



TIP SHEET:

Prior Authorization for Dental Services in an Outpatient Facility

Nevada Medicaid policy authorizes payment for certain dental services in hospital or surgical centers. Please refer to [Medicaid Services Manual Chapter 1000 Dental, Section 1003.17](#) for additional information on these requirements.

Prior Authorization Requirements for the Dental Provider (Provider Type 22):

For Medicaid recipients of all ages: If prior authorization (PA) is required for the dental procedure (Current Dental Terminology (CDT) code), the dentist rendering the service must obtain prior authorization. To determine PA requirements, please review the [Authorization Criteria Search Function](#).

Prior Authorization Requirements for the Outpatient/Surgical Center Setting:

For Medicaid recipients ages 5 and under or ages 21 and older: Prior authorization is required for the Outpatient facility. Prior authorization must be requested at least eight business days prior to the date of service.

To request a PA for the facility:

Step 1: Create a Dental PA with Process Type: Dental or Retro Dental if the recipient has retro-eligibility.

Step 2: Complete Recipient, Rendering Provider and Diagnosis Information.

Step 3: Enter Current Procedural Terminology (CPT) code **41899** into the service detail, as well as applicable dates and Medical Justification.

Step 4: The prior authorization request must include the following attachments:

- A letter of medical necessity signed by the provider that clearly identifies why the procedure(s) could not be completed in an office setting. This letter must also include the name and National Provider Identifier (NPI) of the outpatient facility.
- A completed American Dental Association (ADA) form listing all dental procedures (CDT codes) to be performed.

Once the PA is reviewed and approved, Nevada Medicaid will transfer the prior authorization number to the outpatient facility.

For Medicaid recipients ages 6 to 20, specific authorization is not required for the outpatient facility.

Additional Notes: All dental-related services must be billed/requested with the most appropriate dental code. 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 will need to confirm code coverage using the [Search Fee Schedule](#) tool by entering the CPT code and Service Category "Practitioner Services." Prior authorization requirements can be found using the [Authorization Criteria Search Function](#).

Outpatient prior authorization requests for medical CPT codes will not utilize the above process and will instead follow the medical authorization requirements for the facility.