

# Nevada Medicaid and Nevada Check Up News



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## **Quarterly Update on Claims Paid**

Nevada Medicaid and Nevada Check Up paid out, through claims and capitation payments, a total of \$1,853,650,339.90 during the three-month period of October, November, and December 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.

## **Battle Born State Plan Provider Enrollment Requirement Update**

Effective January 1, 2026, Subsection 1 of NRS 695K.230 requires providers who are enrolled or contracted with Nevada Medicaid, a Nevada Medicaid Managed Care Organization, or the Public Employees' Benefits Program to also enroll as a contracted provider with at least one Battle Born State Plan.

However, to ensure sufficient access to covered services during the program's first year, the Nevada Health Authority has issued a waiver of this requirement through December 31, 2026. Providers are strongly encouraged to work with Battle Born State Plan carriers during this time to prepare for compliance by January 1, 2027.

Please visit the following link for more information: [Notice of Waiver of Enforcement of the Subsection 1 of NRS 695K.230](#).

## **Participate in the All-Payer Claims Database Advisory Committee**

Are you passionate about improving health care transparency and quality in Nevada? Here's your chance to make an impact!

The Nevada Health Authority (NVHA) is recruiting members for the All-Payer Claims Database (APCD) Advisory Committee, a group that plays a vital role in guiding how health care data is collected and used to benefit all Nevadans.

We're currently seeking Nevada residents for the following positions:

- A member who is a provider of health care
- A member who represents a health facility

A member who represents a health maintenance organization (as defined in [NRS. 695C.030](#))

- A member who represents a private insurer
- A member who represents a nonprofit organization that represents consumer of health care services

Interested? Submit your application [here](#), along with a follow-up email to [communityandprovider@nvha.nv.gov](mailto:communityandprovider@nvha.nv.gov) with your resume attached.

# Nevada Health Authority Announces NevadaMedicaid.nv.gov and Changes to Medicaid.nv.gov

[Medicaid.nv.gov](https://www.Medicaid.nv.gov) and [NevadaMedicaid.nv.gov](https://www.NevadaMedicaid.nv.gov) have a new look that directs users to the appropriate location based on what they are looking for.

Medicaid.nv.gov includes resources for members (such as applications for Medicaid and benefits information), providers (such as fee schedules, policy, and waiver information), and community partners (such as information on program details, data dashboards, and Nevada Health Authority information). Medicaid.nv.gov also includes a chat bot, FAQs, and opportunities to provide feedback.

NevadaMedicaid.nv.gov is the Nevada Medicaid policy and programs website, which was previously DHCFP.nv.gov. DHCFP is short for Division of Health Care Financing and Policy which was renamed Nevada Medicaid by the legislature in 2025.

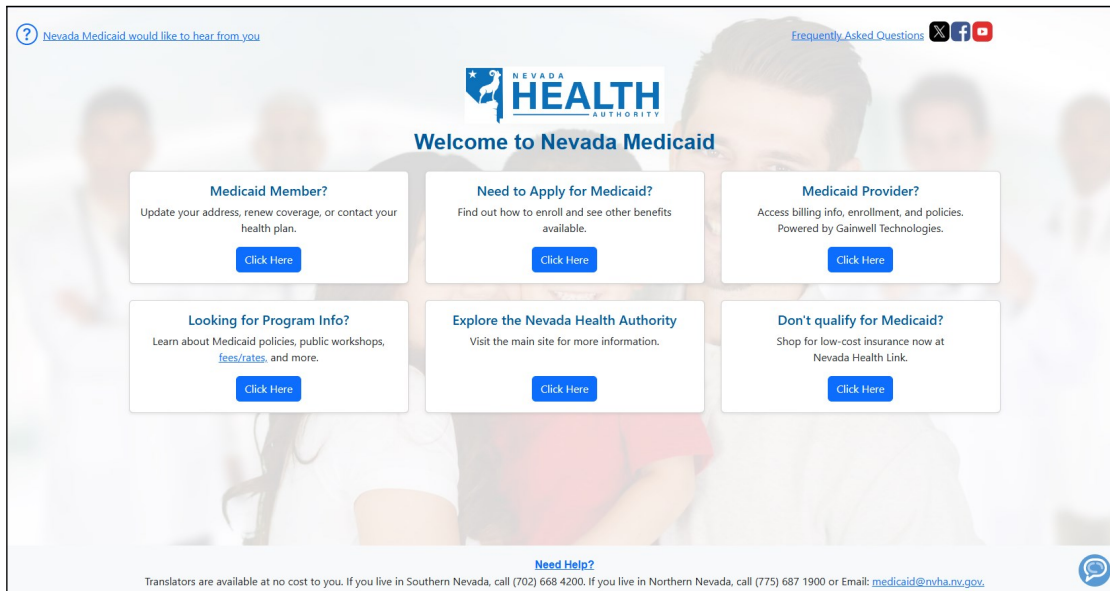
If you have difficulty finding information, please reach out to [PIO@nvha.nv.gov](mailto:PIO@nvha.nv.gov) with “Nevada Medicaid Website” in the subject line.

Thank you for your patience as we modernize and adapt for a healthier Nevada.

## NevadaMedicaid.nv.gov home page:



## Medicaid.nv.gov home page:



### NOW OPEN: Nevada's Rural Health System Flex Fund!

The Nevada Health Authority (NVHA) is proud to announce that first funding opportunity under the state's [Rural Health Transformation](#) (RHT) Program is now available!

The Nevada Rural Health System Flex Fund is designed to support the unique needs of our rural health providers in supporting capital expenditures and equipment to enhance and modernize local rural health care infrastructure. NVHA invites all partners to explore this (and future) opportunities under the state's RHT program and consider how these resources can help transform health care access and outcomes in rural Nevada.

- View the Request for Applications (RFA): [Nevada's RHT Funding Opportunities](#)
- **Round 1 Deadline: April 30, 2026, by 11:59pm PT.**

*Note: If funds remain after this first cycle, NVHA will open a second round of applications.*

For questions, contact the Nevada Rural Health Transformation Team at [RHTP@nvha.nv.gov](mailto:RHTP@nvha.nv.gov).

### Update Your Information Within 30 Days of Changes

Nevada Medicaid encourages all providers to review and update their demographic and enrollment information as needed. Instructions for completing demographics updates through the [Provider Web Portal](#) are available [here](#). Instructions for completing provider revalidations and updates through the [Provider Web Portal](#) are available [here](#).

This will help members find providers through the [Search Provider](#) feature, ensure accurate results and help Nevada Medicaid comply with state law regarding demographic reporting. A reminder that any changes must be reported to Nevada Medicaid within 30 calendar days ([Medicaid Services Manual \(MSM\) Chapter 100](#)).

Providers are also encouraged to keep their PWP user account information updated. Instructions for completing Provider Profile information through the Provider Web Portal are available [here](#) in section 1.6.

### Medicaid Behavioral Health Providers in Nevada Get Raise to Help Children

Nevada Medicaid is boosting pay for children's behavioral health services across the state by up to 25%, including higher incentives in rural Nevada and for services provided at home. These changes are retroactive to January 1, 2025. The pay increase is expected to help up to 320,000 Nevada children and youth under 21 who are eligible for behavioral health services such as psychotherapy, basic skill training, and psychosocial rehabilitation.

"Reforming provider reimbursement rates is one of many tools in our box to address the behavioral health needs of Nevadans," said **Ann Jensen, Nevada Medicaid Administrator**. "The bottom line is, we need more behavioral health providers serving youth in our state at home and in their communities. This rate increase supports Nevada's transformative goals to improve behavioral health for kids."

This rate reform is a unique model. It increases the base rates and incentivizes care delivered in high-need settings. All reimbursement rates for outpatient behavioral health services delivered to children, such as therapy at home, in a clinic, or in school, increased by an average of 10 percent. When these services are delivered in rural Nevada, the reimbursement rate increases by another 10 percent. Additionally, if a child receives this service at home, reimbursement increases another 5 percent.

All Managed Care Organization health plans are required to reimburse providers at least the rate of the State's Fee for Service rates. This ensures providers will see this rate increase for all youth receiving Medicaid coverage in the State.

"We are excited about the Medicaid rate increases for behavioral health services," said **Steve Shell, Founder and Executive Director of the Behavioral Health Association of Nevada**. "They will enable our providers to better serve our communities and support those most in need. Up to this point the reimbursement rates for all payers have not kept up

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**Behavioral Health Providers Raise...** *Continued from page 3*

with the mounting costs to do business. This shows that the Nevada Health Authority is committed to listening to providers and moving Medicaid rates to a more reasonable level for some critical behavioral health services. It is a meaningful step toward expanding access to essential services for Nevadans and ensuring that providers can continue to deliver the high-quality care that Nevadans deserve."

Behavioral health services for youth in Nevada were found by the United States Department of Justice (DOJ) to be insufficient in 2022, with inadequate services available at home and in the community. In 2025 the State of Nevada entered a [settlement with the DOJ](#) to transform children’s behavioral health services. Hundreds of stakeholders have met regularly since the fall of 2024 to help shape the state’s transformative model, which includes new services and a new health plan for children with behavioral health needs, set to launch in 2027.

For more information, visit the [Children’s Behavioral Health Transformation website](#).

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

Nevada Medicaid and Gainwell Technologies, its fiscal agent, have reviewed all prior authorization (PA) submissions for the fourth 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 <b>OR</b> Requested service does not meet Nevada Medicaid policy criteria for reimbursement	Providers should review their <a href="#">Provider Type Medicaid Services Manual Policy Chapter</a> as well as their <a href="#">Provider Type Billing Guidelines</a> 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 <b>must</b> 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 <a href="#">Chapter 4: Prior Authorization</a> 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 <b>OR</b> 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 <a href="#">Chapter 2: Eligibility Benefit Verification</a> of the PWP User Manual for more information.
Late notification; prior authorization time-lines 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 <a href="#">Billing Manual</a> for prior authorization timely filing information.
Invalid preauthorization request form submitted, resubmit request with a current form	Providers should review their <a href="#">Provider Type Billing Guidelines</a> for more information regarding which form should be submitted. Providers must also review the <a href="#">Forms Page</a> 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 <a href="#">Web Announcement 3747</a> for instructions on how to submit a PA reconsideration request properly.

## Resetting Provider Web Portal and Provider Flex Passwords

Effective February 17, 2026, to improve account security, passwords will no longer be sent through email to reset Provider Web Portal (PWP) or Provider Flex passwords. Instead, users will now be sent an email with a link to a secure page where they will verify their identity and then reset their password.

If a delegate does not know the name, birth date, last 4 of DLN, and/or delegate code that is on file under their PWP account, they need to contact their administrator to obtain this information.

Detailed instructions for resetting passwords have been updated in the [PWP User Manual Chapter 1: Getting Started](#) and the [Provider Flex User Guide: Getting Started](#). Please see the currently posted resources or contact the Gainwell Technologies Contact Center at (877) 638-3472 for assistance.

## 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.
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 <a href="#">Search Fee Schedule</a> for more information.
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 <a href="#">Provider Web Portal (PWP)</a> 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.
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 <a href="#">Provider Flex</a> tool to be able to bill for dates of service. Visit the <a href="#">Provider Enrollment</a> webpage for more information.

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### *Professional Claim Denial Reasons... Continued from page 5*

Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
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 <a href="#">Search Fee Schedule</a> for more information.
5035	5035	Exact Duplicate: Practitioner to Practitioner	Claim is an exact duplicate of a previously paid claim. Providers need to review claim history and submit an adjustment or void the claim if changes are needed. This may be completed in the <a href="#">PWP</a> .  Please review the <a href="#">PWP User Manual Chapter 3: Claims</a> for further instruction.
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 <a href="#">Search Fee Schedule</a> for more information.
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.
3001	0192	Prior Authorization not Found	Providers are advised to proceed with the following steps: <ul style="list-style-type: none"> <li>• Verify that the prior authorization request has been submitted and approved.</li> <li>• Verify the correct authorization number has been placed on the claim.</li> <li>• Verify that the Dates of Service (DOS) billed on the claim match the time span of the approved authorization.</li> <li>• Verify that the authorization number corresponds with the correct NPI and recipient ID before resubmitting the claim.</li> <li>• Verify that units are available on the approved authorization.</li> </ul>

### 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://nevadamedicaid.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.