First Health Services Corporation
A Magellan Health Company

Billing Guidelines for Provider Type 22

Dentist

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.

Effective September 1, 2008 for Nevada Check Up recipients: Orthodontia is no longer covered and dental coverage is limited to $600 per State fiscal year (July 1 through June 30).

Pregnant recipients may receive periodontal scaling, root planning, a second cleaning during pregnancy and treatment of inflamed gums around wisdom teeth.

Reference

Please see the Dental Fee Schedule and MSM Chapter 1000 for detailed program information such as service coverage and limitations and provider responsibilities. These documents are on the Division of Health Care Financing and Policy (DHCFP) website, http://dhcfp.nv.gov.

The ADA Claim Form Instructions are on First Health Services' website, http://nevada.fhsc.com.

Recipients in Rural Nevada

Dental and orthodontia services provided in rural areas of Nevada are billed under the Fee For Service (FFS) benefit plan. Submit claims and prior authorization requests to First Health Services.

Recipients in Urban Clark and Washoe Counties

Temporary Assistance to Needy Families (TANF) and the Children's Health Assurance Program (CHAP), provide for emergency dental care only until the recipient is transitioned to a Managed Care Organization (MCO) at the beginning of their second full month of eligibility.

After transitioning to an MCO, a recipient under age 21 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 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

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 ADA Claim Form Instructions for additional information.

Prior Authorization

If you have any questions about 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 is eligible to receive the service you are requesting.
- Use the Dental Fee Schedule to verify a service is covered and if that service requires prior authorization

Documentation to Include

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 (Send a clear copy. Do not submit original x-rays.)
  - Client Treatment History Report (form FH-26)
  - Handicapping Labiolingual Deviation (HLD) Index Report (form FH-25)

Forms FH-25 and FH-26 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.

Submission Deadlines

Submit prior authorization requests 1-2 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.

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 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.

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 faxes back a "Dental Authorization Determination" form that includes an "unofficial" determination for the request. X-rays and supporting documentation are not returned unless specifically requested.

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.

Concurrent Authorization

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 already-authorized service dates. On your request, be sure to include the reason for requesting extended treatment.

Incomplete Requests

If information is incomplete on an authorization request, First Health Services will fax the provider a "Dental Provider Authorization Notice" that lists the additional information required to process the request, and a date that the information is due back. If the additional information is not received by the due date, the request is given a "technical denial."

Denied Requests

If your request is denied due to clinical reasons, 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.

For technical denials, First Health Services faxes notification to the provider only. The recipient does not receive notification of a technical denial.