Nevada Medicaid and Nevada Check Up News

Volume 21, Issue 4
Fourth Quarter 2024

Inside This Issue:

Speaking with Members in Plain Language

Nevada Medicaid staff recently used Plain Language guidelines to transform the Medicaid Welcome and Renewal letters sent to members. The goal of Plain Language is to make communications easy to understand. With Plain Language, members are more likely to take action to stay insured and be healthy. Nevada Medicaid is taking this approach with all member communications and striving for reading level targets of 6th grade or lower. Please share this fun video that explains the importance of plain language with your staff.

Providers who are interested in reviewing their existing and future communications for plain language standards, learning more and/or training to better communicate with members can visit the federal Plain Language website and Plain Language Association International. The Center for Health Literacy is also a good resource.

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,497,877,527.77 in claims during the three-month period of July, August and September 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.

Providers and Partners Asked to Share Flyers

Nevada Medicaid has created nearly 30 flyers and fact sheets for members and providers over the past three years. They help members and providers to stay informed. The Division of Health Care Financing and Policy (DHCFP) is working to upload all material to one web page. Providers and community partners can review, print, post and distribute them. Visit the Fact Sheets & Flyers web page from Nevada Medicaid today.

Nevada Medicaid is Implementing Multi-Factor Authentication Starting January 22, 2025

Multi-Factor Authentication (MFA) is an additional layer of security used to verify your identity when accessing the Provider Web Portal (PWP) and/or Pre-Admission Screening Resident Review (PASRR). Once MFA is implemented, login will require your username and password, along with a second form of verification, which will be a code sent to your mobile device.

Nevada Medicaid will be implementing MFA for all PWP and PASRR users on **January 22, 2025**. To enable MFA Providers will be required to select one of the following methods for authentication:

1. Mobile application (OKTA Verify or Google Authenticator)
2. Text Messages
3. Voice call

Although these changes will be effective on January 22, 2025, please review the following training materials that walk through the MFA process:

- EVS User Manual
- Parts 1 and 2 of the Using the Electronic Verification System (EVS) training videos on the Nevada Medicaid YouTube channel
- Frequently Asked Questions (FAQ)

Attention All Providers: Top Prior Authorization Denial Reasons

The Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid fiscal agent have reviewed all prior authorization (PA) submissions for the third 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 EVS portal. Review Chapter 2: Eligibility Benefit Verification of the EVS User Manual for more information.

Continued on page 3

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 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.
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.
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.

Continued on page 4

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 paya-ble 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.
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. Providers 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.
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.
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 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.

Continued on page 5

Professional Claim Denial Reasons… *Continued from page 4*

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
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.
2502	2590	Client Covered by Medicare B	The recipient has Medicare Part B. Charges must be billed to Medicare before billing Nevada Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of the explanation of benefits. For more information on submitting claims, please review the EVS User Manual Chapter 3: Claims.
1051	1504	Performing Provider not on Provider Database	Providers should ensure that the performing NPI is enrolled 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 Online Provider Enrollment (OPE) tool to be able to bill for dates of service. Visit the Provider Enrollment webpage for more information.
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.
1076	1012	Prov Contract not Valid on DOS – DTL (detail level date of service)	Indicates that the billing provider is not contracted with Nevada Medicaid for the dates of service listed on the claim. If not contracted, you will need to submit a new enrollment application to Nevada Medicaid. Visit the Provider Enrollment webpage for more information.
1048	0025	Provider Terminated – DTL DOS (detail level date of service)	Indicates that the billing or rendering provider is not contracted with Nevada Medicaid for the dates of service listed on the claim. If not contracted, you will need to submit a new enrollment application to Nevada Medicaid. Visit 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 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.