

Dentist

Dental Services Program Overview

Recipients Age 21 and Older

Adult Medicaid recipients may receive the following dental services subject to a \$1,000 expenditure limit per calendar year: diagnostic; preventive; periodontal; and operative (fillings and crowns). Additional benefits for Medicaid-eligible adults age 21 and older, not subject to the expenditure limits, include emergency, dentures and palliative care. There is no adult benefit coverage for endodontics or non-emergency extractions. For more information on services covered for those age 21 and older, including service limitations and prior authorization requirements, please see [Attachment A of this Provider Type \(PT\) 22 Billing Guide](#).

Adult recipients on the Waiver for Individuals with Intellectual and Developmental Disabilities (IDD Waiver) are eligible to receive expanded dental services to include restorations, root canals and preventive care. The expanded dental services for the IDD Waiver recipients have a maximum limit of \$2,500 annually.

Recipients Under Age 21

Those referred for diagnosis/treatment under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program are eligible to receive the full range of dental care without authorization, with the exception of orthodontics which requires prior authorization. For more information on EPSDT covered services, including service limitations and prior authorization requirements, please see [Attachment A of this PT 22 Billing Guide](#).

Recipients Who are Pregnant

Medicaid recipients are covered for dental prophylaxes and certain periodontal services and operative, diagnostic and preventative procedures during pregnancy period. These pregnancy-related services require prior authorization and are not subject to the \$1,000 annual calendar year expenditure maximum. For more information on pregnancy-related covered services, including service limitations and prior authorization requirements, please see [Attachment A of this PT 22 Billing Guide](#). Please note that Nevada Medicaid has an administrative exception policy that would allow exceptions to policy limitations for medical necessity in exceptional cases.

Billing Reimbursement Submission Instructions

Fee for Service Recipients

Dental services provided to **Medicaid Fee for Services (FFS) recipients** are billed through the FFS benefit delivery system. Benefit coverage, with limitations and prior authorization requirements can be found on the [PT22 Billing Guide supplement, Attachment A](#).

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

Managed Care (LIBERTY Dental Plan) Recipients

Dental services provided to **Managed Care recipients** are billed through LIBERTY Dental Plan, who manages the Nevada Medicaid Dental Benefits Administrator (DBA) benefit delivery system. Please note exception below for orthodontic and IDD Waiver services.

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Please visit [LIBERTY online](#) for more Information on managed care dental benefits available in **urban Clark and Washoe Counties**, including coverage limitations and prior authorization requirements. Effective July 1, 2026, dental providers that are partnered with Liberty Dental Plan can provide the expanded dental services to persons age 21 and older.

****All** Orthodontic and IDD Waiver Services ARE Billed through FFS Benefit Delivery System**

Whether recipients are enrolled under the **FFS** or **Managed Care (LIBERTY)** benefit delivery systems, all claims for orthodontic and IDD Waiver services are billed through FFS. Submit applicable prior authorization requests and claims to Gainwell Technologies, Nevada Medicaid's fiscal agent, as noted in the FFS section above.

Fee for Service (FFS) Only Information Below

See Sections for: Policy, Recipient Eligibility, Benefit Coverage, Limitations, \$1,000 Annual Expenditure Limit Information, and Prior Authorization Requirements

FFS Policy

Please see the following documents on the Nevada Health Authority, Nevada Medicaid website at: nevadamedicaid.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.
- [MSM Chapter 2100](#) covers policy and requirements for those eligible for the IDD Waiver for expanded dental services.
- [Provider Type 22 Dental Fee Schedules](#) webpage provides Nevada Medicaid rates for dental services and IDD Waiver dental services.

FFS 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 to verify recipient eligibility are:

- **Provider Web Portal (PWP):** To access the PWP, visit the Nevada Medicaid provider website at medicaid.nv.gov. Select the "PWP" tab to review the User Manual and to register or login to the PWP. The PWP 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.

FFS Benefit Coverage, Limitations and \$1,000 Annual Expenditure Limit Information

The following document contains a reference table to determine FFS coverage, limitations and prior authorization requirements for the Nevada Medicaid and Nevada Check Up Dental Program services available to adults 21 and over and those covered under the ESPDT or Pregnancy benefits.

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

Effective July 1, 2026 – The expanded dental services covered for Medicaid-eligible adults age 21 and older are subject to a \$1,000 expenditure limit per calendar year. The \$1,000 annual expenditure limit will be calculated with the FFS Fee Schedule for Provider Type 22 - Dentists, using the reimbursement rates for the individual CDT/CPT/HCPCS code services performed. Validation of calculations and related questions

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should be directed to Nevada Medicaid.

Services provided that exceed the annual \$1,000 limit are non-covered benefits and the financial responsibility of the recipient when the written requirements of MSM 100, Section 105.3 C. are met. The weekly Remittance Advice will note the new error code 5751 (\$1000 Allowed Per Calendar Year) for applicable claims as follows:

- Pay (Partial Claim) – Audit 5751 will post for claim amounts paying up to the \$1,000 maximum, leaving non-covered balances subject to recipient financial responsibility. Please note that non-covered "partial claim" balances are based on the FFS fee schedule reimbursement rate for the individual CDT/CPT/HCPCS code services performed.
- Deny (Full Claim) – Audit 5751 will post for claims amounts when no remaining benefit is available. These are non-covered balances subject to recipient financial responsibility.

For the expanded dental services for **IDD Waiver recipients**, the following Attachment B of the PT 22 Dental Billing Guide contains a reference table with the procedure codes and service limitations specific to expanded dental services.

- [Attachment B: Fee-for-Service Coverage, Limitations and Prior Authorization Requirements for Dental Services for the Waiver for Individuals with Intellectual and Developmental Disabilities](#)

FFS Prior Authorization (PA) Requirements

Except for services for IDD Waiver recipients, 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 medicaid.nv.gov, must be used to request authorization for all services. See the [PWP User Manual 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 [PWP 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

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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:

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 [medicaid.nv.gov](https://www.nv.gov/medicaid) for a list of covered CDT codes, prior authorization requirements and service limitations.

Outpatient Facility Requests

- **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. It should be noted orthodontia is not included under the ID Waiver expanded dental benefits.

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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.

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 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.

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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.

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 Nevada Medicaid. Fair Hearing instructions are included in the written notification sent to the recipient. Providers can submit a Fair Hearing request to Nevada Medicaid 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@gainwelltechnologies.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 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.

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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 medicaid.nv.gov (select "Forms" from the "Providers" menu).
- The Gainwell Technologies 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.