

# Dental Program

Medicaid Services Manual (MSM) Chapter 1000

Annual Medicaid Conference  
October 2012

Presented by: **DHCFP**  
**HPES**

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# Overview

- Chapter 1000
- Billing Guide
- Emergency and Palliative Care
- Categories of Dental Services
- Frequent Claim Denial Codes
- Learning Check



# Disclaimer

- Nevada Medicaid and Nevada Check Up policies are updated on a regular and ongoing basis. To assure you are in compliance, always use current versions of all policies.
- The slides in this handout are not designed to replace current policies and may not be used as a policy reference.



# Medicaid Manuals



Nevada  
Medicaid  
Operations  
Manual



Nevada  
Check Up  
Manual



Nevada  
Medicaid  
Services  
Manual



# Nevada Department of Health and Human Services

## Division of Health Care Financing and Policy



Nevada Department of Health and Human Services

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## Medicaid Services Manual - **Complete Document in PDF Format (1365 pages - 4.8 MB) Current Version 6-12-2012**

### Table of Contents

Medicaid services and the policies that govern those services can be found in the chapters of the Medicaid Services Manual (MSM). As a provider, you should be familiar with your specific chapter, as well as Chapter 100, Eligibility, Coverage and Limitations, Chapter 3100, Hearings, and Chapter 3300, Surveillance, Utilization and Review Subsystem. Manual Transmittal Letters (MTLs) are chapters or sections of the chapter that are pending revisions. Once they have been approved through the public hearing process the changes are then incorporated into the Chapter. A history of all revisions (MTLs) are kept under each Chapter.

### 100-Medicaid Program (**ARCHIVES**)

- [Chapter](#) (6-12-12)
- [Table of Contents](#) (6-12-12)
- [MTL](#) (6-12-12)

### 200-Hospital Services (**ARCHIVES**)

- Nevada Check Up Manual
- NV Medicaid Operations Manual
- NV Medicaid Services Manual (5-8-12)
  - [MTL](#) (5-8-12)

### 300-Radiology Services (**ARCHIVES**)



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# Service Limitations – 1 of 2

## Provider Type 22 Billing Guide

### Program Overview

**Recipients age 21 and older** may receive medically necessary dentures, emergency extractions and palliative care only.

**Recipients under age 21** may receive a larger range of dental services including orthodontia, certain restorative services and routine maintenance to promote dental health.

**Recipients who are pregnant** may receive periodontal scaling, root planning, a second cleaning during pregnancy and treatment of inflamed gums around wisdom teeth. Services for recipients who are pregnant require prior authorization.

### *Smoking Cessation Counseling for Pregnant Women*

As of October 13, 2011, CPT codes 99406 and 99407 are used to bill smoking cessation counseling for pregnant women only. For all other recipients, these services are billed using the appropriate Evaluation and Management (E&M) office visit code.

### Reference

Please see the following documents on the HP Enterprise Services website at <http://medicaid.nv.gov>:

- [Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid Dental Program](#)
- [ADA Claim Form Instructions](#)

Please see the following documents on the Division of Health Care Financing and Policy (DHCFP) website at <http://dhcfc.nv.gov>:

- [MSM Chapter 100](#) contains important information applicable to all provider types.
- [MSM Chapter 1000](#) covers dental program policy and requirements.



# Service Limitations – 2 of 2

## Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid and Nevada Check Up Dental Program

### Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid and Nevada Check Up Dental Program

- Updated July 12, 2012 -

In the following table:

**00** = Prior authorization is not required for EPSDT/Healthy Kids and for adult emergency services.

**01** = Prior authorization is required.

**02** = Prior authorization is required. Covered services are for 1) adjacent/abutment tooth for partials or 2) for a pregnancy-related service (recipients age 21 years

**NC** = This code is not a covered benefit.

CPT codes, descriptions and other data only are copyright © 2008 American Medical Association. All rights reserved. Applicable FARS/DFARS apply. CPT is a registered trademark ® of the American Medical Association. Current Dental Terminology, fourth edition (CDT) (including procedure codes, definitions (descriptors) and other data) is copyrighted by the American Dental Association. © 2008 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Code	CDT-5 Short Description and Coverage	Service for Persons Up to Age 21	Pregnancy-Related Service	Service for Persons Age 21 Years and Older	Service Limits
<b>DIAGNOSTIC AND PREVENTIVE (D0100-D2999)</b>					
D0120	PERIODIC ORAL EVALUATION	00	00	NC	1 unit per 11 months
D0140	LIMIT ORAL EVAL PROBLM FOCUS	00	00	00	3 units per 6 months
D0145	ORAL EVALUATION PT < 3YRS	00 - 6 months up to the age of 3 years	NC	NC	
D0150	COMPREHENSVE ORAL EVALUATION	00	00	NC	1 unit per year
D0160	EXTENSV ORAL EVAL PROB FOCUS	00	00	00	
D0170	RE-EVAL,EST PT,PROBLEM FOCUS	00	00	00	
D0210	INTRAOR COMPLETE FILM SERIES	00	00	00	1 unit per 11 months
D0220	INTRAORAL PERIAPICAL FIRST F	00	00	00	2 units per 3 months
D0230	INTRAORAL PERIAPICAL EA ADD	00	00	00	17 units per rolling year
D0240	INTRAORAL OCCLUSAL FILM	00	00	00	2 units per 12 months
D0270	DENTAL BITEWING SINGLE FILM	00	00	00	1 unit per 6 months
D0272	DENTAL BITEWINGS TWO FILMS	00	00	00	1 unit per 6 months
D0273	BITEWINGS - THREE FILMS	00	00	00	
D0274	DENTAL BITEWINGS FOUR FILMS	00	00	00	1 unit per 6 months
D0277	VERT BITEWINGS-SEV TO EIGHT	00	00	00	
D0290	DENTAL FILM SKULL/FACIAL BON	00	00	00	
D0322	DENTAL TOMOGRAPHIC SURVEY	00	00	00	
D0330	DENTAL PANORAMIC FILM	00	00	00	1 unit per 3 years
D0340	DENTAL CEPHALOMETRIC FILM	00	00	00	1 unit per 36 months
D0350	ORAL/FACIAL PHOTO IMAGES	00	00	00	
D0360	CONE BEAM CT	00	00	00	



# Emergency Care

Emergency dental services do not require prior authorization.

- For those persons under 21 years of age, emergency care involves those services necessary to control bleeding, relieve significant pain and/or eliminate acute infection, and those procedures required to prevent pulpal death and/or the imminent loss of teeth.
- For persons 21 years and older, emergency care consists of emergency extractions and palliative care.

# Palliative Care

- Care that relieves or *alleviates significant* dental pain or bleeding or infection.



# EPSDT

- Early and Periodic Screening, Diagnosis and Treatment
- Under age 21 (up to age 20)
- Medicaid Services Manual (MSM) Chapter 1500 – Healthy Kids Program



# Medical Necessity

## MSM Chapter 100:

- Defined: *Medical Necessity* - A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability.
- *Medical Necessity* applies to dental services.



# Diagnostic and Preventive Services

Current Dental Terminology (CDT) codes D0100 – D0999  
MSM Chapter 1003.1

- Defined: Branch of dentistry used to identify and prevent dental disorders and disease
- EPSDT – Yes, covered
- Adults (over 21) – Diagnostic services needed for emergency extractions and palliative care



# Restorative Dental Services

CDT codes D2000 – D2999

MSM Chapter 1003.2

- Defined: Branch of dentistry used to restore the integrity of the teeth through the use of fillings or crowns
- EPSDT – Yes, covered
- Adults (over 21) – With Prior Authorization ... fillings and crowns when medically necessary to preserve abutment tooth for partials



# Endodontic Services

CDT codes D3000 – D3999

MSM Chapter 1003.3

- Defined: Branch of dentistry specializing in disease or injury that affects the root tips or nerves in the teeth through the use of root canals
- EPSDT – Yes, covered
- Adults (over 21) – Not covered



# Periodontic Services

CDT codes D4000 – D4999

MSM 1003.4

- Defined: branch of dentistry used to treat and prevent disease affecting supporting bones, ligaments and gums of the teeth.
- EPSDT – Yes, covered
- Adults – Palliative Treatment (D4355 and D4999)
- Pregnant Women:
  - Scaling and Root Planning
  - 2nd Cleaning During Pregnancy
  - Treatment of Inflamed Gums around 3rd Molars



# Prosthodontic Services

CDT codes D5000 – D5999

MSM Chapter 1003.6

- Medically Necessary
- Prevent Progression of Weight Loss
- Promote Adequate Mastication
- One Full or Partial Every Five Years
- Partials are Conditional
- 3rd Molars are not Replaceable
- Employment: DWSS
- Recipient's Signature
- Embedding



# Oral Surgery

CDT codes D7000 – D7999

MSM Chapter 1003.8

- Defined: Branch of dentistry using surgery to treat disorders/diseases of the mouth.
- EPSDT – Yes
- Adults – Emergency extractions and palliative treatment



# Orthodontic Services

CDT codes D8000 – D8999

MSM Chapter 1003.9

- Defined: Branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function.
- EPSDT – Yes, with prior authorization
- Adults – Not covered
- Orthodontist enrolled as orthodontic specialist
- Handicapping Labiolingual Deviation (HDL) Index of 26 or Higher
- Full Payments



# Adjunctive Services

CDT codes D9000 – D9999

MSM Chapter 1003.10

- Defined: Branch of dentistry for unclassified treatment
- EPSDT – Yes, covered without prior authorization
- Adults – Palliative treatment and anesthesia



# Program Modifications



# News for 2012

## Web Announcement (WA)

- 8-30-2012 WA 513  
CDT code D9215 (local anesthesia in conjunction with operative or surgical procedures)
- 8-13-2012 WA 505  
Must bill CPT codes on CMS-1500 Claim Form
- 6-25-2012 WA 492  
CDT code D0240 has a limitation of two units per rolling year
- 5-16-2012 WA 477  
CPT Code D0230 Instructions for resubmission  
Intraoral, Periapical, each additional film (2 to 17 units)



# New for 2013

The ADA Dental Claim Form will be revised to incorporate a significant change in the HIPAA standard, which will enable a dentist to include a diagnosis code (ICD-9-CM) when needed on a claim.



# Following the Process



# Service Process Flow

Recipient provides proof of identity and Medicaid/Managed Care Card



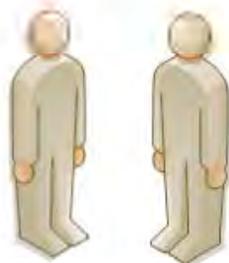
Dental providers must inform the recipient of his/her financial responsibility before rendering any uncovered service.



Provider verifies Medicaid eligibility and if necessary obtains Prior Authorization before rendering service.



Recipient keeps appointment and Provider delivers service



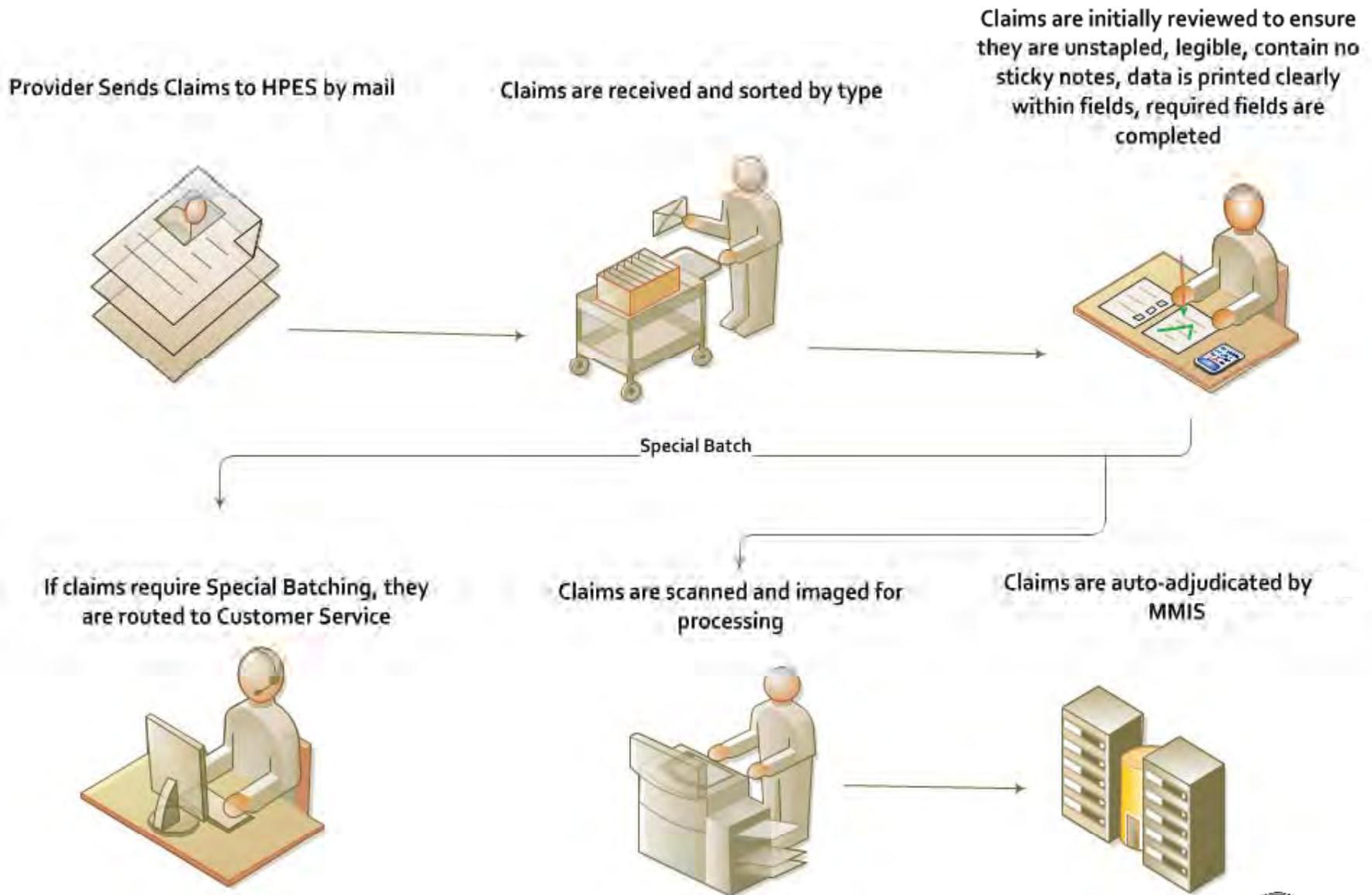
Provider bills services to TPL if applicable prior to billing NV Medicaid.



Provider completes a claim and submits it for processing.



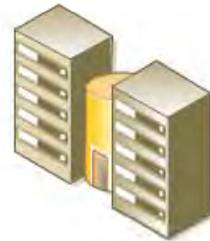
# Claims Process Flow



# Claims Process Flow - continued

MMIS edits check for: Current CPT/HCPCS coding; Current ICD-9 coding; CPT and ICD-9 compatibility; Valid provider enrollment; Recipient eligibility; Duplicate claim; Prior authorization (if applicable); TPL billed (if applicable); Clinical claim editor; Claims are adjudicated as Paid, Pended or Denied

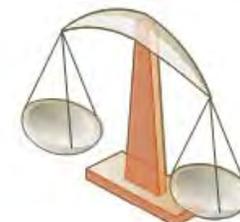
**Paid claims:** A payment and Remittance Advice is sent to the Provider



**Pended claims:** can pend for various reasons and can be reviewed by the claims staff when necessary. Some claims may pend and will auto process once the edit for the pend has been resolved.

**Denied claims:** MMIS sets a denial edit and an RA is sent to the provider with the denial reason code(s); Providers have the right to appeal

Providers have the right to appeal within 30 days of original denial date; If the appeal is upheld, providers have the right to request a fair hearing (through DHCFP) within 90 days from the appeal denial.



# Frequent Denial Codes



# Frequent Denial Codes

- 0155 – Procedure requires authorization
- 0208 and 0308 – Date of service exceeds filing limit
- 0301 and 0302 – Duplicate payment request – same provider, same dates of service
- 0313 – Bill any other available insurance
- 0316 – Medicaid has more TPL policies than claim documentation shows
- 0318 – Recipient not authorized on date of service billed
- 0453 – Enrolled in MCO



# Edit 0155

Procedure requires authorization

- Ensure a valid, **approved** prior authorization number is listed on claim in field 2
- Ensure prior authorization was issued to the servicing National Provider Identifier (NPI) billed on the claim
- Prior authorization dates must be within the dates of service on claim

**APPROVED**



# Edits 0208 and 0308

Date of service exceeds filing limit



- Providers must bill Medicaid for all claims within the specific time frame set by Medicaid
- To be considered timely, claims must be received by the fiscal agent within 180 days from the date of service or the date of eligibility decision, whichever is later
- For out-of-state providers or when a third party resource exists, the timely filing period is 365 days – MSM *Chapter 100, Section 105.2B*



# Edits 0301 and 0302

Duplicate payment request – Same provider, same dates of service

Review your remittance advice to determine if the service has already been paid. In most cases, the service being submitted has already been paid (including a zero payment) to the provider.



# Edits 0313 and 0316

Bill any other available insurance (0313)

Medicaid has more TPL policies than claim documentation shows (0316)

- Verify the recipient's other insurance(s)
- Bill the recipient's other insurance(s) first
- Send the claim with the primary EOB(s) attached
- Bill only one line per claim with the primary EOB(s) attached to each claim
- Bill only for the recipient's legal obligation to pay
- If the primary insurance denied the claim, applied payment to the co-insurance and/or deductible, or if primary insurance was terminated or exhausted, send claim to Customer Service for special batching



# Edit 0318

Recipient not authorized on Date(s) of Service billed

- Always verify recipient eligibility through EVS, ARS or a swipe card system, prior to rendering services.
- If the recipient receives retroactive eligibility, first refund any monies collected from the recipient then submit the claim to the appropriate Medicaid program, i.e., Medicaid Fee For Service (FFS), Health Plan of Nevada (HPN) or Amerigroup.



# Edit 0453

Recipient enrolled in HMO

- Always verify recipient's eligibility through the Electronic Verification System (EVS), the Audio Response System (ARS) or a swipe card system prior to rendering services
- Send your claim to the appropriate Managed Care Organization (MCO) in which the recipient is enrolled for the date(s) of service(s)
- If services are for Orthodontia, send claims to the Medicaid FFS program



# Questions?

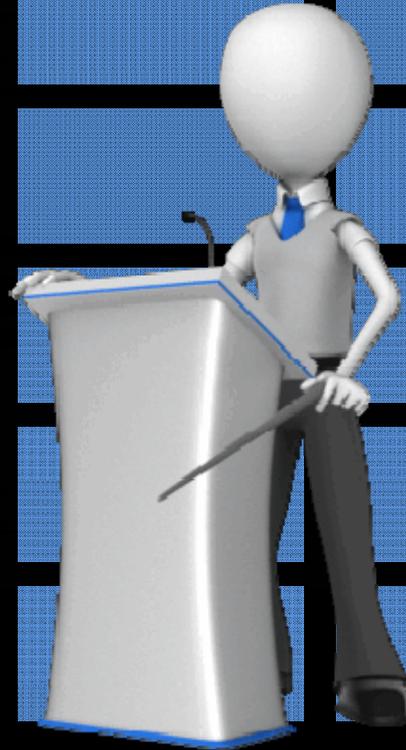


Chapter  
1000

Services

Denial Edits

Medley



# Learning Check



Chapter 1000	Services	Denial Edits	Medley
100	100	100	100
200	200	200	200
300	300	300	300
400	400	400	400
500	500	500	500



## Chapter 1000

Dental program policy and requirements can be found in MSM Chapter 100.  
True or False

[Return to Main Board](#)

[Answer](#)



# Chapter 1000

False

[Return to Main Board](#)



## Chapter 1000

Recipients age \_\_\_\_ and \_\_\_\_  
may receive medically  
necessary dentures,  
emergency extractions and  
palliative only care.

[Return to Main Board](#)

[Answer](#)



# Chapter 1000

21 and older

[Return to Main Board](#)



## Chapter 1000

Care that relieves or alleviates significant pain or bleeding or infection is called?

[Return to Main Board](#)

[Answer](#)



# Chapter 1000

## Palliative

[Return to Main Board](#)



## Chapter 1000

EPSDT stands for?

Return to Main Board

Answer



## Chapter 1000

# Early and Periodic Screening, Diagnosis and Treatment

[Return to Main Board](#)



## Chapter 1000

\_\_\_\_\_

is not required for EPSDT  
and adult emergency  
services.

[Return to Main Board](#)

[Answer](#)



# Chapter 1000

## Prior Authorization

[Return to Main Board](#)



## Services

Diagnostic and Preventive  
Services are defined in  
which subsection of  
Chapter 1000?

[Return to Main Board](#)

[Answer](#)



# Services

MSM  
1003.1

[Return to Main Board](#)



## Services

Which branch of dentistry is used to restore the integrity of the teeth through the use of fillings or crowns?

[Return to Main Board](#)

[Answer](#)



Services

# Restorative Dental Services

[Return to Main Board](#)



## Services

Endodontic Services are covered for adults (over 21).  
True or False

[Return to Main Board](#)

[Answer](#)



Services

False

[Return to Main Board](#)



## Services

Periodontal Services are not covered for pregnant women.  
True or False

[Return to Main Board](#)

[Answer](#)



Services

False

[Return to Main Board](#)



## Services

Only dentists with a specialty of orthodontia will be allowed to bill D8660 for reimbursement.  
True or False

[Return to Main Board](#)

[Answer](#)



Services

True

[Return to Main Board](#)



## Denial Edits

What does  
Edit 0313  
require?

[Return to Main Board](#)

[Answer](#)



## Denial Edits

Bill any other available  
insurance

[Return to Main Board](#)



## Denial Edits

What is claim denial code  
0155?

[Return to Main Board](#)

[Answer](#)



# Denial Edits

Prior Authorization  
Required

[Return to Main Board](#)



## Denial Edits

Claims must be received by  
the fiscal agent within \_\_\_\_  
days from the date of  
service.

[Return to Main Board](#)

[Answer](#)



# Denial Edits

180

[Return to Main Board](#)



## Denial Edits

Prior to submitting a Medicaid claim, who should you bill first?

[Return to Main Board](#)

[Answer](#)



## Denial Edits

Bill the recipient's other insurance

[Return to Main Board](#)



## Denial Edits

Pended claims or claims  
denied for missing  
information should be  
appealed.  
True or False

[Return to Main Board](#)

[Answer](#)



# Denial Edits

False

[Return to Main Board](#)



## Medley

Providers should review  
Web Announcements for  
updates on policy and  
procedure changes?  
True or False

[Return to Main Board](#)

[Answer](#)



Medley

True

[Return to Main Board](#)



# Medley

Claims can be adjudicated  
as Paid, \_\_\_\_\_ or  
Denied.

[Return to Main Board](#)

[Answer](#)



Medley

Pended

[Return to Main Board](#)



# Medley

Providers should verify  
eligibility \_\_\_\_\_ to  
rendering services.

Return to Main Board

Answer



Medley

prior

[Return to Main Board](#)



## Medley

Medicaid Management  
Information System (MMIS)  
automatically checks for  
duplicate claims?

True or False

[Return to Main Board](#)

[Answer](#)



Medley

True

[Return to Main Board](#)



# Medley

Providers have a right to appeal a claim within \_\_\_\_ days of the original denial date.

[Return to Main Board](#)

[Answer](#)



# Medley

30

[Return to Main Board](#)



# Contacts

- Jon Kirwan  
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(775) 684-3706
- Nedra Daugherty  
HP Enterprise Services, Provider Training  
(775) 335-8568



# Contact information

## **Customer Service Center**

Claim inquiries and general information

Phone: (877) 638-3472

## **Automated Response System (ARS)**

Phone: (800) 942-6511

## **Assistance with Prior Authorizations**

Phone: (800) 525-2395

## **Requests for Provider Training**

Email: [NevadaProviderTraining@hp.com](mailto:NevadaProviderTraining@hp.com)



Thank you for your attention

Please complete the course evaluation  
before leaving class

Enjoy the remainder of your day

