period of October, November and December 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.

Nevada Medicaid Centralized Credentialing

Nevada Medicaid Centralized Credentialing was implemented on February 28, 2025. Credentialing establishes that healthcare providers have the qualifications to render services based on licensure, certification, work history and other relevant elements.

Centralizing the credentialing process will mean a single Credentialing Verification Organization (CVO) will conduct primary source verification, streamlining the process and aligning outcomes.

Frequently asked questions (FAQ) are available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Providers/FAQs.pdf

For more information, see the Medicaid Centralized Credentialing page of the Division of Health Care Financing and Policy (DHCFP) website.

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: https://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 Prior Authorization Denial Reasons for the Fourth Quarter of 2024

The Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid fiscal agent have reviewed all prior authorization (PA) submissions for the fourth quarter of 2024 and have compiled a list of the top reasons for which prior authorizations have been denied. The table below lists the top denial reasons for the prior authorizations and instructions to providers on how to avoid future prior authorization denials.

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 **OR** Medical information provided does not meet medical necessity criteria	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.
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 Provider Web Portal (PWP). Review Chapter 2: Eligibility Benefit Verification of the PWP User Manual for more information.

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Top Prior Authorization Denial Reasons… *Continued from page 2*

Denial Reason Description	Suggested Action to Avoid Future Denials
Additional information requested not received; preauthorization request rejected	Providers **must** review their prior authorization (PA) requests in the PWP. 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 PWP 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.
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.
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 the Provider Web Portal (PWP) User Manual Chapter 3: Claims for more information.

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Professional Claim Denial Reasons… *Continued from page 3*

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
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 PWP 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.
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 PWP and access their "Affiliated Providers" page to see current linkage information. See Web Announcement 2982 for more information. If the rendering NPI is not linked, the provider should submit an update requesting linkage.
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 PWP. Please review the PWP User Manual Chapter 3: Claims and for further instruction.

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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
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 Contact Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511.
676	841	DOS Exceed 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.
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 National Provider Identifier (NPI) and recipient ID before resubmitting the claim. • Verify that units are available on the approved authorization.

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact the Contact 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.