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. For more information on services provided under the Healthy Kids Program (EPSDT), see Chapter 1500 of the Medicaid Services Manual.

Recipients who are pregnant may receive some periodontal services (see the Fee-for-Service 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 services provided in rural areas of Nevada are billed under the Fee for Service (FFS) benefit plan. Orthodontic services are billed under the FFS benefit plan for both rural and urban areas. Submit claims and prior authorization requests to DXC Technology, Nevada Medicaid's fiscal agent. DXC Technology is referred to as Nevada Medicaid throughout this document.

Recipients in Urban Clark and Urban Washoe counties:

LIBERTY Dental Plan (LIBERTY) became the Dental Benefits Administrator for Nevada Medicaid effective January 1, 2018.

All prior authorization requests and dental claims (excluding orthodontics) for managed care recipients for dates of service on or after January 1, 2018, should be sent to LIBERTY.

Policy

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.
- MSM Chapter 1500 covers policy and requirements for the Healthy Kids Program (EPSDT).
- Provider Type 22 Dental Reimbursement Rates provides Nevada Medicaid rates for all dental services.

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. 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.
- 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.

Dentist

- 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.

Billing Instructions

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

- Fee-for-Service Coverage, Limitations and Prior Authorization Requirements for the Nevada Medicaid and Nevada Check Up Dental Program
- ADA Claim Form Instructions

Note: Provider type 22 (Dentist) providers are instructed to submit dental claims with tooth surface codes indicated in alphabetical order.

Prior Authorization (PA)

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 www.medicaid.nv.gov, must be used to request authorization for all services. See the Electronic Verification System (EVS) Chapter 4 Prior Authorization for instructions.

The provider submits the request for authorization on the Provider Web Portal and uploads the forms and clinical documentation. The provider must attach a document in the Provider Web Portal to move the prior authorization request to the review status. If x-rays are needed, and are not digital and uploadable, they may be mailed after the request is submitted. The provider can indicate in the medical justification field that they are mailing any documents that could not be scanned or uploaded. If the mailed x-rays are not received by Nevada Medicaid within 30 days, the request will be automatically canceled.

> Mail dental and orthodontia x-rays to:
> Nevada Medicaid
> Prior Authorization – Dental Department
> P.O. Box 30042
> Reno, Nevada 89520-3042

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:
  o Anchors for partial dentures.

Dentist

- o 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.
  - o 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.
  - o 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.
  - o 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 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.
- 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 the Nevada Medicaid fiscal agent, 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.

Providers are instructed to create the request for authorization and provide the required documentation through the Provider Web Portal and must include the following:

- 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.

Dentist

- 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)

X-rays may be mailed, but all other documentation should be submitted through the Provider Web Portal.

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:

- 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.

Prior Authorization for Medications

The Nevada Medicaid Preferred Drug List (PDL) is online at 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

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.

Dentist

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

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 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 a Fair Hearing request to the DHCFP. Fair Hearing instructions are included in the written notification sent to the recipient. Providers can submit a Fair Hearing request to the DHCFP 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 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 nvpeer_to_peer@dxc.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

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.

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.

Dentist		

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.

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.

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.

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

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.