

Nevada Medicaid and Nevada Check Up News



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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out, through claims and capitation payments, a total of \$1,908,534,165.62 during the three-month period of January, February, and March 2026. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

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

Participate in the Medicaid Advisory Committee (MAC)

The Nevada Health Authority (NVHA), Medicaid Division, is seeking members for the Medicaid Advisory Committee (MAC). The MAC is comprised of stakeholders, providers, managed care plans, patient advocates, and Beneficiary Advisory Council (BAC) members who share lived experiences. To address health-related social needs, the MAC also includes representatives from the Department of Human Services (DHS) sister agencies. The MAC will advise the State Medicaid Director on policy development and Medicaid program administration.

We're currently recruiting for:

- A member of a profession in the field of health care who is familiar with the needs of persons with low income, the resources required for their care and the availability of those resources.
- A person who holds a license to practice dentistry in the state.
- person who holds a license to practice medicine in the state; and is certified by the Board of Medical Examiners in a medical specialty.
- A person who holds a certificate of registration as a pharmacist in the state.
- An administrator of a hospital or clinic for health care.

Interested? Submit your application [here](#). For more information, visit the [Medicaid Advisory Committee \(MAC\) Homepage](#).

Reminder to Check Known System Issues

Providers are reminded and encouraged to regularly check the [Nevada Medicaid Known System Issues List](#). This list provides up-to-date information on current issues related to the Medicaid Management Information System (MMIS) that are impacting a significant number of providers.

Provider Enrollment Moratoria

Attention Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Home Health Agency (HHA), Hospice and Hospice, Long-Term Care Providers:

The Centers for Medicare & Medicaid Services (CMS) has implemented two six-month federal moratoria on new provider enrollments.

Effective February 27, 2026, new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) enrollment applications will be denied for the duration of the moratorium.

Effective June 11, 2026, new Home Health Agency (HHA), hospice and hospice, long-term care enrollment applications will be denied for the duration of the moratorium.

These restrictions do not apply to revalidations, changes of ownership, and updates to existing enrollments.

Nevada Medicaid has an enrollment moratorium exemption process in place for DMEPOS, HHA, hospice and hospice, long-term care applicants seeking to furnish services in areas where access to care concerns exist.

Applicants wishing to request a moratorium exemption must complete the appropriate form along with their online Nevada Medicaid enrollment application:

- DMEPOS: [DMEPOS Enrollment Moratorium Exemption Request Form](#)
- HHA, Hospice and Hospice, Long-Term Care: [Enrollment Moratorium Exemption Request Form - HHA & Hospice](#)

If you have any questions regarding the moratoria, please direct them to providerenrollment@nvha.nv.gov with the subject line: DMEPOS Moratorium or HHA, Hospice & Hospice, Long Term Care Group Moratoria

If you have questions regarding the Medicare DMEPOS Moratoria please visit: [Provider Enrollment Moratoria | CMS](#)

Nevada Medicaid Swift Revalidation of High-Risk Providers

On April 23, 2026, State Medicaid Agencies received notification from the Centers for Medicare & Medicaid Services (CMS) asking all states for their collaboration to conduct a “swift revalidation” of Medicaid providers who are considered to be an elevated risk for vulnerability to fraud, waste, or abuse. These providers will be required to complete revalidation within the next few months, regardless of the previously established 5-year or 3-year cycle. Revalidation is part of each state’s federal program integrity requirements.

Beginning in June 2026, Nevada Medicaid will initiate this “swift revalidation” process. Impacted providers shall begin receiving updated revalidation notices 60 days prior to their new revalidation due date. We encourage providers who receive notification to submit a complete revalidation request promptly to avoid any disruption in enrollment or claims payment.

*Impacted Provider Types/Specialties include:

- PT 19 - Skilled Nursing Facilities
- PT 29 - Home Health Agencies
- PT 33 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- PT 58/205 - Waiver for Persons with Physical Disabilities, Specialized Medical Equipment/Supplies

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Swift Revalidation... *Continued from page 2*

- PT 63 - Rehabilitative Residential Treatment Services
- PT 64 - Hospice
- PT 65 - Hospice, Long Term Care
- PT 93/708 - Opioid Treatment Program

Please note: High-Risk providers are subject to Fingerprint-Based Criminal Background Checks and Site Visits as a condition of participation.

To assist providers, Nevada Medicaid has prepared a [Frequently Asked Questions \(FAQs\)](#) document with additional guidance. The FAQ document will be updated as appropriate, so please check back as needed.

If you have additional questions about swift revalidations, please contact Gainwell Technologies Contact Center at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Pacific Time Monday through Friday.

We appreciate your cooperation and continued partnership as we work to maintain a high-quality, compliant provider network for Nevada Medicaid recipients.

Update Your Information Within 30 Calendar Days of Changes

Nevada Medicaid encourages all providers to review and update their demographic and enrollment information as needed. Instructions for completing demographics updates through the [Provider Web Portal](#) are available [here](#). Instructions for completing provider revalidations and updates through the [Provider Web Portal](#) are available [here](#).

This will help members find providers through the [Search Provider](#) feature, ensure accurate results and help Nevada Medicaid comply with state law regarding demographic reporting. A reminder that any changes must be reported to Nevada Medicaid within 30 calendar days ([Medicaid Services Manual \(MSM\) Chapter 100](#)).

Providers are also encouraged to keep their PWP user account information updated. Instructions for completing Provider Profile information through the Provider Web Portal are available [here](#) in section 1.6.

Transportation Support

Nevada Medicaid is here to support communities, members, and providers as they strive to provide members with transportation to appointments. Please find the flyer attached in [Web Announcement 3882](#) with helpful tips regarding transportation. You can print it and post it to help others too in offices, schools, and community centers. It is also posted [here](#) so that you can share it on social media, through email or other channels with your favorite relevant transportation image. Please note that many of the flyers on the page mentioned above are being updated to reflect the latest information and the Nevada Health Authority logo.

Attention All Providers: Top Prior Authorization Denial Reasons for the First Quarter of 2026

Nevada Medicaid and Gainwell Technologies, its fiscal agent, have reviewed all prior authorization (PA) submissions for the first quarter of 2026 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 medical necessity criteria OR Requested service does not meet Nevada Medicaid 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 Provider Web Portal (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.
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 PWP. Review Chapter 2: Eligibility Benefit Verification of the PWP 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.
Reconsideration request is denied for technical reasons; PA requirements were not met for submission within the required timeframe	Per Nevada Medicaid guidelines, a request for reconsideration of an adverse determination must be submitted within 30 days of the date of decision. Providers can reference Web Announcement 3747 for instructions on how to submit a PA reconsideration request properly.
Documentation Illegible	Ensure attached forms and supporting documentation are accurate and legible.
Recipient Benefit Plan is Hospice	Hospice providers must submit an FA-91 Form with all relevant fields completed. To process a discharge, the provider must also submit a signed physician discharge order and discharge summary.

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 Co-insurance, Deductible or Copay Due	Providers will need to verify the co-insurance, deductible or co-pay amount in the Medicare crossover details fields.
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.
1047	0205	Provider Terminated—DTL Performing	Providers should ensure that the performing NPI is enrolled with Nevada Medicaid for the dates of service. Providers should check their enrollment status via the Search Provider tool. If not contracted, you will need to submit a new application to Nevada Medicaid. Visit the Provider Enrollment webpage for more information.
1009	1009	Contract Could not be Determined	Providers should review the billing provider contract dates to verify that the provider is contracted with Nevada Medicaid for the dates of service listed on the claim. Providers may need to submit a new enrollment application to Nevada Medicaid via the Provider Flex tool to be able to bill for dates of service. Visit the Provider Enrollment webpage for more information.
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 PWP by reviewing the Member Eligibility tab, or by utilizing Gabby™ by calling the Gainwell Technologies Contact Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511.

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Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
1076	1012	Prov Contract not Valid on DOS – DTL (detail level date of service)	The billing provider is not contracted with Nevada Medicaid for the dates of service listed on the claim. If not contracted, providers should submit a new enrollment application to Nevada Medicaid via the Provider Flex tool to be able to bill for dates of service. Visit the Provider Enrollment webpage for more information.
1852	1852	Billing Provider Failed To Revalidate	Providers should review the billing provider contract dates to verify that the provider is contracted with Nevada Medicaid for the dates of service listed on the claim. Providers may need to submit a re-enrollment application to Nevada Medicaid via the Provider Flex tool unless they are within 365 days from the date of contract termination, wherein a re-validation application can be submitted via the PWP to be able to bill for dates of service upon approval. See Web Announcement 3369 as well as the Provider Enrollment webpage for more information.
1008	1508	Billing Prov is not a Grp/Performing is a Grp Prov	Providers should review claims to ensure that a Group National Provider Identifier (NPI) is listed as the billing NPI and that an individual NPI is listed as the rendering or performing provider.
1854	1854	Rendering Provider Failed To Revalidate	Providers should review the rendering provider contract dates to verify that they are contracted with Nevada Medicaid for the dates of service listed on the claim. Providers may need to submit a re-enrollment application to Nevada Medicaid via the Provider Flex tool unless they are within 365 days from the date of contract termination, wherein a re-validation application can be submitted via the PWP to be able to bill for dates of service upon approval. See Web Announcement 3369 as well as the Provider Enrollment webpage for more information.

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://nevadamedicaid.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.