Dental and Orthodontia Provider Training
Objectives
Objectives

- Locate Medicaid Policy
- Locate and utilize the Authorization Criteria Function
- Properly submit a Prior Authorization via the Electronic Verification System (EVS) on the Provider Web Portal (PWP)
- Access the Search Fee Schedule and DHCFP Rates Unit
- Locate Billing Information
- Submit Claims using Direct Data Entry (DDE) via the EVS Secure Provider Web Portal
Medicaid Website
EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period.

To access EVS, user must have internet access and a computer with a web browser.
Locating the Medicaid Services Manual (MSM)

- Step 1: Highlight “Quick Links” from top blue tool bar
- Step 2: Select “Medicaid Services Manual” from the drop-down menu
- Note: MSM Chapters will open in a new webpage through the DHCFP website
Locating the Medicaid Services Manual, continued

To do a keyword search on any PDF document, click Ctrl F to generate the search box. Enter the desired search word and click Previous or Next.

- Medicaid Services Manual - Complete
- 100 Medicaid Program
- 200 Hospital Services
- 300 Radiology Services
- 400 Mental Health and Alcohol and Substance Abuse Services
- 500 Nursing Facilities
- 600 Physician Services
- 700 Reimbursement, Analysis and Payment
- 800 Laboratory Services
- 900 Private Duty Nursing
- 1000 Dental
- 1100 Ocular Services
- 1200 Prescribed Drugs
- 1300 DME Disposable Supplies and Supplements
- 1400 Home Health Agency
- 1500 Healthy Kids Program
- 1600 Intermediate Care for Individuals with Intellectual Disabilities
- 1700 Therapy
- 1800 Adult Day Health Care

- Select “Chapter 1000”
- From the next page, always make sure that the “Current” policy is selected
Authorization Criteria
Function
Authorization Criteria is located at www.medicaid.nv.gov under “Featured Links”
Authorization Criteria, continued

- Step 1 – Select “Code Type”
- Step 2 – Input either a Procedure Code or Description. This field uses a predictive search
- Step 3: Input Provider Type
- Step 4: Select “Search”
Verify that “Effective Date” ends in 2299. This will provide the current information.

For more information regarding PA Requirements, please review “Attachment A: Fee-for-Service Coverage, Limitations and Prior Authorization Requirements” located on the Billing Page.
Submitting a Prior Authorization (PA)
Navigating the PWP

Once registered, users may access their accounts from the PWP “Home” page by:

1. Entering the User ID
2. Clicking the Log In button
Navigating the PWP, continue

Once the user has clicked the Log In button, they will need to provide identity verification as follows:

3. Type in their answer to the Challenge Question to verify identity
4. Choose whether log in is on a personal computer or public computer
5. Click the Continue button
The user will continue providing identity verification as follows:

6. Confirming that the **Site Key** and **Passphrase** are correct
7. Entering **Password**
8. Clicking the **Sign In** button

NOTE: If this information is incorrect, users should not enter their password. Instead, they should contact the help desk by clicking the **customer help desk** link.
Once the provider information has been verified, the user may explore the features of the PWP, including:

A. Additional tabs for users to research eligibility, submit claims and prior authorization requests, access additional resources, and more
B. Important broadcast messages
C. Links to contact customer support services
D. Links to manage user account settings, such as passwords and delegate access
E. Links to additional information regarding Medicaid programs and services
F. Links to additional PWP resources
Navigating the Provider Web Portal

The tabs at the top of the page provide users quick access to helpful pages and information:

A. **My Home**: Confirm and update provider information and check messages
B. **Eligibility**: Search for recipient eligibility information
C. **Claims**: Submit claims, search claims, view claims and search payment history
D. **Care Management**: Request PAs, view PA statuses, and maintain favorite providers
E. **File Exchange**: Upload forms online
F. **Resources**: Download forms and documents
G. **Switch Providers**: Where delegates can switch between providers to whom they are assigned. The tab is only present when the user is logged in as a delegate.
Create Authorization
- Create authorizations for eligible recipients

View Authorization Status
- Prospective authorizations that identify the requesting or servicing provider

- Maintain Favorite Providers
- Create a list of frequently used providers
- Select the facility or servicing provider from the providers on the list when creating an authorization
- Maintain a favorites list of up to 20 providers
Before You Create a Web Portal Prior Authorization Request
Before You Create a Prior Authorization Request

- Verify eligibility to ensure that the recipient is eligible on the date of service for the requested services.

- Use the Provider Web Portal's PA search function to see if a request for the dates of service, units, and service(s) already exists and is associated with your individual, state or local agency, or corporate or business entity.

- Review the coverage, limitations and PA requirements for the Nevada Medicaid Program before submitting PA requests.

- Use the Provider Web Portal to check PAs in pending status for additional information.
The Provider Web Portal allows dental providers, or their delegates, the ability to search recipient treatment history online through the secured areas of the Provider Web Portal.

Log in to the Provider Web Portal and then click **Treatment History** under the Claims tab. Instructions are available in Chapter 9 (Treatment History) of the EVS User Manual.
Attach the appropriate FA Form(s)

- Refer to [www.medicaid.nv.gov/providers/forms/forms.aspx](http://www.medicaid.nv.gov/providers/forms/forms.aspx) for the forms options.
- Verify that all fields are completed on the appropriate form(s) for the requested service.
- Type information into the form. Illegible forms will not be processed.
- The explanation of the reason that a request is being made and any special circumstances should be explicit and concise.
- All information including start dates and procedure codes must be consistent with information entered on the Provider Web Portal — Prior Authorization Request. If information is not consistent, it will cause delays.
Client Treatment History Form (FA-26)

Reminders:

‒ Please use the current form FA-26 posted on the Providers Forms webpage at www.medicaid.nv.gov for orthodontic prior authorization requests.

‒ Form FA-26 must be completed in its entirety.

‒ Provide the reason for the referral.

‒ Include the treating dentist’s telephone number.
Orthodontic Medical Necessity (OMN) Form (FA-25)

Reminders:
- Enter the provider’s name and National Provider Identifier (NPI).
- Enter the recipient’s full name and ID.
- Score the applicable condition.
- Date and sign the form.
Partial Denture Delivery Receipt (FA-27A)

Reminders:
- Complete the form in its entirety
- All signatures must be present.
- Do not bill Nevada Medicaid for partial dentures until delivered to recipient and the form is completed.
- Claim cannot be submitted prior to the delivery date.
Denture Delivery Receipt (FA-27B)

Reminders:

– Complete the form in its entirety.
– All signatures must be present.
– Do not bill Nevada Medicaid for dentures until delivered to recipient and the form is completed.
– Claim cannot be submitted prior to the delivery date.
ADA Dental Claim Form
Submit with all Dental and Orthodontia PA requests

Required:
- **Field 1** — Required Type of transaction — Check statement of actual services. Also check EPSDT/Title XIX if this claim is for a recipient under age 21. *(Note: Retrospective authorization is not available for non-emergency dental services. In the case of an emergency, a retrospective request may be submitted the next business day after service is rendered.)*
- **Field 12** — Subscriber/Policyholder name (Last, First, Middle Initial, Suffix), Address, City, State and ZIP Code — Enter the recipient’s full name and address.
- **Field 15** — Policyholder/Subscriber identifier (ID#) — Enter the recipient’s 11-digit recipient ID as it appears on their Medicaid card.
ADA Dental Claim Form, continued

Reminders:

– Recipients age 21 and older may receive emergency extractions, palliative care and dentures/prosthetic care under certain guidelines and limitations.

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

– Pregnant recipients may receive some periodontal services (see the Coverage, Limitations, and PA Requirements for the Nevada Medicaid and Nevada Check Up Dental Program), diagnostic restorative, and preventative care. Services for recipients who are pregnant require PA.
**ADA Dental Claim Form – Price Breakdown**

**Reminder**

Enter the price breakdown in the Description column as described in this example:

- Banding, followed by your usual and customary charge for banding.
- Periodic Adjustment, the number of months in the treatment, \( x \) (multiplied by), your usual and customary charge per visit.
- Retention, followed by your total charge for retainers.
Create a Prior Authorization Request
Key Information

Recipient Demographics
— First Name, Last Name and Birth Date will be auto-populated based on the recipient ID entered

Diagnosis Codes
— All PAs will require at least one valid diagnosis code

Searchable Diagnosis and Current Dental Terminology (CDT) codes
— Enter the first three letters or the first three numbers of the code to use the predictive search

PA Attachments
— Attachments are required with all PA requests. Attachments can only be submitted electronically.
— PA requests received without an attachment will remain in pended status for 30 days.
Submitting a PA Request

1. Hover over the Care Management tab
2. Click Create Authorization from the sub-menu
Submitting a PA Request

3. Select the authorization type (Dental)
4. Choose an appropriate Process Type from the drop-down list
5. The Requesting Provider Information is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.
Submitting a PA Request, continued

8. Enter Service Provider Information
Submitting a PA Request, continued

9. Select a Diagnosis Type from the drop-down list
10. Enter the Diagnosis Code. Once the user begins typing, the field will automatically search for matching codes.
11. Click the Add button

NOTE: Repeat steps 9-11 to enter up to nine codes. The first code entered will be considered the primary.
• If you click the **Add** button with an invalid diagnosis code, an error will display. You must ensure the diagnosis code is correct, up-to-date with the selected **Diagnosis Type**, and does not include decimals.
Submitting a PA Request, continued

• Once a diagnosis code has been entered accurately, and the Add button has been clicked, the diagnosis code will display under the Diagnosis Information section. If a user wishes to remove the code from the PA request, click Remove located in the Action column.
12. Enter detail regarding the service(s) provided into the Service Details section.
13. Click the Add Service button.

Note: A maximum of 27 service details may be requested per PA request.
After clicking the **Add Service** button, the service details will display in the list.

**NOTE:** You may enter additional details as needed. If you wish to copy a service detail, click **Copy** located in the Action column. To remove the detail, click **Remove**.
The Transmission Method will default to EL-Electronic Only as attachments must be sent via the portal.

- ADA Claim Form must be submitted with every prior authorization request.
- Users should review their Dental Billing Guidelines for additional information regarding prior authorizations.
14. Choose the type of attachment being submitted from the Attachment Type drop-down list.
15. Click the Browse button
16. Select the desired attachment from your computer using the window that pops up
17. Click the Open button

- Allowable file types include: .doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff
18. Click the Add button.
Submitting a PA Request, continued

• The added attachment displays in the list.

• To remove the attachment, click Remove in the Action column.

• Add additional attachments by repeating steps 14-18.

NOTE: The total attachment file size limit before submitting a PA is 4 MB. When more attachments are needed beyond this capacity, the user will first submit the PA. Afterwards go back into the PA using the View Authorization Response page, click the edit button to open the PA and then add more attachments.
19. Click the Submit button
20. Review the information on the PA request

21. Click the Confirm button to submit the PA for processing

• NOTE: If updates are needed prior to clicking the Confirm button, click the Back button to return to the “Create Authorization” page.
• After you click the Confirm button, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.
Submitting a PA Request, continued

• A. Print Preview: Allows you to view the PA details and receipt for printing.
• B. Copy: Allows you to copy member or authorization data for another authorization.
• C. New: Allows you to begin a new PA request for a different member.
Viewing the Status of PAs
Viewing the Status of PAs

1. Hover over the Care Management tab
2. Click View Authorization Status
Viewing the Status of PAs, continued

3. Click the ATN hyperlink of the PA you wish to view.
Viewing the Status of PAs, continued

4. Click the plus symbol to the right of a section to display its information.

5. Review the information as needed.
6. Review the details listed in the Decision / Date and Reason columns

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/2018</td>
<td>01/12/2019</td>
<td>10</td>
<td>10</td>
<td>_</td>
<td>CPT/HCPCS 0003P INACTIVE TOBACCO USE, NO SMOKING</td>
<td></td>
<td>Certified In Total 01/12/2019</td>
<td>_</td>
</tr>
</tbody>
</table>

Service Provider / Service Details Information

- Provider ID: 1831573690
- ID Type: NPI
- Name: HOSPITALIST SERVICES OF NEVADA MANDAVIA
In the Decision / Date column, you may see one of the following decisions:

- **Certified in Total**: The PA request is approved for exactly as requested.
- **Certified Partial**: The PA request has been approved, but not as requested.
- **Not Certified**: The PA request is not approved.
- **Pended**: The PA request is pending approval.
- **Cancel**: The PA request has been canceled.
• When the Decision / Date column is not “Certified in Total” information will be provided in the Reason column. For example, if a PA is not certified (A), the reason why it was not certified displays (B).
Viewing the Status of PAs, continued

- C. From Date and To Date: Display the start and end dates for the PA.
- D. Units: Displays the number of units originally on the PA.
- E. Remaining Units or Amount: Remaining dollar amount.
- F. Code: Displays the CDT/CPT/HCPCS code on the PA.
- G. Medical Citation: Indicates when additional information is needed for authorizations (including denied).
The Medical Citation field indicates if additional information is needed for all authorizations (including denied). Click “View” to see the details and clinical notes provided by Nevada Medicaid or click “Hide” to collapse the information panel.

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Remaining Units</th>
<th>Amount</th>
<th>Code</th>
<th>Medical Citation</th>
<th>Decision / Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/17/2013</td>
<td>02/17/2013</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>Hide</td>
<td>Not Certified 02/21/2013</td>
<td>–</td>
</tr>
<tr>
<td>02/20/2031</td>
<td>02/20/2031</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td>View</td>
<td>Not Certified 02/22/2013</td>
<td>–</td>
</tr>
<tr>
<td>02/17/2013</td>
<td>02/20/2013</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>Revenue 0121-R&amp;B-2 BED-MED-SURG-GYN</td>
<td></td>
<td>Certified in Total 02/24/2013</td>
<td>–</td>
</tr>
</tbody>
</table>
Viewing the Status of PAs, continued

- **H - Edit**: Edit the PA.
- **I - View Provider Request**: Expand all sections to view the information.
- **J - Print Preview**: Display a printable version of the PA with options to print.
Searching for PAs
Searching for PAs

- Prospective Authorizations and Search Options tabs will be displayed.
- The Prospective Authorizations tab displays PAs by either the requesting or servicing provider.
- The Search Options tab allows a search by either recipient or provider information.
- To view the details of an authorization, click the ATN. It will be blue in color and underlined.
1. Click the Search Options tab
2. Enter search criteria into the search fields
A. **Authorization Tracking Number:** Enter the ATN to locate a specific PA.

B. **Day Range:** Select an option from the list to view PA results within the selected time period.

C. **Service Date:** Enter the date of service to display PA with that date of service.

**NOTE:** Without an ATN, a **Day Range** or a **Service Date** must be entered. If the PA start date is more than 60 days ago, a **Service Date** must be entered.
D. Status: Select a status from this list to narrow search results to include only the selected status.
E. **Recipient ID**: Enter the unique Medicaid ID of the client.
F. **Birth Date**: Enter the date of the birth for the client.
G. **Last Name** and **First Name**: Enter the client’s first and last name.

**NOTE**: Enter only the **Recipient ID** number or the client’s last name, first name and date of birth.
Searching for PAs, continued

H. **Provider ID**: Enter the Provider’s unique NPI.

I. **ID Type**: Select the Provider’s ID type from the drop-down list.

J. **This Provider is the**: Select whether the Provider is the Servicing or Requesting Provider.
3. Click the Search button

4. Select an ATN hyperlink to review the PA
Submitting Additional Information
Submitting Additional Information

1. Click the Edit button to edit a submitted PA request

Additional information may include:
- Requests for additional services
- Attachments
- “FA-29 Prior Authorization Data Correction” form
- “FA-29A Request for Termination of Service” form
2. Add additional diagnosis codes, service details, and/or attachments

Note: Existing information in the field cannot be updated. A Data Correction form must be submitted for changes to any previously submitted information.
Submitting Additional Information, continued

3. Click the Resubmit button to review the PA information
4. Review the information
5. Click the Confirm button

- NOTE: The PA number remains the same as the original PA request when resubmitting the PA request.
Options if a PA is Not Approved
Denied Prior Authorization

If a prior authorization is denied by Nevada Medicaid, the provider has the following options:

– Request for a Peer-to-Peer Review (avenue used in order to clarify why the request was denied or approved with modifications)

– Submit a Reconsideration Request (avenue used when the provider has additional information that was not included in the original request)

– Request a Medicaid Provider Hearing
Peer-to-Peer Review

- The intent of a peer-to-peer review is to clarify the reason the PA request was denied or approved but modified.
- This is a verbal discussion between the requesting clinician and the clinician that reviewed the request for medical necessity.
- The provider is responsible for having a licensed clinician who is knowledgeable about the case participate in the peer-to-peer review.
- Additional information is not allowed to be presented because all medical information must be in writing and attached to the case.
- Must be requested within 10 business days of the denial.
- Peer-to-peer reviews can be requested by emailing nvpeer_to_peer@gainwelltechnologies.com.
- Only available for denials related to the medical necessity of the service.
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option.
Reconsideration Request

- Reconsiderations can be uploaded via the Provider Web Portal by completing an FA-29B form and uploading to the “File Exchange” on the Provider Web Portal
- Additional medical documentation is reviewed to support the medical necessity
- The information is reviewed by a different clinician than reviewed the original documentation
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option
Reconsideration Request, continued

- A reconsideration must be requested within 30 calendar days from the date of the denial
- The 30-day provider deadline for reconsideration is independent of the 10-day deadline for peer-to-peer review
- Give a synopsis of the medical necessity not presented previously. Include only the medical records that support the issues identified in the synopsis. Voluminous documentation will not be reviewed. It is the provider’s responsibility to identify the pertinent information in the synopsis.
- Only available for denials related to the medical necessity of the service
Medicaid Provider Hearing

- Review Chapter 3100 (Hearings) of the Medicaid Services Manual located on the DHCFP website for further information regarding the Hearing Process
Search Fee Schedule and DHCFP Rates Unit
• Utilize the Search Fee Schedule to determine the Rate of Reimbursement for a Procedure Code
Fee Schedule, continued

- Step 1: Click “I Accept”
- Step 2: Click “Submit”
Fee Schedule, continued

- Step 1: Select Code Type from drop-down menu
- Step 2: Input Procedure Code or Description
- Step 3: Select Service Category from drop-down menu
- Step 4: Click “Search” to populate results
Make sure that when the results have populated, that the correct Procedure and Provider Type are the same as what was originally selected. Verify the Effective Date column to ensure that the code is still payable.

Review the Age Restrictions to make sure that the recipient falls within that age range.

Review the modifier when billing Nevada Medicaid.
DHCFP Rates Unit

- Step 1: Highlight Quick Links from tool bar at www.medicaid.nv.gov
- Step 2: Select Rates Unit
- Step 3: From new window, select Accept
DHCFP Rates Unit, continued

Fee Schedules

The fee schedules found here are updated on an annual basis, sometimes more frequently. Information regarding the annual new code update may be found on this website.

The information contained in these schedules is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein.

- Managed Care Capitation Rates - 2019
- Managed Care Capitation Rates - 2018
- Fee-for-Service xls Fee Schedules

• Locate the “Fee Schedules”
The information contained in these schedules is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein.

- Provider Type 22 Dentists

- Select Appropriate Title to open the PDF pertaining to the Reimbursement Schedule
Medicaid Billing Information
Locating Medicaid Billing Information

• Step 1: Highlight Providers from top blue tool bar

• Step 2: Select Billing Information from the drop-down menu
Effective February 1, 2019, all providers will be required to submit their claims electronically (using Trading Partners or Direct Data Entry [DDE]), as paper claims submission will no longer be accepted with the go-live of the new modernized Medicaid Management Information System (MMIS). Please continue to review the modernization-related web announcements at https://www.medicaid.nv.gov/providers/Modernization.aspx for further details.

Attention All Providers: Requirements on When to Use the National Provider Identifier (NPI) of an Ordering, Prescribing or Referring (OPR) Provider on Claims [Web Announcement 1711]

FAQs: National Correct Coding Initiative (NCCI) Claim Review Edits [Review Now]
Clinical Claim Editor FAQs Updated December 5, 2011 [Review Now]
Third Party Liability Frequently Asked Questions [Review Now]

Review the Billing Manual for more information regarding:
- Introduction to Medicaid
- Contact Information
- Recipient Eligibility
- PA
- Third Party Liability (TPL)
- Electronic Data Interchange (EDI)
- Frequently Asked Questions (FAQs)
- Claims Processing and Beyond
Locating Medicaid Billing Information, continued

- Locate the section header “Billing Guidelines (by Provider Type)"
- Select appropriate Provider Type Guideline
Submitting a Dental Claim via the EVS Secure Provider Web Portal
Understanding Claim Sub Menus
Understanding Claims Sub Menus

1. Hover over **Claims**
2. Select the appropriate sub menu from the options
Understanding Claims Sub Menus, continued

The page displays a listing of Claim activities for the user to choose from.
Submitting a Dental Claim
Submitting a Dental Claim

The Dental Claim submission process is broken out into three main steps:

- **Step 1** - Provider, Patient and Claim Information plus an option to add Other Insurance details
- **Step 2** - Diagnosis Codes
- **Step 3** - Service Details and Attachments
Submitting a Dental Claim: Step 1

1. Hover over the Claims tab
2. Select Submit Claim Dental
Submitting a Dental Claim: Step 1, continued

“Submit Dental Claim: Step 1” page sub-sections to complete:

A. Provider Information
B. Patient Information
C. Claim Information
## Submitting a Dental Claim: Step 1, continued

### Provider Information

<table>
<thead>
<tr>
<th>Billing Provider ID</th>
<th>1407146111</th>
<th>ID Type</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing Provider Service Location</strong></td>
<td>22-SMILES TODAY DENTAL GROUP LLC - 1580 E DESERT INN RD, LAS VEGAS, NEVADA, 89139</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Select the appropriate provider type/service location being billed from the **Billing Provider Service Location** drop-down option.

4. Enter the Rendering ID and ID Type. If the Rendering ID is unknown, click the button adjacent to the **Rendering Provider ID** field.
Submitting a Dental Claim: Step 1, continued

5. Select the desired search tab
6. Enter **Provider ID** and **Provider ID Type**
7. Click the **Search** button, and the search results will populate at the bottom
8. Click the **blue** link in the **Provider ID** column with correct Provider ID

NOTE: This example uses the **Search By ID** tab. Users can also search by the **Search By Organization** or **Search By Name** tabs.
Once the user clicks the Provider ID, it will populate in the Rendering Provider ID field.

<table>
<thead>
<tr>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing Provider ID</strong></td>
</tr>
<tr>
<td><strong>Billing Provider Service Location</strong></td>
</tr>
<tr>
<td><strong>Rendering Provider ID</strong></td>
</tr>
<tr>
<td><strong>Rendering Provider Service Location</strong></td>
</tr>
<tr>
<td><strong>Referring Provider ID</strong></td>
</tr>
</tbody>
</table>

NOTE: If needed, the user may enter a referring, supervising or service facility location the same way the Rendering Provider ID was entered.
Submitting a Dental Claim: Step 1, continued

Patient Information

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recipient ID</strong></td>
</tr>
<tr>
<td>97338188081</td>
</tr>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>MUZAE</td>
</tr>
<tr>
<td>Birth Date</td>
</tr>
<tr>
<td>05/02/1967</td>
</tr>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>WXEVBG</td>
</tr>
</tbody>
</table>

9. Enter the 11-digit Recipient ID and click outside of the field to populate Last Name, First Name and Birth Date.
## Submitting a Dental Claim: Step 1, continued

### Claim Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10. Accident Related</strong></td>
<td></td>
</tr>
<tr>
<td><strong>11. Place of Treatment</strong></td>
<td>11-Physician's Office</td>
</tr>
<tr>
<td><strong>12. Patient Number</strong></td>
<td>12345</td>
</tr>
<tr>
<td><strong>Authorization Number</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Include Other Insurance</strong></td>
<td>□</td>
</tr>
</tbody>
</table>

The following fields with a red asterisk (*) must be completed as follows:

10. Select the **Place of Treatment** from the drop-down list
11. Enter the **Patient Number**
12. Click the **Continue** button

---

**NOTE:** Other optional fields can be completed based on additional details known about the claim.
Submitting a Dental Claim: Step 2

Once the user clicks the Continue button, the “Submit Dental Claim: Step 2” page is first displayed with all panels expanded.

<table>
<thead>
<tr>
<th>#</th>
<th>Diagnosis Type</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>*Diagnosis Type ICD-10-CM</td>
<td>*Diagnosis Code</td>
<td>Add</td>
</tr>
</tbody>
</table>
1. Choose a **Diagnosis Type** (Auto-populates as “ICD-10-CM”)
2. Enter the **Diagnosis Code**. Diagnosis codes are searchable by entering the first three letters or the first three numbers of the code to use a predictive search feature.
3. Click the **Add** button
Submitting a Dental Claim: Step 2, continued

Click the Remove link to remove a diagnosis code from the claim.

Once all the diagnosis codes have been entered, the user will:
4. Click the Continue button
Enter the following service details for the claim:

1. **Svc Date** field
2. **Procedure Code**
3. **Units**
4. **Charge Amount**
5. **Diagnosis Pointers**
6. **Tooth Number** from the drop-down (if applicable)
7. Click the **Add** button to add each service detail
Submitting a Dental Claim: Step 3, continued

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>08/21/2018</td>
<td>14-1st Molar -UL-Permanent</td>
<td>D0191</td>
<td>1</td>
<td>$225.35</td>
<td>Remove</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Click the Submit button
Submitting a Dental Claim: Step 3, continued

9. Click the **Confirm** button

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Tooth Surface</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Units</th>
<th>Charge Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>08/21/2019</td>
<td></td>
<td>14-1st Molar -UL-Permanent</td>
<td></td>
<td>D0191</td>
<td></td>
<td>1</td>
<td>$225</td>
</tr>
</tbody>
</table>

No Other Insurance Details exist for this claim

No Attachments exist for this claim
The “Submit Dental Claim: Confirmation” page will appear after the claim has been submitted. It will display the claim status and Claim ID. The user may then:

- Click the **Print Preview** button to view the claim details
- Click the **Copy** button to copy claim data
- Click the **Adjust** button to adjust the claim
- Click the **New** button to submit a new claim
- Click the **View** button to view the details of the submitted claim
Submitting a Dental Claim: Attachments
To upload attachments in Step 3 to a dental claim:

1. Click the (+) sign on the Attachments panel.
Submitting a Dental Claim: Attachments, continued

2. Click the **Browse** button and locate the file on the user’s computer to attach.

A window will then pop up. From there the user will:

3. Locate and select the file

4. Click the **Open** button

**NOTE:** The **Transmission Method** field will populate with “FT - File Transfer” by default and does not need to be changed.
Submitting a Dental Claim: Attachments, continued

<table>
<thead>
<tr>
<th>#</th>
<th>Transmission Method</th>
<th>File</th>
<th>Control #</th>
<th>Attachment Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Attachment Type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Select the type of attachment from the **Attachment Type** drop-down list.

6. Click the **Add** button to attach the file or click the **Cancel** button to cancel and close the attachment line.

**NOTE:** A description of the attachment may be entered into the **Description** field, but it is not required.
## Submitting a Dental Claim: Attachments, continued

### Attachments

Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Transmission Method</th>
<th>File Description</th>
<th>Control #</th>
<th>Attachment Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FT-File Transfer</td>
<td>nv mmis modernization member operations training qa review v2.docx (124K)</td>
<td>201809214721532</td>
<td>DA-Dental Models</td>
<td>Remove</td>
</tr>
</tbody>
</table>

- Click to add attachment.

Click the **Submit** button to proceed.

### NOTE

To view an attachment the user will click the number in the # column and the attachment will open in a new window. To remove any attachments that were attached incorrectly, use the **Remove** link.
Submitting a Dental Claim: Other Insurance Details
Submitting a Dental Claim: Other Insurance Details

1. Check the Include Other Insurance checkbox located at the bottom of the Step 1 page
2. Click the Continue button
Submitting a Dental Claim: Other Insurance Details, continued

To add a policy or other insurance carrier information:
3. Click (+) in the Other Insurance Details panel at the bottom of the Step 2 page

NOTE: If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto-populate in the Other Insurance Details panel.
### Submitting a Dental Claim: Other Insurance Details, continued

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier Name</th>
<th>Carrier ID</th>
<th>Policy ID</th>
<th>Payer Paid Amount</th>
<th>Paid Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>*Carrier Name: Cigna Healthcare</td>
<td>*Carrier ID: 00526</td>
<td>*Policy ID: 12345</td>
<td>*Policy Holder Last Name: TWGPHZ</td>
<td>*First Name: PJOL</td>
<td>MI</td>
</tr>
</tbody>
</table>

**After clicking the (+):**

4. The user must complete all required fields.

5. Click the **Add Insurance** button to add the Other Insurance details to the claim.

**NOTE:** Click the **Cancel Insurance** button to cancel any updates to the claims adjustment details.
Submitting a Dental Claim: Other Insurance Details, continued

NOTE: Click the **Remove** link to remove any other insurance details unrelated to the claim.

After the additional insurance information has been added, select the Sequence Number to open the Claim Adjustment Details section.
Submitting a Dental Claim: Other Insurance Details, continued

6. Complete all sections marked with an asterisk

7. Select Add Adjustment
Submitting a Dental Claim: Other Insurance Details, continued

8. Select Save Insurance
9. Select Continue from the bottom of the page to continue to Step 3 of the claim submission process.
Searching for a Dental Claim
Searching for a Dental Claim

To search for a specific Claim, the user will:

1. Hover over **Claims**
2. Select **Search Claims**
The fastest way to locate a claim is by entering the **Claim ID**.

To search without using the **Claim ID**:

3. Enter **Recipient ID**
4. Enter the **Service From** and **To** date range
5. Click the **Search** button

---

NOTE: When searching for a claim without using the **Claim ID**, the user must enter the **Recipient ID** along with the **Service From** and **To** date range as shown in this example.
Searching for a Dental Claim, continued

6. Click the blue link of the desired claim to access the claim.
Searching for a Dental Claim, continued

The user can view the **Status** of the claim and the **Adjudication Errors**.

<table>
<thead>
<tr>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider ID</td>
</tr>
<tr>
<td>Rendering Provider ID</td>
</tr>
<tr>
<td>Referring Provider ID</td>
</tr>
<tr>
<td>Service Facility Location</td>
</tr>
<tr>
<td>ID Type</td>
</tr>
<tr>
<td>ID Type</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Status: Finalized Denied</td>
</tr>
<tr>
<td>Recipient ID: 97208108001</td>
</tr>
<tr>
<td>Recipient Name: WODEBOO MIZAE</td>
</tr>
<tr>
<td>Gender: Female</td>
</tr>
<tr>
<td>Birth Date: 03/02/1967</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Related:</td>
</tr>
<tr>
<td>Place of Treatment: Physician's Office</td>
</tr>
<tr>
<td>Patient Number: 12345</td>
</tr>
<tr>
<td>Authorization Number:</td>
</tr>
<tr>
<td>Related Claim ICN:</td>
</tr>
<tr>
<td>Previous Claim ICN:</td>
</tr>
<tr>
<td>Note:</td>
</tr>
<tr>
<td>Accident Date:</td>
</tr>
<tr>
<td>Total Allowed Amount: $0.00</td>
</tr>
<tr>
<td>Total Co-pay Amount: $0.00</td>
</tr>
<tr>
<td>Total Charged Amount: $725.25</td>
</tr>
<tr>
<td>Total Paid Amount: $0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjudication Errors</th>
</tr>
</thead>
</table>

Nevada Medicaid – Dental and Orthodontia Provider Training
Searching for a Dental Claim, continued

7. Click **Expand All** on the **Adjudication Errors** panel to view the **Explanation of Benefits (EOB)** codes.
8. User will select the service number in the Svc # column to view.
Viewing Dental Claim Remittance Advice (RA)
To begin locating an RA, the user will:

1. Hover over Claims
2. Select Search Payment History
3. Enter search criteria to refine the search results
4. Click the Search button

NOTE: Users can search for RAs on the Provider Web Portal only for the past 6 months. The default search range is for the past 90 days.
## Viewing Dental Claims: RA, continued

### Search Results

To access a copy of the Remittance Advice, select the 'RA' icon. Access to the RA will require PDF software.

If the RA is too large to display, you will get an error message instead of downloaded RA. You will need to contact Customer Service for assistance.

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Payment Method</th>
<th>Payment Type</th>
<th>Check # / RA #</th>
<th>Total Amount</th>
<th>RA Copy (PDF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/10/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/00005164</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>08/03/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/00005122</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>06/15/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/00004758</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>06/08/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/00004685</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>06/08/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/00004601</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

5. Click on the RA Copy (PDF) icon.
Viewing Dental Claims: RA, continued

To access a copy of the Remittance Advice, select the ‘RA’ icon. Access to the RA will require PDF software.

If the RA is too large to display, you will get an error message instead of downloaded RA. You will need to contact Customer Service for assistance.

Total Records: 5

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Payment Method</th>
<th>Payment Type</th>
<th>Check # / RA #</th>
<th>Total Paid Amount</th>
<th>RA Copy (PDF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/10/2018</td>
<td>CHK</td>
<td>C</td>
<td>0000000000/100005184</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>08/01/2018</td>
<td>CHK</td>
<td>C</td>
<td>0000000000/100005122</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>06/15/2018</td>
<td>CHK</td>
<td>C</td>
<td>0000000000/100004758</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>06/06/2016</td>
<td>CHK</td>
<td>C</td>
<td>0000000000/100004696</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>06/08/2018</td>
<td>CHK</td>
<td>C</td>
<td>0000000000/100004651</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

PDF files require Adobe Acrobat Reader.

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The Nevada Division of Health Care Financing adheres to all applicable privacy policies and standards, including HIPAA rules and regulations, regarding protected health information. Always ensure you have the Department’s approval before sharing any of the information contained in the remittance advice with third parties.

Do you want to open or save RA 100004601.pdf (4.78 KB) from portalmod.mvd.xmv.dcs-usps.com?
Viewing Dental Claims: RA, continued

The user can then print or save the RA to his/her computer.
Copying Dental Claims
Copying Dental Claims

To copy a claim, the user will:

1. Hover over Claims
2. Select Search Claims
3. Enter the Recipient ID

NOTE: The To date will automatically populate to the same date as Service From.
### Copying Dental Claims, continued

<table>
<thead>
<tr>
<th>Service Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rendering Provider ID</td>
</tr>
<tr>
<td>08/27/2018</td>
</tr>
</tbody>
</table>

4. Enter the **Service From**
5. Click the **Search** button

NOTE: The **To** date will automatically populate to the same date as **Service From**.
6. Click the blue link under **Claim ID**
### Copying Dental Claims, continued

7. Scroll down and expand:
   - Adjudication Errors
   - Service Details

8. Click the Copy button at the bottom of the page

---

**Adjudication Errors**

<table>
<thead>
<tr>
<th>Claim / Service #</th>
<th>HIPAA Adj</th>
<th>Description</th>
<th>FOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service # 1</td>
<td>257</td>
<td>PRIMARY DIAGNOSIS CODE MISSING - DETAIL</td>
<td>1630</td>
</tr>
<tr>
<td>Service # 2</td>
<td>261</td>
<td>TOOTH NUMBER MISSING</td>
<td>1800</td>
</tr>
<tr>
<td>Service # 2</td>
<td>1010</td>
<td>RENDERING PROV NOT MEMBER OF BILLING PROV GROUP</td>
<td>3110</td>
</tr>
<tr>
<td>Service # 2</td>
<td>257</td>
<td>PRIMARY DIAGNOSIS CODE MISSING - DETAIL</td>
<td>1630</td>
</tr>
<tr>
<td>Service # 2</td>
<td>1010</td>
<td>RENDERING PROV NOT MEMBER OF BILLING PROV GROUP</td>
<td>3110</td>
</tr>
</tbody>
</table>

**Service Details**

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Tooth Surface</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>08/27/2018</td>
<td></td>
<td></td>
<td></td>
<td>D1051</td>
<td>1</td>
<td></td>
<td>$275.25</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2</td>
<td>08/27/2018</td>
<td></td>
<td></td>
<td></td>
<td>D1354</td>
<td>1</td>
<td></td>
<td>$1,275.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
9. The user will select what portion to copy

For this example, the user has selected **Entire Claim**.

10. Click **Copy**
### Copying Dental Claims, continued

**Submit Dental Claim: Step 1**

* Indicates a required field.

**Provider Information**

- **Billing Provider ID**: 1407146111
- **ID Type**: NPI
- **Billing Provider Service Location**: 22-SMILES TODAY DENTAL GROUP LLC-1580 E DESERT INN RD, LAS VEGAS, NEVADA, 89159
- **Rendering Provider ID**: 1073539177
- **ID Type**: NPI
- **Rendering Provider Service Location**: 20-SMITH, JASON C-11234 ANDERSON ST, LOMA LINDA, CALIFORNIA, 92354

**Patient Information**

- **Recipient ID**: 97338188081
- **Last Name**: MUZAE
- **First Name**: WXEBVG
- **Birth Date**: 05/02/1967

**Claim Information**

- **Accident Related**:  
- **Place of Treatment**: Physician's Office
- **Patient Number**: 12345
- **Authorization Number**:  
- **Include Other Insurance**: ✗
- **Total Charged Amount**: $1,550.25

---

**Fields will be populated with the information selected to copy. Additional changes can be made as needed.**

11. Click **Continue**
### Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Tooth Surface</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Units</th>
<th>Charge Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>08/27/2018</td>
<td></td>
<td></td>
<td></td>
<td>D1351</td>
<td>1</td>
<td></td>
<td>$275.25</td>
</tr>
<tr>
<td>2</td>
<td>08/27/2018</td>
<td></td>
<td></td>
<td></td>
<td>D1354</td>
<td>1</td>
<td></td>
<td>$1,275.00</td>
</tr>
<tr>
<td>3</td>
<td>08/28/2018</td>
<td></td>
<td></td>
<td></td>
<td>D1110</td>
<td>1</td>
<td></td>
<td>$500.25</td>
</tr>
</tbody>
</table>

**No Other Insurance Details exist for this claim**

**No Attachments exist for this claim**

---

12. Click the **Confirm** button
13. Note the Claim ID, under the **Submit Dental Claim: Confirmation** section

14. May also use the provided buttons to:
   - Print Preview
   - Copy Claim Information
   - Create new claim
   - View the details of the submitted claim
Adjusting a Dental Claim
Adjusting a Dental Claim

To begin the claim adjustment process:

1. Enter a **Claim ID**
2. Click the **Search** button
**Adjusting a Dental Claim, continued**

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>TCN</th>
<th>Claim Type</th>
<th>Claim Status</th>
<th>Service Date</th>
<th>Recipient ID</th>
<th>Rendering Provider ID</th>
<th>Medicaid Paid Amount</th>
<th>Paid Date</th>
<th>Recipient Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>5918261000001</td>
<td>3</td>
<td>Dental</td>
<td>Finalized Payment</td>
<td>08/14/2018 - 08/28/2018</td>
<td>00000000004</td>
<td>1043400534</td>
<td>$24.58</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Click the **blue** Claim ID link

**NOTE:** Denied Claims cannot be adjusted. The Claim Status column will indicate “Finalized Payment” if a claim is paid.
4. Make any necessary adjustments to your claim fields.

5. Once all changes have been made, click **Save**.
Adjusting a Dental Claim, continued

6. Click the **Resubmit** button
Adjusting a Dental Claim, continued

7. Click the **Confirm** button

**NOTE:** Click the **Cancel** button to cancel the adjustment.
The Resubmit Claim: Confirmation message will appear after the claim has been submitted. It will display the claim status and new Claim ID.

### Resubmit Dental Claim: Confirmation

<table>
<thead>
<tr>
<th>Dental Claim Receipt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Dental Claim was successfully resubmitted. The claim status is Finalized Payment. The Claim ID is 5918261000002.</td>
</tr>
</tbody>
</table>

Click **Print Preview** to view the claim details as they have been saved on the payer's system.

Click **Copy** to copy member or claim data.

Click **Adjust** to resubmit the claim.

Click **View** to view the details of the submitted claim.
Submitting an Appeal for a Claim
Submitting an Appeal for a Claim

From the homepage, the user will:

1. Select **Secure Correspondence** to start the Appeal process.
Submitting an Appeal for a Claim, continued

The user will then:

2. Select “Claims – Appeals” from the **Message Category** drop-down and fill out all required fields.
Next, the user will:

3. Click the **Browse** button and locate the file supporting the appeal request and select **Add**

4. Click the **Send** button

NOTE: Once the user clicks **Send** and the appeal has been created, the system will create a Contact Tracking Number (CTN). The user can use the CTN to check on the status of the appeal.
Submitting an Appeal for a Claim, continued

After clicking **Send**, a confirmation message will populate with “Your secure message was successfully sent”.

User will then need to:
5. Click the **OK** button
Submitting an Appeal for a Claim, continued

After the user clicks the OK button, they will be directed to the Secure Correspondence - Message Box, where the new CTN can be seen.

<table>
<thead>
<tr>
<th>Status</th>
<th>CTN #</th>
<th>Subject</th>
<th>Message Category</th>
<th>Date Opened</th>
<th>Last Activity Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
<td>4258</td>
<td>Appeal of a denied claim</td>
<td>Claims - Appeals</td>
<td>10/02/2018</td>
<td>10/02/2018</td>
</tr>
<tr>
<td>Open</td>
<td>4255</td>
<td>Testing</td>
<td>Claims - Appeals</td>
<td>09/27/2018</td>
<td>09/27/2018</td>
</tr>
<tr>
<td>Open</td>
<td>4253</td>
<td>Testing from MO</td>
<td>Level 2 Support - Account Issues</td>
<td>09/19/2018</td>
<td>09/19/2018</td>
</tr>
<tr>
<td>Open</td>
<td>4252</td>
<td>Testing 5268 in MO</td>
<td>Level 2 Support - Account Issues</td>
<td>09/18/2018</td>
<td>09/18/2018</td>
</tr>
<tr>
<td>Open</td>
<td>4251</td>
<td>Testing 5268</td>
<td>Claims - Appeals</td>
<td>09/06/2018</td>
<td>09/06/2018</td>
</tr>
<tr>
<td>Open</td>
<td>4227</td>
<td>Testing sample for 5916</td>
<td>Level 2 Support - Account Issues</td>
<td>08/14/2018</td>
<td>08/14/2018</td>
</tr>
<tr>
<td>Closed</td>
<td>4217</td>
<td>Help</td>
<td>Other</td>
<td>07/08/2018</td>
<td>06/03/2018</td>
</tr>
<tr>
<td>Open</td>
<td>4218</td>
<td>Testing Help</td>
<td>Other</td>
<td>07/08/2018</td>
<td>07/08/2018</td>
</tr>
<tr>
<td>Open</td>
<td>4219</td>
<td>Testing help</td>
<td>Other</td>
<td>07/08/2018</td>
<td>07/08/2018</td>
</tr>
<tr>
<td>Open</td>
<td>4138</td>
<td>Testing in Model</td>
<td>Level 2 Support - Account Issues</td>
<td>04/29/2018</td>
<td>04/29/2018</td>
</tr>
</tbody>
</table>
Voiding a Dental Claim
Voiding a Dental Claim

To search for a claim the user will need to:

1. Hover over **Claims**
2. Select **Search Claims**
3. Enter **Claim ID**
4. Click the **Search** button
Voiding a Dental Claim, continued

5. Click the blue Claim ID link to open the claim

NOTE: Denied Claims cannot be voided. The Claim Status column will indicate “Finalized Payment” if a claim is paid.
To void the claim, the user will:

6. Click the **Void** button
Voiding a Dental Claim, continued

7. Click the OK button
Voiding a Dental Claim, continued

8. Click the OK button
Web Announcements
If submitting a PA for an outpatient request, please review Web Announcement 2361 for more information.

Please note that service details must use Procedure Code 41899, and the claim form must reflect the appropriate CDT code.
Web Announcement 1951

August 19, 2019

Attention Provider Type 22 (Dentist):

Dental Radiology and Exam Codes

Some claims submitted by provider type 22 (Dentist) for bitewing images are being denied in error with error code 6126 (Dental services not allowed within six rolling months) when billed within six months of periapical images. Effective August 15, 2019, error code 6126 will be inactivated and the claims will no longer deny in error.

The impacted claims processed on or after February 1, 2019, and before August 19, 2019, that denied in error will be automatically reprocessed. Providers do not need to resubmit or appeal the denied claims. A future remittance advice message will notify providers when the claims are reprocessed. The impacted procedure codes are listed in the following table:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0270</td>
<td>Bitewing - Single Radiographic Image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - Two Radiographic Images</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - Four Radiographic Images</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical Bitewings - Seven to Eight Radiographic Images</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0220</td>
<td>Intraoral - Complete Series of Radiographic Images</td>
</tr>
</tbody>
</table>

Effective August 19, 2019, exam codes and radiology codes will be linked as listed in the following table:

<table>
<thead>
<tr>
<th>Exam Code</th>
<th>Associated Radiology Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120 POE</td>
<td>D0220, D0230, and either D0270, D0272, D0273 or D0274</td>
</tr>
<tr>
<td>D0140 Limited Prob. Focused</td>
<td>D0220, D0230 and either D0270, D0272, D0273 or D0274</td>
</tr>
<tr>
<td>D0145 Oral Eval. &lt;3 yrs</td>
<td>D0240 and D0220, D0230</td>
</tr>
<tr>
<td>D0150 Comp. Exam</td>
<td>D0210 and D0330 or D0220, D0230 and either D0270, D0272, D0273 or D0274</td>
</tr>
<tr>
<td>D0160 Extens. Prob Focused</td>
<td>D0220, D0230 and either D0270, D0272, D0273 or D0274</td>
</tr>
<tr>
<td>D0170 Re-eval</td>
<td>D0220, D0230 and either D0270, D0272, D0273 or D0274</td>
</tr>
<tr>
<td>D0190 Screening</td>
<td>D0330</td>
</tr>
<tr>
<td>D0191 Assessment</td>
<td>D0330</td>
</tr>
</tbody>
</table>

Effective August 19, 2019, error code 6136 (Dental services not allowed on the same date of service) will deny multiple procedure codes for bitewings billed with the same date of service.

Effective August 19, 2019, new error code 6508 (Paid dental exam code not on file) will deny radiology codes if no exam code is billed for the same date of service. The impacted procedure codes are listed in the following table:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Intraoral - Complete Series of Radiographic Images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - Periapical First Radiographic Image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - Periapical each additional Radiographic Image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - Occlusal Radiographic Image</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - Single Radiographic Image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - Two Radiographic Images</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - Three Radiographic Images</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - Four Radiographic Images</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic Radiographic Image</td>
</tr>
</tbody>
</table>
Attention Provider Type 22 (Dentist):

Bill Tooth Surface Codes in Alphabetical Order

Provider type 22 (Dentist) providers are instructed to submit dental claims with tooth surface codes indicated in alphabetical order. If claims with tooth surface codes have denied with edit code 0163 (Surface code does not match authorization), providers are instructed to resubmit the denied claims with the tooth surface codes in alphabetical order. Please resubmit the claims following timely filing guidelines.
Resources
Additional Resources

- For Forms: www.medicaid.nv.gov/providers/forms/forms.aspx
- For EVS General Information: www.medicaid.nv.gov/providers/evsusermanual.aspx
- Web Announcements: https://www.medicaid.nv.gov/providers/newsannounce/default.aspx

DHCFP Contact Information

- Division of Health Care Financing and Policy: http://dhcfp.nv.gov/
- Medicaid Services Manuals, MSM Chapters: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/
Contact Nevada Medicaid
Contact Us – Nevada Medicaid

Customer Service Call Center: 877-638-3472 (M-F 8 a.m. to 5 p.m. Pacific Time)

Prior Authorization Department: 800-525-2395

Provider Field Representative: NevadaProviderTraining@gainwelltechnologies.com
Thank you