MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

March 24, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR *Cody L. Phinney*
Cody L. Phinney (Jun 18, 2020 13:04 PDT)

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1000 – DENTAL

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1000 – Dental, are being proposed to clarify the following: pregnancy related services; remove prior authorization (PA) language for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services; replace the title of "Provider Type (PT 22), Dentist Billing Guide," to the "Medicaid Dental Benefit Schedule"; remove obsolete dental codes; clarify coverage of prosthodontic service requirements for partials and/or full dentures for recipients residing in nursing facilities; revise automatic qualifying conditions for orthodontic treatment; add out-of-state orthodontia policy; clarify coverage of fluoride supplements; remove specific coverage and limitations for Residents of Intermediate Care Facilities; update PA requirements for Hospital/Surgical Centers, Maxillofacial Surgery and other physician services; and updated the References and Cross References section to reflect updated MSM chapter names and contact information.

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 dentists (PT 22), all specialties.

Financial Impact on Local Government: Unknown at this time.

These changes are effective April 1, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 14/20 MSM Chapter 1000 – DENTAL	MTL 14/15, 02/17, 16/17 MSM Chapter 1000 – DENTAL

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1000	**Introduction**	Added "dental hygienists, public endorsed dental hygienists and dental therapists" as dental providers.
	Individuals Under Age 21	Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
		Added "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 the current service limitation."
	Pregnancy Related Services	Added language to refer to the American Dental Association for clinical recommendations and guidelines for treatment of pregnant women for the use of silver diamine fluoride.
		Clarified coverage of pregnancy related services and timeframe for services with approved PAs.
1003	**Nevada Medicaid Policy**	Added list of dental providers who are able to bill for services when enrolled as a Medicaid provider.
		Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.1A	**Diagnostic and Preventive Services (D0100 – D1999)**	Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's website.
1003.1B		Removed prior authorization requirements for services covered under EPSDT.
1003.2A	**Restorative Dentistry Services (D2000 – D2999)**	Clarified language for restorative services that are covered under EPSDT.
1003.2(B)		Removed authorization requirements for EPSDT.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.3(A)	**Endodontic Services (D3000 – D3999)**	Updated language for EPSDT coverage for restorative services. Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.3B		Removed prior authorization requirements for services covered under EPSDT. Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.4A(1)	**Periodontic Services (D4000 – D4999)**	Updated language for EPSDT coverage for Periodontic services.
1003.4A(2)		Removed dental codes D4341 and D4342. Clarified that all codes for periodontal scaling and root planing will be monitored by Medicaid.
1003.4A(3)		Added PA requirement for pregnant women receiving certain periodontal services.
1003.4A(4)		Removed specific palliative treatment codes D4355 and D4999. Removed "comprehensive" from the type of exams.
1003.4B		Removed PA requirements for services covered under EPSDT. Removed language requiring a PA for pregnancy related services. Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.5A(2	**Prosthodontic Services (D5000 - D5999)**	Replaced "emergency" with "comprehensive."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.5A(3)		Clarified qualifications for a partial denture(s).
		Defined posterior balanced occlusion.
1003.5A(6)(d)		Updated required documentation to support medical condition to override 5-year service limitation.
1003.5A(6)(e)		Removed criteria that a letter is required from the recipient's physician/surgeon for dentures.
1003.5A(7)		Restructured language in paragraph.
		Added reference to Section 1003.5.8 for guidance to request an override to the 5-year service limitation.
1003.5B(1)		Revised policy stating that Medicaid will pay for one comprehensive examination per 36 rolling months (Code D0150) in connection with new dentures.
		Added policy for dentists to bill up to two additional exams (D0140) for subsequent denture appointments.
		Added policy that denture claims cannot be submitted prior to the delivery date.
1003.5B(3)		Added policy to have the delivery receipt as a required attachment when submitting a claim for reimbursement.
		Added policy that claims cannot be submitted prior to the date of delivery.
1003.5C(1)		Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.5C(2)(a-b)		Updated PA requirements for partials and/or full dentures for all recipients residing in a nursing facility.
		Clarified requirements in accordance with NRS 631.375.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.5(C)(3)		Replaced "fiscal agent" with "DHCFP" for post payment reviews.
1003.6	**Denture Identification Embedding**	Added NRS definition.
1003.7	**Oral Surgery**	Added "and Maxillofacial" to section title.
1003.7(A)(1)		Clarified covered services for recipients.
1003.7(B)		Added language that a PA is not necessary for most oral and maxillofacial surgery services under EPSDT and persons 21 years of age and older. Removed language regarding pregnancy related services. Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.8	**Orthodontics (D8000 – D8999)**	Clarified language that Medicaid authorizes payment for orthodontics for recipients under 21 years of age when certain conditions are met that confirm medical necessity. Revised language stating Medicaid reimburses for D0350 to Orthodontists only, unless PA is received through EPSDT.
1003.8A(1)		Removed outdated reference to the Children with Special Health Care Needs Program. Added language pertaining to Medicaid adopting the automatic qualifying conditions criteria for orthodontia developed by the American Association of Orthodontists (AAO).
1003.8A(2)		Updated medically necessary orthodontic automatic qualifying conditions, provided by the AAO. Added Section 1003.8D(2) to reference for medical need under EPSDT.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8A(3)(c)		Revised required dental appointment history from three years to two years.
1003.8B(1)		Clarified that payment for orthodontia covers the length of treatment.
1003.8B(3)		Clarified definition of good history for dental appointments.
1003.8B(4)(c)		Revised dental appointment history from three years to two years.
1003.8B(6)(c)		Clarified that Medicaid payment for orthodontic services includes the removal of any banding and retainers at no additional cost to the recipient.
1003.8C(1)(c)		Revised required dental appointment history from three years to two years.
1003.8D(1)		Updated medically necessary orthodontic automatic qualifying conditions, provided by the AAO.
1003.8D(2)		Added the automatic qualifying conditions specified by the AAO have been determined to be medically necessary. Added for orthodontia requests under an EPSDT exception, the request must demonstrate a functional impairment indicative of medical necessity. Specified documentation requirements for submitting a PA request under one of the AAO automatic qualifiers or for EPSDT. Added treatment plan must be included if the request is submitted as an EPSDT exception.
1003.8D(2)(a)		Moved last sentence of "a" to bottom of #2.
1003.8D(2)(b)		Added a PA must include documentation from a Qualified Mental Health Professional (QMHP) acting within their scope of practice, that verifies the psychological need for orthodontia.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8D(2)(c)		Added a functional impairment must be demonstrated for a child suffering from complicating ailments such as cerebral palsy or epilepsy. Added language that Medicaid does not authorize orthodontic treatment based on a future condition, ease of hygiene or aesthetic improvement.
1003.8D(3)(e)		Moved language from old "'e" to new "e" to clarify if the request is submitted under one of the AAO automatic qualifiers, provider must include a treatment plan, principal diagnosis and any significant associated diagnoses and prognosis.
1003.8E		Added policy for out of state orthodontia policy.
1003.9	**Adjunctive General Services (D9000-D9999)**	Added "emergency care."
1003.9A	**Adjunctive General Services (D9000 – D9999)**	Clarified administering of anesthetic agents.
1003.9B		Updated language that a PA is not necessary for most services provided under EPSDT. Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.10	**Persons 21 Years of Age and Older**	Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.10C		Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.11	**Services Not Covered by Medicaid**	Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.11A(1)		Removed language from cosmetic services, as the QIO-like vendor does not approve any dental cosmetic services.
1003.11A(2)		Updated routine and preventive dental care services that are not covered for persons 21 years and older.
1003.12B	**Pharmacy Services**	Added prior authorization is not a requirement for preventative medicaments, such as fluoride supplements, but recommends the prescribers check current policy for any changes.
1003.12C		Added link to Nevada Medicaid Preferred Drug List. Added reference to MSM Chapter 1200 – Prescribed Drugs.
1003.13	**Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)**	Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal.
1003.13A		Added Federal citation CFR 483.460(e-h) which governs the ICF/IID. Deleted language regarding the ICF/IID's responsibilities for dental services.
1003.15C	**Payment of Non-Covered Services**	Clarified policy for services that are outside of what is covered in the benefit schedule can be requested with a PA as an EPSDT exception demonstrating medically need. 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.
1003.16D	**Services Provided in Nursing Facilities**	Removed language pertaining to coverage from Managed Care to FFS "NOTE: If the recipient is covered under Managed Care and has been an in-patient over 45 days, the recipient is then covered by Fee-for-Service from the 46th day forward."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added reference to Section 1003.5C of the chapter for authorization requirements.
1003.17B(1-2)	**Hospital/Surgical Centers**	Updated PA requirements for outpatient/surgical center settings.
1003.17B(1)(a)		Clarified if a PA is required for the dental procedure (CDT code), the dentist rendering the service must obtain PA and to reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 – Billing Guide) for a list of covered CDT codes, PA requirements and service limitations.
1003.17B(2)		Updated language that a PA for dental procedures performed in an outpatient/surgical center setting may require PA. Moved part of paragraph to Section 1003.17B(2)(c).
1003.17B(2)(a)		Clarified language for Medicaid recipients of all ages: If PA is required for the dental procedure (CDT code), the dentist rendering the service must obtain PA and to reference Nevada Medicaid's Dental Benefit Schedule for a list of covered CDT codes, PA requirements and service limitations.
1003.17B(2)(b)		Added new policy for recipients ages five below requiring a prior authorization narrating the clinical reason, including medical necessity, that the recipient is unable to have the services completed in the office.
1003.17B(2)(c)		Clarified PA requirements for recipients ages 6-20.
1003.17B(2)(d)		Revised language for coverage of recipients 21 years of age and older.
1003.18	**Maxillofacial Surgery and Other Physician Services**	Clarified coverage of Temporomandibular Disorders (TMD) and moved to "A" – Coverage and Limitations.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.18A		Added language for adult dental services continue to be restricted to palliative treatment, emergency extractions and dentures/partials. Added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal. Removed specific CPT codes and added language to refer to the Medicaid Dental Benefit Schedule on the QIO-like vendor's web portal for a list of covered codes, prior authorization requirements and service limitations.
1003.18B		Clarified provider responsibility for billing appropriate dental codes. Added providers are encouraged to check the QIO-like vendor's web portal or contact the QIO-like vendor to confirm ability to bill for specific CPT codes.
1003.19	**Conditions for Participation**	Removed duplicative language, specifically referring to dental hygiene. Added "hygienists, public endorsed dental hygienists and dental therapists" as dental providers.
1005	**References and Cross References**	Updated the References and Cross References section to reflect updated MSM chapter names and contact information.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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1000 DENTAL

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.

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

   b. Overjet equal to or greater than 9 millimeters.

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

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

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

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

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

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

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

j. 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 2012 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/.

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