Nevada Medicaid and Nevada Check Up News

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Fourth Quarter 2025

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Quarterly Update on Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers $1,497,877,527.77 in claims during the three-month period of July, August, and September 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.

False Claims Act Initial Certification or Recertification Letters

As part of the federal Deficit Reduction Act of 2005, all health care providers/entities receiving Medicaid funding of more than $5,000,000 annually are required to inform staff, contractors and agents about:

1) Federal and State False Claim Acts,
2) protections as whistleblowers, and
3) the organization's policies and procedures for detecting and preventing fraud, waste and abuse.

Initial Certification and Recertification letters for Nevada Medicaid Fee-for-Service providers/entities receiving a total net payment of more than $5,000,000 (based on Tax ID number) between October 1, 2024, and September 30, 2025, will be mailed in December.

These letters will be mailed via certified mail to the provider's/entity's address on file with Nevada Medicaid and must be responded to with the requested information within 90 calendar days.

If you have any questions concerning a False Claims Act Initial Certification or Recertification letter received, please send an email to nevadamedicaidfca@gainwelltechnologies.com for assistance.

Providers and Partners Asked to Share Flyers

Nevada Medicaid has created nearly 30 flyers and fact sheets for members and providers over the past three years. They help members and providers to stay informed. Nevada Medicaid is working to upload all material to one web page. Providers and community partners can review, print, post and distribute them. Visit the Fact Sheets & Flyers web page from Nevada Medicaid today.

Speaking with Members in Plain Language

Nevada Medicaid staff has used Plain Language to transform Medicaid Welcome and Renewals letters to members. The goal of Plain Language is to make communications easier to understand. That way, members will take the action we want them to take to stay insured and stay and/or get healthier. Nevada Medicaid is taking this approach with all member communications and striving for reading level targets of 6th grade or lower. Here is a fun video about the importance of plain language that you can share with your staff. Providers who are interested in reviewing their existing and future communications for plain language standards, learning more and/or training to better communicate with members can visit the federal Plain Language website and Plain Language Associate International. The Center for Health Literacy is also a good resource.

Reminder to Keep Demographic Information Updated

Providers are reminded to update and maintain the demographic and enrollment information they have 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 on how to submit these.

Attention All Providers: Top Prior Authorization Denial Reasons for the Third Quarter of 2025

Nevada Medicaid and Gainwell Technologies, its fiscal agent, have reviewed all prior authorization (PA) submissions for the third 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 **OR** 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.

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Prior Authorization Denial Reasons… *Continued from page 2*

Denial Reason Description	Suggested Action to Avoid Future Denials
Recipient is no longer eligible for coverage **OR** 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 version of a form is being used.
Reconsideration request is denied for technical reasons; PA requirements were not met for submission within the required timeframe	Per Nevada Medicaid guidelines, a request for reconsideration of an adverse determination must be submitted within 30 days of the date of decision. Providers can reference Web Announcement 3747 for instructions on how to submit a PA reconsideration request properly.

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. 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.
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.

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Professional Claim Denial Reasons… *Continued from page 3*

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
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. Review the Search Fee Schedule for more information.
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.

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.