

**Dentist****Dental Services 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 some periodontal services (see the Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid and Nevada Check Up Dental Program), diagnostic, restorative and preventative care. Services for recipients who are pregnant require prior authorization.

**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 DXC Technology, which is referred to as Nevada Medicaid effective June 26, 2017, throughout this document.

**Recipients in Urban Clark and Urban 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.
- Effective July 1, 2017, the dental services currently provided to Medicaid Managed Care recipients in urban Clark and urban Washoe counties will no longer be managed by the current Managed Care Organizations (MCO). As of July 1, 2017, dental services and claims will be administered through Fee for Service (FFS) until a Dental Benefits Administrator (DBA) can be selected to manage dental services. The Division of Health Care Financing and Policy (DHCFP) is currently in the process of selecting a DBA to serve eligible recipients in the mandatory MCO coverage areas of urban Washoe and urban Clark counties. The DHCFP will notify providers via a letter and a future web announcement of the name and contact information once a DBA is selected.
  - All dental claims with dates of service on or before June 30, 2017, should be sent to the patients' current MCOs: Amerigroup Community Care or Health Plan of Nevada.
  - All dental claims with dates of service on or after July 1, 2017, should be sent to FFS Nevada Medicaid until further notice.

**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 for verifying recipient eligibility are:

- Electronic Verification System (EVS): To access EVS, visit the Nevada Medicaid website at [www.medicaid.nv.gov](http://www.medicaid.nv.gov). Select the "EVS" tab to review the User Manual and to register or login to EVS. EVS is available 24 hours a day, 7 days a week, except during maintenance periods. For assistance



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with obtaining a secured login, contact the Nevada Medicaid Field Representatives at [NevadaProviderTraining@dxc.com](mailto:NevadaProviderTraining@dxc.com).

- Automated Response System (ARS): To access ARS, call (800) 942-6511. The ARS provides eligibility information via the phone. Your NPI/API is required to log on.
- Swipe Card System: To implement a swipe card system, please contact a swipe card vendor directly. Vendors that are certified to provide this service are listed in the Service Center Directory located on the [Electronic Claims/EDI](#) webpage.

## Reference

Please see the following documents on the Nevada Medicaid website at <https://www.medicaid.nv.gov>:

- [Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid and Nevada Check Up Dental Program](#)
- [ADA Claim Form Instructions](#)

Please see the following documents on the Division of Health Care Financing and Policy (DHCFP) website at <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.

## Prior Authorization Requirements

### Dental Requests

- Use the ADA Claim Form and list all dental procedures.
- 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 being provided under pregnancy related services.
  - Do not submit original X-rays as they will not be returned.
- 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.
  - Click here <https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx> to log in to the Provider Web Portal and then click on "Treatment History" under the "Claims" tab.
  - Instructions are available in Electronic Verification System (EVS) User Manual Chapter 9: Treatment History, which is located at <https://www.medicaid.nv.gov/providers/evsusermanual.aspx>.
  - Please note that the code history search is done by the 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 must do a separate search for that code. For history checks regarding dentures/partials, please check any and all related codes.

### Outpatient Requests

- Use the ADA Claim Form and list all dental procedures.



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- The request must include a narrative signed by the provider and stating the clinical rationale for the dental procedures to be done in an “outpatient” setting. Include the outpatient facility name and National Provider Identifier (NPI).
- Outpatient services must be requested at least eight business days prior to service.

### Inpatient Requests

- Use the ADA Claim Form and list all dental procedures.
- The request must include a narrative signed by the provider and stating the clinical rationale for the dental procedures to be done in an “inpatient” setting. Include the inpatient facility name and National Provider Identifier (NPI).
- Inpatient services must be requested at least eight business days prior to 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 Nevada Medicaid, not the MCO. Please see the [ADA Claim Form 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.

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 [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.

Documentation for clinical review for orthodontia must include:

- The ADA Claim Form.
- *Documentation explaining the medical necessity for the service. The request must include a statement signed by the orthodontist stating the diagnosis, treatment plan and prognosis.*
- Diagnostic photographs demonstrating measurements. Diagnostic photographs means photographs that are clear enough to diagnose from. Photos of mounted models must be accompanied by photos and x-rays of the actual patient. Measurements must be documented in photos with a Boley gauge, probe or disposable ruler.
- Panoramic x-rays (Send a clear copy. Do not submit original x-rays as they will not be returned.)
- Client Treatment History Report (form FA-26)
- Orthodontic Medical Necessity (OMN) Form (FA-25)

Authorizations for orthodontia services are effective for one year (e.g., May 26, 2016, through May 25, 2017) 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:



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- 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.

### 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, be sure to include the reason for requesting extended treatment.

### Submitting Prior Authorization Requests

*Submit prior authorization requests 1-2 weeks before the recipient's appointment.*

Requests for prior authorization for dental may be mailed or faxed. Requests for orthodontia must be mailed so that the clinical information is of diagnostic quality.

Mail dental and orthodontia prior authorization requests to:

Nevada Medicaid  
Prior Authorization – Dental Department  
P.O. Box 30042  
Reno, Nevada 89520-3042

Dental fax: (855) 709-6848

### Prior Authorization for Medications

The Nevada Medicaid Preferred Drug List (PDL) is online at <https://www.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

Nevada Medicaid 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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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.

### **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 enrollment or revalidation applications or on the Provider Information Change Form (FA-33). 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 an appeal to the DHCFP. Appeal instructions are included in the written notification sent to the recipient.

A Peer-to-Peer Review or Reconsideration can be requested for prior authorizations that are denied or modified. If you request a Peer-to-Peer and afterward determine a Reconsideration is appropriate, the Reconsideration may be requested if within 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 [peertopeer@groups.ext.hpe.com](mailto:peertopeer@groups.ext.hpe.com) or calling (800) 525-2395 within 10 calendar 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***

*Reconsideration* is a written request from the provider asking Nevada Medicaid or DHCFP (as appropriate) to re-review a denied or reduced authorization request.

### **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 or DHCFP will notify the provider of the outcome of the Reconsideration within 30 calendar days. The 30-day provider deadline for Reconsideration is independent of the 10-day deadline for Peer-to-Peer Review.



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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, this demonstrates failure of the provider to comply with proper documentation requirements. New information will not be considered at a hearing preparation meeting.

**If proper documentation is not submitted as described above, the authorization request will not be considered by Nevada Medicaid at any later date.**

### Documentation for Authorization Reconsideration:

- Give 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.

### Mail dental and orthodontia prior authorization reconsideration requests to:

Nevada Medicaid  
Prior Authorization – Dental Department  
P.O. Box 30042  
Reno, NV 89520-3042

### Forms and Information

- Forms FA-25 and FA-26 are online at <https://www.medicaid.nv.gov> (select "Forms" from the "Providers" menu).
- The Nevada Medicaid 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.

## Smoking Cessation Counseling for Pregnant Women

As of October 13, 2011, CPT codes 99406 and 99407 are used to bill smoking cessation counseling for pregnant women only. For all other recipients, these services are billed using the appropriate Evaluation and Management (E&M) office visit code.