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

REFERENCES

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)

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- NV Medicaid Operations Manual
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APPENDIX A  NEVADA MEDICAID - RECOMMENDED DENTAL PERIODICITY SCHEDULE  

6  HP Confidential - 2012 Annual Medicaid Conference: Dental
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](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://dhcfp.nv.gov](http://dhcfp.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

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 and older).
- **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.

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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
CTD 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

1. Recipient provides proof of identity and Medicaid/Managed Care Card
2. Provider delivers service

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

Recipient keeps appointment and Provider delivers service

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

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

Provider completes a claim and submits it for processing.
Claims Process Flow

Provider Sends Claims to HPES by mail

Claims are received and sorted by type

Special Batch

Claims are scanned and imaged for processing

Claims are auto-adjudicated by MMIS

Claims are initially reviewed to ensure they are unstapled, legible, contain no sticky notes, data is printed clearly within fields, required fields are completed.

If claims require Special Batching, they are routed to Customer Service
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

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

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

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
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?
Learning Check
Dental program policy and requirements can be found in MSM Chapter 100.

True or False
Recipients age ___ and ___ may receive medically necessary dentures, emergency extractions and palliative only care.
Chapter 1000

21 and older

Return to Main Board
Care that relieves or alleviates significant pain or bleeding or infection is called?
Chapter 1000

Palliative

Return to Main Board
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
Diagnostic and Preventive Services are defined in which subsection of Chapter 1000?
Services

MSM 1003.1

Return to Main Board
Which branch of dentistry is used to restore the integrity of the teeth through the use of fillings or crowns?
Restorative Dental Services
Endodontic Services are covered for adults (over 21). True or False
Periodontal Services are not covered for pregnant women.
True or False
Only dentists with a specialty of orthodontia will be allowed to bill D8660 for reimbursement. True or False
Denial Edits

What does Edit 0313 require?

Return to Main Board  Answer
Denial Edits

Bill any other available insurance

Return to Main Board
What is claim denial code 0155?
Prior Authorization Required
Claims must be received by the fiscal agent within ___ days from the date of service.
Denial Edits

180

Return to Main Board
Prior to submitting a Medicaid claim, who should you bill first?
Denial Edits

Bill the recipient’s other insurance

Return to Main Board
Pended claims or claims denied for missing information should be appealed.

True or False
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
Claims can be adjudicated as Paid, __________ or Denied.
Providers should verify eligibility _____ to rendering services.
Medley

prior

Return to Main Board
Medicaid Management Information System (MMIS) automatically checks for duplicate claims?

True or False
Providers have a right to appeal a claim within ___ days of the original denial date.
Contacts

• Jon Kirwan  
  Division of Health Care Financing and Policy  
  (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
Thank you for your attention

Please complete the course evaluation before leaving class

Enjoy the remainder of your day