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

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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.

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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.

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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

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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~~item(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

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.

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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.

      Overjet is recorded with the recipient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. Canines should not be used to measure overjet. The measurement could apply to a protruding single tooth as well as to the whole arch. Overjet of 9 mm or more must be demonstrated with a measuring device to verify the claimed measurement. The provider must submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the recipient's mouth, or photo of models demonstrating measurement mounted in centric relation.

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

      Reverse overjet is recorded with the recipient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. A single tooth in crossbite should not be considered as mandibular protrusion but should be evaluated for individual anterior tooth in crossbite with soft tissue destruction. An individual tooth in crossbite with no visible damage to the periodontal tissues is not considered a handicapping malocclusion. For example, Class 1 mobility is not visible damage. Reverse overjet of 3.5 mm or greater must be demonstrated with a measuring device to verify the claimed measurement. The provider should submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the recipient's mouth, or on models mounted in centric relation.

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

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The posterior crossbite must be one in which the maxillary posterior teeth involved may either be both completely palatal or both completely buccal in relation to mandibular posterior teeth. The posterior crossbite involves two or more adjacent teeth, and one tooth must be a molar. The anterior crossbite must be one in which three or more of the anterior maxillary teeth are lingual to the mandibular maxillary teeth. There must be no functional contact between upper and lower teeth to qualify as a handicapping malocclusion.

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

This condition applies to a general dental or skeletal open bite. A single tooth in ectopic eruption does not qualify as a skeletal or dental open bite. This condition must be demonstrated with a measuring device to verify the claimed measurement. The provider must submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the recipient's mouth, or on models mounted in centric relation. For anterior teeth, the measurement should be placed from incisal edge to incisal edge, and for posterior teeth, the measurement should be from cusp tip to cusp tip to demonstrate the edge-to-edge relationship.

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

Tooth contact with the palate or gingiva must be clearly evident in the mouth. It must be reproducible and visible. On the submitted documentation, the lower teeth must be clearly touching the palate and there must be clear evidence of significant contact and indentation. A photo of the electronic models/scan or mounted casts from the lingual view demonstrating the impingement must be included. This condition is considered to be a handicapping malocclusion. It is strongly recommended that providers submit a clear, well lit, color photo of the maxillary arch that clearly demonstrates the deep impinging overbite and the resulting soft tissue condition.

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

Must be obviously impacted against roots of an adjacent tooth. An unerupted tooth will not be considered impacted. Providers must attach documentation of condition. This condition is considered to be handicapping malocclusion. If it is questionable if the tooth will erupt on its own with sufficient jaw development, the case will be rejected and may be

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resubmitted in the future if the tooth becomes obviously impacted against roots of an adjacent tooth.

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

This condition is considered to be a handicapping malocclusion. For craniofacial anomalies, providers must attach report from the "diagnosing specialist" indicating the diagnosis, the severity and scope of diagnosis, and the resulting complications including effect of the diagnosis on occlusion, oral health, and oral function. Examples of cranio-facial anomalies include cleft lip, cleft palate, hemifacial microsomia, deformational plagiocephaly. These would not include normal or skeletal malocclusion. This section also includes malocclusion due to trauma. For trauma or pathology, a detailed medical history report should be submitted.

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

The recipient should have two or more congenital missing teeth. All of the congenitally missing teeth cannot be in the same quadrant. This means at least two quadrants must be affected by the missing teeth. Teeth that are missing due to extraction (or other loss) will not be considered under this section.

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

The provider must submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the recipient's mouth, or on models mounted in centric relation.

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.

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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.

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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

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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

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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.

Overjet is recorded with the recipient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. Canines should not be used to measure overjet. The measurement could apply to a protruding single tooth as well as to the whole arch. Overjet of 9 mm or more must be demonstrated with a measuring device to verify the claimed measurement. The provider must submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the recipient's mouth, or photo of models demonstrating measurement mounted in centric relation.

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

Reverse overjet is recorded with the recipient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. A single tooth in crossbite should not be considered as mandibular protrusion but should be evaluated for individual anterior tooth in crossbite with soft tissue destruction. An individual tooth in crossbite with no visible damage to the periodontal tissues is not considered a handicapping malocclusion. For example, Class 1 mobility is not visible damage. Reverse overjet of 3.5 mm or greater must be demonstrated with a measuring device to verify the claimed measurement. The provider should submit a photo with the measuring device (Boley gauge, disposable ruler or probe) in the recipient's mouth, or on models mounted in centric relation.

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

The posterior crossbite must be one in which the maxillary posterior teeth involved may either be both completely palatal or both completely buccal in relation to mandibular posterior teeth. The posterior crossbite involves two or more adjacent teeth, and one tooth must be a molar. The anterior crossbite must be one in which three or more of the anterior maxillary teeth are lingual to the mandibular maxillary teeth. There must be no functional contact between upper and lower teeth to qualify as a handicapping malocclusion.

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

This condition applies to a general dental or skeletal open bite. A single tooth in ectopic eruption does not qualify as a skeletal or dental open bite. This condition must be demonstrated with a measuring device to verify the claimed measurement. The provider must submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the recipient's mouth, or on models mounted in centric relation. For anterior teeth, the measurement should be placed from incisal edge to incisal edge, and for posterior teeth, the measurement should be from cusp tip to cusp tip to demonstrate the edge-to-edge relationship.

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

Tooth contact with the palate or gingiva must be clearly evident in the mouth. It must be reproducible and visible. On the submitted documentation, the lower teeth must be clearly touching the palate and there must be clear evidence of significant contact and indentation. A photo of the electronic models/scan or mounted casts from the lingual view demonstrating the impingement must be included. This condition is considered to be a handicapping malocclusion. It is strongly recommended that providers submit a clear, well lit, color photo of the maxillary arch that clearly demonstrates the deep impinging overbite and the resulting soft tissue condition.

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

Must be obviously impacted against roots of an adjacent tooth. An unerupted tooth will not be considered impacted. Providers must attach documentation of condition. This condition is considered to be handicapping malocclusion. If it is questionable if the tooth will erupt on its

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own with sufficient jaw development, the case will be rejected and may be resubmitted in the future if the tooth becomes obviously impacted against roots of an adjacent tooth.

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

This condition is considered to be a handicapping malocclusion. For craniofacial anomalies, providers must attach report from the "diagnosing specialist" indicating the diagnosis, the severity and scope of diagnosis, and the resulting complications including effect of the diagnosis on occlusion, oral health, and oral function. Examples of cranio-facial anomalies include cleft lip, cleft palate, hemifacial microsomia, deformational plagiocephaly. These would not include normal or skeletal malocclusion. This section also includes malocclusion due to trauma. For trauma or pathology, a detailed medical history report should be submitted.

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

The recipient should have two or more congenital missing teeth. All of the congenitally missing teeth cannot be in the same quadrant. This means at least two quadrants must be affected by the missing teeth. Teeth that are missing due to extraction (or other loss) will not be considered under this section.

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

The provider must submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the recipient's mouth, or on models mounted in centric relation.

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.

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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. Nevada Medicaid QIO-like Vendor~~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)

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1005.2 FORMS

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

B. Orthodontic Medical Necessity (OMN) Form (FA-25): https://www.medicaid.nv.gov/Downloads/provider/FA-25.pdf

C. Client Treatment History Form (FA-26): https://www.medicaid.nv.gov/Downloads/provider/FA-26.pdf

D. Partial Denture Delivery Receipt (FA-27A): https://www.medicaid.nv.gov/Downloads/provider/FA-27A.pdf

E. Denture Delivery Receipt (FA-27B): https://www.medicaid.nv.gov/Downloads/provider/FA-27B.pdf

1005.3 DENTAL PERIODICITY SCHEDULE

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

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