# Nevada Medicaid and Nevada Check Up News

Volume 20, Issue 4
Fourth Quarter 2023

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## Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,248,644,733.40 in claims during the three-month period of July, August and September 2023. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

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

***COVID-19 UNWIND:***

## Recipient Nevada Medicaid Disenrollments to Restart Effective January 1, 2024

Nevada Medicaid paused procedural terminations from October to December 2023 as a result of the Centers for Medicare & Medicaid Services (CMS) notice to states issued on August 30, 2023, and referenced in the September 15, 2023 Nevada Department of Health and Human Services (DHHS) Press Release.

Nevada Medicaid has successfully mitigated the compliance requirement and will be restarting recipient disenrollments effective January 1, 2024. See the press release dated December 11, 2023, regarding procedural denials for Medicaid resuming January 1, 2024. Renewal packets due for January 1, 2024, were mailed to households in November 2023. Packets that are not returned will result in recipients being disenrolled in Nevada Medicaid effective January 1, 2024.

Please continue to print, post and share this "Renewing Medicaid is Easy" flyer for recipients.

Providers with questions regarding unwind may visit the Division of Health Care Financing and Policy's Unwinding COVID-19 Information website or send an email to: DHCFP@dhcfp.nv.gov.

## *False Claims Act Initial Certification or Recertification Letters*

As part of the federal Deficit Reduction Act of 2005, all health care providers/entities receiving Medicaid funding of more than $5,000,000 annually are required to inform staff, contractors and agents about:

1) Federal and State False Claim Acts,
2) protections as whistleblowers, and
3) the organization's policies and procedures for detecting and preventing fraud, waste and abuse.

Initial Certification and Recertification letters for Nevada Medicaid Fee-for-Service providers/entities receiving a total net payment of more than $5,000,000 (based on Tax ID number) between October 1, 2022, and September 30, 2023, will be mailed on December 29, 2023.

These letters will be mailed via certified mail to the provider's/entity's mailing address on file with Nevada Medicaid and must be responded to with the requested information within 90 calendar days of December 29, 2023.

If you have any questions concerning a False Claims Act Initial Certification or Recertification letter received after December 29, 2023, please send an email to nevadamedicaidfca@gainwelltechnologies.com for assistance.

# New Provider Training Registration Portal Will Implement in January 2024

As providers were notified in Web Announcement 3217, the Nevada Medicaid Provider Training team announced that in January of 2024 a new training portal will be implemented that will be used for all training registration.

The new portal is called Absorb and is an industry-leading tool for learning management. Absorb will allow for effortless registration, simpler navigation and streamlined communication.

The monthly web announcements detailing upcoming training sessions will provide the link to the new Provider Training Registration Website. The link to the new website is also posted on the Provider Training webpage and the Provider Enrollment webpage.

If you have any questions about this new tool, please send an email to: nevadaprovidertraining@gainwelltechnologies.com.

# Reminder: Online Provider Enrollment (OPE) Updated to Allow All License/Certification Numbers and Information

Effective November 20, 2023, the Online Provider Enrollment (OPE) application was updated to allow providers to enter all applicable license/certification numbers and information during the enrollment process. This change applies to new enrollments, change updates and revalidation applications.

As a reminder, the license/certification number effective and end dates must match what is on file with the licensing board. For providers who are required to have a Secretary of State Business License, the formation date, i.e. date issued, and renewal date will now be required and must match what is on file with the Secretary of State.

Instructions for adding or entering license/certification numbers have been added to the OPE User Manual Chapter 2 – Initial Enrollment Application.

## Top Prior Authorization Denial Reasons for the Third Quarter of 2023

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 2023 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 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<br>**OR**<br>Requested service does not meet DHCFP necessity 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 request 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. |
| Recipient is no longer eligible for coverage<br>**OR**<br>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. |

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## *Top Prior Authorization Denial Reasons…* *Continued from page 2*

| 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 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. |
| Documentation illegible | Providers should re-review the information that was submitted to make sure that the documentation is clear, accurate and legible before submitting to Nevada Medicaid. |

# Professional Claim Denial Reasons and Corresponding Resolutions/Workarounds

The Division of Health Care Financing and Policy and the Nevada Medicaid fiscal agent review claim submissions to monitor the common reasons for professional claim denials. The table below lists the top error codes that 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 |
|---|---|---|---|
| 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 Electronic Verification System (EVS) User Manual Chapter 3: Claims. |
| 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.<br>Please visit Chapter 3: Claims of the EVS User Manual for more information. |
| 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.<br>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) | Provider will need to verify that the recipient is eligible for the dates of service and has the appropriate Benefit Plan.<br>This may be completed in the 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. |
| 4021 | 0698 | No CVG (Coverage) Rule for Procedure | Provider should verify that the code being billed is a payable code by Nevada Medicaid for the specific dates of service.<br>Review the Search Fee Schedule for more information. |

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## *Professional Claim Denial Reasons…* *Continued from page 3*

| 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.<br>Provider will need to verify that the NDC is a payable and covered code.<br>Providers may reach out to the Pharmacy Benefits Manager at: (800) 695-5526 or visit https://nevadamedicaid.magellanrx.com/home |
| 1010 | 3110 | Rendering Prov not Member of Billing Prov Group | Providers should review claims to ensure that the rendering physician is properly linked to the Billing Group for the dates of service.<br>Providers should check their linkage status via the Associated Providers tab of the EVS portal.<br>If not contracted, you will need to submit a new application to Nevada Medicaid. Visit the Provider Enrollment webpage for more information. |
| 1974 | 0030 | OPR (Ordering, Prescribing, Referring) Prov not Enrolled | OPR provider may need to submit an enrollment application to Nevada Medicaid via the Online Provider Enrollment (OPE) tool. For a list of provider types that require the OPR to be listed on the claim, refer to Web Announcement 2832. Visit the Provider Enrollment webpage for more information. |
| 2017 | 0038 | Client Services Covered by HMO Plan | Provider will need to submit the claim to the appropriate Nevada Medicaid HMO/Managed Care Organization (MCO) for processing.<br>Provider may find out which MCO the recipient belongs to by viewing the Member Eligibility tab in EVS or utilizing the ARS at (800) 942-6511. |
| 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.<br>Review the Search Fee Schedule for more information. |
| 1009 | 1009 | Contract Could not be Determined | Review provider contract dates to verify provider is contracted with Nevada Medicaid for dates in question.<br>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 | Provider should ensure that the performing National Provider Identifier (NPI) is enrolled with Nevada Medicaid for the dates of service. |

## 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, and press Option 2 for providers. 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.