

Nevada Medicaid and Nevada Check Up News



Volume 16, Issue 3
Third Quarter 2019

Inside This Issue:

- 2 [Prior Authorization No Longer Required for Radiology Scans](#)
- 2 [Revalidate Timely to Avoid Provider Contract Termination](#)
- 2 [Enrollment and Revalidation Training Materials and Training Sessions](#)
- 2 [Contact Information](#)
- 3 [Attention All Providers: Claim Denial Reasons and Resolutions/Workarounds to Assist Providers in Resolving Claim Denials](#)
- 4 [Known Modernization System Issues](#)

Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers \$1,006,188,172.53 in claims during the three-month period of April, May and June 2019. Nearly 100 percent of current claims continue to be adjudicated within 30 days. Thank you for participating in Nevada Medicaid and Nevada Check Up.

Paper Submissions Are No Longer Returned to Providers

Reminder to Web Announcements [1967](#), [1942](#) and [1923](#): With the implementation of the new, modernized Medicaid Management Information System (MMIS) on February 1, 2019, the following items **must** be submitted electronically to Nevada Medicaid:

- Claims
- Claims Appeals
- Prior Authorization Requests (with the exception of those requiring x-rays or molds to be included)
- Provider Enrollment Applications
- Provider Re-enrollment Applications
- Provider Revalidations
- Temporary Provider Enrollments

Effective October 1, 2019, the above items submitted on paper are securely destroyed and no longer returned to providers or their vendors. For information concerning electronic submissions, please refer to [Web Announcement 1733](#).

Pharmacy Webpages Updated to Display Silver State Scripts Board

The Pharmacy webpages at www.medicaid.nv.gov have been updated to incorporate the changes made to the Pharmacy and Therapeutics (P&T) Committee per Nevada Senate Bill 378. The changes include establishing the Silver State Scripts Board to replace the P&T Committee. The Silver State Scripts Board's responsibilities include the development of the Preferred Drug List (PDL).

Please note: If you have P&T webpages saved to your internet favorites, those hyperlinks will no longer connect you to the website, and you will receive the error "404 – Page Not Found."

Please visit the Pharmacy webpages at www.medicaid.nv.gov and reset your internet favorites to obtain current information regarding Silver State Scripts Board meetings, meeting materials and board members.



Prior Authorization No Longer Required for Radiology Scans

Per the Division of Health Care Financing and Policy (DHCFP) Public Hearing held on August 27, 2019, effective September 1, 2019, prior authorization (PA) is no longer required for all medically necessary Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS) and Positron Emission Tomography (PET) scans. Medicaid Services Manual (MSM) Chapter 300 (Radiology Services) will be updated to reflect this change. Please disregard previous instructions regarding PA requirements for radiology scans.

The provider types impacted by this change include, but are not limited to: 12 (Hospital, Outpatient), 20 (Physician, M.D., Osteopath, D.O.), 22 (Dentist), 24 (Advanced Practice Registered Nurse), 27 (Radiology and Non-Invasive Diagnostic Centers) and 77 (Physician's Assistant).

Providers must use other modalities or less expensive tests, such as computed tomography (CT) scan, ultrasound or standard x-ray, etc., when the other modalities or tests will achieve the required results.

For additional information regarding claims for radiology scans, see [Web Announcement 1962](#).

Revalidate Timely to Avoid Provider Contract Termination

The federal regulation at 42 CFR 455.414 requires that state Medicaid agencies revalidate the enrollment of all providers, regardless of provider types, at least every five (5) years, with the exception of Durable Medical Equipment (DMEPOS) suppliers which must revalidate every three (3) years per 42 CFR 424.57 (g). Nevada Medicaid and Nevada Check Up providers will receive a letter notifying them when to revalidate. Providers are encouraged to revalidate within 60 days of the date on their notification to avoid termination. **Providers may revalidate up to a year in advance of their revalidation due date.**

Providers must revalidate online by logging into the Provider Web Portal through the Provider Login (EVS) link and click on the "Revalidate-Update Provider" link on the My Home page.

The Nevada Medicaid Provider Revalidation Report on the [Provider Enrollment](#) webpage lists each provider and the date their next revalidation is due. To avoid contract termination, your revalidation application must be processed and approved prior to the revalidation due date.

Enrollment and Revalidation Training Materials and Training Sessions

Targeted training presentations regarding Provider Enrollment, Revalidations and Changes for all provider types have been posted to both the [Provider Enrollment](#) webpage and the [Provider Training](#) webpage under "Provider Enrollment and Revalidation Instruction Materials."

The presentations contain step-by-step instructions for the following:

- Initial Individual Application
- Initial Group Application
- Individual Revalidations/Changes
- Group Revalidations/Changes
- Enrolling as an Ordering, Prescribing or Referring (OPR) Provider
- Individual Application for Out-of-State Emergency Services
- Group Application for Out-of-State Emergency Services

Please note: Monthly scheduled trainings will be hosted by Nevada Medicaid's Fiscal Agent regarding the above topics. See [Web Announcement 1963](#) for upcoming Revalidation and Changes training sessions. Additional web announcements will be posted shortly with other training opportunities. Should there be any questions or if a provider requires additional enrollment/revalidation/change training, please contact NevadaProviderTraining@dx.com.

Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact the Nevada Medicaid Provider Customer Service Center by calling (877) 638-3472, press Option 2 for providers, then Option 0 and then Option 2 for claim status. If you have a question regarding prior authorizations, please call (800) 525-2395.

If you have a question about Medicaid Service Policy, you can go to the DHCFP website at <http://dhcfp.nv.gov>. Select "Resources" and then select "Telephone Directory" for the telephone number of the Administration Office you would like to contact.

Attention All Providers:

Claim Denial Reasons and Resolutions/Workarounds to Assist Providers in Resolving Claim Denials

The Division of Health Care Financing and Policy (DHCFP) and the Nevada Medicaid fiscal agent reviewed all claim submissions for the month of June 2019 and compiled a list of the top 10 reasons for which claims denied. The table below lists the top 10 error codes for the claim denials, the error code descriptions and instructions to providers on how to resolve the claim denials.

Please see web announcements at www.medicaid.nv.gov for additional reasons for which claims deny and steps providers can take to resolve the claim denials.

Error Code on Remittance Advice	Error Code Description	Resolution or Workaround
4758	Billing PT/PS Rsten (Provider Type/Provider Specialty Restriction) on Proc (Procedure) Coverage Rule	<p>Providers must verify that the code being billed is payable by Nevada Medicaid.</p> <p>Providers can determine the covered codes by reviewing their Provider Type specific Rates Unit PDF. These can be located at: http://dhcftp.nv.gov/Resources/Rates/FeeSchedules/ or Search Fee Schedule</p> <p>For Waiver Providers Only: If a Waiver provider receives the error code and the claim has been paid, the error code can be disregarded.</p>
1082	Referring NPI (National Provider Identifier) cannot be the same as the Servicing NPI	<p>Provider will need to review the claim to determine which NPI was duplicated and then resubmit the claim with the correct NPIs listed.</p>
2003	Client ineligible on DTL DOS (detail level date of service)	<p>Provider will need to verify that the recipient is eligible for the dates of service and has the appropriate Benefit Plan.</p> <p>This may be completed in the Electronic Verification System (EVS) by reviewing the Member Eligibility tab.</p>
3001	Prior Authorization not Found	<p>Verify that a prior authorization request has been submitted and approved.</p> <p>Verify the correct authorization number has been placed on the claim.</p> <p>Provider will also need to verify that the Dates of Service (DOS) match the time span of an approved authorization and that those DOS match the dates billed on the claim.</p> <p>Provider will also need to verify that the authorization number corresponds with the correct NPI and recipient ID before resubmitting the claim.</p>
452	Calculated Detail Medicare Allowed Amount is Zero	<p>Nevada Medicaid will pay up to the recipient's Medicare Co-Insurance and/or Deductible and if the Co-Insurance or Deductible that is listed on the claim equals zero (0), the claim will deny.</p> <p>Providers must confirm that the Co-Insurance and/or Deductible fields are properly filled out.</p> <p>If Medicare did not pay on the claim, the provider must submit the claim as a Fee-for-Service claim, not as a crossover, and indicate the correct Claim Adjustment Reason Code (CARC) at either the header or detail level of the claim.</p> <p>Please see Web Announcement 1941 for more information.</p>

Continued on page 4

Nevada Medicaid and Nevada Check Up News

Claim Denial Reasons and Resolutions

Continued from page 3

Error Code on Remittance Advice	Error Code Description	Resolution or Workaround
1048	Provider Terminated – DTL DOS	The NPI associated with the claim is not enrolled with Nevada Medicaid. Provider will need to enroll with Nevada Medicaid and the claim can then be resubmitted.
908	PAD (Physician Administered Drug) Detail Denied by PBM (Pharmacy Benefit 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)
5035	Exact Duplicate: Practitioner to Practitioner	Original claim submission was previously paid by Nevada Medicaid. Providers should review their previous Remittance Advice (RA) to determine when the original claim was paid.
1076	Prov (Provider) Contract not valid on DOS – DTL	Provider was not enrolled with Nevada Medicaid on the dates of service rendered to the recipient. Provider will need to be enrolled for the dates of service before resubmitting the claim. Providers can back date their applications or revalidations up to 365 days in order to cover the dates of service only in certain circumstances. If an application is being back dated between 180 and 365 days, sufficient documentation must be provided as to why the application is being back dated and timely filing is still applicable.
1009	Contract could not be determined – DTL	The dates of service on the claim submitted do not fall within the time frame that the provider's contract is active with Nevada Medicaid. Error code could also set due to the fact that the claim was submitted as an incorrect claim type. The provider will need to review their contract/internal records to determine if the dates of service listed on the claim fall within their active contracts. If the wrong dates of service were listed, submit a new claim. Providers should also review all other information listed on the claim to determine if the claim is valid for submission.

Known Modernization System Issues

Providers are reminded to review the [Known Modernization System Issues](#) list for updates on issues impacting claim processing. The link to the list is posted on the [Modernization Project](#) webpage under Known System Issues and Identified Workarounds. The link is also posted on the website in the upper right corner of each page under Notifications.

The top part of the Known Modernization System Issues list contains the descriptions and resolutions/workarounds for issues that are currently being researched. The list provides the impacted provider types, procedure codes and error codes. When the issues are resolved, the list is updated with the date the claims were reprocessed, if applicable, and the issues are moved to the lower section of the document under Closed Issues.