Nevada Medicaid and Nevada Check Up News

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Fourth Quarter 2019

Inside This Issue:

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,113,898,831.44 in claims during the three-month period of July, August and September 2019. Nearly 100 percent of current claims continue to be adjudicated within 30 days. Thank you for participating in Nevada Medicaid and Nevada Check Up.

Reminder:

Modernized Medicaid Management Information System (MMIS) Uses Only Electronic Processes

With the implementation of the new, modernized Medicaid Management Information System (MMIS) on February 1, 2019, the following items must be submitted electronically to Nevada Medicaid:

- Claims
- Claims Appeals
- Prior Authorization Requests
- Provider Enrollment Applications
- Provider Re-enrollment Applications
- Provider Revalidations
- Temporary Provider Enrollments

Effective October 1, 2019, the above items submitted on paper are securely destroyed by Nevada Medicaid and no longer returned to providers or their vendors.

For information concerning electronic submissions, please refer to Web Announcement 1733.

Nevada 837 Electronic Claims and Attachments Functionality Implemented

On November 4, 2019, the Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid fiscal agent implemented a web-based enhancement to allow providers and Trading Partners to submit 837 Health Care Claim claims electronically and upload attachments separately through the Provider Web Portal.

Full functionality is now in place for providers/Trading Partners to use.

Instructions for using this new functionality have been added to:

- the Electronic Verification System (EVS) User Manual Chapter 8: File Exchange and
- the Fee-for-Service Health Care Claim 837 Companion Guides for Dental, Professional and Institutional claims.

Diabetic Supplies to be Covered under Pharmacy Point of Sale (POS) System

Effective with dates of service on or after January 6, 2020, coverage of insulin systems/pumps and supplies and Continuous Glucose Monitors (CGM) has transitioned from being billed under Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) to being billed through the Pharmacy Point of Sale (POS) system. Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs has been updated to allow for coverage of insulin systems and supplies and CGM systems.

In conjunction with this change, the Division of Health Care Financing and Policy (DHCFP) created a list of preferred products. This will help the State lower diabetic supply expenditures without negatively affecting quality and access to care. Effective with dates of service on or after January 6, 2020, only the products below (and their corresponding test strips) will be covered. Recipients who are legally blind may obtain specialized monitors through the prior authorization process.

Preferred Supplies

Description	NDC
Preferred Continuous Glucose Monitors	
G6 SENSOR 3-PACK, RETAIL - US - 3	08627-0053-03
G6 RECEIVER KIT, RETAIL - US - 1	08627-0091-11
G6 RETAIL TRANSMITTER KIT, DEXCOM - 1	08627-0016-01
FreeStyle Libre 14-Day Reader	57599-0002-00
FreeStyle Libre 14-Day Sensor	57599-0001-01
Preferred Insulin Delivery System	
Omnipod Dash 5 pack Pods	08508-2000-05

A webpage devoted to the Diabetic Supply Program is located at: https://www.medicaid.nv.gov/providers/rx/diabeticsupplies.aspx

For complete coverage and limitations, see Medicaid Services Manual Chapter 1200 online at: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/

For billing questions, please contact the OptumRx Technical Center at (866) 244-8554.

Attention Provider Type 33 (Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies):

Update Regarding Claims Denied with Error Codes 1974 and/or 1022

Some claims for provider type 33 (Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies) were being denied in error with error code 1974 (OPR [Ordering, Prescribing, Referring] provider not enrolled) and/or error code 1022 (Referring NPI [National Provider Identifier] required) when the ordering NPI was entered appropriately with the "DK" qualifier. The issue was resolved on September 4, 2019, with updates to the Provider Web Portal. Fields have been added in the Provider Web Portal under "Service Details" labeled "Referring/Ordering Provider ID."

Claims that were denied in error will be automatically reprocessed. Providers do not need to resubmit or appeal the denied claims.

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, press Option 2 for providers, then Option 0 and then Option 2 for claim status. 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 "Resources" and then select "Telephone Directory" for the telephone number of the Administration Office you would like to contact.

Tips for Submitting Accurate Prior Authorization Requests

The following recent web announcements have provided tips of interest to all providers regarding prior authorization (PA) requests. These tips will assist providers with having fewer PA requests denied.

Web Announcement 2044: Prior Authorization Requests Denied for Overlapping Services

Nevada Medicaid providers must submit a Prior Authorization Data Correction Form (FA-29) to end services on a prior authorization (PA) if the recipient terminates services or discharges prior to the end date on the PA. If the FA-29 form is not submitted and the recipient seeks treatment elsewhere, the new PA may be denied due to overlapping services and cause delays in the recipient getting the needed services.

Web Announcement 2039: Resources to Use for Prior Authorization Issues or Questions

Nevada Medicaid providers are reminded the following resources are available when prior authorization (PA) issues or questions arise.

- For assistance with submitting a PA request or navigating the online prior authorization system, please contact the Nevada Medicaid Provider Services Field Representative team by sending an email to: NevadaProviderTraining@dxc.com.
- For questions related to PA policy, please refer to the Medicaid Services Manual Chapters, which are on the Division of Health Care Financing and Policy (DHCFP) website at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/.
- For questions related to PA guidelines, please refer to the Billing Manual, which is a reference for all provider types, or the specific Billing Guide for your provider type, which are on the Nevada Medicaid website at https://www.medicaid.nv.gov/providers/BillingInfo.aspx.

The Nevada Medicaid PA call center is available from 8 a.m. to 5 p.m. Pacific Time on business days to answer any questions that providers may have and are not addressed by using the above resources. The PA call center can be reached by calling (800) 525-2395.

Web Announcement 2021: Top Prior Authorization Denial Reasons for the Third Quarter of 2019

The Division of Health Care Financing and Policy and the Nevada Medicaid fiscal agent have reviewed all prior authorization (PA) submissions for the Third Quarter of 2019 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 DHCFP necessity criteria **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.
Additional information request not received **OR** Preauthorization request denied	Providers **must** review their 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.
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.
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 **OR** 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.

Attention All Providers:

Claim Denial Reasons and Resolutions/Workarounds to Assist Providers in Resolving Claim Denials

The Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid fiscal agent have reviewed all claim submissions for the month of November 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 along with the Explanation of Benefits (EOB) codes that appear 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
908	0908	PAD (Physician Administered Drug) Detail Denied by PBM (Pharmacy Benefits 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).
3959	1178	No Reimb (Reimbursement) Rule for Rev (Revenue) Code	Review the claim for any additional adjudication errors and make any necessary changes. Also review the recipient's dates of eligibility and Benefit Plans. Verify the dates of service associated with the claim.
451	0452	No Crossover Coinsurance or Deductible Due	Provider will need to submit a new claim using the regular Fee-for-Service claim along with the Medicare denial reason. See Web Announcement 1776 for more information.
3347	0609	No Payable Accommodation Code	Error code 3347 will typically post as a denial along with additional denial code(s). Providers must review their submitted claim and open the Adjudication Errors panel.
1070	1464	Procedure Missing on Outpatient Claim	Provider must enter a valid procedure code on the detail level of the claim and submit new claim.
1011	1011	Contract could not be determined – HDR (header level)	Providers must verify that the National Provider Identifier (NPI) being listed is under contract with Nevada Medicaid for the dates of service indicated on the claim.
4801	0116	No Billing Rule for Procedure	Verify that the code being billed is a payable code by Nevada Medicaid. User should review the Search Fee Schedule and/or the DHCFP Rates Unit page 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.

Continued on page 5

Claim Denial Reasons and Resolutions

Continued from page 4

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
3001	0192	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.
2017	0038	Client services covered by HMO (Health Management Organization) Plan	Verify the recipient's eligibility and submit the claim to the appropriate Medicaid Managed Care plan. Eligibility verification may be completed in the Electronic Verification System (EVS) by reviewing the Member Eligibility tab.

Known Modernization System Issues

Providers are reminded to review the Known Modernization System Issues list for updates on issues impacting claim processing. The link to the list is posted on the Modernization Project webpage under Known System Issues and Identified Workarounds. The link is also posted on the website in the upper right corner of each page under Notifications.

The top part of the Known Modernization System Issues list contains the descriptions and resolutions/ workarounds for issues that are currently being researched. The list provides the impacted provider types, procedure codes and error codes. When the issues are resolved, the list is updated with the date the claims were reprocessed, if applicable, and the issues are moved to the lower section of the document under Closed Issues.

Revalidate Timely to Avoid Provider Contract Termination

The federal regulation at 42 CFR 455.414 requires that state Medicaid agencies revalidate the enrollment of all providers, regardless of provider types, at least every five (5) years, with the exception of Durable Medical Equipment (DMEPOS) suppliers which must revalidate every three (3) years per 42 CFR 424.57 (g). Nevada Medicaid and Nevada Check Up providers will receive a letter notifying them when to revalidate. Providers are encouraged to revalidate within 60 days of the date on their notification to avoid termination. **Providers may revalidate up to a year in advance of their revalidation due date.**

Providers must revalidate online by logging into the Provider Web Portal through the Provider Login (EVS) link and click on the "Revalidate-Update Provider" link on the My Home page.

The Nevada Medicaid Provider Revalidation Report on the Provider Enrollment webpage lists each provider and the date their next revalidation is due. To avoid contract termination, your revalidation application must be processed and approved prior to the revalidation due date.