

September 29, 2026

Nevada Medicaid Web Announcement 4020

Attention All Providers: Nevada Medicaid Issues Guidance Regarding Prior Authorization with Managed Care Organizations

General Guidance on Managed Care Organization (“MCO”) Prior Authorization Requirements

Please Note: Prior authorization, duration, quantity, and other requirements for pharmacy and prescribed drugs may differ from the guidance contained in this Web Announcement. Thus, this Web Announcement is intended to make clarifications principally in reference to Nevada Medicaid’s medical benefits, unless otherwise specifically noted.

Pursuant to Section 5.7.2(E) of the Nevada Medicaid managed care contract, Nevada Medicaid managed care organizations (“MCOs”) *“can utilize different authorization requirements than what is used by the State under FFS [Fee-For-Service], as long as they are not more restrictive than FFS[.]”*

This provision refers to the restrictiveness of the underlying clinical criteria used to make a determination as to whether or not a service is medically necessary.

- It does not prohibit an MCO from requiring prior authorization on a service that does not require prior authorization in FFS, unless otherwise required by law.
- Further, it does not prohibit an MCO from approving a prior authorization for different durations or quantities than what are ordinarily approved under FFS, unless otherwise required by a specific minimum authorization requirement or as required by law.
- Finally, it does not prohibit an MCO from requiring specific forms, information, or submission requirements that are different than those required by FFS.

Exceptions to the General Guidance on MCO Prior Authorization Requirements

Pursuant to Section 5.7.3(A) of the Nevada Medicaid managed care contract, an MCO shall not require prior authorization or post-authorization for the following provider types and services (please reference Section 1.1 of the Nevada Medicaid managed care contract for applicable definitions of these providers and services):

- Emergency services
- Family planning services
- Federally Qualified Health Center (“FQHC”) and Rural Health Clinic (“RHC”) services
- Certified Community Behavioral Health Centers (“CCBHC”) services
- The first mental health or Substance Use Disorder (“SUD”) assessment completed in a twelve (12) month period
- Intensive Crisis Stabilization Services (“ICSS”)
- Tobacco cessation treatments

Further, pursuant to [NRS 422.3071](#), an MCO may not require prior authorization for the following:

- Evidence-based goods or services for preventive care that have in effect a grade of “A” or “B” identified by the United States Preventive Services Task Force.
- Preventive care for women described in [45 CFR 147.130\(a\)\(1\)\(iv\)](#).

- Hospice care (as defined in [NRS 449.0115](#)) provided to pediatric patients in a facility for hospice care (as defined in [NRS 449.0033](#)) licensed pursuant to [chapter 449](#) of NRS.
- Care provided to treat neonatal abstinence syndrome provided by a provider of health care (as defined in [NRS 422.3071\(2\)\(c\)](#)) who specializes in pain management for pediatric patients or palliative care provided to pediatric patients.

Please Note: The exceptions discussed in this section principally apply to in-network providers—MCOs may require prior authorization for some of these services when rendered or billed by an out-of-network provider, pursuant to applicable federal regulations.

Additional exceptions to the general guidance in this Web Announcement, which may limit an MCO’s authority to require prior authorizations, can be found, including but not limited to, in [Nevada Revised Statutes \(“NRS”\) Chapter 422](#), [NRS Chapter 695G](#), and the [Nevada Medicaid State Plan](#). Nevada Medicaid intends to publish additional information on this topic in the coming months.

Timeframes for Prior Authorization Requests

Nevada Medicaid MCOs are required to concurrently comply with prior authorization review timelines established by both [42 CFR 438.210\(d\)](#) and [NRS 422.3072](#).

For standard prior authorization requests, an MCO must respond to a standard prior authorization request within two business days, and in accordance with the following:

- A “response” consists of a notice of decision or a request for additional information (“RAI”).
 - A decision is a notice of approval or a notice of denial of a prior authorization request.
 - An RAI is a request for additional information necessary to determine whether an approval or denial decision is appropriate.
- A “business day” means any day that falls on Monday through Friday, excluding Nevada state holidays. Normal business hours are considered 8:00 AM – 5:00 PM Pacific Time.
- For the purposes of computing time for these requirements:
 - The day the prior authorization request is received is considered Day 0;
 - Days 1 and 2 are counted on the business days following Day 0; and
 - The day of receipt is Day 0 regardless of whether the prior authorization request is received outside of normal business hours or on a non-business day.
- The timeframe for standard prior authorization requests may be extended by fourteen (14) calendar days pursuant to 42 CFR 438.210(d)(1)(ii).

For expedited prior authorization requests, an MCO must respond to an expedited prior authorization request within two business days and render a decision on expedited prior authorization requests within seventy-two (72) hours. The timeframe for expedited prior authorization requests may be extended by fourteen (14) calendar days pursuant to 42 CFR 438.210(d)(2)(ii).

Recommendations and Resources for Providers

Providers are encouraged to reference the following resources on the Nevada Medicaid website:

- [Nevada Medicaid State Plan and Nevada Medicaid Check-Up State Plan](#)
- [Nevada Medicaid Services Manual](#)
- [Nevada Medicaid Web Announcements](#)
- [Nevada Medicaid Billing Guides](#)

Providers are encouraged to confirm if prior authorization is required by an MCO, even if the particular service does not require prior authorization in FFS. Additionally, providers are encouraged to confirm with an MCO if any specific duration or quantity limits may apply. Providers can obtain contact information for Nevada Medicaid's MCOs on the [Nevada Medicaid Contact List](#) webpage.

Providers should notify ManagedCare@nvha.nv.gov if:

- An MCO is using clinical criteria which is more restrictive than the clinical criteria required by FFS; or
- An MCO is requiring prior authorization for a service required by law (example: the Nevada Revised Statutes; not the Medicaid Services Manual) to have no prior authorization.