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 $1,002,677,559.41 in claims during the three-month period of January, February and March 2020. Nearly 100 percent of current claims continue to be adjudicated within 30 days. Thank you for participating in Nevada Medicaid and Nevada Check Up.

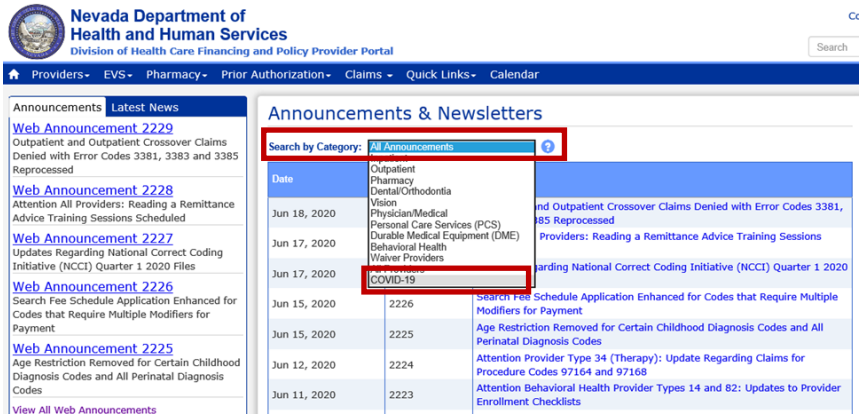
Reminder: Resources Available Regarding Nevada Medicaid Novel Coronavirus (COVID-19) Information and Instructions

The Division of Health Care Financing and Policy (DHCFP) created a Novel Coronavirus (COVID-19) webpage at http://dhcfp.nv.gov/covid19/ to answer frequently asked questions and to share information and resources pertaining to the current status of COVID-19 and its impact on Nevada Medicaid recipients and providers.

The webpage provides the Nevada Medicaid Response to the Novel Coronavirus (COVID-19), as well as useful links for recipients and providers.

- The Recipients section contains links to English and Spanish FAQs, guidance for those being monitored and links to Nevada's Managed Care Organization (MCO) websites.
- The Providers section includes links to a Healthcare Planning Checklist and Telehealth guidelines.
- The Nevada Links section provides links to health agencies.
- The Federal Resource Links section provides access to the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS) and Medicaid.gov.

Multiple web announcements have been posted on the provider website at https://www.medicaid.nv.gov to keep providers informed during the COVID-19 pandemic. Providers may view all related web announcements by selecting the new "COVID-19" category from the drop-down list on the Announcements/Newsletters page as shown below. The full list of published announcements will appear for providers to review.



COVID-19 Billing Guides

The Division of Health Care Financing and Policy (DHCFP) has developed two Nevada Medicaid billing guides for Novel Coronavirus (COVID-19): 1) COVID-19 General Billing Guide and 2) COVID19 Community-Based Testing Billing Guide. These billing guides will be updated as more information is approved by the Centers for Medicare & Medicaid Services (CMS).

All Nevada Medicaid Fee-for-Service billing guides, including the two related to COVID-19, can be found on the Providers Billing Information webpage at: https://www.medicaid.nv.gov/providers/BillingInfo.aspx. The new COVID-19 Billing Guides section is located at the top of the webpage.

COVID-19 Billing Guides

Title	Last Update
COVID-19 General Billing Guide	06/26/2020
COVID-19 Community-Based Testing Billing Guide	06/26/2020

Telehealth Services during the Novel Coronavirus (COVID-19) Pandemic

A provider training presentation was created to provide direction to providers about Telehealth services rendered and billed during the Novel Coronavirus (COVID-19) pandemic. The training presentation provides general billing information as well as guidance for specific topics such as Durable Medical Equipment (DME), Applied Behavior Analysis (ABA), Home Health Agencies, Hospice Care and Pharmaceuticals.

Along with the training presentation, a Nevada Medicaid Novel Coronavirus (COVID-19) Resources and Contact List has also been posted for providers to reference. This document provides website links to federal and state resources and telephone numbers for any questions providers may have.

The Telehealth Provider Training during the Novel Coronavirus (COVID-19) Pandemic presentation and the Resources and Contact List are posted on the Provider Training webpage under Workshop Materials.

May 2020	Telehealth Provider Training during the Novel Coronavirus (COVID-19) Pandemic | Nevada Medicaid Novel Coronavirus (COVID-19) Resources and Contact List

Instructions for Uninsured Patients who Require COVID-19 Testing and Diagnostic Services

Providers who have uninsured patients that have been tested for COVID-19 may direct them to the following Access Nevada website to apply for COVID-19 testing and diagnostic services coverage: https://accessnevada.dwss.nv.gov/public/landing-page and click on the link "Click for COVID-19 Testing Coverage" at the top of the webpage. **This is not an application for full Nevada Medicaid coverage**. Patients must attest to residency, citizenship, Social Security Number (SSN), and that they have no other insurance or do not qualify for regular Medicaid.

When applying for this coverage, the applicant must complete the application in Adobe Acrobat or Adobe Reader and NOT use a default browser PDF-viewer within Chrome or Edge. The form can also be printed and completed. Submission and mailing instructions are located on the form.

Once the application is submitted and reviewed, a "Temporary Special Medicaid Program Notice of Decision" will be mailed to the applicant. For application questions, call Access Nevada at (800) 992-0900.

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.

Top Prior Authorization Denial Reasons Compiled to Assist Providers with Avoiding Future Denials

The Division of Health Care Financing and Policy and the Nevada Medicaid fiscal agent have reviewed prior authorization (PA) submissions and have compiled a list of the top reasons for which prior authorizations have been denied. The table below lists the recent denial reasons for 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 DHCFP necessity criteria **OR** Medical information provided does not meet medical necessity criteria	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 request not received **OR** Preauthorization request rejected	Providers **must** review the Electronic Verification System (EVS) portal. 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 EVS 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 **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 EVS portal. Review Chapter 2: Eligibility Benefit Verification of the EVS 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 **OR** 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 ensure that the most current version of a form is being used.

Don't Miss Upcoming Provider Training Opportunities

Providers are invited to attend provider training sessions that are scheduled on a regular basis. The Provider Training webpage has a Training Announcements section that lists all web announcements published regarding upcoming sessions and the website Calendar lists each session with a link to an announcement that describes the content of the training.

The following three sessions are open to all provider types:

- New and current providers are invited to attend the **New Provider Orientation** virtual workshop, which is offered on a biweekly basis. This workshop includes a high-level overview of the Nevada Medicaid program, website navigation including locating billing information, forms and other helpful resources, getting started on the Electronic Verification System (EVS) and an overview of the EVS secure Provider Web Portal.
- The **Reading a Remittance Advice** training session is held once each month. This training will cover the basics for viewing and reading a remittance advice.
- The **Claims Appeals, Adjustments and Voids** session held each month includes how to properly appeal a denied claim, adjust or void a previously paid claim and locate valuable resources on the Nevada Medicaid website.

Training sessions are also held for specific provider types to address the prior authorization, claims billing and policy of interest to those providers. Some of the scheduled sessions focus on provider types 13 (Psychiatric Hospital, Inpatient), 34 (Therapy), 63 (Residential Treatment Center) and 85 (Applied Behavior Analysis). Sessions are also currently scheduled for Behavioral Health, Dental/Orthodontia and Hospice providers. Please review the Provider Training webpage and the website Calendar for sessions of interest to you, and register soon.

Top Enrollment Return Reasons and Resolutions

The Division of Health Care Financing and Policy and the Nevada Medicaid Fiscal Agent have reviewed all Enrollment submissions and have compiled a list of the top reasons for which Enrollment documents have been returned to providers. The table below lists the top reasons for the returns in March, April and May 2020 along with the instructions on how to resolve the returns.

Note: Several provider enrollment training resources are located on the Provider Enrollment webpage and on the Provider Training webpage under "Provider Enrollment and Revalidation Instruction Materials."

Document Return Description	Resolution
Ownership information is not listed correctly or in its entirety	Users must review the Chapter 2 Addendum: Ownership & Relationships Example for more information regarding the information that must be listed on the application.
License information is being input into fields incorrectly	Information that is input into the documents must match the information from the physical license. Users must review the physical license and confirm the information that is populated matches the information on the physical license. User must verify that when inputting the updated Secretary of State information that the information populated in the License Number field must also match the information populated into the Nevada Business ID field, as well as input the correct License Effective and End Dates. A physical copy of the license must also be included.
Individual providers are listing tax information pertaining to a Group	When an Individual is enrolling with Nevada Medicaid and linking to a Group, Individuals cannot list a Group's Federal Tax ID. Individuals should only list their own Social Security Number (SSN) and the Federal Tax ID field should be left blank.
Enrollment checklist is not being attached	Depending on the Provider Type being selected, the Enrollment Checklist may be required to be uploaded. Users should review the Enrollment Checklist to determine if the checklist is a required document. Example: The Provider Type 14, Specialty 305 checklist contains the following: "This checklist must be completed and submitted with the attachments listed below," which indicates the checklist is required.
Documents that are required on the enrollment checklist are not being attached	Users should re-review their Enrollment Checklist to verify that all documents being requested are uploaded and attached to the application. Be sure to view the most current checklists at Enrollment Checklists.
Provider does not have the correct qualifications for the provider type and/or specialty code that they are enrolling for	Providers should re-review the Enrollment Checklists, the Billing Information webpage and their Medicaid Policy chapter to determine if the correct credentials are present. If their credentials are not associated with the current Provider Type being enrolled in, the user will want to review the other Provider Types and related information to determine the best Provider Type to be enrolled with.
Quality Assurance Policies for Behavioral Health Providers are insufficient	Providers must re-read their Medicaid Policy chapter to determine the guidelines for their Quality Assurance Policy.
Non-authorized users are attempting to sign documents on behalf of a provider	Only Owners or Authorized Users can sign off on documentation. Non-Authorized Users are unable to sign or make changes. Verify that the person listed in the Ownership & Disclosure section under the "Change Authorization Information" is correct.
Qualified Mental Health Associate (QMHA) and Qualified Behavioral Aid (QBA) does not provide adequate proof of completing 16-hour training program.	Qualified Mental Health Associate (QMHA) and Qualified Behavioral Aid (QBA) require 16-hour Core Competency and in-service training to be enrolled. The training must show 16 hours related to skills outlined in Chapter 400 Sections 403.6.A.1B and 403.6.A.1C of the Medicaid Services Manual. Proof of completing the training program must be signed by the Direct or Clinical Supervisor that provided the training.

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Enrollment Return Reasons

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Document Return Description	Resolution
Provider is attempting to enroll an already enrolled provider and the provider being enrolled is not up for revalidation	A provider that is already enrolled with Nevada Medicaid cannot enroll under the same National Provider Identifier (NPI) and Provider Type twice. Verify on the Revalidation Report when the provider is due to revalidate their contract. If a provider needs to make changes to their profile, when in the Electronic Verification System (EVS) / Provider Web Portal, select Revalidate-Update and then select Update Provider.
Provider Type 17 (Special Clinics) are attempting to link individual providers to the Group NPI	Provider Type 17 cannot link Individual providers to their Group NPI. The Individual providers should complete the Ordering, Prescribing and Referring Enrollment Application as the Individual will not be submitting claims. Only the Group will be submitting claims.

Top Claim Denial Reasons and Resolutions and/or Workarounds

The Division of Health Care Financing and Policy and the Nevada Medicaid fiscal agent have reviewed all claim submissions and have compiled a list of the top reasons for which claims have denied in the months of March, April and May 2020. The table below lists the top error codes along with the 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
908	0908	PAD (Physician Administered Drug) Detail Denied by PBM (Pharmacy Benefits 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).
3347	0609	No Payable Accommodation Code	Error code 3347 will typically post as a denial along with additional denial code(s). Providers must review their submitted claim and open the Adjudication Errors panel.
451	0452	No Crossover Coinsurance or Deductible Due	Provider will need to submit a new claim using the regular Fee-for-Service claim along with the Medicare denial reason. See the Submitting Secondary Claims to Nevada Medicaid provider training presentation for more billing information when Third-Party Liability (TPL) is present.
1070	1464	Procedure Missing on Outpatient Claim	Provider must enter a valid procedure code on the detail level of the claim and submit new claim.
4801	0116	No Billing Rule for Procedure	Verify that the code being billed is a payable code by Nevada Medicaid. User should review the Search Fee Schedule for more information.

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Claim Denial Reasons

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Error Code	EOB Code on Remittance Advice	Error Code Description	Resolution or Workaround
3959	1178	No Reimb (Reimbursement) Rule for Rev (Revenue) Code	Review the claim for any additional adjudication errors and make any necessary changes. Also review the recipient's dates of eligibility and Benefit Plans. Verify the dates of service associated with the claim.
1011	1011	Contract could not be determined - HDR	Providers must verify that the NPI being listed is under contract with Nevada Medicaid for the dates of service indicated on the claim.
897	0897	PAD (Physician Administered Drug) – Void Denial	The provider will need to review their claim to determine if the claim has already been voided. This error code occurs when the Pharmacy Benefits Manager (PBM) recoups an entire claim that includes PAD services. Providers are encouraged to resubmit the claim to Nevada Medicaid if the claim has been recouped by the PBM.
2003	3006	Client ineligible on DTL DOS (detail level date of service)	Provider 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 Electronic Verification System (EVS) by reviewing the Member Eligibility tab.
3340	3340	Service not Covered by NV Medicaid	Verify that the code being billed is a payable code by Nevada Medicaid. User should review the Search Fee Schedule for more information.
2533	2533	No Medicare Coverage on File for Recipient	This error will only set when a provider attempts to submit a Medicare crossover claim and the recipient does not have Medicare coverage. Providers should review the recipient's benefit coverages and Third-Party Liability/Other Health Coverage (TPL/OHC) coverages before submitting a claim. If there is no Medicare coverage, do not submit claim as a crossover. If there is a discrepancy regarding the recipient's Medicare Coverage, please reach out to: TPL@dhcfp.nv.gov
708	0039	HCPCS Procedure Requires a Valid NDC	Verify that the Healthcare Common Procedure Coding System (HCPCS) code is accompanied by a valid and payable NDC.
400	1830	Detail Units of Service must be Greater than Zero	Verify that the service line details in the header match the information that is populated in the service line.
3001	0192	Prior Authorization not Found	Verify that a prior authorization request has been submitted and approved. Verify the correct authorization number has been placed on the claim. 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. Provider will also need to verify that the authorization number corresponds with the correct NPI and recipient ID before resubmitting the claim.