MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 28, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1000 – DENTAL

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1000 – Dental are being proposed to strengthen policy and to provide clarity to the Medicaid policy. The proposed revision is in Section 1003.8 – Orthodontics, where authorization for orthodontics will be changed from the Handicapping Labio-lingual Deviation Index scoring to Medically Necessary Orthodontic Automatic Qualifying Conditions. Additional revisions in this section include: Coverage and Limitations, Provider Responsibilities and a new section for Recipient Responsibilities. The prior authorization process is revised to reflect the above changes in qualifying conditions and the required documentation to be submitted for prior authorization.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Provider Type 22 – Dentists enrolled with Nevada Medicaid as a Provider Type 22 with Specialty Code 079 – Orthodontists.

Financial Impact on Local Government: None known.

These changes are effective June 29, 2017.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 30948	MTL 14/15, 02/17
MSM CHAPTER 1000 – DENTAL	MSM CHAPTER 1000 – DENTAL

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8.A.1	**Orthodontics – Coverage and Limiatations**	Removed Panoramic films paragraph, not applicable to the Orthodontic section. Referenced Medically

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Necessary Orthodontic Automatic Qualifying Conditions.
1003.8.A.2	**Orthodontics – Coverage and Limitations**	New Section. Defines Medically Necessary Orthodontic Qualifying Conditions.
1003.8.A.3	**Orthodontics – Coverage and Limitations**	New Section. Provides policy related to attending dental appointments and dental history for orthodontic Prior Authorization (PA).
1003.8.A.4	**Orthodontics – Coverage and Limitations**	New Section. Defines service limitations for orthodontic services.
1003.8.A.5	**Orthodontics – Coverage and Limitations**	New Section. Defines the provider type and specialty type allowed for orthodontic services.
1003.8.B.1	**Orthodontics – Provider Responsibility**	Removed redundant language for clarity and replaced with the provider type and specialty type authorized for orthodontic services.
1003.8.B.2	**Orthodontics – Provider Responsibility**	New Section. Provides policy regarding Client Treatment History Form and who may complete the form.
1003.8.B.3	**Orthodontics – Provider Responsibility**	New Section. Provides policy related to the Client Treatment History Form, regarding appointment attendance, not complying with dental treatment plans and conditions that will deny orthodontic treatment PA requests.
1003.8.B.4	**Orthodontics – Provider Responsibility**	New Section. Provides policy related to appointment attendance and the amount of data required for PA submission.
1003.8.B.5	**Orthodontics – Provider Responsibility**	Moved from 1003.8.B.11 for continuity.
1003.8.B.5.a	**Orthodontics – Provider Responsibility**	New Section. Provides policy related to routine cleanings and examinations during orthodontic treatment.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8.B.6	**Orthodontics – Provider Responsibility**	New Section. Provides policy regarding transfer of orthodontic care for dissatisfaction with a provider, relocation and changing providers.
1003.8.B.7	**Orthodontics – Provider Responsibility**	New Section. Provides policy regarding conditions that an Orthodontist may discontinue treatment.
1003.8.B.8	**Orthodontics – Provider responsibilities**	New Section. Provides policy regarding refunding of unused funds if orthodontic treatment is discontinued.
1003.8.B.9	**Orthodontics – Provider Responsibility**	New Section. Policy clarification related to not assessing or billing a recipient for additional services related to approved orthodontic treatment.
1003.8.B.10	**Orthodontics – Provider responsibility**	New Section. Policy regarding dental records in orthodontic treatment.
1003.8.C	**Orthodontics – Recipient Responsibilities**	New Section. Provides policy regarding recipient's responsibilities regarding appointments, oral hygiene, follow-up and missed appointments. Policy regarding the recipient contacting the Orthodontic provider immediately when missing scheduled appointments, provider changes, eligibility status changes or relocating.
1003.8.D	**Orthodontics – Authorization Process**	Renamed and re-numbered from 1003.8.C to 1003.8.D due to addition of Recipient Responsibilities Section.
1003.8.D.1	**Orthodontics – Authorization Process**	Removed redundant language related to which providers are authorized to review orthodontic PAs. Provided policy clarification related to the Orthodontic Medical Necessity Form, documentation requirements and conditions that qualify as Medically Necessary Orthodontic conditions.
1003.8.D.2.a	**Orthodontics – Authorization Process**	Provided policy clarification related to conditions that are not considered medically necessary for orthodontics.
1003.8.D.2.b	**Orthodontics – Authorization Process**	Provided policy clarification related to the psychological need for orthodontics.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8.D.2.e	**Orthodontics – Authorization Process**	Removed section. Handicapping Labiolingual Deviation (HLD) form will no longer be used for orthodontic PAs.
1003.8.D.3	**Orthodontics – Authorization Process**	Provided policy clarification. Removed redundant language. New language is: PA requests must be submitted on an American Dental Association (ADA) claim form. Remove dental consultant.
1003.8.D.3.a	**Orthodontics – Authorization Process**	Removed reference to HLD form, added Orthodontic Medical Necessity Form.
1003.8.D.3.c	**Orthodontics – Authorization Process**	New Section regarding materials and measurement requirements of x-rays and other diagnostic materials regarding PAs for orthodontics.
1003.8.D.3.d	**Orthodontics – Authorization Process**	New Section. Policy regarding the level of documentation required for PA submission for orthodontics.
1003.8.D.3.e	**Orthodontics – Authorization Process**	Renumbered from 1003.8.D.3.c and language added regarding documentation for orthodontic treatment plans for PA submission.
1003.8.D.3.f	**Orthodontics – Authorization Process**	Renumbered from 1003.8.D.3.d regarding any other documentation to substantiate the PA decision.
1003.8.D.4	**Orthodontics – Authorization Process**	Removed language – not part of the authorization process.
1003.8.D.4	**Orthodontics – Authorization Process**	Renumbered from 1003.8.D.5. Defines provider type and specialty type authorized to request PA for orthodontic services.
1003.8.D.4.a	**Orthodontics – Authorization Process**	Removed redundant language referring to Coverage, Limitations and PA website.
1003.8.D.4.b	**Orthodontics – Authorization Process**	Section removed – not part of the authorization process.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8.D.4.b	**Orthodontics – Authorization Process**	Renumbered from 1003.8.D.4.c. Provides policy clarification regarding extension for orthodontic services.
1003.8.D.4.c	**Orthodontics – Authorization Process**	Provided policy clarification for PA submission.
1003.8.D.4.d	**Orthodontics – Authorization Process**	New Section. Provided policy for QIO-like vendor to shorten orthodontic treatment plans.
1003.8.D.5	**Orthodontics – Authorization Process**	Renumbered from 1003.8.D.6. Provide policy clarification for processing an approved PA for orthodontics and denied PA requests.
1003.8.D.6	**Orthodontics – Authorization Process**	Renumbered from 1003.8.D.7. Provides policy related to claims submission for approved orthodontic treatment.
1003.8.D.8	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.7.b.
1003.8.D.9	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.7.b.
1003.8.D.10	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.7.c.
1003.8.D.11	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.9.
1003.8.D.12	**Orthodontics – Authorization Process**	Removed – not applicable to this section. Rewritten for clarity in Section 1003.8.B.10.

inflammation, infection or peri-radicular radiographic evidence of defect.

3. Elective tooth extractions are not covered by Medicaid. “Elective Tooth Extraction” is the extraction of asymptomatic teeth, that is, teeth without symptoms and/or signs of pathology. It includes the extraction of other asymptomatic teeth without clinical evidence of pathology, including third molars (tooth numbers 1, 16, 17 and 32). The exception is extractions that are deemed medically necessary as part of Prior Authorized orthodontic treatment plan.

B. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT and for some pregnancy related services, or for persons 21 years of age and older, if the service is considered an emergency extraction or palliative care.

Reference the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor’s web portal at www.medicaid.nv.gov in Provider Type 22 Dentist Billing Guide.

1003.8 ORTHODONTICS (D8000 – D8999)

The branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function.

Nevada Medicaid authorizes payment for orthodontics for qualified recipients under 21 years of age.

The Diagnostic Codes D0330, D0350 and D0470 are considered to be “Orthodontia” services only when required for Orthodontia treatment prior authorization.

A. COVERAGE AND LIMITATIONS

1. Medicaid excludes orthodontic work, except that which is authorized by the Children with Special Health Care Needs Program and reimbursed by Medicaid, or when specifically authorized by Medicaid’s QIO-like vendor ~~dental consultant~~ as medically necessary under EPSDT, based on Medically Necessary Orthodontic Automatic Qualifying Conditions.

~~Panoramic films. After an initial panoramic film, additional x-rays of this type require PA, except in an emergency. Examples of emergencies include fractured jaw, unusual swelling, etc.~~

2. Medically Necessary Orthodontic Automatic Qualifying Conditions are deemed medically necessary and are qualified for reimbursement when it is part of a case

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involving treatment of cranio-facial anomalies, malocclusions caused by trauma or a severe malocclusion or cranio-facial disharmony that include, but not limited to:

a. Overjet equal to or greater than 9 millimeters.

b. Reverse overjet equal to or greater than 3.5 millimeters.

c. Posterior crossbite with no functional occlusal contact.

d. Lateral or anterior open bite equal to or greater than 4 millimeters.

e. Impinging overbite with either palatal trauma or mandibular anterior gingival trauma.

f. One or more impacted teeth when eruption is impeded (excluding third molars).

g. Defects of cleft lip or palate, or other craniofacial anomalies or trauma.

h. Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars).

i. Anterior crossbite with soft tissue destruction.

Note: For conditions not listed above, providers may request orthodontic treatment under the EPSDT "Healthy Kids Exception" by demonstrating "Medical Need."

3. Prior to the Orthodontist requesting a Prior Authorization (PA) for Orthodontic services, the following criteria must be met:

a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

b. missed no more than 30 percent of any scheduled appointments, for any reason on all Client Treatment History forms submitted.

c. The referring provider must provide the applicable dental appointment history and not submit more than three years of dental appointment history.

When a recipient is unable to attend dental appointments for any reason, the treatment plan could be jeopardized, or could cause the treatment plan to extend beyond the anticipated time to complete the treatment, for which the Orthodontist is not reimbursed.

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4. Orthodontia treatment is limited to once per a recipient's lifetime for limited transitional treatment (Dental Codes D8010, D8020 and D8040), and once per lifetime for comprehensive orthodontic treatment (Dental Codes D8080 and D8090). If treatment is discontinued for any reason, including the recipient's non-compliance, Medicaid will not authorize a second orthodontia treatment.

5. Medicaid reimburses for orthodontia services only to those providers enrolled with Nevada Medicaid with the orthodontia specialty (Provider Type 22 with Specialty Code 079).

B. PROVIDER RESPONSIBILITY

~~1. Medicaid considers orthodontist billings for "Pre-orthodontic treatment visits" under code D8660 and related procedures. Medicaid will not reimburse billings for "pre-orthodontic treatment visits" under code D8660 and related procedures billed by general dentists. Only dentists with a specialty of orthodontia will be allowed to bill D8660 for reimbursement. A copy of the Client History Form must be completed by the recipient's treating general or pediatric dentist and submitted with the billing. Medicaid may deny orthodontist's payment for their billings if the attached referral report does not show the recipient has a good history of keeping appointments and complying with dental care treatment. Orthodontists should advise recipients to establish good compliance and appointment-keeping histories before requesting initial or subsequent orthodontic treatment.~~

1. Only Dentists with a specialty of Orthodontia: Provider Type 22 with the Specialty Code 079 will be reimbursed for orthodontic services.

2. A copy of the Client Treatment History form must be completed by the recipient's treating general or pediatric dentist and is to be in the orthodontic PA request. The treating orthodontist must complete a new Client Treatment History form when requesting a PA for a second phase of orthodontic treatment.

3. Medicaid shall deny any orthodontic prior authorization requests when the attached Client Treatment History form report does not show the recipient has a good history of keeping dental appointments, which is defined as: missing no more than 30 percent of scheduled appointments for any reason within a 24 month period or not complying with dental care treatment plans, as evidenced by active carious lesions, acute gingivitis, acute periodontitis, poor oral hygiene or other unresolved dental factors that could result in poor orthodontic case success.

4. Prior to the Orthodontist requesting a PA for Orthodontic services, the following criteria must be met:

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a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

b. missed no more than 30 percent of any scheduled appointments, for any reason on all Client Treatment History forms submitted.

c. The referring provider must provide the applicable dental appointment history and not submit more than three years of dental appointment history.

When a recipient is unable to attend dental appointments for any reason, the treatment plan could be jeopardized, or could cause the treatment plan to extend beyond the anticipated time to complete the treatment, for which the Orthodontist is not reimbursed.

5. Coordination with Ancillary Dentists: The orthodontist and any ancillary dentists must coordinate with each other to assure Medicaid will pay for the ancillary dental services. For example, the orthodontist's proposed treatment plan should show he/she will be referring the child for extractions or other services. The ancillary dentist need not obtain separate approval for his/her services.

   a. Additionally, the treating orthodontist must coordinate with the recipient's general dentist or provide in their own orthodontic practice routine cleanings and examinations according to the AAPD periodicity schedule.

6. A recipient may select a new Orthodontist if the recipient becomes dissatisfied with the original Orthodontist or must geographically move before completion of the treatment plan. When a recipient changes providers during active treatment, the provider must comply with the following:

   a. Acceptance of reimbursement by the Orthodontist is considered their agreement to prorate and forward any unused portion of the reimbursement to a Nevada Medicaid contracted Orthodontist, selected by the recipient, to complete the treatment.

   b. The originating provider must not release Medicaid funds to anyone other than another Medicaid orthodontic provider who agrees to use the funds to complete the approved treatment plan. No additional funds will be allocated or approved to the new Orthodontist for the completion of the treatment. Without such an agreement, the originating provider must return the unused fund (see Section 8 below) to the Medicaid fiscal agent at the address listed in Section 1005.1 of this chapter.

c. Medicaid holds the Orthodontist responsible for removing any banding and providing retainers at no additional cost to the recipient. The Orthodontist accepts this responsibility as part of providing Medicaid services.

7. Circumstances in which an Orthodontist may discontinue treatment:

a. Due to the recipients' poor oral hygiene compliance, when identified and documented by the Orthodontist.

b. The recipient fails to contact the Orthodontist's office within a four-month period and/or:

c. When the recipient has not kept at least one appointment within a six-month period.

8. When treatment is discontinued due to any of the reasons listed above, the provider must refund any unused portion of the reimbursement to the Medicaid Fiscal Agent (address listed in Section 1005.1 of this chapter). The provider must contact the Fiscal Agent to request a balance of the remaining funds which should be refunded. It will be based on the approved treatment plan, the services already rendered and the residual amount that will be refunded to the Fiscal Agent. Any refunded unused funds are not available to be used for further or future orthodontic treatment for that recipient.

9. The Orthodontist may not assess the recipient or bill Medicaid for additional charges on broken bands, or other necessary services, even if the recipient's poor compliance or carelessness caused the need for additional services.

10. Providers must maintain a detailed, comprehensive, legible dental record of all orthodontia treatment and care. Legible electronic dental records are acceptable.

C. RECIPIENT'S RESPONSIBILITIES

1. Prior to the Orthodontist requesting a PA for Orthodontic services, the following criteria must be met:

a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

b. missed no more than 30 percent of any scheduled appointments, for any reason.

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c. The recipient's referring provider must provide the applicable dental appointment history and not submit more than three years of dental appointment history.

2. The recipient is responsible for maintaining good oral hygiene on a regular basis, as instructed by the Orthodontist, to maintain the orthodontia treatment plan or orthodontic appliances received.

3. The recipient is responsible to attend all scheduled and follow-up appointments as scheduled as part of the treatment plan.

4. The recipient is responsible for contacting the Orthodontic provider immediately when they are going to miss any scheduled appointments, change providers, or when they have a change in their eligibility status, or when they are moving out of the area.

~~C.~~D. AUTHORIZATION ~~REQUIREMENTS~~ PROCESS

~~1. Medicaid dental consultants use the assistance of board-certified and/or board eligible orthodontists and other dentists for authorization decisions. Consultants may require documentation to substantiate their decisions.~~

1. Request for orthodontic treatment must be Prior Authorized. The PA request must include a completed Orthodontic Medical Necessity (OMN) form. To qualify for authorization, the form must explain the significance of at least one of the following Medically Necessary Orthodontic Automatic Qualifying Conditions, in the OMN form (form found at www.medicaid.gov) or Medical Necessity under EPSDT "Healthy Kids" exception. Clinical documentation must be submitted that substantiates and validates the condition(s) with diagnostic panoramic radiographs, diagnostic photos or photographs of diagnostic models with the automatic qualifying condition.

   Medically Necessary Orthodontics are deemed necessary and qualified when it is part of a case involving treatment of cranio-facial anomalies, malocclusions caused by as a result of trauma or a severe malocclusion or cranio-facial disharmony that includes, but not limited to:

   a. Overjet equal to or greater than 9 millimeters.

   b. Reverse overjet equal to or greater than 3.5 millimeters.

   c. Posterior crossbite with no functional occlusal contact.

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d. Lateral or anterior open bite equal to or greater than 4 millimeters.

e. Impinging overbite with either palatal trauma or mandibular anterior gingival trauma.

f. One or more impacted teeth when eruption is impeded (excluding third molars).

g. Defects of cleft lip or palate or other craniofacial anomalies or trauma.

h. Congenitally missing (extensive hypodontia) of at least one tooth per quadrant (excluding third molars).

i. Anterior crossbite with soft tissue destruction.

Note: For conditions not listed above, providers may request orthodontic treatment under the EPSDT "Healthy Kids Exception" by demonstrating "Medical Need."

2. Requests for orthodontia must explain the significance of one or more of the following considerations of "medical need."

a. Functional factors relating to conditions that hinder effective functioning, including, but not limited to, impaired mastication and muscular dysfunction. Orthodontic treatment is not authorized under medical necessity for the following, but not limited to: a possibility of risk of a future condition, ease of hygiene or esthetic improvement.

b. Factors related to the degree of deformity and malformation which produce a psychological need for the procedure. The psychological need must be based on objective evidence provided by a Qualified Mental Health Practitioner (QMHP) within the scope of their practice and reviewed by the ~~dental consultant~~QIO-like vendor.

c. The recipient's overall medical need for the service in light of his/her total medical condition. For example, an orthodontia need which might be slight in an otherwise healthy child may become quite severe for a child suffering from complicating ailments such as cerebral palsy or epilepsy.

d. The medical appropriateness of an orthodontic treatment plan as opposed to other available dental treatment. Appropriate consideration may be given, for example, to a child's inability to understand and follow a treatment plan where failure to follow the plan would result in medical complications of the child's condition.

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e. A score of 26 or higher on the Handicapping Labiolingual Deviation Index (HLD). (Form found at: www.medicaid.nv.gov)

3. When the orthodontist has assured the above requirements are met, use a separate form to bill the following initial services: examination, diagnosis, diagnostic cast, panoramic x-rays and diagnostic films. These can be provided by a dentist or orthodontist according to services limitations. PA requests must be submitted on an American Dental Association (ADA) claim form.

The following documents are required to be attached with the prior authorization request to the QIO-like vendor's Dental Consultant:

a. HLD Index ReportOrthodontic Medical Necessity (OMN) Form.

b. Client Treatment History Form.

c. A copy of the oral examination record(s), including diagnostic photographs or photos of diagnostic models demonstrating measurements and a copy of a panoramic x-ray. Diagnostic photographs and/or photographs of diagnostic models and panoramic x-rays must be of sufficient quality to confirm the diagnosis, and must include any other documentation or measurements as required in the Orthodontic Medical Necessity Form, to confirm the diagnosis.

d. The provider must submit the appropriate level of documentation to support the diagnosis. Providers are encouraged to use of the recommendations for diagnostic records encompassed in the most current edition of the American Association of Orthodontists "Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics" which includes the recommendations for the use panoramic radiographs, cephalometric radiographs and Intraoral and Extraoral photographs to confirm a diagnosis.

e. c. A Sstatement addressing the diagnosis/treatment plan and prognosis to include the following:.

1. Principal diagnosis and any significant associated diagnoses.

2. Prognosis.

3. Date of onset of the illness or condition and etiology if known.

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4. Clinical significance or functional impairment caused by the illness or condition.

5. Specific services to be rendered by each discipline and anticipated time for achievement of treatment goals.

6. Therapeutic goals to be achieved by each discipline and anticipated time for achievement of the therapeutic goals.

7. A description of previous services that were provided to address the illness/condition and the result of the prior care.

f. d. Any other documentation that may be required to substantiate prior authorization decision.

All forms are located on the The Orthodontic Medical Necessity Form and the Client Treatment History Form are located on the QIO-like vendor's web portal at www.medicaid.nv.gov.

4. The Dental Consultant may require the orthodontist to shorten their treatment plan, periodically reviewing/determining the child's continuing need for active treatment and retention care.

4. 5. All orthodontic treatment authorizations by Medicaid will be to specialists in orthodontia only. Medicaid approves interceptive orthodontia for general dentists and pediatric dentists only. Medicaid's QIO-like vendor will accept PA requests ONLY from those providers with a specialty in Orthodontia (Provider Type 22 with Specialty Code 079).

a. Orthodontists must use one of the codes for "limited" or "comprehensive" orthodontic treatment for bills and payment PA requests. Coverage, Limitations and Prior Authorization requirements document can be found on the QIO-like vendor's web portal at www.medicaid.nv.gov.

b. Use one of the "limited" codes whenever possible. The treating orthodontist should try to achieve tolerances below Medicaid's treatment need criteria.

c.b. Failure to achieve sufficient results in the approved amount of time is sufficient for Medicaid to deny a treatment extension. Medicaid will definitely deny an extension of orthodontic treatment if the results are poor and or the recipient has failed to keep appointments and or comply with treatment.

c. PA submittals requests submitted must show all proposed orthodontic procedures., and Llist the following at a minimum: initial banding, months of treatment including retention treatments, and any retainers. Medicaid expects the provider to render unlisted but necessary treatment components at no additional charge. The provider's usual and customary charge must show for each service. Stating a total fee for all services is not acceptable.

d. The QIO-Like vendor may require the Orthodontists to shorten their treatment plan after reviewing the submitted PA materials and documentation.

5. 6. For orthodontia approvals, a dental consultant will sign the returned request form and indicate the "Total amount" shown on the form. Medicaid's QIO-like vendor will keep a record of the approved payment amount and treatment plan. The fiscal agent will return denied orthodontia request forms to the provider. The QIO-like vendor inputs the disposition for the requested orthodontic service directly in to the current system. No forms are submitted for signature for indication of approved reimbursement amount. The fiscal agent does not return denied orthodontic requests to providers.

6. 7. When the provider begins the authorized work completes the initial banding, he/she must enters the date of service date and the usual and customary charges amount on the claim form, and returns it to the fiscal agent. The fiscal agent will make payment for the total specified on the approved treatment plan.

8. An orthodontist's acceptance of full payment is considered his/her agreement to prorate and forward payment to any orthodontist the recipient may select to complete the orthodontic treatment. The recipient may select a new orthodontist if the recipient becomes dissatisfied with the original orthodontist or must geographically move before finishing treatment. The orthodontist must refund any unused payment when the recipient fails to contact the orthodontist's office within a 4-month period. Also, the orthodontist must refund Medicaid if the recipient has not kept at least one appointment within a 9-month period.

9. Medicaid will adjust the sending provider's future payments if the Medicaid dental consultants determine the provider allotted an insufficient amount of money to the receiving provider or Medicaid.

10. Orthodontists may not assess the recipient for additional charges on broken bands and other necessary services, even if the recipient's poor compliance or carelessness caused the need for additional services. However, orthodontic providers may discontinue treatment due to poor recipient compliance, returning

~~any unused prorated expenditures to Medicaid with a written explanation for the Medicaid fiscal agent's records.~~

~~11. Under no circumstances should the provider release Medicaid money to anyone other than another orthodontist provider who promises to use the money to complete the purchased treatment. Without such a promise, return the money to the QIO-like vendor at the address listed in the cross-reference of this chapter at Section 1005.1. Write refund checks payable to Nevada Medicaid.~~

~~12. Once the remaining portion of the payment is returned, no further payment can be made to complete care for recipients who have become ineligible. Most children who lose Medicaid coverage are seldom able to finance the completion of orthodontic care. Therefore, Medicaid understands and holds the refunding orthodontist responsible for removing any banding and providing retainers at no additional cost to the recipient. Orthodontists accept this responsibility as part of doing business with Medicaid.~~

1003.9 ADJUNCTIVE GENERAL SERVICES (D9000 – D9999)

The branch of dentistry for unclassified treatment including palliative care and anesthesia.

Nevada Medicaid authorizes payment of adjunctive general services for qualified recipients under 21 years of age and for palliative care and anesthesia for persons 21 years of age and older.

A. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age, and for palliative care for persons 21 years of age and older.

For dental codes related to General or IV anesthesia, the provider must show the actual beginning and end times in the recipient's dental record. Anesthesia time begins when the provider physically prepares the recipient for the induction of anesthesia in the operating area, and ends when the provider is no longer in constant attendance (i.e., when the recipient can be safely placed under postoperative supervision).

B. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT. Persons 21 years of age and older require PA unless the service is for emergency extractions or palliative care.

Reference the Coverage, Limitations and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in Provider Type 22 Dentist Billing Guide.

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