# Nevada Medicaid and Nevada Check Up News

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## Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,858,503,989.46 in claims during the three-month period of April, May and June 2025. Nearly 100 percent of current claims continue to be adjudicated within 30 days.

Thank you for participating in Nevada Medicaid and Nevada Check Up.

# Reminder to Keep Demographic Information Updated

Providers are encouraged to update and maintain the demographic and enrollment information on file with Nevada Medicaid. This information is used for the Search Provider feature and ensures that accurate results are returned.

To update this information, submit a Demographics update or a Revalidation or Update application through the Provider Web Portal (PWP). See the PWP User Manual Chapter 12 and the Provider Flex Revalidation and Updates User Guide for instructions.

## *Complete Anonymous Rate Review Survey*

Nevada Medicaid is asking for your help! Each year, Nevada Medicaid surveys groups of our providers to get feedback on the rates Medicaid pays for services. This input is critical for our budget and policy update process. Fewer than 6 percent of providers respond. To increase participation and the quality of data, we would like to know the challenges you face in completing Quadrennial Rate Reviews (QRR). Please complete this 6-question anonymous survey to inform our next QRR survey. A flyer is attached in Web Announcement 3720 that you can print and post to explain the importance of completing the survey.

Providers should calculate the complete cost per code, per encounter. This can include overhead such as facility, utilities, rent, etc. It can also include direct costs such as wages, vendors, supplies, etc. For questions regarding calculating cost per code, contact your Certified Public Accountant.

Here are additional resources to help you calculate the cost of providing services:

- How your revenue cycle management affects patient and surprise billing
- Understanding cost per patient
- QRR website

If you have any questions, you can email QRR@nvha.nv.gov.

# Provider Flex Enrollment Training Sessions in October 2025

Nevada Medicaid and the Gainwell Technologies Provider Training Team would like to invite all providers, delegates, and staff to attend an Enrollment Overview training session. This hour and a half long training will provide step-by-step instructions on how to properly fill out a Nevada Medicaid Provider Enrollment application using Provider Flex. Sessions are differentiated by individual, group, behavioral health individual, and behavioral health group providers.

Sessions will have a maximum registration of thirty (30) attendees and will include a question-and-answer portion at the end. Please visit the Provider Training Registration Website to register for the October training sessions. The session dates and times are listed in Web Announcement 3690.

# Quadrennial Rate Review Survey Due November 7, 2025

Now is your chance to help ensure that reimbursement rates accurately reflect costs. Quadrennial Rate Review (QRR) surveys may assist in justifying rate adjustments. Data gathered from provider responses directly contributes to the analysis of current reimbursement rates and may assist in justifying rate adjustments in the future.

**If you are in the list below, please complete the survey located on the QRR page and send the Excel files to QRR@nvha.nv.gov by November 7, 2025.**

- ***17** (Special Clinics) **specialty 166** (Family Planning)*
- ***17** (Special Clinics) **specialty 169** (Freestanding Birthing Centers)*
- ***17** (Special Clinics) **specialty 174** (Public Health)*
- ***17** (Special Clinics) **specialty 183** (Comprehensive Outpatient Rehab Facilities (CORF))*
- ***17** (Special Clinics) **specialty 195** (Community Health Clinics – State Health Division)*
- ***17** (Special Clinics) **specialty 198** (Human Immunodeficiency Virus (HIV))*
- ***24** (Advanced Practice Registered Nurses (APRN))*
- ***27** (Radiology and Non-invasive Diagnostic Centers)*
- ***35 specialty 987** (Non-Emergency Secure Behavioral Transports (NESBHT))*
- ***38** (Waiver or Individuals with Intellectual and Developmental Disabilities (ID))*
- ***93** (Substance Use Treatment Services) **specialty 706** (Peer Recovery Support Specialist (PRSS))*
- ***93** (All remaining Specialties for Substance Use Treatment Services)*

For more information, including a full annual schedule and detailed instructions, please visit the QRR website. These reviews are to comply with the provisions of NRS 422.2704.

For questions, write to QRR@nvha.nv.gov.

# Use Current Forms to Request Prior Authorization for Services

Providers are reminded to always use the current Nevada Medicaid forms when requesting prior authorization (PA) for services as the forms are updated periodically.

For example, all forms with multiple pages have been updated to add fields for the recipient's name, the date of request, and the page number to each additional page. This update is to comply with the Medical Record Documentation Policy detailed in Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program, section 103.13.

All forms are available on the Forms webpage of the Nevada Medicaid Provider website.

## *Attention All Providers: Top Prior Authorization Denial Reasons for the Second Quarter of 2025*

Nevada Medicaid and Gainwell Technologies, its fiscal agent, have reviewed all prior authorization (PA) submissions for the second quarter of 2025 and have compiled a list of the top reasons for which prior authorizations have been denied. The table below lists the top denial reasons for the prior authorizations and instructions to providers on how to avoid future prior authorization denials.

| Denial Reason Description | Suggested Action to Avoid Future Denials |
|---|---|
| Request does not meet medical necessity criteria<br>**OR**<br>Requested service does not meet Nevada Medicaid policy criteria for reimbursement | Providers should review their Provider Type Medicaid Services Manual Policy Chapter as well as their Provider Type Billing Guidelines and generally accepted standards of care. Providers must document all relevant clinical aspects that should be considered when reviewing the request for medical necessity. |
| Additional information requested not received, preauthorization request rejected | Providers **must** review their prior authorization requests in the Provider Web Portal (PWP). Providers should check the portal frequently; if a PA is in a "Pending" status please review the notes to determine if additional information has been requested. Providers can review Chapter 4: Prior Authorization of the PWP User Manual in order to learn about how to review the status of a PA as well as additional information regarding submitting additional documents that are requested by Nevada Medicaid. |
| Recipient is no longer eligible for coverage<br>**OR**<br>Recipient not eligible on requested dates of service | Providers should review the recipient's eligibility information prior to PA submission. This is done through the PWP. Review Chapter 2: Eligibility Benefit Verification of the PWP User Manual for more information. |
| Late notification; prior authorization timelines not met | Prior authorization was submitted outside of timely filing rules and Nevada Medicaid is unable to accept any requests that are not within the appropriate time frame. Providers should review Chapter 4 of the Nevada Medicaid Billing Manual for prior authorization timely filing information. |
| Invalid preauthorization request form submitted, resubmit request with a current form | Providers should review their Provider Type Billing Guidelines for more information regarding which form should be submitted. Providers must also review the Forms Page to determine that the most current |

# Professional Claim Denial Reasons and Corresponding Resolutions/Workarounds

Nevada Medicaid and Gainwell Technologies, its fiscal agent, review claim submissions to monitor the common reasons for professional claim denials. The table below lists some of the error codes providers have been receiving recently for their denied professional claims. For each error code, the table also lists the corresponding 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 |
|---|---|---|---|
| 452 | 452 | No Medicare Coinsurance, Deductible or Copay Due | Providers will need to verify the co-insurance, deductible or co-pay amount in the Medicare crossover details fields. |
| 2003 | 3006 | Client ineligible on DTL DOS (detail level date of service) | Providers will need to verify that the recipient is eligible for the dates of service and has the appropriate Benefit Plan.<br><br>This may be completed in the Provider Web Portal (PWP) by reviewing the Member Eligibility tab, or by utilizing Gabby™ by calling the Contact Center at (877) 638-3472 or the Automated Response System (ARS) at (800) 942-6511. |
| 1008 | 1508 | Billing Prov is not a Grp/ Performing is a Grp Prov | Providers should review claims to ensure that a Group National Provider Identifier (NPI) is listed as the billing NPI and that an individual NPI is listed as the rendering or performing provider. |
| 1047 | 0205 | Provider Terminated – DTL Performing | Providers should ensure that the performing NPI is enrolled with Nevada Medicaid for the dates of service. Providers should check their enrollment status via the Provider Flex tool. If not contracted, you will need to submit a new application to Nevada Medicaid. Visit the Provider Enrollment webpage for more information. |
| 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.<br><br>Review the Search Fee Schedule for more information. |

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## *Professional Claim Denial Reasons…* *Continued from page 4*

| Error Code | EOB Code on Remittance Advice | Error Code Description | Resolution or Workaround |
|---|---|---|---|
| 1009 | 1009 | Contract Could not be Determined | Providers should 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 tool to be able to bill for dates of service. Visit the Provider Enrollment webpage for more information. |
| 1076 | 1012 | Prov Contract not Valid on DOS – DTL (detail level date of service) | The billing provider is not contracted with Nevada Medicaid for the dates of service listed on the claim. If not contracted, providers should submit a new enrollment application to Nevada Medicaid. Visit the Provider Enrollment webpage for more information. |
| 1048 | 0025 | Provider Terminated – DTL DOS (detail level date of service) | The billing or rendering provider is not contracted with Nevada Medicaid for the dates of service listed on the claim. If not contracted, providers should submit a new enrollment application to Nevada Medicaid. Visit the Provider Enrollment webpage 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. |
| 1852 | 1852 | Billing Provider Failed To Revalidate | Providers should 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 re-enrollment application to Nevada Medicaid via the Provider Flex tool unless they are within 365 days from the date of contract termination, wherein a revalidation application can be submitted via the Provider Web Portal (PWP) to be able to bill for dates of service upon approval. See Web Announcement 3369 as well as the Provider Enrollment webpage for more information. |

## Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact the Gainwell Technologies Contact Center by calling (877) 638-3472. 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 Nevada Medicaid website at http://dhcfp.nv.gov. Select the "Resources" drop-down list, then select "Telephone Directory" and look for the telephone number of the Administration Office you would like to contact.