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Nevada Medicaid Web Announcement 3745

Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for September 2025 Professional Claims

Nevada Medicaid and its fiscal agent have reviewed all claim submissions for the month of September 2025 and have compiled a list of the top reasons for which professional claims have been denied. The table below lists the top 10 error codes along with the Explanation of Benefits (EOB) codes that appear on the remittance advice for the claim denials, the error code descriptions, and instructions to providers on how to resolve the claim denials.

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
452	452	No Medicare Coinsurance, Deductible or Copay Due	Providers should verify the co-insurance, deductible, or co-pay amount in the Medicare crossover details fields.
3001	0192	Prior Authorization not Found	Providers are advised to proceed with the following steps: • Verify that the prior authorization request has been submitted and approved. • Verify the correct authorization number has been placed on the claim. • Verify that the Dates of Service (DOS) billed on the claim match the time span of the approved authorization. • Verify that the authorization number corresponds with the correct NPI and recipient ID before resubmitting the claim. • Verify that units are available on the approved authorization.
5035	5035	Exact Duplicate: Practitioner to Practitioner	Claim is an exact duplicate of a previously paid claim. Provider will need to review claim history and submit an adjustment or void the claim if changes are needed. This may be completed in the Provider Web Portal (PWP) . Please review the PWP User Manual Chapter 3: Claims for further instruction.
4021	0698	No CVG (Coverage) Rule for Procedure	Providers should verify that the code being billed is a payable code by Nevada Medicaid for the specific dates of service. Review the Search Fee Schedule for more information.

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
1009	1009	Contract Could not be Determined	Review the billing provider contract dates to verify that the provider is contracted with Nevada Medicaid for the dates of service listed on the claim. Providers may need to submit a new enrollment application to Nevada Medicaid via the Provider Flex Enrollment webpage for more information.
2502	2590	Client Covered by Medicare B	The recipient has Medicare Part B. Charges must be billed to Medicare before billing Nevada Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of the explanation of benefits. For more information on submitting claims, please review the PWP User Manual Chapter 3: Claims
4371	1379	Claim Type Restriction on Proc Cvg Rule	Providers should review the claim type that was submitted to Nevada Medicaid and ensure that the correct claim type was used. Please visit PWP User Manual Chapter3: Claims for more information.
3340	3340	Service not covered by NV Medicaid	Providers should verify that the code being billed is a payable code by Nevada Medicaid for the specific dates of service. Review the Search Fee Schedule for more information.
4801	116	No Billing Rule for Procedure	If no active billing rules exist for the procedure, providers should verify that the code being billed is a payable code by Nevada Medicaid for the specific dates of service. Review the Search Fee Schedule for more information.
2003	3006	Client ineligible on DTL DOS (detail level date of service)	Providers should verify that the recipient is eligible for the dates of service and has the appropriate Benefit Plan. This may be completed in the PWP by reviewing the Member Eligibility tab, or by utilizing Gabby™ by calling the Gainwell Technologies Contact Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511.