First Health Services Corporation
A Coventry Health Care Company

Billing Guidelines for Provider Type 22

Dentist

Program Overview

For recipients age 21 and older, Nevada Medicaid covers only necessary dentures, emergency extractions and palliative care. Recipients under age 21 may receive a larger range of dental services including orthodontia, certain restorative services and routine maintenance to promote overall dental health.

State policy for dental services is in the Nevada Medicaid Services Manual, Chapter 1000, online at http://dhcfp.state.nv.us.

Benefit Plan for Rural Nevada and Urban Washoe County

In rural areas of Nevada and in urban Washoe County, all dental services (including orthodontia) are billed under the FFS benefit plan. Submit prior authorization requests and claims to First Health Services.

Benefit Plans for Urban Clark County

In urban Clark County, certain eligibility programs such as Temporary Assistance to Needy Families (TANF) and the Children's Health Assurance Program (CHAP), offer coverage for emergency care only during the first month of eligibility. Recipients in these eligibility programs are transitioned to a Managed Care Organization (MCO) at the beginning of their second month of eligibility. After transitioning to an MCO, the recipient is eligible to receive non-emergency dental services.

Other eligibility programs, such as Medical Assistance for the Aged, Blind and Disabled (MAABD) and Foster Children programs, offer full dental coverage from the first day of eligibility. Recipients in these eligibility programs are not transitioned to an MCO.

It is important to verify a recipient's eligibility each time before providing services.

Orthodontia

Orthodontia is covered for eligible recipients. 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 First Health Services, not the MCO. Please see the Prior Authorization chapter of this manual for further requirements.

Dental Prior Authorization

If you have any questions regarding prior authorization, please contact First Health Services' Prior Authorization Department at (800) 648-7593.

Before submitting a prior authorization request:

- Verify that the recipient is covered under the Medicaid FFS benefit plan, and that the recipient is eligible to receive the service you are requesting.
- Use MSM Chapter 1000, to verify coverage and prior authorization requirements. The MSM is available on the DHCFP web site at http://dhcfp.state.nv.us or through First Health Services web site.

Benefit Plan for Rural Nevada and Urban Washoe County

In rural Nevada and Urban Washoe County, dental services (including orthodontia) are covered under the Fee For Service (FFS) benefit plan. Submit all prior authorization requests and claims to First Health Services.

Benefit Plans for Urban Clark County

In urban Clark County, certain eligibility programs such as Temporary Assistance to Needy Families (TANF) and the Children's Health Assurance Program (CHAP), offer coverage for emergency care only during the first month of eligibility. Recipients in these eligibility programs are transitioned to a Managed Care Organization (MCO) at the beginning of their second month of eligibility. After transitioning to an MCO, the recipient is eligible to receive non-emergency dental services.

Other eligibility programs, such as Medical Assistance for the Aged, Blind and Disabled (MAABD) and Foster Children programs, offer full dental coverage from the first day of eligibility. Recipients in these eligibility programs are not transitioned to an MCO.

It is important to verify a recipient's eligibility each time before providing services.

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 First Health Services, not the MCO.

Submit Requests 1-2 Weeks before Service

Submit prior authorization requests one to two weeks before the recipient's appointment. Routine procedures usually take one week to process. More complex procedures are reviewed by a dental consultant and processing may take up to two weeks.

Documentation to Include with Your Request

When requesting prior authorization, include the ADA form and the following:

- Documentation explaining the medical necessity for the service. This includes relines or tissue conditioning services.
- For orthodontia requests, all of the following are required:
  - Diagnostic photographs
  - Panoramic x-rays
  - Client Treatment History Report (FH-26)
  - Handicapping Labiolingual Deviation (HLD) Index Report (FH-25)

Forms FH-25 and FH-26 (for orthodontia requests) are online at http://nevada.fhsc.com (select "Forms" from the "Providers" menu).

Mailing Address

Mail prior authorization requests to:

First Health Services
Health Care Management
P.O. Box 30042
Reno, Nevada 89520-3042

Prior Authorization for Medications

The Nevada Medicaid Preferred Drug List (PDL) is online at http:nevada.fhsc.com (select "Preferred Drug List" from the "Pharmacy" drop-down menu). This list contains Nevada Medicaid "preferred" drugs for over 20 drug classes. Prior authorization is required for non-listed drugs within these classes and as otherwise noted on the PDL.

If you have questions regarding medications, please contact our Pharmacy Technical Call Center at (800) 884-3238.

Requesting Additional Dates (Concurrent Authorization)

After you request authorization, First Health Services mails a "Notice of Medical Necessity Determination" letter. This letter tells you whether the requested service was approved or denied and, if approved, the authorized service dates.

An approved authorization is valid for the authorized service dates only. If additional dates of service are required, you must request continued (concurrent) authorization by submitting another authorization request to First Health Services *prior* to the end of the authorized service dates. On your request, be sure to include the reason for requesting extended treatment.

Requesting Past Dates (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 was not eligible for Medicaid on the date of service, but later became eligible. The Welfare Division can determine the recipient eligible for up to three months in the past. The date the Welfare Division determines eligibility is called the "date of decision." If the recipient is determined eligible for past dates and you provided services within that period, you may request a retrospective authorization within 90 days from the date of decision. (This does not apply to Nevada Check Up recipients; 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).

How to Request Retrospective Authorization

To request retrospective authorization:

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

After Submitting Your Request

First Health Services uses state and federal guidelines to review and determine whether services meet the established requirements for payment.

After processing your request, First Health Services mails back your ADA claim form, any enclosures (e.g., x-rays) and a "Dental Authorization Determination" form that includes an "unofficial" determination for the request.

One to two days later, the MMIS generates your "official" determination letter. This letter, called the "Pre-Authorization Notification," includes the approved codes, units, authorized service period and, if applicable, your Authorization Number. It is recommended that you keep this letter in the recipient's medical file for future reference.

An approved prior authorization does not confirm recipient eligibility or guarantee payment of claims.

If you have any questions regarding this process, contact First Health Services' Prior Authorization Department at (800) 648-7593.

Incomplete Requests

If any information is incomplete on your prior authorization request, First Health Services will send back your request and documentation with a Dental Authorization Determination form indicating the additional information needed to process your request.

Denied Requests

If your request is denied, both the provider and the recipient receive written notification from First Health Services and the recipient may submit an appeal to the DHCFP. Appeal instructions are included in the written notification sent to the recipient.