



Dentist

Dental Services Program Overview

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. For more information on services provided under the Healthy Kids Program - (Early Periodic Screening, Diagnostic, and Treatment - EPSDT), see Chapter 1500 of the Medicaid Services Manual.

Recipients who are pregnant may receive some periodontal services (see the Fee-for-Service Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid and Nevada Check Up Dental Program), diagnostic, restorative and preventative care. Services for recipients who are pregnant require prior authorization.

Recipients in rural Nevada: Dental services provided in rural areas of Nevada are billed under the Fee for Service (FFS) benefit plan. Orthodontic services are billed under the FFS benefit plan for both rural and urban areas. Submit prior authorization requests and claims to DXC Technology, Nevada Medicaid's fiscal agent. DXC Technology is referred to as Nevada Medicaid throughout this document.

Recipients in Urban Clark and Urban Washoe counties:

LIBERTY Dental Plan (LIBERTY) became the Dental Benefits Administrator for Nevada Medicaid effective January 1, 2018.

Policy

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

- [MSM Chapter 100](#) contains important information applicable to all provider types.
- [MSM Chapter 1000](#) covers dental program policy and requirements.
- [MSM Chapter 1500](#) covers policy and requirements for the Healthy Kids Program.
- [Provider Type 22 Dental Reimbursement Rates](#) provides Nevada Medicaid rates for dental services.

Recipient Eligibility

Verify a recipient's eligibility each time before submitting a prior authorization request and before providing services. It is recommended that providers check eligibility monthly.

Options available to providers for verifying recipient eligibility are:

- **Electronic Verification System (EVS):** To access EVS, visit the Nevada Medicaid website at www.medicaid.nv.gov. Select the "EVS" tab to review the User Manual and to register or login to EVS. EVS is available 24 hours a day, 7 days a week, except during maintenance periods.
- **Automated Response System (ARS):** To access ARS, call (800) 942-6511. The ARS provides eligibility information via the phone. Your National Provider Identifier (NPI) is required to log on.
- **Swipe Card System:** To implement a swipe card system, please contact a swipe card vendor directly.

Billing Instructions

The following document contains a reference table to determine Fee-for-Service coverage, limitations and prior authorization requirements for the Nevada Medicaid and Nevada Check Up Dental Program.

- [Fee-for-Service Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid and Nevada Check Up Dental Program](#)

Submit claims using Direct Data Entry (DDE) through the Electronic Verification System (EVS) secure [Provider Web Portal](#) or use an approved Trading Partner to submit your claims. See [EVS User Manual Chapter 3 Claims](#) and the [Dental 837D](#)



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[Companion Guide](#) for claim submission instructions.

Note: Provider type 22 (Dentist) providers are instructed to submit dental claims with tooth surface codes indicated in alphabetical order.

Prior Authorization (PA)

Before submitting a prior authorization request:

- It is the provider's responsibility to verify that the recipient is covered under the Nevada Medicaid program and is eligible to receive the service you are requesting.
- Providers are advised to use the [Fee-for-Service Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid and Nevada Check Up Dental Program](#) document to verify a service is covered and if that service requires prior authorization.

Submitting Prior Authorization Requests

Submit prior authorization requests 1-2 weeks before the recipient's appointment.

The [Provider Web Portal](#), at www.medicaid.nv.gov, must be used to request authorization for all services. See the Electronic Verification System (EVS) Chapter 4 Prior Authorization for instructions.

Providers will need to submit the request(s) for authorization on the Provider Web Portal and upload the forms and clinical documentation. Providers must attach a document in the Provider Web Portal to move the prior authorization request to the review status.

Dental Requests

- Use the ADA Claim Form and list all dental procedures to be performed.
- X-rays are recommended and can save time with the review process when submitted for services including but not limited to:
 - Anchors for partial dentures.
 - Restorative services provided under pregnancy-related services.
- Dental History Requests: 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 click on "Treatment History" under the "Claims" tab.
 - Instructions are available in the [Electronic Verification System \(EVS\) User Manual Chapter 9: Treatment History](#).
 - Please note that the code history search is completed by individual code. For example, if you do a search using procedure code D0330, the search results will only return a history of paid claims for D0330 for the recipient. If a related code would also impose a limit on the procedure code you are proposing to use, you must do a separate search for that code. For history checks regarding dentures/partials, please check any and all related codes.

Outpatient Requests

- Prior authorization for dental procedures performed in an outpatient/surgical center setting may require prior authorization.
- Use the ADA Claim Form and list all dental procedures to be performed.
- The request must include a narrative signed by the provider stating the clinical rationale for the dental procedures to be completed in an "outpatient" setting. Include the outpatient facility name and your NPI.
- Outpatient services must be requested at least eight business days prior to the date of service and must follow the age specific requirements below:



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Recipients of All Ages: For Medicaid recipients of all ages: If PA is required for the dental procedure (CDT code), the dentist rendering the service must obtain prior authorization. Reference Nevada Medicaid's Fee-for-Service Coverage, Limitations and Prior Authorization Requirements (Attachment A of the PT 22 Billing Guide) document located on the provider website at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

Recipients Ages Five and Below: For Medicaid recipients ages five and below, prior authorization is required for the outpatient facility. The authorization request must include a narrative signed by the provider with the clinical rationale for the dental procedure to be completed in an outpatient setting. The narrative must detail the clinical reason, including medical necessity, that the recipient is unable to have the services completed in the office.

Recipients Ages Six to 20: For Medicaid recipients ages six to 20, specific authorization is not required for the anesthesiologist and/or outpatient facility. Procedures done as outpatient services for recipients less than 21 years of age in a hospital or surgical center must be identified. The provider must enter "Outpatient Facility Services" at the top of the Examination and Treatment Plan box of the claim form.

Recipients 21 Years of Age and Older: For Medicaid recipients 21 years of age and older, the outpatient facility services must be prior authorized. The authorization request must include a narrative signed by the provider with the clinical rationale for the dental procedure to be completed in an outpatient setting. The narrative must detail the clinical reason that the recipient is unable to have the services completed in the office.

Inpatient Requests

- Use the ADA Claim Form and list all dental procedures to be performed.
- The request must include a narrative signed by the provider stating the clinical rationale for the dental procedures to be completed in an "inpatient" setting. Include the inpatient facility name and your NPI.
- Inpatient services must be requested at least eight business days prior to the date of service.

Orthodontia

In all areas of Nevada, orthodontia is provided through the FFS benefit plan and requires a dentist's referral. Prior authorization requests and claims for orthodontia must be submitted to the Nevada Medicaid fiscal agent. Please see the [Dental PA Instructions](#) and the [Orthodontic Medical Necessity \(OMN\) Form \(FA-25\)](#) for specific information required for requesting review for medical necessity and prior authorization for orthodontia.

Providers are instructed to create the request for authorization and provide the required documentation through the Provider Web Portal. The request must include the following:

- The ADA Claim Form.
- Documentation explaining the medical necessity for the service.
- A Treatment Plan signed by the orthodontist including the diagnosis, treatment and prognosis.
- Diagnostic photographs demonstrating measurements. Diagnostic photographs means photographs that are clear enough to confirm a diagnosis. Photos of mounted models must be accompanied by photos and x-rays of the patient. Measurements must be documented in photos with a Boley gauge, probe or disposable ruler.
- Panoramic x-rays (Attach a clear copy.)
- Client Treatment History Form (FA-26)
- Orthodontic Medical Necessity (OMN) Form (FA-25)

All documentation must be submitted through the Provider Web Portal.



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Authorizations for orthodontia services are effective for one year (e.g., May 26, 2020, through May 25, 2021) and are not to exceed the date immediately prior to the recipient's 21st birthday as long as the recipient is Medicaid eligible.

Retrospective Authorization

A retrospective authorization is an authorization that is granted *after* a dental service is provided. Retrospective authorization may be granted only when:

- The recipient is determined Medicaid eligible for past dates and you provided services within those dates. You must request retrospective authorization within 90 days of the date of the eligibility decision. (This does not apply to Nevada Check Up recipients as Nevada Check Up does not offer retroactive eligibility.)
- Services are provided under life-threatening circumstances or serious health complication circumstances (e.g., from conditions such as HIV, AIDS, cancer or bone marrow or organ transplants).

To request retrospective authorization:

- Complete the ADA claim form as you would for a prior authorization request. Include dates of service in the appropriate fields.
- Write "Retrospective" in the top margin of the claim form. Do not write over bar coding or in claim form fields.
- If a service was provided under life threatening circumstances, include documentation certifying the services were necessary due to health complicating conditions such as HIV, AIDS, cancer, bone marrow transplantation or post organ transplant.

Concurrent Authorization

If additional dates of service are required, you must request continued (concurrent) authorization by submitting another authorization request to Nevada Medicaid *prior* to the end of the already authorized service dates. On your request, include the reason for requesting extended treatment.

Prior Authorization for Medications

The Nevada Medicaid Preferred Drug List (PDL) is available online at www.medicaid.nv.gov (select "Preferred Drug List" from the "Pharmacy" menu). This list contains Nevada Medicaid *preferred* drugs for over 20 drug classes. Prior authorization is required for non-listed drugs within listed classes and as otherwise noted on the PDL.

If you have questions regarding medications, please contact our Pharmacy Technical Call Center at (866) 244-8554.

After Submitting Your Request

The Nevada Medicaid fiscal agent uses state and federal guidelines to review and determine whether services meet the established requirements for payment. The Provider Web Portal will have the determination, dates of service and code(s) requested for review.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Incomplete Requests and Requests for Additional Information

When requests for prior authorization are pended for additional information, Nevada Medicaid generates a notice requesting additional information. This notice is mailed to the "Mail To" address that providers have chosen on the enrollment or revalidation applications. In addition, a note is placed in the Provider Web Portal with notification that the request is in a pending status awaiting receipt of additional information. The note in the portal and the letter specify the additional information that is needed and when the information is due in order to complete the request for review. If the information is not received within the specified time frame, the request for review will be denied.



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Denied Requests

If your request is denied, both the provider and the recipient receive written notification from Nevada Medicaid and the recipient may then submit a Fair Hearing request to the DHCFP. Fair Hearing instructions are included in the written notification sent to the recipient. Providers can submit a Fair Hearing request to the DHCFP after exhausting the appeals process available through the Nevada Medicaid fiscal agent. For more information on requesting a State Fair Hearing, see [MSM Chapter 3100](#).

A *peer-to-peer review* or *reconsideration* can be requested by providers for prior authorizations that are denied or modified. If you request a peer-to-peer review and afterward determine a reconsideration is appropriate, the reconsideration may be requested if it meets the timelines identified below. Once a reconsideration is requested, you no longer have the option of requesting a peer-to-peer review of the prior authorization.

Peer-to-Peer Review

A provider may request a *peer-to-peer review* by emailing nvpeer_to_peer@dxc.com or calling (800) 525-2395 within 10 business days of the adverse determination. A peer-to-peer review does not extend the 30-day deadline for reconsideration.

Peer-to-peer reviews are a physician-to-physician discussion or in some cases between the Nevada Medicaid second level clinical review specialist and a licensed clinical professional operating within the scope of their practice. The provider is responsible for having a licensed clinician who is knowledgeable about the case participate in the peer-to-peer review.

Reconsideration

A *reconsideration* is a written request from the provider asking Nevada Medicaid to re-review a denied or reduced authorization request. Use form FA-29B to submit your request through the Provider Web Portal.

A reconsideration is not available for technical denials.

The provider must request reconsideration within 30 calendar days from the date of the original determination.

For a reconsideration request, the provider is also responsible to provide additional medical information (e.g., intensity of service, severity of illness, risk factors) that might not have been submitted with the original/initial request that supports the level of care/services requested.

Nevada Medicaid or the DHCFP will notify the provider of the outcome of the reconsideration within 30 calendar days. The 30-day provider deadline for a reconsideration is independent of the 10-day deadline for a peer-to-peer review.

If proper medical justification is not provided to Nevada Medicaid in an initial/continued stay request, a peer-to-peer review, and/or a reconsideration review, Nevada Medicaid considers the lack of proper medical justification a failure of the provider to comply with proper documentation requirements.

Documentation for Authorization Reconsideration:

- Provide a synopsis of the medical necessity not presented in the initial authorization request that you wish to have considered.
- Include only the medical records that support the medical necessity issues identified in the synopsis.

Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Forms and Information

- Forms FA-25 and FA-26 are available online at www.medicaid.nv.gov (select "Forms" from the "Providers" menu).



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- The Nevada Medicaid Prior Authorization Department is available to answer providers' questions on dental and orthodontia prior authorization requests. This department can be reached by calling (800) 525-2395.

Smoking Cessation Counseling for Pregnant Women

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.