Known Issues Updated on 07/03/2025 | Page 1

The Known Issues List provides up-to-date information on current issues related to the MMIS that are impacting a significant number of providers. This document is intended to provide a concise list of current problems identified/reported in recent months. Please note that this is an informational list only. The resolution priority of an issue is not determined by whether or not it appears on this list.

NOTES: Updated items or new items added this week will appear in bold text. Items are sorted by Open Issues, then Closed Issues below.

Known Issues-OPEN

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
188	**Claims, Professional, Professional Crossover, Provider Types 24 and 74**	**Claims submitted by provider types 24-*(Advanced Practice Registered Nurse)* and 74-*(Nurse Midwife)* for procedure codes that were updated per the 82nd Legislature SB 504 & 439 rate parity were not reprocessed to pay the correct rate in the reprocessing effort on 01/08/2025.**	• **Providers: No additional action needed.** • **Once resolved, claims will be automatically reprocessed.**	**07/08/2024**	**N/A**	**TBD**
186	Claims, Provider Type 33 (Durable Medical Equipment (DME), Disposable, Prosthetics)	Some claims processed between April 21, 2025, and April 28, 2025, may have denied inappropriately for Healthcare Common Procedure Coding System (HCPCS) codes for Provider Type 33-*(Durable Medical Equipment (DME), Disposable, Prosthetics)* with error code 5663-(*Amount Reduced by History Rental Payment*) when the HCPCS code is billed with a modifier other than RR or NU. **Update: Some claims were not reprocessed in the first reprocessing effort on June 3, 2025.**	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed. • **Claims that were not captured in the first reprocessing effort will be reprocessed automatically.**	04/23/2025 **06/24/2025**	04/28/2025	06/03/2025 **TBD**
185	Provider FLEX	Providers attempting to start a Change/Update or Revalidation application in the Provider Web Portal (PWP) are being routed to the Provider Flex Enrollment sign-in page.	• Navigate back to the Provider Web Portal and restart the application.	04/22/2025	TBD	N/A
184	Provider FLEX	Providers are unable to resume a Change/Update or Revalidation application that was started prior to the FLEX blackout period. When trying to resume the application, the page displays a spinning magnifying glass, and the system is having an issue routing the user to the proper application.	• Contact the Gainwell Contact Center by calling 877-638-3472.	04/22/2025	TBD	N/A

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182	Claims	Claims submitted with a National Drug Code (NDC) for covered adult vaccines are denying inappropriately with error code 868-(*HCPCS/NDC not a rebatable drug).* Adult vaccines are not rebatable but are a covered service.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	11/01/2024	04/21/2025	TBD
180	Claims, Provider Type 20-(*Physicians, M.D., Osteopath, D.O.*)	Some claims are denying inappropriately with edit 5081– *(Inpatient Visit Same Provider Specialty Same Day Not Allowed)* when another PT20 in a different provider group saw the member on the same day.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	06/06/2024	TBD	TBD
175	Claims, Outpatient	Provider Type 29-(*Home Health Agency and Private Duty Nursing Services)* claims that were not submitted through an Electronic Visit Verification (EVV) system between January 1, 2024, and March 19, 2024, may not have adjudicated correctly. As of March 19, 2024, PT 29 claims not submitted through an EVV system will deny with error code 749-*(EVV services must be submitted through an EVV system*).	• Providers: PT 29 is required to submit claims through an EVV system. • Nevada Medicaid will determine if claims will be automatically reprocessed.	03/19/2024	03/19/2024	TBD

Known Issues-CLOSED

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
1	Claims, Professional Claims	Claim will pend if the claim date spans across different Prior Authorization (PA) Line Items The claim will show edit *3009-(PARTIAL PA FOUND – EOB 0399)* on the Web Portal.	• Provider: No additional action needed. Once resolved, claims will be released for processing. • For any claims that were denied between 1/25/19 and 1/29/19 and not resubmitted that are now outside of timely filing, please resubmit the claim with an attachment referencing this ITW and the ICN# that was denied.	1/29/2019	2/28/2019	N/A
2	Prior Authorization	The Date of Decision for recipient eligibility is currently not available in the EVS system.	• Provider: Prior authorizations should continue to be submitted for review and decision. • Until further notice, the timely filing requirements for prior authorization(s) related only to retro-eligibility will not be applied. • Clinical requirements will still be enforced.	1/31/2019	2/18/2019	N/A
3	Claims, Dental Claims	Dental claims will deny when the rendering provider on the claim is not equal to the rendering provider on the history claim. The claim will show edit *5065-(Possible Duplicate)* on the Web Portal until this issue has been resolved.	• Provider: No additional action needed. Once resolved, claims will be released for processing.	2/2/2019	10/7/2019	2/19/2020
4	Claims, Inpatient and Outpatient Claims	Inpatient and outpatient claims will suspend when the date variables entered are incorrect. The claim will show edit *5006-(Possible Duplicate of a Previously Paid Claim/Detail)* on the Web Portal.	• Provider: No additional action needed. Once resolved, claims will be released for processing.	2/2/2019	2/6/2019	N/A
5	Claims, XOVOT (Crossover-Other) Claims	Crossover only claims are being denied at this time. The claim will show edit *4801-(Service Not Covered*) on the Web Portal.	• Provider: No additional action needed. Once resolved, claims will be released for processing.	2/2/2019	2/8/2019	2/8/2019

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6	Long-Term Care (LTC) Claims	LTC claims are being denied. The claim will show the following edits on the Web Portal: • *270-(Header Total Billed Amount Missing)* • *508-(HDR Billed AMT Not Equal to DTL Billed AMT SUM)*	• Provider: No additional action needed.	2/2/2019	2/2/2019	2/5/2019
7	IVR Eligibility Check Error	An error is occurring in the IVR when checking the eligibility for an National Provider Identifier (NPI) that has no taxonomy code associated to it.	• Provider: Use the Web Portal to validate eligibility.	2/1/2019	2/12/2019	N/A
8	Claim Submission & Provider Enrollment	Effective dates for some Providers' National Provider Identifier's (NPI) were incorrectly converted, which can cause an error to appear on the Web Portal when submitting claims. The claim will show the following edits on the Web Portal: • *1012-(Attending PROV Not Enrolled)* • *1974-(OPR PROV Not Enrolled)*	• Provider: No additional action needed. Once resolved, claims will be released for processing.	2/2/2019	2/3/2019	2/12/2019

9	Claims Submission, Other Insurance Information	An error is occurring when a user copies a claim that contains other insurance information, as the procedure code value is missing at the service detail line.
		
		The following error will appear until resolved: *SubmitClaim error – Error: System.NullReferenceException: Object reference not set to an instance of an object*
			• Provider:
			  ○ Option 1: Enter a new claim using the copy "recipient information" functionality, until a resolution is in place.
			  ○ Option 2: Enter a new claim without using the copy functionality, until a resolution is in place.
				2/5/2019	2/18/2019	N/A

10	Web Portal, Search Fee Schedule, Prior Authorization Criteria	The Search Fee Schedule and Prior Authorization Criteria was providing inaccurate information for certain codes, as follows: • Magnetic Resonance Imaging (MRI) • Magnetic Resonance Spectroscopy (MRS) • Magnetic Resonance Angiography (MRA) • Positron Emission Tomography (PET)	• Provider: Users can now use the Portal to confirm authorization requirements. • Claims paid without a PA are subject to reprocessing. • Provider may request a retro-active authorization.	2/1/2019	2/25/2019	2/25/2019

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11	Claims, H0004 & H2014	Claims reported with H0004-(*Alcohol and/or drug services*) and H2014-(*Skilled Training and Development, 15 minutes*) were paying an incorrect rate.	• Provider: No additional action needed. • Claims will be adjusted to pay the correct rate.	2/5/2019	2/7/2019	2/14/2019
12	Claim & Prior Authorization Submissions	An error may appear on the Web Portal when a user tries to create a Prior Authorization or Claim for a recipient with an apostrophe (‘) in their name.	• Provider: o *For Prior Authorizations*: Users can contact the call center regarding this issue. o *For Claims*: Please hold off on submitting these claims.	2/5/2019	2/19/2019	N/A
13	Provider Enrollment, API	Users that have an Atypical Provider Identifier (API) cannot access the Online Provider Enrollment (OPE) application for revalidation and change/update enrollment applications.	• Provider: Please hold off on submitting a revalidation and/or change/update. If this is an urgent request, please contact the call center.	2/6/2019	2/19/2019	N/A
14	Web Portal, Secure Correspondence	Delegate users cannot reply to secure correspondence messages submitted on the Web Portal.	• Provider: The delegate user can have the Admin/Provider user log-in and reply to the message or you can contact the call center.	2/6/2019	2/13/2019	N/A
15	Remittance Advice	Providers with multiple provider types associated to their National Provider Identifier (NPI) are unable to view all of their Remittance Advice (RA) documents on the Web Portal.	• Provider: Can contact the call center to obtain a copy of their RA.	2/7/2019	2/8/2019	N/A
16	Provider Enrollment, Revalidation and Change/Update Applications	Providers who try to complete their Revalidation and Change/Update Applications using the Online Provider Enrollment (OPE) tool may see an error on the “Request Information” panel that they cannot proceed to complete their application.	• Provider: Submit a New enrollment application, instead of submitting a Revalidation and/or Change/Update Application with a letter attached indicating that this is a Revalidation or Change Application. If this is an urgent request, please contact the call center.	2/7/2019	2/25/2019	N/A
17	Claims and Prior Authorization	Claims with multiple lines are not being validated through all of the lines when a Prior Authorization is approved for intervals. Claims denied inappropriately between dates: 1/29/2019 - 2/7/2019 with edit 3000-(*Units exceeds authorized units on prior authorizations)* will be reprocessed.	• Provider: No additional action needed.	2/7/2019	2/8/2019	2/8/2019

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18	Claims, Applied Behavior Analysis	Applied Behavior Analysis (ABA) Procedure Code: *97153-(Adaptive Behavior TX by Tech)* is missing from audit *5036-(Possible Duplicate Practitioner to Practitioner*), which is causing claims to deny.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/8/2019	2/12/2019	2/13/2019
19	Claims, Dental	The following dental codes were incorrectly end-dated and caused inappropriate claim denials for: • *D4341-(Periodontal Scaling and Root Planning)* • *D1206-(Topical Fluoride Varnish)*	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/9/2019	2/12/2019	3/1/2019
20	Claims	Claims may be denying inappropriately with the below error codes when billing across days: • 5611-(*24 Units Alwd/Day)* • 5537-(*One Unit Allowed Per Day)* • 5538-(*Thirty-Two Units Allowed Per Day)* • 5539-(*Eight Units Allowed Per Day)* • 5603-(*Eight Units Allowed per Day)* • 5608-(*16 Units Allowed Per Day – PA override*) • 5622-(*One Unit Allowed Day Per Day)* • 5649-(*One Unit Allowed Per Day)* • 5686-(*4 Units Allowed Per Day-PA Override)*	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/9/2019	2/11/2019	2/9/2019
21	Claims	Code 92133-*(Cmptr Ophth img optic nerve)* was incorrectly end-dated and caused inappropriate claim denials.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/10/2019	2/22/2019	2/21/2019
22	Claims	Code Q3014-(*Telehealth Facility Fee)* was incorrectly end-dated and caused inappropriate claim denials.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/10/2019	2/12/2019	2/14/2019
23	Pregnant Women, Medicare Eligibility	All Eligibility Verification Responses are returning Qualified Medicare Beneficiary (QMB) and Special Low Income Medicare Beneficiaries (SLMB) as benefit plans for all pregnant women.	• Provider: Medicare enrollment information is available on the "Other Insurance Details" of the EVS response, IVR and EDI 271. • The "Other Coverage Details" page will display if the recipient actually has Medicare Coverage. If no coverage is displayed, then they do not have Medicare Coverage.	2/8/2019	2/27/2019	N/A

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24	Claims, Physician and Outpatient Claims	Physician and Outpatient claims are suspending for edit 7200-(*Miscellaneous Claims Xten Error*) when the clinical claims editor (ClaimsXten) is unable to process the claim.	• Provider: No additional action needed. • Once resolved, claims will be released for processing.	2/9/2019	3/25/2019	3/25/2019
25	Claims, Professional	Professional crossover claims for mass resubmissions are causing inappropriate claim denials for edit: 452-*(Calculated Detail Medicare Allowed Amount is Zero),* as the Medicare information is not getting copied from the original claim to the resubmitted claim.	• Provider: No additional action needed. Once resolved, claims will be reprocessed.	2/9/2019	2/26/2019	2/26/2019
26	Claims, Appeals	Providers appealing converted legacy system claims by using secure correspondence are receiving an error when trying to use the legacy system's denial code reason(s).	• Provider: Select a denial code that has a similar denial reason that was used in the legacy system and put the actual code in the message of the secure correspondence to process your claims appeal.	2/11/2019	2/13/2019	N/A
27	Prior Authorizations, NOD Letters	Some blank Provider Notification of Determination (NOD) letters were sent that did not include details related to the service and the decision status.	• Provider: Use the Web Portal to review the PA determination. If there are additional questions, please contact the PA call center.	2/13/2019	3/11/2019	N/A
28	Provider Enrollment, Individuals Linking to a Group	An error may appear on the Web Portal when trying to link a National Provider Identifier (NPI) to a Group Provider when using an active group with inactive members. The following error may appear until resolved: "*The NPI you are trying to add is not valid. It may not be a valid Group NPI or it has been disabled or end dated."*	• Provider: Attach a document with a written request to link to a group on the enrollment application.	2/7/2019	3/4/2019	N/A
29	Claims Submission, Other Insurance Information	Claims are denying inappropriately for Edit 2504-*(Client Covered by Private Insurance)* that has diagnosis code Z00129-*(Encounter for routine child health exam).*	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/13/2019	2/27/2019	2/26/2019
30	Claims, Non-Covered Code	Claims are denying inappropriately for Procedure Code 94618-*(Pulmonary Stress Testing),* as the code is incorrectly listed as a non-covered code.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/13/2019	3/1/2019	2/27/2019

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31	Prior Authorization, PCS	Some of the Personal Care Services (PCS) service plans are displaying an incorrect provider name.	• Provider: No additional action needed. • Nevada Medicaid is e-mailing the service plan information to the Provider with a note when the Provider name was displayed in error. • There is no impact to PA or Claims.	2/20/2019	3/4/2019	N/A
32	Claims, Advanced Practice Registered Nurses and Physician's Assistant	Some claims may be denying inappropriately for Provider Types: 24-*(Advanced Practice Registered Nurses)* and 77-*(Physician's Assistant)* regarding procedure code 99224-(*Subsequent Observation Care).* The claim will show the following edits on the Web Portal: • 5051-(*Possible Duplicate of Previously Paid Claim/Detail*) • 5004-(*Claim/Detail Conflicts with Previously Paid Service on Same or Overlapping DA*)	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/21/2019	3/9/2019	3/9/2019
33	Claims, Behavioral Health	Some claims may be denying inappropriately for Provider Type 82-*(Behavioral Health Rehabilitation Treatment)* for H0002-(*Alcohol and/or Drug screening)* and H2012-*(Behavioral health day treatment per hour) for the following codes:* • 300-(*Qualified Mental Health Professional*) • 301-*(Qualified Mental Health Associate Specialties)* The claim will show edit 4150-*(Rendering Provider is not certified to perform procedure billed)* on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/21/2019	3/1/2019	3/1/2019

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34	Claims, Residential Treatment Centers and Hospital, Outpatient	Some claims may be denying inappropriately for Provider Types: 63-(Residential Treatment Centers) and 12-(Hospital, Outpatient). The claim will show the following edits on the Web Portal: • 5051-(*Possible Duplicate of Previously Paid Claim/Detail*) • 5004-(*Claim/Detail Conflicts with Previously Paid Service on Same or Overlapping DA*)	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/23/2019	3/14/2019	3/14/2019
35	Claims, PCS	Some claims may be denying inappropriately for Personal Care Services (PCS) as possible duplicates. The claim will show edit 5034-(*Possible Duplicate: PCS to PCS*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/23/2019	3/1/2019	3/1/2019
36	Claims, PCS	Some claims may be denying inappropriately for Personal Care Services (PCS) Providers for Third Party Liability (TPL) editing. The claim will show edit 2504-(*Client Covered By Private Insurance*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/25/2019	3/1/2019	3/1/2019
37	Claims, Dental and Professional	Some users are receiving an error ("*Unable to process your claim*") on the Web Portal when trying to adjust Dental and Professional claims with multiple diagnosis pointers.	• Provider: Please hold off on submitting these claim adjustments. Please check back frequently for updates.	2/26/2019	3/4/2019	3/4/2019
38	Claims, Prior Authorization	Historical utilization of Prior Authorizations (PA) are causing some claims to pay additional units, which exceeds the PA allowed units.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed and overpayments will be recouped, as applicable.	2/19/2019	3/6/2019	3/6/2019
39	Claims, Dental	Some dental claims may be denying inappropriately for Provider Type 22-(*Dentist*) under procedure code: D8660-(*Preorthodontic treatment examination*). The claim will show edit 5510-(*One Unit Allowed per Lifetime*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/21/2019	3/1/2019	3/1/2019

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40	Claims, Special Clinics, School Based Health Centers	Some claims are denying inappropriately for Provider Type 17, Specialty 174-(*Special Clinics: School Based Health Centers (SBHC)),* as the rate was end dated in error. The claim will show edit 3958-(*No Reimbursement Rule for Procedure*) on the Web Portal.	• Provider: <u>No additional action needed.</u> • Once resolved, claims will be automatically re-processed.	2/28/2019	3/5/2019	3/5/2019
41	Claims, Other Insurance	An error may appear on the Web Portal that prevents some claims from getting submitted online when the user selects the "Other Insurance" option. The following error may appear until resolved: "*We had a problem processing last request*."	• Provider: <u>Please hold off on submitting these claims, if you receive this error message. Please check back frequently for updates.</u>	3/4/2019	3/11/2019	N/A
42	Claims, Prior Authorization Member ID	Some claims are not denying appropriately when the Member ID used on the claim does not match the Member ID on the Prior Authorization (PA), which causes the claim to be paid against the wrong Member ID. Future claims submitted using the same PA may deny because all of the units have been used.	• Provider: <u>Please validate you are using the correct member ID's PA on the claim submission.</u> • Once resolved, claims will be automatically re-processed and units on the PA will be adjusted.	3/1/2019	3/28/2019	3/28/2019
43	Claims, CLIA License Number	Some claims are denying inappropriately as the system is currently only looking at the Billing Provider ID to find a valid CLIA License Number, instead of the rendering Provider CLIA License Number. The claim will show edit 4208-(*CLIA License number Invalid*) on the Web Portal.	• Provider: <u>No additional action needed.</u> • Once resolved, claims will be automatically re-processed.	2/27/2019	4/8/2019	4/8/2019

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44	Claims, EPSDT	Some claims are denying inappropriately for services covered under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) program when submitted with an approved authorization that includes pricing. The claim could show the following edits on the Web Portal: • 4149-*(Billing provider is not certified to bill service)* • 4150-*(Rendering provider is not certified to perform procedure billed)* • 4871-*(Procedure code is not billable on this claim type)*	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	3/6/2019	3/11/2019	3/15/2019
45	Claims, Crossover	Some Medicare claims are denying inappropriately when the claim is a crossover to Medicaid without a payment from Medicare due to deductible or if the service is denied by Medicare for dual eligible members. The crossover claim(s) will show edit 0452-(*Calculated detail Medicare Allowed Amount is Zero*) on the Web Portal. The non-crossover claim(s) will suspend with Edit 2500-(*Client covered by Medicare A*) or Edit 2502-(*Client covered by Medicare B*) as appropriate for review of the attachments.	• Provider: Please resubmit denied claims via the Web Portal, along with a copy of the Medicare EOB (Explanation of Benefits) and remark codes/descriptions.	2/26/2019	3/14/2019	N/A
46	Claims, Healthcare Common Procedure Coding System	Some claims with Healthcare Common Procedure Coding System (HCPCS) codes for members over the age of 21 were priced incorrectly, as the Pediatric Enhancement Rate was used instead of the Adult Rate, which is causing an overpayment. The Pediatric Enhancement Rates are also displaying the incorrect reimbursement amounts on the Provider Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed and overpayments will be recouped, as applicable.	3/8/2019	3/25/2019	3/25/2019

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47	Dental Claims	Some claims for bitewing images are being denied incorrectly when billed within 6 months of periapical images with error code 6126-(*Dental Services Not Allowed within Six Rolling Months*). Bitewing Images Procedure Codes: • D0270-(*Dental Bitewing Single Film*) • D0272-(*Dental Bitewings Two Films*) • D0273-(*Dental Bitewings Three Films*) • D0274-(*Dental Bitewings Four Films*) • D0277-(*Vert Bitewings-Sev to Eight*) Periapical Images Procedure Codes: • D0210-(*Intraoral Complete Series of Radiographic Images*) • D0220-(*Intraoral Periapical First File*) D0230-(*Intraoral Periapical EA Add Film*)	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	3/20/2019 and 4/1/2019	8/19/2019	11/8/2019
48	Claims, Category of Service	Some claims are suspending with edit 931-(*Internal Error-Fund Code Assignment Failed*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	3/27/2019	5/6/2019	5/8/2019
49	Claims, DME	Some claims are denying inappropriately for Healthcare Common Procedure Coding System (HCPCS) codes for Provider Type 33- (*Durable Medical Equipment (DME), Disposable, Prosthetics*). The claim will show edit 4801-(*No Billing Rule for Procedure*) on the Web Portal until this issue has been resolved.	• Provider: No additional action needed. • Once resolved, claims will be released for processing.	4/2/2019	5/21/2019	5/21/2019
50	Claims, Provider Type 44 (Swing Bed, Acute Hospital)	The Provider Type 44 Billing Guidelines informs providers to submit with Type of Bill 0281-(*Skilled Nursing Facility-Swing Beds, admit through discharge claim*), which is not an available option on the Web Portal at this time.	• Provider: Submit your claim via EDI. • After the issue is resolved, providers with claims outside of timely filing as a result of not being able to submit will need to submit on the Web Portal including an attachment requesting review of timely filing per Known Issue #50.	4/9/2019	5/20/2019	N/A

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51	Claims, Managed Care, NDC (National Drug Code)	When a member is enrolled with a Medicaid Managed Care Organization (MCO), all details on outpatient or outpatient cross-over claims are being denied correctly with error code 2017-(*Client services covered by HMO*), except for Physician-Administered Drug (PAD) claim details. The PAD details billed with National Drug Codes (NDC) are being paid in error, as the service should also be denied with error code 2017-(*Client services covered by HMO*).	• Provider: No additional action needed.	4/12/2019	5/1/2019	6/25/2019
52	Claims, CPT Code 99475	Some claims billed with CPT code 99475-(*Initial Inpatient Pediatric Critical Care*) are being denied incorrectly with error code 4714-(*Age restriction on billing rule*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/8/2019	5/6/2019	6/24/2019
53	Claims, PT 13 (Psychiatric Hospital, Inpatient)	Some claims for Provider Type 13 are being denied incorrectly with error codes 4151 (Billing PT/PS Restriction on Revenue Code Billing Rule) and 4712-(*Age Restriction on Revenue Code Billing Rule*). Claims should be payable for members age 0-20 or 22 if the member was receiving services prior to turning age 21, and for members age 65 and older.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/10/2019	6/17/2019	6/27/2019
54	Claims, CPT Codes 01967 and 01968	Some claims billed with CPT codes 01967-(*Neuraxial labor analgesia/anesthesia for planned vaginal delivery*) and 01968-(*Anesthesia for caesarean delivery following neuraxial labor analgesia/anesthesia*) are pricing incorrectly.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/12/2019	4/25/2019	7/19/2019
55	Claims, Prior Authorization	Some claims are denying inappropriately with error codes 3008-(*Prior Auth Service Conflict*) and 3026-(*Modifier Does Not Match PA*) when the service and modifier billed on the claim do match the Prior Authorization (PA).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/12/2019	N/A	6/24/2019

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56	Claims, HCPCS Code H2011-GT	Some claims billed with the code H2011- (*Crisis Intervention service, per 15 minutes*) and modifier GT-(*Via interactive audio and video telecommunications systems*) are being denied incorrectly with error code 7270- (*Invalid procedure modifier combination*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/19/2019	6/3/2019	12/11/2019
57	Claims, Medicare Crossover Claims	Some claims are suspending with error code 931-(*Internal error-fund code assignment failed*) when Medicare crossover claims are received with a payment from Medicare, and Nevada Medicaid does not have a record of the member having Medicare.	• Provider: No additional action needed. • Claims that suspend with error code 931 are reprocessed on a weekly basis.	4/17/2019	6/17/2019	N/A
58	Claims, Provider Type 65 (Hospice Long Term Care)	Some claims for Provider Type 65-(*Hospice Long Term Care*) submitted with a Patient Status of 41 indicating that the patient expired in the medical facility are being denied incorrectly with error code 572-(*Accommo-dation units not equal to header data range*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/25/2019	4/06/2020	5/27/2020
59	Claims, EDI (Electronic Data Interchange) Claims	New Electronic Data Interchange (EDI) claims submitted with a frequency code of “6” in Loop 2300, Segment REF02 is resulting in claims not completing the adjudication process when the initial claim has already been voided.	• Provider: For providers submitting claims through EDI and a claim has already been voided or denied, do not utilize frequency code “6” when resubmitting the claim. A new edit will be implemented to deny these claims. Providers are advised to utilize frequency code “1” in Loop 2300, Segment REF02 instead. • Once the new edit has been implemented, the impacted claims will be denied. • Providers will need to resubmit their claims. • The EDI Companion Guide will be updated appropriately.	5/6/2019	8/5/2019	N/A

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60	Claims, Institutional Claims	Some institutional claims are being denied incorrectly with error codes 676-(*Date of service exceeds timely filing)* and 677-(*Timely filing limit exceeded*) when the through date of service at the header level is within timely filing.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/8/2019	6/17/2019	N/A
61	Claims	Some claims with CPT codes that were new in 2018 and submitted prior to the recycle reflected on August 17, 2018, remittance advices (Web Announcement 1662) are still showing as denied status with error codes 210-(*No rates on file*) and 309-(*Services not covered) incorrectly*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/6/2019	7/24/2019	7/24/2019
62	Claims	Some claims have been denied incorrectly with error code 3383-(*Sterilization consent form required – header level*) and/or 3384-(*Sterilization consent form required – detail level*) when a sterilization consent form was attached to the claim.	• Provider: No additional action needed. • Any claims with sterilization consent forms attached that were incorrectly denied with these error codes prior to 7/15/2019 can be resubmitted within timely filing. • Any claims submitted with sterilization consent attached that were incorrectly denied with these error codes prior to 7/15/2019 that are outside of timely filing as a result can be resubmitted with an attachment referencing this Known Issue and the ICN# that was denied.	5/1/2019	7/15/2019	N/A
63	Claims, All Provider Types including Provider Type 85 (Applied Behavior Analysis)	Some claims for all provider types including Provider Type 85-(*Applied Behavioral Analysis*) have denied or cutback incorrectly with error code 155-(*Prior authorization required*) as referenced in Web Announcements 1794 and 1803.	• Provider: No additional action needed.	12/20/2017	5/23/2019	5/22/2019 & 5/23/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
64	Claims, Provider Type 32 (Ambulance Air or Ground)	Some claims for Provider Type 32-(*Ambulance Air or Ground*) have denied incorrectly with error codes 4531-(*Procedure denied as duplicate to another current procedure*) / 4532-(*Procedure denied as duplicate to another historical procedure*) or 5056-(*Same procedure different modifiers, same date*), when there is more than one transport service on the same date of service.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed. • See Web Announcement 2431 for updates.	1/14/2019	10/05/2020	02/11/2021
65	Claims, Waiver Providers	Some claims for the below waiver provider types have been denied incorrectly with error code 4014-(*no pricing segment on file*). • 38-(*Home & Community Based Waiver-Individuals with Intellectual Disabilities and Related Conditions*) • 48-(*Home & Community Based Waiver for the Frail Elderly*) • 58-(*Waiver for Persons with Physical Disabilities*) • 59-(*Home & Community Based Services Waiver for the Elderly-Augmented Personal Care Services*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/29/2019	6/24/2019	7/1/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
66	Claims, Institutional Crossover Claims	Providers are not seeing Claims Adjustment Reason Codes (CARC) 23-(*The impact of prior payer(s) adjudication including payments and/or adjustments*) on the 835 file for Medicare bad-debt. In the previous MMIS system, Institutional crossover pricing adjustment amounts were made under two explanation of benefits (EOB)s: • ACA-CONTRACTUAL ADJUSTMENT to indicate what Medicaid allowed for the service (which was tied to CARC 45) • ATP-THIRD PARTY PAYMENT to reflect the adjustments made for Medicare payment. (which was tied to CARC 23) In the new MMIS, the institutional crossover pricing adjustments amounts are under a single EOB 9915 Medicare crossover claim cutback applied, which is tied to CARC 45-(*Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed to allow the institutional crossover claims to apply two separate EOB's with the appropriate CARC's	5/6/2019	7/19/2019	10/3/19
67	Financial, Payment Number Issue	Some check numbers and check status are showing in error on the remittance advice (RA), as some are showing check numbers from the prior year as uncashed.	• Provider: No additional action needed. • We are working to resolve this issue for future RA's created.	6/19/2019	10/07/2019	N/A
68	Claims, Institutional	Claims submitted through a clearinghouse with a Diagnosis Related Group (DRG) will not copy appropriately for resubmission via Direct Data Entry (DDE) on the Provider Web Portal, as DRG is not currently utilized by Nevada Medicaid. Claims that are copied and resubmitted with DRG are being denied with error code 4040-(2nd diagnosis code not on file).	• Provider: When resubmitting claims initially submitted through a clearinghouse with a DRG via DDE on the Provider Web Portal, providers are advised to confirm that the DRG is removed from the 2nd diagnosis field and appropriate ICD-10 diagnosis codes are included.	5/29/2019	6/27/2019	N/A

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
69	Claims, Professional	Some claims for the Healthcare Common Procedure Coding System (HCPCS) below are denying incorrectly with the error codes 4014-(*No pricing segment on file*), 4021-(*No cvg rule for procedure*) and 4209-(*No pricing segment for proc_mod combo*) when the service is billed with the (KU) modifier: E0705, E0951, E0955-E0957, E0960, E0973, E0978, E0981, E0982, E0985, E0995, E1002-E1008, E1010, E1016, E1020, E1028, E1029, E2207-E2210.	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	5/30/2019	7/9/2019	7/26/2019
70	Claims, Physician Administered Drug	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) codes J9019-*(Injection, asparaginase 1,000 IU*), J7205-(*Injection Factor VIII Fc fusion protein per IU*), J7207-*(Injection, Factor VIII, antihemophilic factor, recombinant, PEGylated, 1U*) and CPT 90674-(Vaccine for influenza administration into muscle 0.5 ml dosage), are being denied incorrectly with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table*).	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	5/17/2019	5/20/2019	7/19/2019
71	Claims, Physician Administered Drug	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) code J7297-(*Levonorgestral-releasing intrauterine contraceptive system*) are being denied incorrectly with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table).*	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	6/11/2019	7/15/2019	12/12/2019
72	Claims, Physician Administered Drug	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) code J9145-(*injection, daratumumab 10mg*) are being denied incorrectly with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table).*	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	6/28/2019	7/15/2019	12/12/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
73	Claims, Physician Administered Drug	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) code J6786-(*Treprostinil, inhalation solution, FDA-approved final product, non-compunded, administered through DME, unit dose form, 1.74 mg*) are being denied incorrectly with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table).*	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/1/2019	7/15/2019	8/9/2019
74	Claims, Professional	Some claims billed with Healthcare Common Procedure Coding System (HCPCS) L1851-(*Knee orthosis KO, double upright, thigh and calf, with adjustable flexion and extension joint, with or without varus/valgus adjustment, prefabricated. Off the shelf*) and modifier NU are being denied incorrectly with error code 6000-(*Manual pricing required*).	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	6/14/2019	8/12/2019	8/30/2019
75	Claims, Professional Claims	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) L4360-(*walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise*) have denied incorrectly with error code 3001-(*Prior authorization not found*). Prior Authorization is not required for this service.	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	6/17/2019	7/9/2019	N/A
76	Claims	Some claims billed with the ICD-10 diagnosis code H40.1234-(*open angle glaucoma, low tension, bilateral, indeterminate stage*) as the primary/principal/first listed diagnosis code are being denied incorrectly with error code 4039-(*diagnosis cannot be used as principal diagnosis*).	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	5/28/2019	7/29/2019	8/16/2019
77	Claims, Dental	Some claims for orthodontia services are being denied incorrectly with error code 0463-(*enrolled in DBA*).	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	2/12/19	7/18/2019	7/18/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
78	Claims, Dental	Some claims billed with CDT codes D0367-(*cone beam CT capture and interpretation with field of view of both jaws, with or without cranium*), D7240-(*removal of impacted tooth-completely bony*), D7210-(*extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap*) and D3220-(*therapeutic pulpotomy excluding final restoration, removal of pulp coronal to the dentinocemental junction and application of medicament*) are denying incorrectly with error code 1009-(*contract could not be determined*).	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	5/22/2019	7/19/2019	7/19/2019
79	Claims, Institutional	Additional clarification concerning claims denied with error code 3347-(*No payable accommodation code*). If all of the accommodation revenue codes on the claim are denied for any reason at the detail (for example, error code 3001-(*Prior authorization not found*), then edit 3347 will post at the header to deny all details on the claim. Claims for inpatient services including Skilled Nursing Facilities must have at least one payable accommodation revenue code on the claim.	• Provider: Review all edits posted to the claim at the detail level, make appropriate corrections and resubmit the claim within timely filing.	6/28/2019	9/16/2019	N/A
80	Claims, Dental	Some dental claims are being denied incorrectly with error code 5065-(*Possible duplicate; dental to dental*) when the rendering provider on the claim is different than rendering provider on the history claim. *[This is a duplicate issue to item #3]*	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed to reflect the correct error code 5064 to indicate that the service is a duplicate of a claim submitted by another rendering provider.	5/21/2019	10/7/2019	02/19/2020
81	Claims, Professional	Some claims billed with the HCPCS V2020-(*Frames, purchases*), V2107-(*Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens*) and V2108-(*Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00 sphere, 2.12 to 4.00d cylinder, per lens*) being denied incorrectly with error code 4021-(*No cvg rule for procedure*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	6/20/2019	7/29/2019	8/9/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
82	Claims, Professional	Some claims billed with the HCPCS A4623-(*Tracheostomy, inner cannula*), and E0971-(*Wheelchair anti-tipping device*), have denied incorrectly with error codes 5551-(*Two units allowed per rolling month-PA override*), 5584-(*One unit allowed per rolling 60 months-PA override*) and/or 5638-(*Two units allowed per rolling month*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/22/2019	8/19/2019	8/30/2019
83	Claims, Provider Type 33-DME	Some claims for PT 33-(*Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies*) are being denied incorrectly with error codes 1974-(*OPR provider not enrolled)* and/or error code 1022-(*Referring NPI required*) when the ordering NPI is entered appropriately with the "DK" qualifier.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/21/2019	9/4/2019	9/5/2019 and 1/14/2020
84	Claims, Provider Type 47-Indian Health Program	Some x-over claims submitted by Provider Type 47-(*Indian Health Services (IHS) and Tribal Clinics*) are being reimbursed incorrectly for only the Medicare coinsurance and/or deductible amounts.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/17/2019	7/29/2019	12/11/2019
85	Claims, Professional and Institutional Claims	Some claims for sterilization related services, requiring a sterilization consent to be attached to the claim, have been denied incorrectly with error codes 3383-(*Sterilization form required-header*) and/or 3384-(*Sterilization form required-detail*) when the physician or facility name on the consent form did not correspond with the claim. The physician and facility name must be completed on the sterilization consent form, but are not required to correspond with the claim being submitted.	• Provider: Please resubmit claims denied for this reason within timely filing or within 60 calendar days of July 19, 2019; whichever is later. Please include an attachment referencing this Known Issue for review.	5/22/2019	7/15/2019	N/A
86	Claims	Some claims submitted for laboratory services requiring a Clinical Laboratory Improvement Amendments (CLIA) license number are being denied incorrectly with error code 4208-(*CLIA license number invalid*), when the CLIA license number is valid and on file for the rendering provider.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/2/2019	03/02/2020	09/23/2020

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
87	Claims	Some claims submitted with the Healthcare Common Procedure Coding System (HCPCS) code A4456-(*adhesive remover, wipes*) are being denied incorrectly with error code 5512-(*one unit allowed per 3 rolling months*). The correct limitation for A4456 in 50 units per rolling month.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/18/2019	12/16/2019	03/31/2020
88	Claims	Some Medicare crossover inpatient claims are being denied incorrectly with error code 5050-(*Possible dupe: inpatient vs NF or ICIID*).	• Provider: Please resubmit inpatient crossover claims denied in error between 1/28/19 and 10/28/19 with error code 5050-(*Possible dupe: inpatient vs NF or ICIID - when the inpatient claim did not require a prior authorization due to Medicare coverage*) within timely filing. Any claims that have exceeded timely filing as of 1/29/2020 must be submitted with a cover letter referencing this Known Issue and be submitted within 60 calendar days of 1/29/2020.	6/28/2019	10/28/2019	N/A
89	Claims	Some dental claims submitted with the code D2930-(P*refab stnlss steel crwn pri*) are being denied incorrectly with error code 6110-(*Dental SVCS allowed per lifetime*) when the service is rendered for the same tooth numbers.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/20/2019	12/23/2019	04/29/2020
90	Claims	Some claims submitted between 6/7/19 and 7/18/19 have being denied incorrectly with error code 4200-(*Claim priced at zero*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/16/2019	7/19/2019	09/12/2019
91	Claims, Physician Administered Drug	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) code J7175 (injection Factor X, human 1 IU) are being denied incorrectly with error codes 4149-(Billing PT/PS restriction on proc billing rule) and 4871-(Claim type restriction on proc billing table).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/23/2019	8/5/2019	12/12/2019
92	Claims, Professional Claims	Some professional claims submitted by Provider Type 20 (physician, M.D., Osteopath, D.O.) with CPT code 76377 (3-D radiographic procedure with computerized image post-processing) have been denied incorrectly with error code 4150 (per/facility pt/ps restriction proc billing rule).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/11/2019	8/5/2019	8/30/2019

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93	Claims, Institutional Claims	Some institutional claims for have denied incorrectly with error code 4105-(*no flat fee on file*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/19/2019	7/19/2019	9/12/2019
94	Claims, Institutional Claims and Professional Claims	Some claims submitted prior to 1/25/2019 have denied incorrectly with error codes 0074-(*adjustment denied-original payment request already adjusted/voided*) and/or 0075-(*adjustment denied-original payment request already adjusted/voided*).	• Institutional providers were provided a workaround to allow claims to process. During a Hospital Association Workgroup Meeting on 09/16/2019, it was determined that hospitals have no outstanding claims with error codes 0074 and 0075. • Professional providers: The impacted claims have been automatically reprocessed.	4/12/2018	1/25/2019	NA (Institutional Claims) 6/25/2020 (Professional Claims)
95	Claims, Professional Claims	Some claims submitted by Provider Types 24-(*advanced practice registered nurse-APRN*) and 74-(*nurse mid-wife*) with CPT code 99495-(*transitional care management services, moderate complexity*) are being denied incorrectly with error code 4014-(*no pricing segment on file*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/16/2019	8/5/19	8/9/19
96	Claims, Professional Claims	Some claims submitted by Provider Types 33-(*Durable Medical Equipment,Prosthetics, Orthotics and Disposable Medical Supplies*) with HCPCS A7033-(*pillow for nasal cannula type interface*) and A7038-(*filter disposable, used with positive pressure airway device*) are being denied incorrectly with error code 5551-(*two units allowed per rolling month-PA override*) when the limitation has not been exceeded. The correct limitation is two units per rolling month per code.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	6/11/2019	12/16/2019	03/31/2020

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
97	Claims, Professional Claims	Some claims submitted by Provider Types 33-(*Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies*) with HCPCS A7035-(*headgear used with positive airway pressure device*), A7036- (*chinstrap used with positive airway pressure device*), A7039-(*filter, non-disposable, used with positive airway pressure device*) and A7046-(*water chamber for humidifier used with positive airway pressure device, replacement each*) are being denied incorrectly with error code 5563- (*one unit allowed per six rolling months-PA override*) when the limitation has not been exceeded. The correct limitation is one unit per six rolling months per code.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	6/11/2019	12/9/2019	03/24/2020
98	Claims, Professional Claims	Some claims submitted by Provider Type 17, Specialty 181-(*Special Clinics: Federally Qualified Health Centers*) with the encounter code T1015-(*clinic visit/encounter, all-inclusive*) have been denied incorrectly with error code 4150-(*perf/facility pt/ps restriction proc billing rule*).	• Provider: No additional action needed. • Claims will be automatically reprocessed.	7/24/2019	8/5/2019	08/30/2019
99	Claims, Physician Administered Drug	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) code J9271-(*injection, pembrolizumab 1mg*) are being denied incorrectly with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table*).	• Provider: No additional action needed. • Claims will be automatically reprocessed.	7/24/2019	8/19/2019	12/12/2019
100	Claims, Dental Claims	Some Provider Type 22-(*Dentist*) are being denied incorrectly with error code 2504-(*client covered by private insurance*) when the member has a Medicare replacement plan on file as the primary carrier, along with Fee for Service eligibility).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	7/25/2019	9/30/2019	11/8/2019
101	Claims, Professional Claims	Some claims submitted by Provider Type 20-*(Physician, M.D., Osteopath, D.O.*) with CPT code 77417- (*therapeutic radiology port image*) have been denied incorrectly with error code 4150-(*perf/facility pt/ps restriction proc billing rule*).	• Provider: No additional action needed. • Claims will be automatically reprocessed.	7/26/2019	8/5/2019	8/23/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
102	Claims, Physician Administered Drug	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) code J7301-(*Levonorgestrel-releasing intrauterine contraceptive system, Sklya 13.5mg*) are being denied incorrectly with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	8/7/2019	8/12/2019	8/30/2019
103	Claims, Professional Claims	Some claims submitted by Provider Type 21-(*Podiatrist*), with CPT code 29540-*(strapping of ankle/foot)* have been denied incorrectly with error code 3958-(*no reimb rule for proc)*.	• Provider: No additional action needed. • Claims will be automatically reprocessed.	7/12/2019	8/19/2019	9/4/2019
104	Claims, Institutional Claims	Some inpatient institutional claims submitted prior to 1/25/2019 may have had the patient liability amount deducted in full for a member within the same month, for more than one provider.	• Provider: No additional action needed. • Claims are being reviewed for possible further action.	1/24/2019	1/25/2019	N/A
105	Claims, Institutional Claims	Some inpatient institutional claims are not being reviewed for Medicare Part B payment information when Part A has exhausted.	• Providers will be notified when the MMIS is updated and the new process is implemented. This will be a go-forward change and will not impact claims previously processed.	7/31/2019	05/18/2020	N/A
106	Claims	In some instances, claims have denied with error code 676-(*DOS exceeds timely filing limit*) and/or error code 677-(*timely filing limit exceeded*) when the member has retro-active eligibility for the date(s) of service being billed.	• Providers will need to resubmit impacted claims with an attachment referencing this Known Issue#, as well as the ICN# of the incorrectly denied claim for reconsideration.	8/7/2019	8/19/2019	N/A
107	Claims, Professional Claims	Some claims submitted by Provider Type 17, Specialty 181-*(Federally Qualified Health Centers*) with CPT code 41899-(*unlisted procedure, dentoalveolar structures*) have been denied incorrectly with error code 2502-(*client covered by Medicare B*).	• Provider: No additional action needed. • Claims will be automatically reprocessed.	8/7/2019	9/30/2019	10/25/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
108	Claims, Professional Claims	Some Provider Type 33-(*Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies*) claims submitted with HCPCS code K0002-(*standard hemi low seat wheelchair*) have been denied incorrectly with error code 3001-(*prior authorization required*) when the limit of 1 unit per 60 months has not been exceeded.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	8/6/2019	9/16/2019	10/25/2019
109	Claims and Portal, Institutional Claims	Some Provider Type 12-(*Hospital, Outpatient*) claims are being mapped to PT 10-(*Outpatient Surgery, Hospital Based*) as providers do not currently have the ability to select the service location when submitting prior authorization (PA). The portal is in the process of being updated to allow providers to select the service location.	• Provider: Until the update occurs, providers with prior PAs that have been mapped to the incorrect institutional provider type are advised to contact the Prior Authorization Department at 1-800-525-2395 to have the PA corrected.	7/21/2019	3/2/2020	N/A
110	Claims, Physician Administered Drug	Some physician-administered drug claim files are processing out of order when a correction or update to a previously paid claim is received. Some claims are processed before the void is processed resulting in a duplicate paid claim reject.	• Provider: No additional action needed. • Claims were automatically reprocessed.	8/29/2019	2/18/2020	6/30/2020
111	Claims, Institutional Claims	Some claims submitted by Provider Type 19-*(Nursing Facility*) are being reimbursed incorrectly when the member has been approved at the ventilator level of care.	• Provider: After further research, only one provider was impacted by this issue. Provider was notified to resubmit the claim.	7/17/2019	9/25/19	N/A
112	Claims, Professional Claims	Some claims submitted beginning 2/1/2019 by Provider Type 20-*(Physician, M.D., Osteopath, D.O.)* with CPT code 59510-*(cesarean delivery with pre and post care)* and modifier 22-*(increased procedural services)* have been denied incorrectly with error code 3932-*(No proc reimb rule for rendering PT/PS)*.	• Provider: No additional action needed. • Claims will be automatically reprocessed.	8/21/2019	9/23/2019	10/25/2019
113	Claims, Physician Administered Drug	Some claims billed with the Healthcare Common Procedure Coding System (HCPCS) code J9354-(*Injection, ado-trastuzumab emtansine, 1mg*) are being denied incorrectly with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table*).	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	10/24/2019	11/25/2019	12/12/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
114	Claims, Physician Administered Drug	Some claims billed with Healthcare Common Procedure Coding System (HCPCS) code J9306-(*Injection, pertuzumab, 1mg*) are being denied incorrectly with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table*).	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	10/24/2019	11/25/2019	12/12/2019
115	Claims, CPT Code 36573	Some claims billed with CPT code 36573-(*Insertion of PICC, without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older*) are being denied incorrectly with error code 4714-(*Age restriction on billing rule*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/8/2019	3/2/2020	06/18/2020
116	Claims	Some claims have suspended for an extended period of time with error code 7200-(*Miscellaneous claims x-ten error*).	• Provider: No additional action needed. Once resolved, claims will be automatically released for processing.	11/13/2019	1/6/2020	1/21/2020
117	Claims	Some claims were denied incorrectly with error code 7201(*Denied-claims x-ten response failed*) in November 2019.	• Provider: No additional action needed. Once resolved, claims will be automatically reprocessed.	12/3/2019	1/6/2020	1/21/2020
118	Provider Enrollment	Provider Type 15-(*Registered Dietitian*) does not have the option in the Online Provider Enrollment tool to associate providers or groups.	• Providers applying as a PT 15 should include the Associated Provider form (which is available within the system) or a letter indicating the group/individual they want to associate with their record.	12/4/2019	2/3/2020	NA
119	Claims, Institutional Claims, Provider Type 63-Residential Treatment Centers	Some claims for Provider Type 63-(*Residential Treatment Centers*) have been underpaid due to claims not being processed in chronological order, resulting in incorrect prior authorization units being utilized.	• Provider: No additional action needed. Once resolved, claims within 2 years of the recycle will be automatically reprocessed. Please review Web Announcement 1947 for details concerning how to correctly submit claims in chronological order per approved prior authorization lines.	6/7/2019	8/14/2019	1/10/2020

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
120	Claims, Professional Claims	Some claims submitted by Provider Type 14-(*Behavioral Health Outpatient Treatment*) and Provider Type 26-(*Psychologist*) have been denied incorrectly with error codes 5690-(*26 units allowed per calendar year-PA override*) and 5691-(*18 units allowed per calendar year-PA override*), when the limitations have not been exceeded. Please refer to Web Announcement 1663 for current limitation information. Additionally, Medicare crossover claims are not subject to the limitations, but are counted toward the totals for the calendar year.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed. • **The recycle has been canceled.** • **DHCFP will be reviewing and following up with impacted providers once internal reviews have been completed.**	07/23/2019	06/01/2020	**The recycle has been canceled.**
121	Provider Web Portal, Dental Providers	When searching dental treatment history on the Provider Web Portal, history is not reflected when a tooth# is included in the search.	• Provider: When searching dental treatment history on the Provider Web Portal, providers should complete the search without including a tooth# so that all history for the code can be viewed until Provider Web Portal tooth number functionality can be resolved.	1/30/2020	3/2/2020	N/A
122	Claims	Some claims have been denied incorrectly with error code 3381-*(Abortion Certificate Required – header)*, 3383-*(Sterilization Form Required – header)* and 3385-*(Hysterectomy Form Required – header)*.	• Provider: No additional action needed. • Claims that were incorrectly denied with these error codes will be automatically reprocessed.	12/13/2019	05/18/2020	05/27/2020
123	Claims, Provider Type 32-*(Ambulance, Air or Ground)*	Ground Emergency Medical Transportation (GEMT) services, billable by PT 32 ambulance providers, were carved out of the Managed Care Organization (MCO) contracts effective 1/1/2020 and are now billed as Fee-for-Service Medicaid. However, some GEMT claims for MCO-enrolled recipients are being denied with Explanation of Benefits (EOB) code 0038/error code 2017-*(Client services covered by HMO plan)*.	• Ground transportation claims submitted by PT 32 with procedure code A0434 (Specialty care transport) for Managed Care Organization (MCO)-enrolled recipients with dates of service on or after January 1, 2020, and submitted through April 13, 2020, that denied with EOB code 0038/error code 2017 will need to be resubmitted by the provider by August 30, 2020. Resubmit the claim using a U4 modifier followed by a two-alpha character modifier indicating the origination (e.g., recipient's home) and destination (e.g., hospital) of the recipient. A0434 claims for air transports will need to be submitted to the MCO in	01/28/2020	04/13/2020	10/07/2020 (See Known Issue #142 for further details)

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			which the recipient was enrolled at the time of transport. Providers with claims outside of timely filing will need to resubmit the claims on the Provider Web Portal and include an attachment requesting review of timely filing per Web Announcement 2187 or Known Issue 123. • Claims for all other GEMT services procedure codes (other than procedure code A0434) with dates of service on or after January 1, 2020, and submitted through April 13, 2020, that denied with EOB code 0038/error code 2017 will be automatically reprocessed. • See Web Announcement 2325 and Web Announcement 2432 for further details.			
124	Claims, Provider Type 17-*(Special Clinics)*	Some claims billed by Provider Type 17-*(Special Clinics)* for procedure code 11981-(*Insertion of drug delivery implant into tissue)* are being denied incorrectly with EOB Code 0192/Error Code 3001-(*Prior Authorization (PA) is required for this service. An approved PA was not found).*	• Provider: <u>No additional action needed.</u> • Once resolved, denied claims will be recycled.	02/04/2020	03/02/2020	03/12/2020
125	Claims	On 3/9/2020 – 3/10/2020, claims submitted suspended with error code 853-(*HCPCS-Annual Update-Suspend Claims)*. The suspended claims will be released for adjudication on Thursday, 3/12/2020.	• <u>Provider:</u> No additional action needed.	03/10/2020	03/12/2020	N/A
126	Claims, Professional and Professional Crossover	A new issue related to closed Known Issue 94 resulted in some professional claims and professional crossover claims denying incorrectly. The affected claims were submitted prior to 1/25/2019 and were denied incorrectly with error codes 0074-(*adjustment denied – original payment request already adjusted/voided*) and/or 0075-(*adjustment denied – original payment request already adjusted/voided*).	• Provider: <u>No additional action needed.</u> • Claims will be automatically reprocessed.	01/07/2020	6/25/2020	6/25/2020

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127	Claims	Some claims submitted after 1/27/2019 with CPT code 50387-(*Removal and replacement of externally accessible nephroureteral catheter requiring fluoroscopic guidance, including radiological supervision and interpretation*) submitted by provider types 20-(*Physician*), 24-(*Advanced Practice Registered Nurse*) and 77-(*Physician's Assistant*) have been denied in error with error code 4801-(*No billing rule for procedure*).	• Provider: No additional action needed. • Claims will be automatically reprocessed.	02/28/2020	04/27/2020	05/22/2020
128	Claims	Some claims billed with Healthcare Common Procedure Coding System (HCPCS) code J9022-(*Inj, Atezoolizumab, 10 mg*), J9023-(*Injection, Avelumab, 10 mg*), J9032-(*Injection, Belinostat, 10 mg*), J9034-(*Injection, Bendeka, 1 mg*), J9042-(*Brentuximab Vedotin Inj*), Q5107-(*Inj MVASI 10 MG*), Q5109-(*Injection. IXIFI, 10 MG*), Q5111-(*Injection Udenyca 0.5 MG*), Q5112-(*Inj Ontruzant 10 MG*), Q5113-(*Inj Herzuma 10 MG*), Q5114-(*Inj Ogivri 10 MG*), Q5115-(*Inj Truxima 10 MG*), Q5116-(*Inj Trazimera 10 MG*), Q5117-(*Inj Kanjinti 10 MG*), Q5118-(*Inj Zibabev 10 MG*) are being denied in error with error codes 4149-(*Billing PT/PS restriction on proc billing rule*) and 4871-(*Claim type restriction on proc billing table*).	• Provider: No additional action needed. • Claims will be automatically reprocessed.	03/25/2020	04/20/2020	06/26/2020
129	Claims	Some claims have denied incorrectly with error code 508-(*HDR billed amount not equal to DTL billed amount sum),* when the sum of the detail billed amounts does equal the header billed amount.	• Provider: No additional action needed. • Dental claims that denied in error with error code 508 and also denied with error code 264-*(Invalid date of service)* were not reprocessed as the denial for invalid date of service was appropriate.	03/19/2020	6/20/2020	NA

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
130	Claims	Some claims submitted by Provider Types 20-(*Physician, M.D., Osteopath, D.O.)* with specialties 146-*(Psychiatry)* and 147-*(Psychiatry Child)*, PT 47-*(Indian Health Program)*, PT 52-*(Indian Health Services Outpatient Tribal)* and PT 79-*(Indian Health Services Hospital Outpatient Non-Tribal)* after 12/2/2019 have denied incorrectly with error codes 5003-*(Poss conflict: PT 13 psych hosp inpat vs others)* and 5004-*(Poss conflict: PT 63 RTC vs others)*, or been voided incorrectly with Explanation of Benefits (EOB) code 8223-*(Services included in inpatient stay)*.	• Provider: No additional action needed. • Claims will be automatically reprocessed.	06/08/2020	07/20/2020	03/26/2021
131	Claims, Professional Claims	Some claims submitted by PT 14-*(Behavioral Health Outpatient Treatment)* with specialties 300-*(Qualified Mental Health Professional)*, 306-*(Licensed Marriage and Family Therapist)* and 307-*(Clinical Professional Counselor)* beginning 2/1/2019 have been denied incorrectly with error code 2502-*(Client Covered by Medicare Part B)* and Explanation of Benefits (EOB) code 2590-(*The client has Medicare. Charges must be billed to Medicare before billing Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of explanation of benefits).* The provider type and specialties listed above are not eligible to enroll with Medicare and are unable to submit claims to Medicare as the primary carrier.	• Provider: No additional action needed. • Claims will be automatically reprocessed.	06/19/2020	08/24/2020	11/11/2020
132	Claims, Crossover Claims	Some crossover claims are being reimbursed when there is no patient responsibility (coinsure-ance/deductible) amount submitted on the claim.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	05/07/2020	09/08/2020	12/22/2020
133	835 Remittance Advice	12 trading partners did not receive their 835 files from the 7/3/2020 payment cycle due to an unexpected file failure. The team is continuing to resolve these and is targeting transmissions by end of week 7/17/2020.	• Providers may review claims activity from the 7/3/2020 cycle using the proprietary remittance advices available on the web portal.	07/08/2020	07/17/2020	NA

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
134	Claims, Professional Claims	Some claims submitted through AuthentiCare® beginning 9/29/2019 by Provider Types 48-(*Home and Community Based Waiver for the Frail Elderly*) and 58-(*Home and Community Based Waiver for Persons with Physical Disabilities*) with procedure codes S5120-(*Attendant care service/15 min*), S5130-(*Homemaker service [not otherwise specified – NOS] per 15 min*) and S5150-(*Unskilled respite care/15 min*) may have been denied in error with error code 1945-(*Mult. prov. locs for billing prov. spec-hdr*) when the provider has the same National Provider Identifier (NPI) for both PTs 48 and 58; with different taxonomy codes.	• Providers: No additional action needed. • Claims will be automatically reprocessed.	05/08/2020	11/16/2020	03/04/2021
135	Claims, Dental Claims	Some dental claims submitted with procedure code D1353-(*Sealant Repair per Tooth*) have denied incorrectly with error code 5562-(*1 Unit Allowed per 36 Rolling Months – PA Override*) when D1353 was billed within the rolling 36 months for different tooth numbers.	• Providers: No additional action needed. • Claims will be automatically reprocessed. • See Web Announcement 2342 for further details.	06/09/2020	09/08/2020	10/28/2020
136	Provider Web Portal, PCS	There is an issue with uploading the NMO-7073 form (Functional Assessment Service Plan) using the File Exchange page in Provider Web Portal.	• Providers: FASP NMO-7073 can be emailed in a secure fashion to nvmmis.pcs@dxc.com	09/10/2020	09/21/2020	NA
137	Claims, Professional Claims	Some claims submitted by Provider Type 74-(*Nurse Midwife*) with CPT code 76830-(*Transvaginal US Non-OB*) have been denied incorrectly with error code 3932-(*No proc Reimb rule for rendering PT/PS*).	• Providers: No additional action needed. • Claims will be automatically reprocessed.	9/10/2020	10/05/2020	11/18/2020
138	Claims, Professional Claims	Some claims submitted by Provider Type 20-(*Physician, M.D., Osteopath, D.O.*) with CPT code 78597-(*Lung perfusion differential*) have been denied incorrectly with error code 3932-(*No proc reimb rule for rendering PT/PS*).	• Providers: No additional action needed. • Claims will be automatically reprocessed.	9/22/2020	10/05/2020	11/17/2020
139	Claims	Some claims are denying incorrectly with error code 4053-(*Principal ICD Procedure Code not on File*) when being billed with the following COVID-19 ICD-10-PCS procedure codes: XW013F5,	• Providers: No additional action needed. • Claims will be automatically reprocessed.	10/07/2020	12/08/2020	03/26/2021

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		XW033E5, XW033F5, XW033G5, XW033H5, XW043E5, XW043F5, XW043G5, XW043H5, XW0DXF5, XW13325 or XW14325.				
140	Claims, Professional Claims	Some claims billed with CPT codes 97802-(*Medical nutri-tion therapy, individual*), 97803-(*Medical nutrition therapy, individual, subsequent*) and 97804-(*Medical nutrition ther-apy, group*) are denying incorrectly with error code 5549-*(16 Per 365 Days, 8 Per Next 365 Days – PA Override)*.	• Providers: No additional action needed. • Claims will be automatically reprocessed.	11/05/2020	01/20/2021	03/26/2021
141	Claims, Professional Claims	Procedure Codes 99304-99306-*(Initial Nursing Facility Visit)*, 99307-99310-*(Subsequent Nursing Facility Visit)* and 99318-*(Nursing Facility Annual Assessment)* are missing from audits/error codes 5036-(*Possible Duplicate: Practitioner to Practitioner)* and 5038-*(Possible Duplicate: Provider Type 20 vs Others)*, which is causing some claims to deny incorrectly beginning 2/1/2019.	• Providers: No additional action needed. • Claims will be automatically reprocessed.	11/03/2020	01/05/2021	04/09/2021
142	Claims, Provider Type 32-*(Ambulance, Air or Ground)*	Ground Emergency Medical Transportation (GEMT) services billable by PT 32 ambulance providers for procedure codes (other than procedure code A0434): Some claims with dates of service on or after January 1, 2020, and submitted through April 13, 2020, that denied with EOB code 0038/error code 2017-(*Client services covered by HMO plan*) were found to be missing from the recycle associated with Known Issue #123 and Web Announcement 2325.	• Providers: No additional action needed. • Claims will be automatically reprocessed. • See Web Announcement 2432 for updates.	11/23/2020	02/11/2021	02/11/2021
143	Claims, Professional Claims	Some professional claims submitted by Provider Type 20-(*Physician, M.D., Osteopath, D.O.)* with CPT codes 76000-*(Fluoroscopy)* and 78071-(*Parathyrd Planar W/WO Subtrj*) have been denied incorrectly with error code 4150-*(perf/-*	• Providers: No additional action needed. • Claims will be automatically reprocessed.	09/02/2020	01/05/2021	02/25/2021

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		facility pt/ps restriction proc billing rule – provider is not certified to perform procedure billed).				
144	Claims, Dental Claims	Some dental claims submitted by Provider Type 22-*(Dentist)* with CDT codes including D4341-(*Periodontal Scaling & Root Planing*) have been denied incorrectly with error code 4801-(*No Billing Rule for Procedure*) for recipients with the PREG (Pregnancy) benefit.	• Providers: No additional action needed. • Claims will be automatically reprocessed.	08/13/2020	02/08/2021	03/26/2021
145	Prior Authorizations, Provider Type 19 (Nursing Facility)	Some prior authorizations for the Behaviorally Complex Care Program with Provider Type 19-*(Nursing Facility)* are not showing the authorized cost per unit on the PWP-(*Provider Web Portal*) under the View Authorization Response page.	• Provider Action: Until the system issue is resolved, Behaviorally Complex Care Program providers can send an email to LTSS@dhcfp.nv.gov to obtain authorized cost per unit amount.	12/29/2020	3/15/2021	NA
146	Provider Enrollment	Ordering, Prescribing and Referring (OPR) enrollment applications cannot be saved or submitted at this time.	• Nevada Medicaid is asking OPR providers to hold their new OPR enrollment applications until the issue is resolved. • Once this issue is resolved, OPR providers will be able to submit their enrollment applications with a retroactive effective date. Enrollment applications can have an effective date up to six months in the past.	2/22/2021	3/2/2021	NA
147	Provider Enrollment	Some users are experiencing an error when initiating a Change/Update through the secure Provider Web Portal (EVS). Nevada Medicaid has identified the problem and is working on a resolution.	• At this time there is no work around.	2/22/2021	3/8/2021	NA
148	Claims, Professional Claims	Some claims submitted by Provider Type 17, Specialty 188-*(Special Clinics: Certified Community Behavioral Health Centers)* with the encounter code T1040-*(Community Behavioral Health Clinic Services Per Diem)* are denying incorrectly with error code 4209-*(No Pricing Segment for Procedure/Modifier Combination*) when the service is billed with the modifier Q2-(*Demo Procedure, Service)*.	• Providers: No additional action needed. • Claims will be automatically reprocessed.	03/23/2021	04/05/2021	05/06/2021

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149	Claims, Professional Claims	Some claims submitted as of 03/16/2021 by Provider Types 21-*(Podiatrist),* PT 30-*(Personal Care Services-Provider Agency),* PT 34, Specialty 027-*(Therapy, Physical Therapy)*, PT 34, Special-ty 028-(*Therapy, Occupational Therapy)* and PT 83-*(Personal Care Services-Intermediary Service Organization)* may be denying incorrectly with error code 1009-(*Contract could not be determined)*.	• Providers: No additional action needed. • Claims will be automatically reprocessed.	03/30/2021	04/05/2021	06/18/2021
150	Claims, Other Insurance (TPL) Submitted	Some claims submitted between the dates of 02/16/2021 and 04/09/2021 with Third Party Liability coinsurance/deductible/co-pay are not being processed appropriately, which may have resulted in an overpayment. All provider types may have been impacted.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed and overpayments will be recouped, as applicable.	03/19/2021	04/09/2021	02/28/2022
151	Claims, Medicare Crossover Claims	Medicare Crossover claims received from COBA-*(Coordination of Benefits Agreement)* have not been processed since June 2, 2021, due to an issue with the movement of the files. The issue has been resolved and all claims received since June 2, 2021, will be processed on June 30, 2021.	• Providers: No additional action needed. • Impacted claims will appear on the July 9, 2021, Remittance Advice.	06/30/2021	06/30/2021	NA
152	Claims	Some claims are denying incorrectly with error code 1009-*(Contract could not be determined*) when submitted with a rendering National Provider Identifier (NPI) at the header and not submitted on all the detail claim lines.	• Providers: Please resubmit claims denied for this reason as Nevada Medicaid has found that when the claim is resubmitted the error no longer occurs.	07/28/2021	09/20/2021	NA
153	Claims, Provider Type 17-(Special Clinics)	Some claims submitted with date of service (DOS) on or after 03/31/2021 billed by Provider Type 17-(*Special Clinics)* with Provider Specialty 215-(*Substance Abuse Agency Model (SAAM))* for procedure code H0038-*(Self-Help/Peer Services, Per 15 Minutes)* are being denied incorrectly with Explanation of Benefits (EOB) code 0192/error code 3001-*(Prior Authorization (PA) is required for this service. An approved PA was not found*).	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	11/16/2021	11/29/2021	03/17/2022
154	Claims, Outpatient, Provider Type 34-(Therapy)	Some claims processed after September 20, 2021, and billed by Provider Type 34-*(Therapy)* are being denied incorrectly with error code 3959-(*No reimbursement rule for revenue code*).	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	11/22/2021	01/31/2022	07/07/2022

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155	Claims, Professional, Outpatient, Medicare Crossover	Procedure Codes 91307-*(Pfizer severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(coronavirus disease [COVID-19] vaccine)*, 0071A-*(Pfizer-BioNTech Covid-19 Pediatric Vaccine - Administration - First dose)* and 0072A-*(Pfizer-BioNTech Covid-19 Pediatric Vaccine - Administration - Second dose)* are denying incorrectly with error code 3337-*(Non-Cov Proc Due to CMS Termination)*.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	12/22/2021	02/28/2022	07/26/2022
156	Claims, Residential Treatment Centers	Some claims may have denied inappropriately for Provider Type 63-*(Residential Treatment Centers*) with error code 4239-(*Recipient not enrolled with LOC/Hospice*).	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	03/24/2022	03/21/2022	07/07/2022
157	Claims, Inpatient Provider Type 56 and Claims, Professional Provider Type 30	Some claims submitted by Provider Type 56-(*Inpatient Rehabilitation and Long Term Acute Care (LTAC) Specialty Hospitals*) and Provider Type 30-(*Personal Care Services - Provider Agency*) are being denied incorrectly with error code 5005-(*Claim/detail conflicts with a previously paid service on the same or overlapping date of service*) when the admit and discharge dates are the same.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	05/13/2022	01/30/2023	NA
158	Claims, Professional, Outpatient, Medicare Crossover	Some claims are denying inappropriately with error code 5530-*(One Unit Allowed Per 8 Rolling Months)* when the service is being billed with modifiers 59, 80, 82 or AS.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	07/22/2022	08/01/2022	NA
159	Claims	Some claims with Remittance Advice date August 5, 2022, were denied incorrectly with error code 7201-*(Denied-claims x-ten response failed)*.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	08/19/2022	08/03/2022	10/12/2022

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160	Medicare Crossover Claims	Medicare Crossover claims processed between 11/21/2022 and 11/30/2022 may have posted error codes 4366 and/or 4367-(*Medicare Coinsurance Greater than Medicare Paid Amount*) in error when there is a positive Medicare Payment amount.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	11/28/2022	11/30/2022	08/07/2024
161	Physician-Administered Drug (PAD) Claims, EVS (Provider Web Portal) and EDI (Electronic Data Interchange) Claims	Some Physician-Administered Drug (PAD) voids are not voiding. When providers attempt to void a PAD claim in the Provider Web Portal (EVS), the claim is reprocessing to pay rather than voiding. This issue is also occurring when voiding through the Electronic Data Interchange (EDI).	• Providers: No additional action needed. • Once a resolution/work around has been determined, additional information will be communicated.	11/18/2022	01/17/2023	03/22/2023
162	Inpatient Claims	Some claims for Provider Type 11-(*Hospital, Inpatient*) are being denied or cut back inappropriately with error codes 5643-(*3 Units Allowed Per Delivery - PA Override*) and 5644-(*4 Units Allowed Per C-Section Delivery - PA Override*) when there is a valid prior authorization submitted on the claim and on file.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	01/06/2023	02/21/2023	NA
163	Inpatient Claims	The claims adjudication update described in Web Announcement 2943-*(Revenue Code Must Be Exact Match on Inpatient Claim and Prior Authorization)* which was posted November 21, 2022, resulted in some inpatient claims denying in error with error code 3000-*(units exceed authorized units on prior authorization)* or error code 3001-*(prior authorization required)* when the date of service was prior to November 21, 2022.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	01/06/2023	03/20/2023	6/8/2023

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
164	Claims, Professional and Dental	Some claims submitted by Provider Types 20-(*Physician, M.D., Osteopath, D.O.*), 22-(*Dentist*), 24-(*Advanced Practice Registered Nurses*), 72-(*Nurse Anesthetist*), 74-(*Nurse Midwife*) and 77-(*Physician's Assistant*) may have denied inappropriately with error code 3958-(*No Reimbursement Rule for Procedure*).	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	01/31/2023	02/01/2023	02/03/2023 and 02/10/2023
165	Claims, Dental, Outpatient and Professional	Some claims processed on 02/07/2023 between the hours of 1 am and 9 am PT-*(Pacific Time)* may have been denied inappropriately with error code 4014-*(no pricing segment on file).*	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	02/07/2023	02/07/2023	02/10/2023
166	Claims, Dental	Some dental claims with a date of service on or after 01/01/2023 that were processed on or after 03/27/2023 may be denying inappropriately for Provider Type 22-*(Dentist)* with error codes 4150-*(Rendering provider is not certified to perform procedure billed)* and 4748-(*Current Benefit Plan Restriction on Procedure Billing Rule).*	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	04/07/2023	04/10/2023	07/11/2023
167	Claims, Ambulance Provider type 32 Professional and Medicare Crossover claims	Some claims submitted by Provider Type 32-*(Ambulance)* with Modifier DR-(*Diagnostic or Therapeutic to Residence*) or GR-*(Hospital-based ESRD Facility to Residence*) are denying inappropriately with error code 4257-(*Modifier restriction for proc billing rule*).	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	04/12/2023	06/01/2023	08/22/2023
168	Member, Eligibility	It has been identified that eligibility verification responses may return an incorrect Redetermination Date (RD) of 01/01/1900. Although 01/01/1900 can present correctly when an RD date is not on file, the error is causing a date of 01/01/1900 to return at a higher rate than normal.	• Providers should not communicate RD dates of 01/01/1900 to members (Nevada Medicaid recipients) at this time. Providers should direct members to AccessNevada or visit/call their local welfare office to obtain their RD date.	06/27/2023	07/17/2023	NA

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
169	Claims, Professional and Outpatient	Some claims submitted by Physicians or Outpatient hospitals on or after 06/28/2023 for Physician Administered Drugs (PAD) may have denied inappropriately with error code 4871-(*Claim type restriction on procedure billing rule*).	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	06/29/2023	07/10/2023	09/06/2023
170	Claims, Professional and Outpatient Hospitals	Some claims submitted by Physicians or Outpatient Hospitals on 07/30/2023 and 08/10/2023 for Physician Administered Drugs (PAD) may have denied inappropriately with error code 0909-(*PAD Detail denied – contact the Pharmacy Benefit Manager*). Update: Claims reprocessed on 12/06/2023 may have denied with error code 908 *(PAD detail denied by Pharmacy Benefit Manager*) with Explanation of Benefits (EOB) 8699 – 83-*(Duplicate paid/captured claim*).	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed. • Claims that denied with error code 908 with first claim reprocessing effort will be reprocessed automatically.	09/05/2023 01/11/2024	10/31/2023 05/20/2024	First claim recycle effort: 12/06/2023 Second claim recycle effort: 06/10/2024
171	Claims, Professional	Some claims submitted by Provider Type 85-(*Applied Behavior Analysis (ABA)*) on or after 08/21/2023 are incorrectly denying with error code 5716-*(Limit of 12 hours per day per NPI*). Some claims are overpaying when multiple rendering National Provider Identifiers are submitted on the same claim.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	09/07/2023	10/16/2023	05/08/2024
172	Claims, Professional	Some subsequent claims submitted by Provider Type 86-*(Specialized Foster Care)* on or after 09/18/2023 are incorrectly denying with error code 3353-(*Specialized Foster Care Checklist PT 86*) when the initial claim was already submitted and paid with the Specialized Foster Care Checklist.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	09/27/2023	10/06/2023	10/06/2023
173	Provider; Group Enrollments	During the group enrollment process, board members are being required to report % of ownership. This field should be optional.	• Provider: No action required at this time. Expected resolution date is 12/21/2023. This Known Issue will be updated upon resolution.	12/19/2023	12/21/2023	NA

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
174	Claims, Professional	Paid claims submitted by Provider Types 30-*(Personal Care Services - Provider Agency)*, 83-*(Personal Care Services - Intermediary Service Organization)*, 48-*(Home and Community Based Waiver for the Frail Elderly)* and 58-*(Home and Community Based Waiver for Persons with Physical Disabilities)* that were processed through Electronic Visit Verification (EVV) between 01/24/24 and 02/05/24 that did not adjudicate at the correct rate will be reprocessed.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	03/18/2024	03/29/2024	03/29/2024
176	Claims, Dental	Effective April 1, 2024, some dental claims are denying with error code 4014-(*No pricing segment on file*) for recipients with the Intellectual Disabilities Waiver (IDW) benefit plan.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	04/22/2024	05/20/2024	06/14/2024
177	Claims, Dental	Some dental claims processed after June 3, 2024, may have denied inappropriately with error code 4014-*(No pricing segment on file)*. Update: Some dental claims were not reprocessed in the first reprocessing effort on June 18, 2024.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed. • Claims that were not captured in the first reprocessing effort will be reprocessed automatically.	06/05/2024 07/24/2024	06/10/2024	First claim recycle effort: 06/18/2024 Second claim recycle effort: 08/06/2024

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
178	Claims, Professional and Outpatient Hospitals	Some claims submitted by Physicians or Outpatient Hospitals since May 20, 2024, are being denied inappropriately with error code 6134-*(Unbundling of Tech/Prof modifiers)* for radiology services when billed with modifiers 26-*(Professional Component)* or TC-*(Technical Component)*.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	06/14/2024	07/22/2024	09/04/2024
179	Claims, Professional, Professional Crossover	Some procedure codes were not included in the 82nd Legislature SB 504 & SB 439 Physician Rate increase and are continuing to pay at the old rate.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	07/08/2024	10/28/2024	01/08/2025
181	Claims, Professional, Professional Crossover	Some claims for the following procedure codes are denying inappropriately with error codes 4014-*(No pricing segment on file)* and 4209-*(No pricing segment for procedure/modifier comb)* when billed without a modifier: • A4624-(*Tracheal suction tube*) • A4628-(*Oropharyngeal suction catheter*) • H0004-(*Alcohol and/or drug services*) • H2011-(*Crisis intervention service, 15 min)* Q3014-*(Telehealth facility fee)*	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	10/30/2024	11/25/2024	01/22/2025
183	Claims, Dental	Beginning February 10, 2025, some dental procedure codes are incorrectly requiring tooth anatomy information, causing claims to deny with error code 261-*(Tooth number missing)*. In addition, some procedure codes are incorrectly requiring quadrant information, causing claims to deny with error code 4120-*(Procedure code requires area of oral cavity).*	• Provider: No additional action needed. • Updates made to the impacted procedure codes to require tooth anatomy or quadrant information have been reversed in the MMIS. Claims will no longer deny with error codes 261 and 4120.	02/21/2025	03/17/2025	N/A

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
186	Claims, Provider Type 33 (Durable Medical Equipment (DME), Disposable, Prosthetics)	Some claims processed between April 21, 2025, and April 28, 2025, may have denied inappropriately for Healthcare Common Procedure Coding System (HCPCS) codes for Provider Type 33-*(Durable Medical Equipment (DME), Disposable, Prosthetics)* with error code 5663-(*Amount Reduced by History Rental Payment*) when the HCPCS code is billed with a modifier other than RR or NU.	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	04/23/2025	04/28/2025	06/03/2025
187	Claims, Institutional Claims	Some institutional claims submitted with Physician Administered Drug (PAD) details are denying incorrectly with error code 709-(*Provider type/specialty is not allowed to bill NDC*).	• Providers: No additional action needed. • Once resolved, claims will be automatically reprocessed.	06/11/2025	06/16/2025	N/A