MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 23, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER
/Jessica Kemmerer/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1000 – DENTAL

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1000 – Dental are being proposed to update the American Dental Association's (ADA) Dental Claim Form required for all prior authorization requests, claims, adjustments, and voids. Currently, the ADA 2012 version is required. The Division of Health Care Financing and Policy (DHCFP) proposes to allow the continued use of the ADA Dental Claim Form version 2012 and allow newer versions of this form. Additionally, the DHCFP is proposing to remove a duplication of congenitally missing teeth, listed as part of the Medically Necessary Orthodontic Automatic Qualifying Conditions.

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: This proposed change affects all Medicaid enrolled Provider Type (PT 22) – Dentists, all specialties.

Financial Impact on Local Government: None.

These changes are effective February 24, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 05/21 MSM Chapter 1000 – Dental	MTL 14/20 MSM Chapter 1000 – Dental

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8(A)(2)(a)	**Orthodontics Coverage and Limitations**	Removed duplicate medically necessary orthodontic automatic qualifying condition "a. Congenitally missing teeth (excluding third molars) of at least one tooth per quadrant."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8(D)(1)	**Authorization Process**	Removed duplicate medically necessary orthodontic automatic qualifying condition "a. Congenitally missing teeth (excluding third molars) of at least one tooth per quadrant."
1005.2	**Forms**	Clarified 2012 or newer version of ADA dental claim form required is for all prior authorization requests, claims, adjustments, and voids.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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INTRODUCTION

The Nevada Medicaid Dental Services Program is designed to provide dental care under the supervision of a licensed provider. Dental services provided shall maintain a high standard of quality and shall be provided within the coverage and limitation guidelines outlined in this Chapter and the Quality Improvement Organization-Like (QIO-Like) Vendor's Billing Guide. All Medicaid policies and requirements are the same for Nevada Check Up members, unless otherwise specified in the Nevada Check Up Manual Chapter 1000.

Dentists, dental hygienists, public health endorsed dental hygienists and dental therapists participating in Nevada Medicaid shall provide services in accordance with the rules and regulations of the Nevada Medicaid program. Dental care provided in the Nevada Medicaid program must meet prevailing professional standards for the community-at-large. Any dental provider who undertakes dental treatment as covered by Nevada Medicaid must be qualified by training and experience in accordance with the Nevada State Board of Dental Examiners rules and regulations.

All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association (ADA). All dental services, including without limitation, examinations, radiographs, restorative and surgical treatment, as well as record keeping are to be provided in accordance with current ADA guidelines and the ADA Code of Ethics, and are to be coded according to the definitions and descriptions in the current ADA Code on Dental Procedures and Nomenclature (CDT Code) manual. All dental services must conform to the statutes, regulations and rules governing the practice of dentistry in the state in which the treatment takes place.

Nevada Medicaid provides dental services for most Medicaid-eligible individuals under the age of 21 as a mandated service, a required component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. For Medicaid-eligible adults age 21 years and older, dental services are an optional service as identified in this chapter and the Billing Guide documents located at www.medicaid.nv.gov in Provider Type (PT) 22 Dentist.

Individuals under Age 21

Through the EPSDT benefits, individuals under the age of 21 receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention of oral disease and maintenance of dental health. The EPSDT program assures children receive the full range of necessary dental services, including orthodontia when medically necessary and pre-approved by the Nevada Medicaid QIO-like vendor.

Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) reflects prior authorization requirements, covered CDT codes and service limitations. Prior authorization

(PA) is not required for most services covered under EPSDT, except when seeking medically necessary services that are outside of what is covered in the benefit schedule. For example, a PA request needs to be submitted for a child who needs cleanings every three months rather than the six months allowed by current service limitations.

The EPSDT screening provider may refer children for dental services. However, such a referral is not necessary if the parent otherwise elects to contact a Medicaid dental provider. The local Medicaid District Office can direct the parent/guardian to local dental providers.

Individuals age 21 and older

Dental services for Medicaid-eligible adults who qualify for full Medicaid benefits receive emergency extractions, palliative care and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations as detailed in Section 1003.5 of this chapter.

Pregnancy Related Services

Nevada Medicaid offers expanded dental services in addition to the adult dental services covered for Medicaid-eligible pregnant women. These expanded pregnancy related services require a PA. In order to reduce the risk of premature birth due to periodontal disease, pregnant women will be allowed dental prophylaxes, fluoride varnish and certain periodontal and restorative services during pregnancy. Refer to Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) for covered CDT codes, services limitations and PA requirements. Providers are expected to refer to the American Dental Association for current clinical recommendations, guidelines and contraindications for treatment of pregnant women, including the use of silver diamine fluoride. Medical providers and/or Managed Care Organizations should provide a dental referral when it is discovered that a recipient is pregnant. Dental providers should attach a copy of the referral or provide a statement of pregnancy in the comment section of the ADA claim form for any PA requests for pregnancy related dental services. Pregnancy related dental services are discontinued on the date of delivery or termination of pregnancy, except services that were authorized but not completed prior to the end of the pregnancy. An approved PA request for pregnancy related dental services will be authorized from the date the request was received through the expected delivery date, unless a shorter timeframe is requested by the provider. Services authorized are honored through the time authorized on the prior authorization request, regardless of whether the services have been started or not. Example: a pregnant woman is authorized for one prophylaxis for the period of April 1st through September 30th. She gives birth on August 1st. The woman has until September 30th to receive her prophylaxis.

1001 AUTHORITY

Nevada Revised Statute (NRS) 631 – Dentistry and Dental Hygiene.

The State Plan of Nevada describes the amount, duration and scope of dental care and services provided to the categorically needy in Attachments 3.1-A 10 and 3.1-A 12b.

The Centers for Medicare and Medicaid Services (CMS) state that necessary and essential dental services are mandatory for all eligible Medicaid children under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) under the Social Security Act (SSA) 1905(r)(3). The Nevada EPSDT program provides children with services that are in addition to those available to adult recipients as cited in the Code of Federal Regulations (CFR) Title 42 Section 441.56.

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Dentists, public health endorsed dental hygienists and dental therapists enrolled with Nevada Medicaid are able to bill for services provided to Medicaid eligible recipients.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in PT 22 Dentist Billing Guide for a list of CDT codes detailing prior authorization requirements and service limitations.

1003.1 DIAGNOSTIC AND PREVENTIVE SERVICES (D0100 – D1999)

The branch of dentistry used to identify and prevent dental disorders and disease.

The United States Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. Nevada Medicaid lists these recommendations in Medicaid Services Manual (MSM) Chapter 600, Attachment A.

The USPSTF recommends application of fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption, and oral fluoride supplementation starting at six months of age for children whose water supply is fluoride deficient.

Nevada Medicaid promotes oral health by providing coverage for routine, periodic oral examinations and preventive treatment, fluoride treatment and sealant application for children, in accordance with the recommendations of the American Dental Association (ADA) and the American Academy of Pediatric Dentists (AAPD) for the prevention of tooth decay and the promotion of good oral health. Medicaid's coverage for preventive services, for children, is guided by the recommendations of the ADA and AAPD. Periodic dental examinations and routine preventive treatment should begin with eruption of the first tooth and before the first birthday, and should continue every six months or as recommended by the dentist. The examination includes assessment of pathology and injuries, growth and development and caries risk assessment. Anticipatory guidance/counseling should be an integral part of each dental visit. Counseling on oral hygiene, nutrition/dietary practices, injury prevention and non-nutritive oral habits should be included.

Nevada Medicaid authorizes payment of diagnostic and preventive dental services for qualified recipients.

A. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT for persons less than 21 years of age. Coverage for persons over 21 years of age is limited to diagnostic services needed for emergency extractions or palliative care.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.2 RESTORATIVE DENTISTRY SERVICES (D2000 – D2999)

The branch of dentistry used to restore the integrity of the teeth through the use of fillings or crowns.

Nevada Medicaid authorizes payment of restorative dentistry for qualified recipients.

A. COVERAGE AND LIMITATIONS

Restorative services are covered under EPSDT for persons less than 21 years of age.

For recipients age 21 years and older, with a PA, Nevada Medicaid reimburses for certain fillings and crowns on teeth that are an abutment (anchor) tooth for that partial denture. The ADA defines an abutment tooth as "a tooth used as a support for a prosthesis" (i.e. partial denture). Nevada Medicaid also reimburses for palliative treatment for persons 21 years of age and older. Pregnancy related services and coverage are listed in the Nevada Medicaid Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) found in the QIO-like vendor's web portal at www.medicaid.nv.gov.

Fillings are limited to the use of amalgam or tooth colored restorations.

Tooth preparation, acid etching, all adhesives (including bonding agents) liners and bases, polishing and curing and occlusal adjustment of either the restored tooth or the opposing tooth, is part of the amalgam restoration and must be included in the fee for the restoration. If pins are used, they should be reported under the appropriate code.

Tooth colored restorations refers to a broad category of materials including, but not limited to, self-curing composite, light-cured composite and glass ionomers. Tooth preparation, acid etching, adhesives, bonding agents, liners, bases and curing are included as part of the resin based composite restoration. If pins are used, they should be reported under the appropriate code.

The ADA defines an Indirect Pulp Cap as a nearly exposed pulp that is covered with a protective dressing to protect the pulp from additional injury and to promote healing. If the pulp is exposed and the provider attempts to cover it in the hopes of avoiding further injury to the nerve, that would be a Direct Pulp Cap (D3110). Placing a protective covering under a deep filling to help avoid sensitivity or pulpal irritation is not a billable service and is included in the restoration as a "liner."

Crowns are limited to stainless steel and composite resin repairs.

Reference the Nevada Medicaid Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.3 ENDODONTIC SERVICES (D3000 – D3999)

The branch of dentistry specializing in disease or injury that affects the root tips or nerves in the teeth through the use of root canals.

Nevada Medicaid authorizes payment of endodontics for qualified recipients.

A. COVERAGE AND LIMITATIONS

Restorative services are covered under EPSDT for persons less than 21 years of age.

Reference the Nevada Medicaid Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov.

1003.4 PERIODONTIC SERVICES (D4000 – D4999)

The branch of dentistry used to treat and prevent disease affecting supporting bones, ligaments and gums of the teeth.

Nevada Medicaid authorizes payment of periodontics for qualified recipients.

A. COVERAGE AND LIMITATIONS

1. Periodontic services are covered under EPSDT for persons less than 21 years of age. Periodontal services for persons less than 21 years of age are limited to either four quadrants of scaling and root planing every two years with a maximum of four periodontal maintenance treatments annually or a maximum of two dental prophylaxis treatments annually.

2. Medicaid carefully monitors for the appropriate use of the codes for periodontal scaling and root planing. These codes are generally limited to recipients who are at least 14 years old. Providers' in-office records must verify x-rays, periodontal charting and diagnoses documenting the need for these procedures.

3. Periodontal scaling and root planing for pregnant recipients is a covered service that requires a PA. Due to the risk of pregnancy gingivitis, Medicaid will cover a second cleaning during pregnancy as well as 100% coverage of the treatment of inflamed gums around wisdom teeth during pregnancy. Medical providers and/or Managed Care Organizations should provide a dental referral when a recipient becomes pregnant. Dental providers should attach a copy of the referral or provide

a statement of pregnancy in the comment section of the ADA claim form to any PA requests for pregnancy related dental services. Pregnancy related dental services are discontinued on the date of delivery or termination of pregnancy, except for services that were authorized but not completed prior to the end of the pregnancy.

4. Palliative treatment is covered for persons 21 years of age and older.

Medicaid also monitors for the appropriate use of the code for full mouth debridement. This code is typically reserved for severe cases in which the licensed dental provider is unable to complete an oral evaluation because the tooth surfaces are covered by thick deposits of plaque and calculus. The full mouth debridement involves gross removal of the prominent plaque and calculus deposits, making it possible for a licensed dental provider to inspect the oral cavity for signs of decay, infection or gum disease. CDT Code D4355 is a preliminary treatment that should be completed before the exam and should not occur on the same day.

Reference the Nevada Medicaid Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.5 PROSTHODONTICS SERVICES (D5000 – D6999)

The branch of dentistry used to replace missing teeth or restore oral structure through the use of partials, dentures, etc.

Nevada Medicaid provides payment benefits of certain prosthodontics for qualified recipients. Emergency prosthetic repair refers to dental prosthetics that are rendered completely unserviceable. Loose dentures or dentures with broken/missing teeth do not meet the intent of the definition unless irritation is present and sufficiently documented. The dentist's in-office records must substantiate the emergency for the purposes of Medicaid post-payment utilization review and control.

A. COVERAGE AND LIMITATIONS

1. Partial dentures and full dentures may be provided when medically necessary to prevent the progression of weight loss and promote adequate mastication. Medicaid limits reimbursement of services to one new full or partial denture per five years. Given reasonable care and maintenance, prostheses should last five years. Education given by the dentist on the proper care of the prostheses is expected and included in the purchase of any prosthetic service.

2. Medicaid will pay for necessary emergency x-rays required to diagnose Medicaid covered removable prostheses. No PA is necessary for the initial comprehensive examination and x-rays. The dentist's office records must substantiate the recipient's medical necessity (e.g., x-ray evidence, reported significant loss of

weight, sore and bleeding gums, painful mastication, etc.). Payment for the examination and x-rays may be withdrawn if post-payment reviews of in-office records do not substantiate the medical necessity. Payment for dentures or partials includes any adjustments or relines necessary for six months after the date of delivery.

3. A person qualifies for a partial denture if four or more teeth in sequence are missing unilaterally, or four or more teeth are missing that would cause the person to have difficulty with mastication.

   A benefit when replacing permanent teeth is due to a lack of posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:

   a. five posterior permanent teeth are missing, (excluding 3rd molars); or

   b. all four 1st and 2nd permanent molars are missing; or

   c. the 1st and 2nd permanent molars and a premolar are missing on the same side.

   Third molars are not considered in the qualification for dentures. Teeth anterior to the third molars (including second molars) are considered in qualification for dentures. For example, a partial would be appropriate for someone missing teeth numbers 2, 3, 4 and 5 because these are four missing teeth in sequence. A partial would be appropriate for someone missing teeth numbers 18, 19, 20 and 28 or 29 because the person would be expected to have difficulty with mastication. A partial would not be appropriate for someone missing teeth numbers 19, 20 and 31 because there are not enough teeth missing for significant difficulty with mastication.

4. Third molars are not replaceable as missing teeth nor are they considered in the qualification for payment of partial dentures. Second molars are replaceable as missing teeth with missing posteriors in the same quadrant as explained in the above examples. A flipper may be used as a temporary replacement for employment purposes when an anterior tooth is extracted. For healing purposes, a flipper may be used temporarily when the partial for an anterior tooth will not be available for greater than three months.

5. A person may also qualify for a partial when missing any one of the six upper or lower anterior teeth (6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 or 27) when necessary for employment. A supportive written Division of Welfare and Supportive Services (DWSS), New Employees of Nevada (NEON) report meets the employment verification requirement. The NEON report must be maintained in the recipient's dental record for retrospective review.

6. Requests to override the 5-year limitation on full and partial dentures will require a PA and will only be considered for the following exceptional circumstances:

   a. Dentures were stolen (requires a copy of the police report). Also under consideration is if the theft is a repeatedly occurring event. The recipient must exercise reasonable care in maintaining the denture.

   b. Dentures were lost in a house fire (requires a copy of the fire report or other notification documenting the fire such as a newspaper article).

   c. Dentures were lost in a natural disaster (requires a copy of documentation from Federal Emergency Management Agency (FEMA), the American Red Cross or any other documentation indicating that the recipient's residence was in the area affected by the natural disaster).

   d. Dentures no longer fit due to a significant medical condition. Requires documentation regarding the supporting medical condition, such as a letter from the recipient's physician/surgeon supporting the medical need, and a letter from the dentist stating that the existing denture cannot be made functional by adjusting or relining it and that new dentures will be functional. Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.

   e. Dentures could not be made functional by the issuing dentist. Requires a letter from the recipient's new dentist and the recipient. The dentist stating that the existing denture cannot be made functional by adjusting or relining it, the medical necessity for the new denture and that the new denture will be functional. The recipient stating that they returned to the issuing dentist requesting the denture be made functional and the issuing dentist was unable to comply (see Section 1003.5.8). Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.

   Process to request an override based on the above exceptional circumstances requires PA. The provider must submit the following in the PA request:

   f. A properly completed ADA claim form clearly marked "Request for Denture Override".

   g. Copies of current radiographs when requesting an override for a partial denture to a full denture.

   h. Any supporting documentation listed in this section, as applicable.

   i. A cover letter that clearly describes the circumstances of the case.

j. These requests must be submitted electronically through Medicaid's QIO-like vendor's web portal.

7. Medicaid will pay for a maximum of one emergency denture reline and/or adjustment not more often than once every six months, with a maximum of six relines or adjustments every five years, beginning six months after the date of partial/denture purchase Denture/partial relines and adjustments required within the first six months are considered prepaid with Medicaid's payment for the prosthetic. No prior approval is required for relines or adjustments. The provider's in-office records must substantially document the medical emergency need. Dentists should search the recipient's service history in the provider portal or call or write to the fiscal agent to ensure the reline is not being done within six months of the date of the last reline or new denture purchase. A claim submitted for a reline or adjustment sooner than six months since the last payment for a reline or adjustment will deny for payment. Post payment review will be done to assure that medical necessity of the service has been substantially documented.

8. If the recipient is unable to wear the denture, the recipient must schedule an appointment with the issuing dentist to have the denture/partial made functional. Factors which would cause the denture to not be functional would include improper fit, sore or bleeding gums and painful mastication. If the issuing dentist is unable to make the denture functional, resulting in the recipient requiring services from another dentist, a full or partial recoupment of payment may occur less the cost of the laboratory services. When the issuing dentist receives a recoupment notice the dentist must provide a copy of the invoice detailing the laboratory charges so that it may be deducted from the recoupment amount. The requirements in Section 1003.6 are applicable if a dentist requests a new denture within a five year period.

B. PROVIDER RESPONSIBILITY

1. New dentures or partials (or their replacements every five years) must be evaluated for medical necessity. Medicaid will pay for one comprehensive examination per 36 rolling months (Code D0150) in connection with new dentures or denture replacements only. Dentists may bill the comprehensive examination charge at the time of the comprehensive exam. Dentists may bill up to two additional exams (D0140) for subsequent denture appointments. The claim for the prosthetic should not be submitted to Nevada Medicaid prior to the delivery date.

2. Keep diagnosable, panoramic or full mouth x-rays as part of the dentist's record for all removable prosthetics. The x-rays and dentists office notes must substantiate all missing teeth.

3. The recipient must sign and date a delivery receipt to verify that the dentures/partials were received and are accepted and/or acceptable. The date of the

signature on the delivery receipt must be the date the dentures/partials were received by the recipient. The delivery receipt must include the recipient's name, quantity, detailed description of the time(s) delivered and the date and time of delivery and be maintained in the recipient's dental record. The delivery receipt is a required attachment when submitting the claim for reimbursement through the QIO-like vendor's web portal. Claims cannot be submitted prior to the date of delivery.

C. AUTHORIZATION REQUIREMENTS

1. PA is required for partials and/or full dentures for all recipients residing in Nursing Facilities or receiving Hospice services. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

2. Requests for partials and/or full dentures for all recipients residing in Nursing facilities or receiving Hospice services must explain the significance of the medical need. PA requests must include:

   a. One letter each from the recipient's primary care physician and dentist documenting the recipient's medical need for the service in considering his/her total medical condition.

   b. The below information must be included in the prior authorization request. The information can be contained within the letter signed by the attending physician, in a separate letter from the facility's social worker or other appropriate staff, included as documentation from chart notes, etc., or provided in a combination. Include:

      1. Current weight compared to the previous year (to determine whether there has been fluctuation); and

      2. Type of diet; and

      3. Diagnosis; and

      4. Mental status relating to the recipient's ability to understand the use and care of the partials and/or full dentures. If the recipient is unable to care for the dentures, include details on who will care for them. Any other factors relating to conditions that hinder effective functioning, including but not limited to, impaired mastication, muscular dysfunction, ability to swallow and reason for poor nutrition. When documenting reason for poor nutrition, specify whether this is related to dental structures or related to the recipient's

physical or medical condition, and whether the poor nutrition will be improved with dentures.

3. No PA is required for partials and/or full dentures for all other recipients. Post payment review will be completed at the discretion of the DHCFP with recoupment of payment for any partials or full dentures not meeting the above policy for qualification of coverage.

1003.6 DENTURE IDENTIFICATION EMBEDDING

Nevada Medicaid provides payment of denture identification embedding for qualified recipients.

A. COVERAGE AND LIMITATIONS

Any removable prosthetic appliance paid for by the Nevada Medicaid program must have permanent identification labeling embedded in it as defined in NRS 631.375. All artificial teeth, dentures or other removable dental appliances, at the time they are manufactured or sent to a laboratory for repair, must be identified with the name or social security number of the owner by:

1. Embedding the name or number in the material of the appliance;

2. Adding the name or number with an adhesive; or

3. Making the appliance in any manner consistent with advances in technology and approved by the Board.

B. PROVIDER RESPONSIBILITY

Medicaid requires embedding of the recipient's first initial, last name or the last four digits of the social security number for complete dentures, partial dentures with acrylic saddles and when relining unmarked appliances. In cases of insufficient room, you may reduce the person's name and identifiers to the first and second initials or the last four digits of the social security number.

Code D5899 and descriptor "ID Embedding" must be completed by delivery unless the prosthetics already show such markings and the provider so states.

C. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not require PA for ID embedding.

1003.7 ORAL AND MAXILLOFACIAL SURGERY (D7000 – D7999)

The branch of dentistry using surgery to treat disorders/diseases of the mouth.

Nevada Medicaid authorizes payment of oral surgery for qualified recipients.

A. COVERAGE AND LIMITATIONS

1. Services are covered under EPSDT for persons less than 21 years of age. For pregnant women and persons 21 years of age and older, services are covered as emergency care or palliative treatment.

2. Tooth extraction coverage is limited to cases involving symptomatic teeth with clinical symptoms and/or signs of pathology, including acute or chronic pain, 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 a prior authorized orthodontic treatment plan.

B. AUTHORIZATION REQUIREMENTS

No PA is necessary for most oral and maxillofacial surgery services under EPSDT and for persons 21 years of age and older if the service is considered an emergency extraction or palliative care.

Reference Nevada Medicaid’s Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor’s web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

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 when certain conditions are met that confirm medical necessity.

Diagnostic Code D0350 is considered to be an “Orthodontia” service only code when required for Orthodontia treatment prior authorization. Nevada Medicaid reimburses for D0350 to Orthodontists only, unless prior authorization is received through EPSDT.

A. COVERAGE AND LIMITATIONS

1. Nevada Medicaid excludes orthodontic work, except that which is authorized by Medicaid's QIO-like vendor as medically necessary Nevada Medicaid has adopted the automatic qualifying conditions list developed by the American Association of Orthodontists' (AAO) Committee on Medically Necessary Orthodontic Care. If a recipient under age 21 does not meet the criteria for any of the AAO's automatic qualifying conditions, but the orthodontist finds there is a medical need for orthodontic work as defined under Section 1003.8.D.2, services can be requested under EPSDT.

2. Medically Necessary Orthodontic Automatic Qualifying Conditions are deemed medically necessary and are qualified for reimbursement when it is part of a case involving treatment of cranio-facial anomalies, malocclusions caused by trauma or a severe malocclusion or cranio-facial disharmony that include, but are not limited to:

   a. Overjet equal to or greater than 9 millimeters.

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

   c. Anterior and/or posterior crossbite of three or more teeth per arch.

   d. Lateral or anterior open bite equal to or greater than 2 millimeters; of four or more teeth per arch.

   e. Impinging overbite with evidence of occlusal contact into the opposing soft tissue.

   f. Impactions where eruption is impeded but extraction is not indicated (excluding third molars).

   g. Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology.

   h. Two or more congenitally missing teeth (excluding third molars) of at least one tooth per quadrant.

   i. Crowding or spacing of 10 millimeters or more, in either the maxillary or mandibular arch (excluding third molars).

   Note: For conditions not listed above, providers may request orthodontic treatment under the EPSDT "Healthy Kids Exception" by demonstrating medical need as defined in Section 1003.8(D)(2).

3. 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 on all Client Treatment History forms submitted.

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

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

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 (PT 22 with Specialty Code 079).

B. PROVIDER RESPONSIBILITY

1. Only Dentists with a specialty of Orthodontia: PT 22 with the Specialty Code 079 will be reimbursed for orthodontic services. Payment for orthodontia covers the length of treatment.

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. "Good history "is defined as: missing no more than 30 % 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:

   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% 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 two 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 payment for orthodontic services includes the removal of 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; and/or

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

c. 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. The refund amount 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 bill the recipient or 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% of any scheduled appointments, for any reason.

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

2. The recipient is responsible for maintaining good oral hygiene on a regular basis, as instructed by the Orthodontist and/or dentist, 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.

D. AUTHORIZATION PROCESS

1. Requests 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.nv.gov) or medical need under an 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 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. Anterior and/or posterior crossbite of three or more teeth per arch.

   d. Lateral or anterior open bite equal to or greater than 2 millimeters; of four or more teeth per arch.

   e. Impinging overbite with evidence of occlusal contact into the opposing soft tissue.

   f. Impactions where eruption is impeded but extraction is not indicated (excluding third molars).

g. Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology.

h. Two or more congenitally missing teeth (excluding third molars) of at least one tooth per quadrant.

i. Crowding or spacing of 10 millimeters or more, in either the maxillary or mandibular arch (excluding third molars).

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

2. The automatic qualifying conditions specified by the AAO have been determined to be medically necessary. Requests for orthodontia under an ESPDT exception must demonstrate a functional impairment indicative of medical necessity. The PA request 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.

b. Factors related to the degree of deformity and malformation which produce a psychological need for the procedure. The PA request must include documentation from a Qualified Mental Health Practitioner (QMHP) acting within the scope of their practice that verifies the psychological need; the documentation must be based on objective evidence and reviewed by the 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. A functional impairment must be demonstrated.

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.

Medicaid does not authorize orthodontic treatment based on the possibility of risk of a future condition, ease of hygiene or aesthetic improvement.

3. 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:

   a. Orthodontic 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 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 of panoramic radiographs, cephalometric radiographs and Intraoral and Extraoral photographs to confirm a diagnosis.

   e. If the request is submitted under one of the AAO automatic qualifiers, include a treatment plan, principal diagnosis and any significant associated diagnoses, and prognosis.

      If the request is submitted as an EPSDT exception, 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.

      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.

8. Treatment plan.

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

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. Medicaid's QIO-like vendor will accept PA requests ONLY from those providers with a specialty in Orthodontia (PT 22 with Specialty Code 079).

a. Orthodontists must use one of the codes for "limited" or "comprehensive" orthodontic treatment for claims and PA requests.

b. Medicaid will deny an extension of orthodontic treatment if the results are poor or the recipient has failed to keep appointments or comply with treatment.

c. PA requests submitted must show all proposed orthodontic procedures and list 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. The QIO-like vendor inputs the disposition for the requested orthodontic service directly into 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. When the provider completes the initial banding, he/she must enter the date of service and the usual and customary charges amount on the claim form and return it to the fiscal agent. The fiscal agent will make payment for the total specified on the approved treatment plan.

E. OUT – OF STATE ORTHODONTIA

Nevada Medicaid will not pay for the continuation of orthodontic treatment if the recipient started their treatment with an out-of-state provider. Nevada Medicaid will pay for the removal of the orthodontic appliance(s) under EPSDT. The new, Nevada orthodontist can then submit a PA request following the NV Medicaid criteria detailed in Section 1003.8(D).

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

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 emergency care, palliative care and anesthesia for persons 21 years of age and older.

A. COVERAGE AND LIMITATIONS

Services are covered under EPSDT for persons less than 21 years of age; palliative care is covered 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 administering the anesthetic agent initiates the appropriate anesthesia and monitoring protocol 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 for most services under EPSDT. Persons 21 years of age and older require PA unless the service is for emergency extractions or palliative care.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.10 PERSONS 21 YEARS OF AGE AND OLDER

Nevada Medicaid authorizes payment for qualified persons 21 years of age and older for partials, dentures, emergency extractions and palliative care only.

A. COVERAGE AND LIMITATIONS

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

B. PROVIDER RESPONSIBILITY

1. Providers must keep all substantiating x-rays on file for a minimum of six years following the date of service. Providers must keep the x-rays, related charting and other case documentation easily available to Medicaid reviewers during this period.

2. The Medicaid program considers emergency extractions a program benefit without prior or post approval. This includes the use of in-office sedation or anesthesia. The program does not cover extractions for cosmetic purposes. Dentists need not routinely submit substantiating x-rays to the Medicaid fiscal agent. However, Medicaid will periodically request copies of x-rays substantiating third molar extractions (teeth 1, 16, 17 and 32 for adults and children) related to tissue impaction, partial and full bony and surgical versus simple extractions. The dentists on-file x-rays must reveal sufficient bone and root complications for difficult surgical removal procedures.

3. For treatment necessary to avoid life-threatening health complications, providers perform services necessary to prevent life-threatening deterioration of a person's physical health without PA even though the services do not immediately qualify as Medicaid covered emergency services. The dentist must certify the services were medically necessary due to health complicating conditions such as HIV, AIDS, cancer, bone marrow transplantation or post kidney transplant. The dentist's certification must be part of a note explaining why the treatment was necessary to avoid life-threatening problems. For example, the dentist may explain successful cancer treatment or organ transplantation depended on extractions or treatment of caries to protect the recipient's compromised immune system from the stress of oral infection.

C. AUTHORIZATION REQUIREMENTS

No authorization is needed if the service is for emergency extraction or palliative care. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.11 SERVICES NOT COVERED BY MEDICAID

A. COVERAGE AND LIMITATIONS

Nevada Medicaid does not cover the following services:

1. Cosmetic services.

2. Routine and preventive dental care, such as periodic prophylaxis, sealants, silver diamine fluoride application, restoration of incipient or minor decay, treatment of sensitivity to hot and cold or other minor pain is not covered for persons 21 years of age and older. (Prophylaxes and restorative dental services under pregnancy related services require PA and are reviewed on an individual basis).

3. Crowns are not allowed for persons 21 years of age and older, except where required on an anchor or abutment tooth for a partial denture. Gold crowns are not a covered benefit for any age.

4. For persons 21 years of age and older, Temporal Mandibular Disease (TMD) services are not covered by Nevada Medicaid except for adult emergency services.

5. No show appointments or charges for missed appointments are not allowed.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.12 PHARMACY SERVICES

Nevada Medicaid authorizes payment of pharmacy services for qualified recipients.

A. COVERAGE AND LIMITATIONS

Fluoride supplements are covered only for recipients less than 21 years old.

B. PROVIDER RESPONSIBILITY

At this time, PA is not required for preventative medicaments like fluoride supplements when prescribed by a dentist; however, it is recommended that prescribers check current policy for any changes made.

The recipient must present the prescription with a Nevada Medicaid card to a Medicaid participating pharmacy provider. Providers must verify eligibility prior to service.

C. AUTHORIZATION PROCESS

These guidelines do not change any Medicaid policy regarding non-covered medications or medications which always require PA.

The Nevada Medicaid Preferred Drug List (PDL), PA requirements and quantity limits are available on the www.medicaid.nv.gov website.

Refer to the pharmacy policy located in MSM Chapter 1200 Prescribed Drugs.

1003.13 RESIDENTS OF INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

Nevada Medicaid authorizes payment for Medicaid covered services provided in an ICF/IID to full Medicaid-eligible recipients.

All dental services provided to recipients in an ICF/IID are administered under the same policy coverage and limitations provided throughout this dental chapter. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

A. COVERAGE AND LIMITATIONS

Under Federal regulations (CFR 483.460(e-h), the ICF/IID is required to provide or make arrangements for comprehensive dental diagnostic and treatment services for their residents.

B. PROVIDER RESPONSIBILITY

For dental services beyond the Medicaid covered benefit, the dentist must establish a relationship with the ICF/IID facility staff to assure verification of the recipient's ICF/IID residency, and payment source for dental services prior to service.

1003.14 PROVIDERS OUTSIDE NEVADA

Nevada Medicaid authorizes payment for out-of-state providers under Medicaid guidelines.

A. COVERAGE AND LIMITATIONS

Out-of-state providers are subject to the coverage and limitations of dental services under Nevada Medicaid.

B. PROVIDER RESPONSIBILITY

Out-of-state providers are subject to all Medicaid rules and guidelines.

C. AUTHORIZATION REQUIREMENTS

Out-of-state providers must use the same PA process as in-state dental providers.

1003.15 PAYMENT OF NON-COVERED SERVICES

A. COVERAGE AND LIMITATIONS

Nevada Medicaid does not authorize payment for non-covered services.

B. PROVIDER RESPONSIBILITY

Dental providers must inform the recipient of his/her financial responsibility before rendering any uncovered service. Consider this done when the recipient or a responsible designee signs a written document acknowledging acceptance of financial responsibility for each specific itemized service. The signed document must state, "I understand Medicaid will not cover the above itemized service cost(s). I agree to pay for the services."

If Medicaid covers a procedure, the provider cannot charge the recipient for the balance after Medicaid's payment. Also, providers cannot charge Medicaid for one covered service and provide a different service. For example, since Medicaid does not cover restorations or prosthetics made of gold, Medicaid's payment on a covered restoration or prosthesis cannot be used to offset one made of gold. The recipient would need to pay the complete charge for the gold restoration or prosthesis, or the recipient must accept the Medicaid benefit service only.

C. RECIPIENT RESPONSIBILITY

Services exceeding program limitations are not considered Medicaid benefits. These services are the financial responsibility of the recipient. For persons less than 21 years of age, medically necessary services that are outside of what is covered in the benefit schedule can be requested with a PA as an EPSDT exception. For example, a PA request needs to be submitted for a child who needs cleanings every three months rather than the six months allowed by current service limitations.

D. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not authorize payment for non-covered services.

1003.16 SERVICES PROVIDED IN NURSING FACILITIES

Nevada Medicaid authorizes payment for services provided in nursing facilities to qualified recipients eligible with full Medicaid benefits.

A. COVERAGE AND LIMITATIONS

All dental services provided to recipients in a nursing facility are administered under the same policy coverage and limitations provided throughout this Dental Chapter.

B. PROVIDER RESPONSIBILITY

Medicaid advises dentists to confirm the recipient's eligibility through the Eligibility Verification System (EVS) for the month the service will be provided and retain a copy prior to service. Medicaid advises dentists to develop procedures with nursing facility staff to screen for ineligible recipients. Medicaid recommends dentists become users of EVS by making arrangements with Medicaid's QIO-like vendor.

C. NURSING FACILITY RESPONSIBILITY

Nursing facility staff must screen for Medicaid eligibility.

D. AUTHORIZATION REQUIREMENTS

PA is required for partials and/or full dentures for all recipients residing in nursing facilities or receiving Hospice services. See Section 1003.5.C.

1003.17 HOSPITAL/SURGICAL CENTERS

A. COVERAGE AND LIMITATIONS

Nevada Medicaid authorizes payment for certain dental services in hospital or surgical centers for qualified recipients with PA unless it is an emergency.

B. AUTHORIZATION REQUIREMENTS

1. Inpatient Hospital Setting: Prior authorization for inpatient hospitalization for a dental procedure is necessary for Medicaid reimbursement.

   a. If PA is required for the dental procedure (CDT code), the dental consultant must obtain prior authorization. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

   b. PA must be obtained from Medicaid's QIO-like vendor or the Managed Care Organization (MCO) to certify the necessity for the recipient to be hospitalized for the performance of the inpatient dental procedure. The certification must be done before or on the date of the admission.

      The provider must write, "Hospital Admission" at the top of the Examination and Treatment Plan box of the claim form.

2. Outpatient/Surgical Center Setting: Prior authorization for dental procedures performed in an outpatient/surgical center setting may require prior authorization.

   a. For Medicaid recipients of all ages: If PA is required for the dental procedure (CDT code), the dentist rendering the service must obtain prior authorization. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

   b. For Medicaid recipients ages five and below, prior authorization is required for the outpatient facility. The authorization request must include a narrative signed by the provider with the clinical rationale for the dental procedure to be completed in an outpatient setting. The narrative must detail the clinical reason, including medical necessity, that the recipient is unable to have the services completed in the office.

   c. For Medicaid recipients ages 6 to 20, specific authorization is not required for the anesthesiologist and/or outpatient facility. Procedures done as outpatient services for recipients less than 21 years of age in a hospital or surgical center must be identified. The provider must write "Outpatient Facility Services" at the top of the Examination and Treatment Plan box of the claim form.

   d. For Medicaid recipients 21 years of age and older, the outpatient facility services must be prior authorized. The authorization request must include a narrative signed by the provider with the clinical rationale for the dental procedure to be completed in an outpatient setting. The narrative must detail the clinical reason that the recipient is unable to have the services completed in the office.

   e. All dentists providing surgical center services to Medicaid recipients must retain in-office copies of x-rays, intra-oral preoperative photographs (when necessary) and documentation necessary to substantiate service need. The substantiating evidence must be retained and remain readily available for no less than six years. Medicaid holds the provider responsible for assuring the evidence is sufficient for the Medicaid agency's post utilization review/control purposes.

   f. In situations where the dentist believes his treatment plan to have weak support from x-rays, intra-oral photographs, etc., the dentist should submit the evidence with a request for PA. Without PA, Medicaid will reclaim payment for the services if post service review findings do not support the dentist's treatment plan and medical necessity.

g. Medicaid does not reimburse providers for travel and hospital call related costs for services done in an outpatient surgical center.

1003.18 MAXILLOFACIAL SURGERY AND OTHER PHYSICIAN SERVICES

Nevada Medicaid authorizes payment for maxillofacial surgery and other physician services for qualified recipients.

A. COVERAGE AND LIMITATIONS

Temporomandibular Disorders (TMDs) encompasses a variety of conditions. For recipients less than 21 years of age, TMD services may be provided by a dentist or medical doctor under EPSDT. Coverage for the medical management of TMD related disease for recipients will be limited to appropriate current TMD related diagnosis codes.

Adult dental services continue to be restricted to palliative treatment, emergency extractions and dentures/partials.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

B. PROVIDER RESPONSIBILITY

Program utilization control requires that each type of provider (dentist, physician, pharmacist, etc.) be delineated with the use of a specific PT number. For example, dentists are a PT 22 while physicians are a PT 20. Providers also have the option to choose a specialty type. For example, a PT 22 can choose a specialty type of Maxillofacial Surgery (Specialty 170) or Oral Surgery (Specialty 080). All dental related services must be billed/requested with the most appropriate dental code found on the QIO-like vendor's web portal at www.medicaid.nv.gov. For certain oral and maxillofacial surgery procedures, when an appropriate dental code is not available, a CPT Code may be used if Medicaid allows the code to be billed by a PT 22, Specialty 080 and/or 170. Providers are encouraged to check the www.medicaid.nv.gov website or contact the QIO-like vendor to confirm ability to bill for specific CPT codes.

The CPT Code for fluoride varnish application which can be administered by PT 17, 20, 24 and 77 should be billed on a CMS 1500 form using the most appropriate and available ICD diagnosis code.

C. AUTHORIZATION REQUIREMENTS

See B. Provider Responsibility.

1003.19 CONDITIONS FOR PARTICIPATION

All dental providers must have a current license issued by the Nevada State Board of Dental Examiners to practice dentistry. Dental specialists must be dental specialties that are recognized and approved by the American Dental Association and the Nevada State Board of Dental Examiners and be enrolled as a Nevada Medicaid provider. Out of state dentists must meet the licensing requirements of the state in which they practice and be enrolled as a Nevada Medicaid provider.

Dental services may also be performed in a clinic setting as long as the care is furnished by or under the direction of a dentist. The clinic must have a dental administrator and all professional staff, dentists, hygienists, public endorsed hygienists, dental therapists, etc. must have a current Nevada license and/or certification from the appropriate state licensing board.

1003.20 IMPROPER BILLING PRACTICE

Providers must bill only for the dates when services were actually provided, in accordance with this MSM Chapter and the PT 22 Billing Guide.

Any provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

Improper billing practices may include but are not limited to:

A. Submitting claims for unauthorized procedures or treatments.

B. Submitting claims for services not provided.

C. Submitting false or exaggerated claim of the level of functional impairment or medical necessity to secure approval for treatment and reimbursement.

D. Submitting claims for treatment or procedures without documentation to support the claims.

E. Submitting claims for unnecessary procedures or treatments that are in excess of amount, scope and duration necessary to reasonably achieve its purpose.

F. Submitting claims for dental services provided by unqualified personnel.

Any Dental provider who improperly bills the DHCFP for services rendered is subject to all administrative and corrective sanctions and recoupment in accordance with MSM Chapter 3300 – Program Integrity. All Medicaid overpayments are subject to recoupment.

Any such action taken against a dental provider by the DHCFP has no bearing on any criminal liability of the provider.

1004 HEARINGS

Please reference Nevada MSM Chapter 3100 for the Medicaid Hearing process.

1005 REFERENCES AND CROSS REFERENCES/FORMS

Other sources which may impact the provision of Dental services include, but are not limited to the following:

Chapter 100: Medicaid Program
Chapter 200: Hospital Services
Chapter 300: Radiology Services
Chapter 500: Nursing Facilities
Chapter 600: Physician Services
Chapter 1200: Prescribed Drugs
Chapter 1500: Healthy Kids Program (EPSDT)
Chapter 1600: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Chapter 2100: Home and Community-Based Services Waiver for Individuals with Intellectual Disabilities
Chapter 3100: Hearings
Chapter 3300: Program Integrity

1005.1 CONTACTS

A. Nevada Medicaid Provider Enrollment
Division of Health Care Financing and Policy
1100 East William Street
Carson City, NV 89701
(775) 684-3705
https://dhcfp.nv.gov

B. DXC Technology
Customer Services Center
(For claim inquiries and general information)
(877) 638-3472
www.medicaid.nv.gov

C. Prior Authorization for Dental
(800) 525-2395 (Phone)

1005.2 FORMS

A. The ADA Dental Claim Form 2012 or newer version is required for all prior authorization requests, claims, adjustments and voids.

1005.3 DENTAL PERIODICITY SCHEDULE

The recommended periodicity schedule can be found at http://www.aapd.org/.