Nevada Medicaid and Nevada Check Up News

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Second Quarter 2025

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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,788,168,391.63 in claims during the three-month period of January, February and March 2025. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

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

Looking for Information?

Here are some great resources to help guide you to success!

- Nevada Medicaid has YouTube videos posted for various topics, including navigating our new Provider Flex tool and the Provider Web Portal: https://www.youtube.com/@nvmedicaid/playlists
- Billing Guidelines are posted for all provider types and contain information such as covered/ non-covered services, prior authorization requirements, and other provider type specific information- https://www.medicaid.nv.gov/providers/BillingInfo
- Provider Enrollment Information Booklet
- Enrollment Checklists

A New Enrollment Solution is Here!

Nevada Medicaid and the Gainwell Provider Training Team would like to invite all providers, delegates and staff to attend a Provider Flex Enrollment Overview training session. Please see Web Announcement 3647 for details and registration information.

Provider Flex-Enrollment Overview: This hour and a half training will provide step-by-step walkthrough instructions on how to properly fill out a Nevada Medicaid enrollment application using Provider Flex. Sessions are differentiated by individual, group, behavioral health individual (PT 14 and 82), and behavioral health group (PT 14 and 82) providers. Sessions will have a maximum registration of thirty (30) attendees and will include a question-and-answer portion at the end.

Please review our FAQ for a list of the most frequently asked questions about the Provider Flex tool.

Anonymous Survey of Compliance Officers

We need your help to improve health literacy in our state. For the first time, we are asking facility compliance officers to complete an anonymous survey about your language access and cultural competency efforts. For instance, here at Nevada Medicaid we offer translation, take cultural competency classes and we focus on using plain language and lowering reading levels for our member materials. Are you making similar efforts with social media, letters, forms, in-person translation or other facility materials?

We want to better track efforts across Nevada Medicaid service providers, learn from them, and ultimately improve health literacy. So, every two years, Nevada Medicaid will be asking compliance officers from each facility who serve Nevada Medicaid members to answer a few questions to demonstrate that they are working to meet the cultural and language needs of members. Since this is the first year of the survey, it will be a baseline for future years that can demonstrate improvement. Please do not complete the survey unless you are responsible for compliance at your facility. The survey is available here and responses are due by July 31, 2025.

The results of the survey will be included in the Nevada Medicaid 2026 Language Access Plan report. These reports are a requirement for all state agencies by Nevada Revised Statue 232.0081 with assistance from the Governor's Office of New Americans. That office is a valuable resource that may be able to assist you with your efforts. As required, a public meeting will be held prior to the publication of the 2026 Medicaid Language Access Plan report. To stay informed regarding public meetings, sign up for the Nevada Medicaid Updates email list and other lists here.

Last year's Nevada Medicaid Language Access Plan report can be found here. If you have questions, do not hesitate to reach out to CommunityAndProvider@DHCFP.nv.gov.

Nevada Health Authority is Official and DHCFP Becomes Nevada Medicaid Effective July 1, 2025

Carson City, NV - We are excited to announce that the Nevada Health Authority (NVHA) is officially on its way with the Governor's signature on June 11, 2025, to enact Senate Bill 494 and launched on July 1, 2025. The *Division of Health Care Financing and Policy* can now officially go by its common name *Nevada Medicaid*.

Take a look at the new websites for NVHA.nv.gov and Medicaid.nv.gov as part of this change.

The goals of this new Department have been resoundingly clear since the beginning: unify similarly aligned agencies to leverage the purchasing power of Medicaid, lower healthcare costs for Nevadans, bring more providers to the state, improve health care quality and streamline Medicaid eligibility.

To do that, the following teams, some of which were all or in part under the Nevada Department of Health and Human Services, will now be a part of the new Nevada Health Authority:

- Nevada Medicaid (formerly Division of Health Care Financing and Policy)*
- Medicaid eligibility from the Division of Welfare and Supportive Services*
- Patient Protection Commission*
- Public Employees Benefit Program
- Silver State Health Insurance Exchange (NevadaHealthLink.com)
- Office of Analytics*
- Governor's Council on Developmental Disabilities*
- Graduate Medical Education from the Governor's Office of Science, Innovation & Technology
- Waiver Provider Oversight from Aging and Disability Services Division*
- Health Care Quality and Compliance from the Division of Public and Behavioral Health*

* Previously all or in part under the Nevada Department of Health and Human Services.

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Nevada Health Authority… *Continued from page 2*

The NVHA transition team is hard at work behind the scenes meeting with impacted entities to ensure a seamless transition and that work will continue as normal. We would like to reassure state staff that this is simply a transition of authority. Positions and duties are expected to remain largely the same with business as usual. Our team is becoming stronger with complementary expertise to more effectively achieve shared goals over time.

We are committed to keeping Nevadans informed throughout the process with a new email list. Do you know someone who might like to be added? Sign up here.

Thank you for being a partner in the evolution of Nevada health care. Please visit nvha.nv.gov for additional information.

Attention All Providers: Top Prior Authorization Denial Reasons for the First Quarter of 2025

Nevada Medicaid and Gainwell Technologies, its fiscal agent, have reviewed all prior authorization (PA) submissions for the first quarter of 2025 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 Nevada Medicaid 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.
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.
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.

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Prior Authorization Denial Reasons… *Continued from page 3*

Denial Reason Description	Suggested Action to Avoid Future Denials
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 Level of Care (LOC) for this PA service type	Providers need to correct the LOC being requested or update the code being requested to match the LOC being provided. Providers should review their Provider Type Billing Guidelines for more information around LOC requirements.

Professional Claim Denial Reasons and Corresponding Resolutions/Workarounds

Nevada Medicaid and Gainwell Technologies, its 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.
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 Contact 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
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.
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.
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.
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 Customer Service Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511.
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.
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.

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Professional Claim Denial Reasons… *Continued from page 5*

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.
1010	3110	Rendering Prov not Member of Billing Prov Group	Providers 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 National Provider Identifier (NPI) is not linked, the provider should submit an update requesting linkage.
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 OPE Tool to be able to bill for dates of service. Visit the Provider Enrollment webpage for more information.
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 enrollment status via the Online Provider Enrollment (OPE) Tool . If not contracted, you will need to submit a new application to Nevada.

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Professional Claim Denial Reasons… *Continued from page 6*

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
3400	3400	Medicaid Cannot Pay for Vaccines Available Through VFC	Providers should verify that the recipient is between ages 0 and 18 at the time of service. Vaccines are covered for recipients within this age range by the Vaccines for Children (VFC) Program. For more information about the program, eligibility requirements, and provider requirements, please visit VFC Program.

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact the Gainwell Technologies 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 Nevada Medicaid 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.