February 11, 2021

Announcement 2425

Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for January 2021 Claims

The Division of Health Care Financing and Policy and the Nevada Medicaid fiscal agent have reviewed all claim submissions for the month of January 2021 and have compiled a list of the top 10 reasons for which claims have denied. The table below lists the top 10 error codes along with the Explanation of Benefits (EOB) code that appears on the remittance advice for the claim denials, the error code descriptions and instructions to providers on how to resolve the claim denials.

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
3347	0609	No Payable Accommodation Code	Error code 3347 will typically post as a denial along with additional denial code(s). Providers must review their submitted claim and open the Adjudication Errors panel.
908	0908	PAD (Physician Administered Drug) Detail Denied by PBM (Pharmacy Benefits Manager)	The National Drug Code (NDC) on the Physician Administered Drug claim was denied by the Pharmacy Benefit Manager. Provider will need to verify that the NDC is a payable and covered code. NDC information can be located at: https://www.medicaid.nv.gov/providers/ndc.aspx Providers may also reach out to the Pharmacy Benefits Manager at: 866-244-8554 (Pharmacy Help Desk).
4801	0116	No Billing Rule for Procedure	Provider should verify that the code being billed is a payable code by Nevada Medicaid. Review the Search Fee Schedule for more information.
451	0452	No Crossover Coinsurance or Deductible Due	Provider will need to submit a new claim using the regular Fee-for-Service claim along with the Medicare denial reason. See the Submitting Secondary Claims to Nevada Medicaid provider training presentation for more billing information when Third-Party Liability (TPL) is present.
4874	0770	Claim Type Restriction on Rev Code Billing Rule	Provider must review the Revenue Code(s) listed on the claim to determine if the Revenue Code(s) being used are appropriate for that claim type.
1070	1464	Procedure Missing on Outpatient Claim	Provider must enter a valid procedure code on the detail level of the claim and submit new claim.

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
4871	1521	Claim Type Restriction on Proc Billing Rule	Provider must review the Procedure Code(s) listed on the claim to determine if the Procedure Code(s) being used are appropriate for that claim type.
1011	1011	Contract could not be determined – HDR (header level)	Provider must verify that the NPI being listed is under contract with Nevada Medicaid for the dates of service indicated on the claim.
3959	1178	No Reimb (Reimbursement) Rule for Rev (Revenue) Code	Provider must review the claim for any additional adjudication errors and make any necessary changes. Also review the recipient's dates of eligibility and Benefit Plans. Verify the dates of service associated with the claim.
2003	3006	Client ineligible on DTL DOS (detail level date of service)	Provider will need to verify that the recipient is eligible for the dates of service and has the appropriate Benefit Plan. This may be completed in the Electronic Verification System (EVS) by reviewing the Member Eligibility tab.