First Health Services Corporation

22 Dentist

Dental Program Overview

Dental Prior Authorization

Dental 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.

Some dental services require prior authorization. Please see the Prior Authorization chapter of this manual for further instruction.

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.

State Policy: Coverage and Limitations

State policy for dental services is in the Nevada Medicaid Services Manual, Chapter 1000, online at http://dhcfp.state.nv.us. The last section of Chapter 1000 contains a table that lists all covered services and prior authorization requirements. Figure DS-1 is an excerpt from this table.

Figure DS-1

CURRENT DENTAL TERMINOLOGY (CDT-4) CODES AND PAYMENTS RATES
COVERED BY NEVADA MEDICAID
R- routine for EPSDT/Healthy Kids, **EM**- adult/emergency, **PA**- prior authorization required age 21 years and over,
O- orthodontia authorization required **A** – okay for Adults

ADDENDUM DENTAL CODES ACCEPTED BY NEVADA MEDICAID (FEE FOR SERVICE)

CODE	*CDT-4 SHORT DESCRIPTION AND COVERAGE*	*INDICATOR*
	DIAGNOSTIC AND PREVENTIVE (D0100-D1999)	
D0120	Periodic oral evaluation *allowed once per 12 months*	R
D0140	Limited oral evaluation, problem focused replaces emergency evaluation	R/EM
D0150	Comprehensive oral evaluation, replaces initial exams *allowed once per provider*	R
D0160	Detailed and extensive oral evaluation problem focused, by report	R
D0170	Re-evaluation - limited, problem focused (established recipient; not post operative visit	R
D0210	intra-oral, complete series (including bitewings) *clearly diagnosable/identified as "right and "left" not to be taken with excessive frequency*	R/EM

Rates

Medicaid dental rates can be located through the First Health Services web site as shown below.

Figure DS-2

Dental Prior Authorization

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

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.

When to Request Prior Authorization

The end of Chapter 1000 in the Medicaid Services Manual (MSM) lists all covered dental services and tell which services require prior authorization.

Figure DPA-1 is an excerpt from Chapter 1000. Procedures with "PA" in the "Indicator" column or that specify "by report" require documentation that explains the medical necessity of the service.

Figure DPA-1

CURRENT DENTAL TERMINOLOGY (CDT-4) CODES AND PAYMENTS RATES
COVERED BY NEVADA MEDICAID
R- routine for EPSDT/Healthy Kids, **EM**- adult/emergency, **PA**- prior authorization required age 21 years and over,
O- orthodontia authorization required **A** – okay for Adults

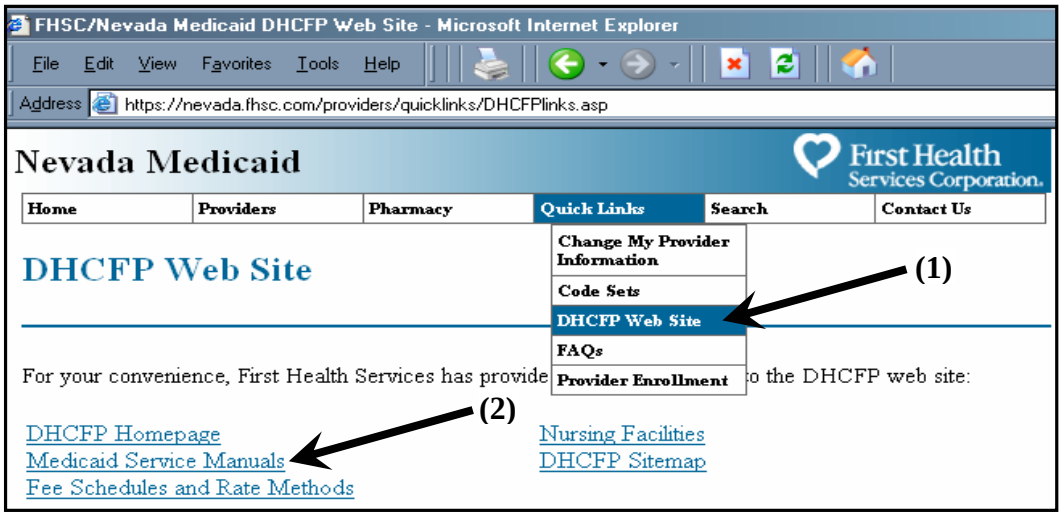
CODE	*CDT-4 SHORT DESCRIPTION AND COVERAGE*	*INDICATOR*
D4274	Distal or proximal wedge procedure - when not performed in conjunction with surgical procedures in the same anatomical area.	PA
D4320	Provisional splinting - intracoronal	R
D4321	Provisional splinting - extracoronal	R
D4341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth spaces, per quadrant *Carefully monitored for appropriate use,* *generally limited to recipients at least 14 years old.* *In-office records must verify x-rays, periodontal charting and diagnoses documenting need for procedure.*	R
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	R
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	R/EM
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue - per tooth, by report	R
D4910	Periodontal maintenance	R
D4999	Unspecified periodontal procedure, by report	PA

Before Requesting Prior Authorization

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 as shown in Figure DPA-2.

Figure DPA-2



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.

Requesting Authorization with the ADA 1999, version 2000 Claim Form

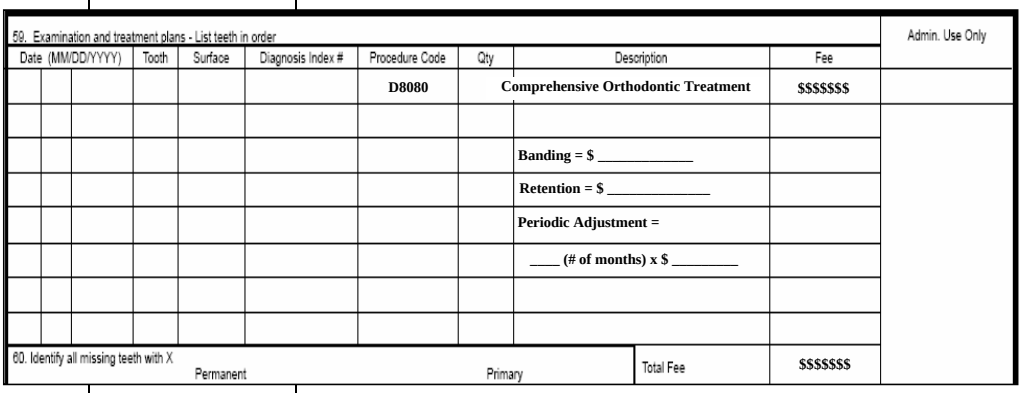
Use Table DPA-1 to create a dental prior authorization request using the ADA 1999, version 2000 claim form. Please refer to "Documentation to Include with Your Request" later in this chapter for the list of supplemental documentation that must be included with your request (e.g., x-rays, models).

Table DPA-1

Field	Requirement	Description
1	**Required**	**Dentist's pre-treatment estimate, Dentist's statement of actual service, Specialty** Check "Dentist's pre-treatment estimate."
2	**Required**	**Medicaid Claim, EPSDT, Prior Authorization #** • Check "Medicaid Claim" if the request is for a recipient age 21 or older. • Check "EPSDT" if the request is for a recipient under age 21.
8	**Required**	**Patient Name (Last, First, Middle)** Enter the recipient's last, first and middle name.
12	**Required**	**Date of Birth**
13	**Required**	**Patient ID #** Enter the 11-digit number on the recipient's Medicaid card.
42	**Required**	**Name of Billing Dentist or Dental Entity** Enter the name of the provider or entity that is billing Medicaid for these services.
43	**Required**	**Phone Number**
44	**Required**	**Provider ID #** Enter the 9-digit Provider Medicaid Number of the provider or entity that is billing Medicaid for these services.
46	**Required**	**Address** After reviewing your request, First Health Services mails back the prior authorization request (claim form) and any included documentation to the address you provide in this field.

Field	Requirement	Description
48	**Conditional**	**First visit date of current series:** Enter the first visit date related to this service request. For example, if you (1) provided an evaluation on May 1, 2004 that indicated necessity for follow-up care and then (2) submitted your prior authorization request for continuing services on May 8, 2004, you would enter 05/01/2004 in this field - the date of the recipient's first visit.
50	**Required**	**City** Enter the city for the address in Field 46.
51	**Required**	**State** Enter the state for the address in Field 46.
52	**Required**	**Zip Code** Enter the zip code for the address in Field 46.
53	**Conditional**	**Radiographs or models enclosed?** If you submit radiographs and/or models with your request, check "Yes" and enter the number of radiographs and/or models. The "Documentation to Include with Your Request" section later in this chapter lists documentation to submit with various prior authorization requests.
54	**Conditional**	**Is treatment for orthodontics?** If you are requesting prior authorization for orthodontia services, (1) check "Yes," (2) enter the date that the appliance was placed and (3) enter the number of months of treatment remaining.
55	**Conditional**	**If prosthesis (crown, bridge or denture), is this initial placement:** If you are requesting an initial placement for crowns, bridges or dentures, check "Yes." If you are requesting replacement for crowns, bridges or dentures, check "No" and enter the reason for replacement..
56	**Conditional**	**Is treatment result of occupational illness or injury?** If the treatment is a result of illness or injury, check "Yes." Give a brief description and the date of the illness or injury.
57	**Conditional**	**Is treatment result of:** If the treatment is a result of an auto accident or other type of accident, check the appropriate box. Enter the date of the accident and give a brief description.

Field	Requirement	Description
59	**Conditional**	**Date (MM/DD/YY)** Enter the dates of service only if requesting a retrospective authorization. When requesting a retrospective authorization, also write "Retrospective" on the top of your claim form (do not write "Retrospective" over bar coding or in the claim form fields). Please refer to the "Retrospective Authorizations" section later in this chapter for more information.
	Conditional	**Tooth** If applicable, enter the tooth identifier (01-32 or A-T) or quadrant identifier (UL, UR, LL or LR) that relates to the procedure. Use 2 digits to enter all numeric tooth identifiers. Tooth number "1" must be entered as "01," tooth number "2" must be entered as "02" and so on through tooth number "09."
	Conditional	**Surface** Tooth Surface When applicable, enter a tooth surface code. The valid values are: B – Buccal D – Distal F – Facial I – Incisal L – Lingual M – Mesial O – Occulusal
	Required	**Procedure Code** Enter the 5-digit CDT code for the procedure.
	Conditional	**Qty** If applicable, enter the number of requested units.

<table>
<tr><th>Field</th><th>Requirement</th><th>Description</th></tr>
<tr><td></td><td>Conditional</td><td>Description
Enter the description for the service.
For orthodontia, use the claim lines to break down the comprehensive charges as shown below:
 
<table>
<tr><td colspan="9">59. Examination and treatment plans - List teeth in order</td><td>Admin. Use Only</td></tr>
<tr><td colspan="3">Date (MM/DD/YYYY)</td><td>Tooth</td><td>Surface</td><td>Diagnosis Index #</td><td>Procedure Code</td><td>Qty</td><td>Description</td><td>Fee</td><td></td></tr>
<tr><td colspan="3"></td><td></td><td></td><td></td><td>D8080</td><td></td><td>Comprehensive Orthodontic Treatment</td><td>$$$$$$$</td><td></td></tr>
<tr><td colspan="3"></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="3"></td><td></td><td></td><td></td><td></td><td></td><td>Banding = $ _____</td><td></td><td></td></tr>
<tr><td colspan="3"></td><td></td><td></td><td></td><td></td><td></td><td>Retention = $ _____</td><td></td><td></td></tr>
<tr><td colspan="3"></td><td></td><td></td><td></td><td></td><td></td><td>Periodic Adjustment =</td><td></td><td></td></tr>
<tr><td colspan="3"></td><td></td><td></td><td></td><td></td><td></td><td>____ (# of months) x $ _____</td><td></td><td></td></tr>
<tr><td colspan="3"></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="3"></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">60. Identify all missing teeth with X
Permanent Primary</td><td colspan="2">Total Fee</td><td>$$$$$$$</td><td></td></tr>
</table>
The breakdown of fees for branding, retention and periodic adjustment should equal the price for complete orthodontic treatment in the Fee column. Enter this information exactly as shown above. Do not enter breakdown amounts in the Fee column.</td></tr>
<tr><td>60</td><td>Conditional</td><td>Identify all missing teeth with X
When applicable, identify which teeth are missing by putting an “X” over the appropriate tooth number(s).</td></tr>
<tr><td>61</td><td>Conditional</td><td>Remarks for unusual services
Use this field to add additional information about your request and/or explain the reason that the service is medically necessary.</td></tr>
</table>

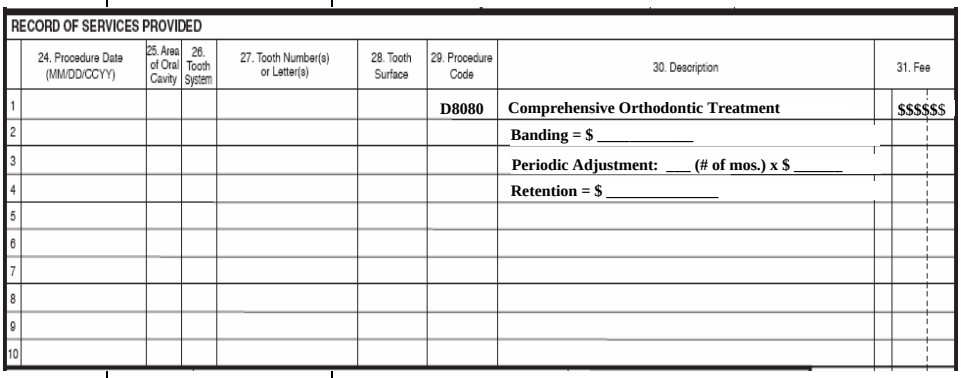
First Health Services Corporation.

Requesting Authorization with the ADA 2002 Claim Form

Use Table DPA-2 to create a dental prior authorization request using the ADA 2002 claim form. Please refer to "Documentation to Include with Your Request" later in this chapter for the list of supplemental documentation that must be included with your request (e.g., x-rays, models).

DPA-2

Field	**Requirement**	**Description**
HEADER INFORMATION -----		
1	Required	**Type of Transaction** Check "Request for Predetermination/Preauthorization."
PRIMARY SUBSCRIBER INFORMATION -----		
15	**Required**	**Subscriber Identifier (SSN or ID#)** Enter the recipient's 11-digit Recipient ID Number assigned by Nevada Medicaid.
PATIENT INFORMATION -----		
20	Required	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Enter the recipient's full name and address.
21	**Required**	**Date of Birth (MM/DD/YY)** Enter the recipient's date of birth in MM/DD/YY format.
RECORD OF SERVICES PROVIDED -----		
24	Conditional	Procedure Date When requesting retrospective authorization, enter the date service was provided and write "Retrospective" in the top margin of your claim form (do not write over bar coding or in claim form fields). Please refer to the "Retrospective Authorizations" section later in this chapter for further instructions. If you are not requesting retrospective authorization, leave this field blank.
27	Conditional	Tooth Number(s) or Letter(s) If applicable, enter the tooth identifier (01-32 or A-T) or quadrant identifier (UL, UR, LL or LR) that relates to the procedure. Use 2 digits to enter all numeric tooth identifiers. Tooth number "1" must be entered as "01," tooth number "2" must be entered as "02" and so on through tooth number "09."

Field	Requirement	Description
28	**Conditional**	**Tooth Surface** When applicable, enter a tooth surface code. The valid values are: B – Buccal D – Distal F – Facial I – Incisal L – Lingual M – Mesial O – Occulusal
29	**Required**	**Procedure Code** Enter the 5-digit CDT code to describe the service.
30	**Required**	**Description** Enter the description for the service. For orthodontia, use the claim lines to break down the comprehensive charges as shown below:  RECORD OF SERVICES PROVIDED 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee 1 | D8080 | Comprehensive Orthodontic Treatment | $$$$$$ 2 | Banding = $ _____ 3 | Periodic Adjustment: ___ (# of mos.) x $ _____ 4 | Retention = $ _____ 5 6 7 8 9 10 The fees for branding, periodic adjustment and retention should equal the price for complete orthodontic treatment in Field 31. Enter this information exactly as shown above. Do not enter breakdown amounts in Field 31.
31	Conditional	Fee If requesting orthodontia, enter your usual and customary charge (as shown in the image above). Otherwise, leave this field blank.
33	Conditional	Total Fee If requesting orthodontia, enter your usual and customary charge (the same amount entered in Field 31). Otherwise, leave this field blank.
MISSING TEETH INFORMATION -----		
34	**Conditional**	**(Place an 'X' on each missing tooth)** When applicable, identify which teeth are missing by putting an "X" over the appropriate tooth number(s).
35	**Conditional**	Remarks If necessary, use this field to enter additional clinical information regarding the request.

Field	Requirement	Description
ANCILLARY CLAIM/TREATMENT INFORMATION -----		
39	**Conditional**	**Number of Enclosures** If you submit radiographs, oral images and/or models with your request, enter the number of each in the boxes provided. The "Documentation to Include with Your Request" section later in this chapter lists documentation that must be submitted with various prior authorization requests.
40	**Conditional**	**Is Treatment for Orthodontics?** If you are requesting prior authorization for orthodontia services, check "Yes" and complete Fields 41 and 42.
41	**Conditional**	**Date Appliance Placed (MM/DD/YY)** If applicable, enter the date the appliance was placed. If you are requesting authorization for initial placement, write "Initial."
42	**Conditional**	**Months of Treatment Remaining** Enter the number of months of treatment remaining. If this is a request for initial placement, write the number of months the appliance will be in place.
45	**Conditional**	**Treatment Resulting from** Specify whether treatment/services are a result of an auto accident, other accident or occupational illness/injury. Then, complete Field 46. If treatment/services are a result of an auto accident, also complete both Field 46 and Field 47.
46	**Conditional**	**Date of Accident (MM/DD/YY)** If treatment/services are a result of an accident, enter the date of the accident.
47	**Conditional**	**Auto Accident State** If treatment/services are a result of an auto accident, enter the two-letter abbreviation for the state where the accident took place.
BILLING DENTIST OR DENTAL ENTITY -----		
48	**Conditional**	**Name, Address, City, State, Zip Code** If you submit radiographs, oral images and/or models with your request, enter the mailing address First Health Services should use to return the enclosures to you.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION -----		
53	**Required**	**Signed (Treating Dentist)** The treating/servicing dentist must sign the authorization request.
54	**Required**	**Provider ID** Enter the 9-digit Provider Medicaid Number of the billing provider.

Field	Requirement	Description
56	**Required**	**Address, City, State, Zip Code** Enter the mailing address of billing provider.
57	**Required**	**Phone Number** Enter a phone number for the contact person for the request.

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" drop-down menu).

Mailing Address

Mail prior authorization requests to:

First Health Services
Health Care Management
P.O. Box 30043
Reno, Nevada 89520-3043

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.