Dentist

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.

Reference

Please see the following documents on the Magellan Medicaid Administration, Inc. website at http://nevada.fhsc.com:

- 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, http://dhcfp.nv.gov:

- MSM Chapter 100 contains important information applicable to all provider types.
- MSM Chapter 1000 covers dental program policy and requirements.
- Provider Type 22 Dental Reimbursement Rates provides Nevada Medicaid rates for all dental services

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 Magellan Medicaid Administration.

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 Magellan Medicaid Administration, not the MCO. Please see the ADA Claim Form Instructions for specific prior authorization and claim instruction.

Dental History Requests

Effective January 4, 2010, providers must submit form FA-26A to request a recipient's dental history from Magellan Medicaid Administration.

If you have questions about requesting a recipient's dental history, please contact Magellan Medicaid Administration' **Prior Authorization Department at (800) 648-7593**.

Prior Authorization

The Magellan Medicaid Administration Prior Authorization Department is available to answer providers' questions on dental prior authorization. This department can be reached by calling (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 Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid Dental Program document 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.
- 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 FA-26)
  - Handicapping Labiolingual Deviation (HLD) Index Report (form FA-25)

Forms FA-25, FA-26 and FA-26A are online at http://nevada.fhsc.com (select "Forms" from the "Providers" menu).

Mailing Address

Mail prior authorization requests to:

Magellan Medicaid Administration
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" 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 (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

Magellan Medicaid Administration uses state and federal guidelines to review and determine whether services meet the established requirements for payment.

After reviewing your request, Magellan Medicaid Administration generates and mails to the provider a 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.

X-rays and supporting documentation are not returned to the provider unless specifically requested.

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

Concurrent Authorization

If additional dates of service are required, you must request continued (concurrent) authorization by submitting another authorization request to Magellan Medicaid Administration *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, Magellan Medicaid Administration 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 Magellan Medicaid Administration and the recipient may then submit an appeal to the DHCFP. Appeal instructions are included in the written notification sent to the recipient.

For technical denials, Magellan Medicaid Administration mails notification to the provider only. The recipient does not receive notification of a technical denial.