August 23, 2019

Announcement 1958

Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for June 2019 Claims

The Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid fiscal agent have reviewed all claim submissions for the month of June 2019 and have compiled a list of the top 10 reasons for which claims have denied. The table below lists the top 10 error codes for the claim denials, the error code descriptions and instructions to providers on how to resolve the claim denials.

Error Code on Remittance Advice	Error Code Description	Resolution or Workaround
4758	Billing PT/PS Rstcn (Provider Type/Provider Specialty Restriction) on Proc (Procedure) Coverage Rule	Providers must verify that the code being billed is payable by Nevada Medicaid. Providers can determine the covered codes by reviewing their Provider Type specific Rates Unit PDF. These can be located at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/ or Search Fee Schedule **For Waiver Providers Only:** If a Waiver provider receives the error code and the claim has been paid, the error code can be disregarded.
1082	Referring NPI (National Provider Identifier) cannot be the same as the Servicing NPI	Provider will need to review the claim to determine which NPI was duplicated and then resubmit the claim with the correct NPIs listed.
2003	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.
3001	Prior Authorization not Found	Verify that a prior authorization request has been submitted and approved. Verify the correct authorization number has been placed on the claim. Provider will also need to verify that the Dates of Service (DOS) match the time span of an approved authorization and that those DOS match the dates billed on the claim. Provider will also need to verify that the authorization number corresponds with the correct NPI and recipient ID before resubmitting the claim.

Error Code on Remittance Advice	Error Code Description	Resolution or Workaround
452	Calculated Detail Medicare Allowed Amount is Zero	Nevada Medicaid will pay up to the recipient's Medicare Co-Insurance and/or Deductible and if the Co-Insurance or Deductible that is listed on the claim equals zero (0), the claim will deny. Providers must confirm that the Co-Insurance and/or Deductible fields are properly filled out. If Medicare did not pay on the claim, the provider must submit the claim as a Fee-for-Service claim, not as a crossover, and indicate the correct Claim Adjustment Reason Code (CARC) at either the header or detail level of the claim. Please see Web Announcement 1941 for more information.
1048	Provider Terminated – DTL DOS	The NPI associated with the claim is not enrolled with Nevada Medicaid. Provider will need to enroll with Nevada Medicaid and the claim can then be resubmitted.
908	PAD (Physician Administered Drug) Detail Denied by PBM (Pharmacy Benefit 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. NDC information can be located at: https://www.medicaid.nv.gov/providers/ndc.aspx Providers may also reach out to the Pharmacy Benefits Manager at: 866-244-8554 (Pharmacy Help Desk)
5035	Exact Duplicate: Practitioner to Practitioner	Original claim submission was previously paid by Nevada Medicaid. Providers should review their previous Remittance Advice (RA) to determine when the original claim was paid.
1076	Prov (Provider) Contract not valid on DOS – DTL	Provider was not enrolled with Nevada Medicaid on the dates of service rendered to the recipient. Provider will need to be enrolled for the dates of service before resubmitting the claim. Providers can back date their applications or revalidations up to 365 days in order to cover the dates of service only in certain circumstances. If an application is being back dated between 180 and 365 days, sufficient documentation must be provided as to why the application is being back dated and timely filing is still applicable.
1009	Contract could not be determined – DTL	The dates of service on the claim submitted do not fall within the time frame that the provider's contract is active with Nevada Medicaid. Error code could also set due to the fact that the claim was submitted as an incorrect claim type. The provider will need to review their contract/internal records to determine if the dates of service listed on the claim fall within their active contracts. If the wrong dates of service were listed, submit a new claim. Providers should also review all other information listed on the claim to determine if the claim is valid for submission.