November 17, 2026

Nevada Medicaid Web Announcement 4061

Attention Provider Type 22 (Dental): Pregnancy-Related Dental Claims

Pregnancy-related dental services are not subject to the $1,000 annual calendar year expenditure maximum; however, some dental claims for pregnant members have been incorrectly applied toward the $1,000 annual maximum. Effective November 16, 2026, all pregnancy-related dental services are payable under the Pregnancy (PREG) benefit plan, and claims will no longer apply to the $1,000 annual maximum.

The prior authorization (PA) requirements and service limitations for all services are the same and can be reviewed on Attachment A: Fee-for-Service Coverage, Limitations and Prior Authorization Requirements of the Provider Type 22 (Dental) Billing Guide.

Additionally, some dental claims may have been denied with error code 4021 (No coverage rule for procedure) if the service was not covered under the member's benefit plan, but the member was pregnant. Under the PREG benefit plan, claims will no longer be denied with error code 4021.

As a reminder, additional dental benefits are available to Medicaid recipients during pregnancy, and providers should ensure that eligible members are informed of these pregnancy-related dental services. Following delivery, or after the due date listed on the prior authorization, only standard adult dental benefits apply. For a complete list of services, please see Attachment A: Fee-for-Service Coverage, Limitations and Prior Authorization Requirements.

Note: Dental services are not covered under Pregnancy Presumptive Eligibility.

Pregnancy-related dental claims that were impacted by the $1,000 annual maximum or that denied inappropriately will be reprocessed automatically to adjudicate correctly. Impacted claims have dates of service on or after July 1, 2026.

When claims are reprocessed, please be aware that all system and clinical claim editor edits are applicable. As a result, there may be no additional payment, and other claim denials may be received. Providers have the right to appeal denied claims, including those denied upon reprocessing. Please refer to Medicaid Services Manual Chapter 100 and the Billing Manual for information concerning the claim appeal process and time frames.