ATTACHMENT J-17.1

OFFICE OF UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION DENTAL SERVICES

DEPARTMENT OF HEALTH
Department of Health Care Finance

OFFICE OF UTILIZATION MANAGEMENT	POLICY AND PROCEDURES

SUBJECT: Revised Prior Authorization Process for Fee-for-Service Dental Services for District of Columbia Medicaid

Effective Date: December 1, 2009		**Last Date Revised**

The District of Columbia Medicaid program covers dental services when they are prescribed by an actively-enrolled dentist or oral surgeon, and when they are covered in accordance with DC Medicaid State Plan.

Prior authorization is required for certain dental services with some limitations, including:

D0470	STUDY MODELS
D2970	TEMP CROWN (FRACTURED TOOTH)
D3347	RETREATMENT OF PREVIOUS R
D4211	GINGIVECTOMY OR GINGIVOPL
D4263	BONE REPLCE GRAFT FIRST S
D4341	PERIODONTAL SCALING AND R
D7320	ALVEOLOPLASTY NOT IN CONJ
D7460	EXCISION OF RANULA
D7472	REMOVAL OF TORUS PALATINU
D7850	MENISCECTOMY
D7953	BONE REPLACEMENT GRAFT
D7972	SURG REDCT FIBROUS TUBERO
D8080	COMPRE DENTAL TX ADOLESCE
D9221	GENERAL ANESTHESIA EA AD
D0160	EXTENSV ORAL EVAL PROB FO
D3351	APEXIFICATION/RECALC INIT
D3426	ROOT SURGERY EA ADD ROOT
D4210	GINGIVECTOMY OR GINGIVOPL
D4264	BONE REPLCE GRAFT EACH AD
D7285	BIOPSY OF ORAL TISSUE HAR
D7310	ALVEOLOPLASTY IN CONJUNCT
D7340	STOMATOPLASTY PER ARCH UN
D7451	REMOVAL ODONTOGENIC CYST,
D7471	REM EXOSTOSIS ANY SITE
D7473	REMOVE TORUS MANDIBULARIS
D7840	CONDYLECTOMY
D7860	ARTHROTOMY
D7940	OSTEOPLASTY(PROGNATHISM,M
D7960	FRENULECTOMY

D8090	COMPRE DENTAL TX ADULT
D8999	ORTHODONTIC PROCEDURE
D9220	GENERAL ANESTHESIA
D9420	HOSPITAL VISIT
D9940	OCCLUSAL GUARDS, BY REPOR

DHCF contracts with a federally recognized Quality Improvement Organization (QIO) to verify the medical necessity for requested dental procedures. DHCF's QIO will execute the prior authorization process in advance of a dental provider supplying the service for a Medicaid beneficiary in accordance with the DC Medicaid State Plan.

Prior authorization for Dental Services will be requested via a 719A Form. The 719A Form is the requesting provider's written prescription for dental procedures.

Purpose:
To help ensure that beneficiaries receive appropriate dental services and to make efficient use of recipient and DHCF resources.

Procedures:

I. Requesting (Prescribing) Provider Requests Approval:

1. Every requesting dental provider is to complete fields 1-6, 8, 9, 13, 15 A, and 15 B on the DHSA Form 719A. The requesting provider also completes fields 7, 10 and 11 of the 719 Form with appropriate. American Dental Association (ADA) procedure code, quantity of units requested and estimated charges. The requesting provider faxes the 719A Form and the appropriate supporting documentation to the QIO Prior Authorization Unit.
2. The requesting provider shall call the QIO Prior Authorization Unit for all inquiries.

II. Billing Provider forwards 719A Form to QIO Prior Authorization Unit:

1. The billing provider receives the 719A Form via mail, fax, or web portal (when available) from the requesting provider; or via hand delivery from the beneficiary.
2. Every billing provider is to insert its business name and DC Medicaid ID number in the upper right corner of the 719A Form.
3. Every billing provider is to enter the code with the appropriate modifier for the equipment or service being requested into field 7 of the 719A Form.
4. Every billing provider is to complete field 11 of the 719A Form by estimating the customary and usual charge for the requested service or equipment.
5. The billing provider transmits the request to the QIO Prior Authorization Unit via mail, fax, or web portal (when available).

III. QIO Prior Authorization Process and Timelines

A Written Prior Authorization Process

1. **Beneficiary and billing provider eligibility verification.** The QIO Prior Authorization Unit will start the prior authorization process by verifying the:

a. Patient's eligibility for Medicaid (located in the MMIS Recipient Subsystem screen), including the patient's active coverage period, as follows:
    - Date of services requested shall not exceed recipient's eligibility end dates;
    - If the recipient's eligibility end date is 999999, they are eligible for services indefinitely.
    - If specific eligibility codes are present, the request for prior authorization will be denied.
b. Billing Provider's status as an enrolled Medicaid provider (located in the MMIS Provider Subsystem screen);
    - Active Status (01)→Eligible to provide services; or
    - Inactive Status→ Not eligible to provide services.
c. Presence of appropriate diagnosis and ADA procedure codes;
d. Written justification and supporting documentation; and
e. Requesting provider signature and date.

2. **Administrative review.** The QIO Prior Authorization Unit will review the 719A Form using the following criteria:
    a. If the date of service precedes the request for prior authorization, the request for prior authorization will be denied.
    b. If the date of service precedes the date of the requesting provider's signature the request for prior authorization will be denied.
    c. The date of the requesting provider's signature will be the first day of the six (6) month authorization time period, if authorization is granted.
    d. Prior authorization requests will be denied if dates included with a dates of service range are:
        i. before prior authorization approval;
        ii. before the date of the requesting provider's signature; or
        iii. after six (6) months from the date of the requesting provider's signature. The QIO Prior Authorization Unit will direct the billing provider to submit a 719A form with dates of service that meet the criteria listed above.
    e. Prior authorization requests for repairs will be denied if the repair is covered by the product's warranty. The QIO, will request a warranty for repair requests on products received by the beneficiary thirty (30) days or less prior to the submission date of the 719A request.
    f. Prior authorization requests for rentals will be denied if:
        i. the frequency of the rental is inconsistent with the code definition;
        ii. the time period requested is for the lifetime of the beneficiary (i.e. entering a '99' in field number 9 of the 719A form); or
        iii. the total cost to rent the product exceeds the cost to purchase the product per the DHCF fee schedule.

3. **Clinical review.** The QIO Prior Authorization Unit will review the 719A Form and supporting documentation for the:
    a. Presence of appropriate diagnosis and procedure codes; and
    b. Written justification and supporting documentation.

The QIO will use medical criteria approved by DHCF to approve or deny payment.

If the 719A Form contains an imprecise procedure code, such as a miscellaneous "99" code, the QIO Prior Authorization Unit will request that the billing provider resubmit the 719A Form using more precise procedure code(s), if available. If a miscellaneous code continues to be used, the QIO will forward the PA request to DHCF's Utilization Management unit who will discuss the miscellaneous coding with the Dental Provider.

The QIO will utilize DC Medicaid claims history and any other accessible historical information on a beneficiary in its prior authorization request review and determination.

4. **Data submission to MMIS.** If the request for the dental service is approved, the QIO Prior Authorization Unit remotely and electronically enters approval data into the MMIS Prior Authorization Subsystem. Upon the entry of all necessary data, a prior authorization number is generated. The data entry process includes populating the following fields:
   A. approval status-→A (indicating approval)
   B. provider Letter Status-→Y (mail letter to provider)
   C. recipient Number
   D. billing Provider Number
   E. approver ID Number
   F. dates of Service Range
   G. diagnosis Code
   H. procedure Code (see list)
   I. unit Number (for each procedure code requested)
   J. tooth number(s)
   K. estimated Charge; and
   L. prior authorization number is auto-assigned.

5. **Pricing.** If the request for dental service is approved, the QIO will adhere to the guidance below when entering data into the 'Approved Amount' field of the MMIS Prior Authorization Subsystem.
   i. If the estimated charge of the dental service is equal to or greater than, the dollar amount included in the current DHCF fee schedule, the QIO will enter '00'.
   ii. If the estimated charge of the dental service is less than the dollar amount included in the current DHCF fee schedule, the QIO will enter the estimated charge.
   iii. If a procedure code for dental service does not have a price on the current District Medicaid Fee Schedule, the 719A Form is forwarded to DHCF for manual pricing.

6. **Transmittal of notification to billing provider and beneficiary.** The QIO faxes to the billing provider written notification of the approval or denial determination

related to the prior authorization request. Additionally, the beneficiary is mailed written notification of the approval or denial determination related to the prior authorization request.

a. Notification of an approval will include a prior authorization number, approved dates of service range, approved HCPCS or CPT codes, approved reimbursement total, and approved units.
b. Notification to a requesting provider of a denial will include the denied service range, HCPCS codes, units and information on appeals of denial determinations.
c. Notification to the beneficiary of a denial will include instructions on how to appeal a denial.

B. Timelines

a. The QIO Prior Authorization Unit will return all incomplete 719A Forms to the requesting provider via fax immediately. No action will be taken by the QIO until a complete 719A Form is received.

b. Within five (5) business days, the QIO Prior Authorization Unit will conduct a review of each complete 719A Form, and fax to the requesting provider a decision if the requested dental service is included within DHCF's fee schedule. If the service requires manual pricing, the request will be sent to MAA within five (5) business days.

c. If the requested dental service is not included within DHCF's fee schedule, the complete 719A Form will be faxed to DHCF. Within five (5) business days, DHCF will review and manually price the requested service and fax a decision to the QIO Prior Authorization Unit. In total, within ten (10) business days from the date of receipt from the requesting provider, the QIO Prior Authorization Unit will fax a decision to the requesting provider.

d. *All incomplete 719A forms will be returned to the requesting provider via fax immediately.* The requestor will have five (5) business days to complete the form and fax it back to the Prior Authorization Unit. The QIO will use medical criteria approved by DHCF.

e. Authorization of a dental service is valid for a period of sixty (60) days.

f. Within three (3) business days of the determination, QIO Prior Authorization Unit will fax written notification of denied services including information on appeal rights, to the requesting provider and mailed to the recipient

C. *Tracking*

The QIO will maintain a tracking log of all prior authorization requests and transactions, that includes the following:

a. beneficiary name and Medicaid ID number;

b. requesting physician name and Medicaid ID number (if a Medicaid provider);
c. billing provider name and Medicaid ID number;
d. date of service;
e. the type of service requested;
f. date of determination; and
g. prior authorization number issued.

The tracking log will be updated monthly on the QIO's web portal, under 'Out Patient'.

IV. Billing Provider Submits Claim to ACS

All DME/POS claims submitted to DHCF for payment must include the prior authorization number provided by the QIO (which is obtained and generated from the MMIS system) in Box 23 of the CMS 1500 as part of their claim submission.

V. Appeals Process:

A If the prior authorization is not granted, the billing provider, beneficiary, or beneficiary's representative may fax a request for reconsideration to the QIO Prior Authorization Unit.

B The QIO Prior Authorization Unit will:

a) Arrange for a reviewer, other than the reviewer who performed the initial review, to perform the reconsideration review; and

b) Issue the reconsideration decision within twenty-one (21) business days of the reconsideration request. Providers and beneficiaries will receive written notice within 5 business days of the reconsideration determination.

- If approved, the QIO Prior Authorization Unit electronically and remotely enters the approval data into the Prior Authorization Subsystem of the MMIS. If not approved, the QIO will provide written notification of denied services to the provider and beneficiary including information on further appeal rights.

C. If billing providers, the beneficiary, or the beneficiary's representative choose to appeal the QIO's reconsideration decision, the billing provider, beneficiary, or the beneficiary's representative may request a fair hearing from the DC Office of Administrative Hearings. Providers, beneficiaries, or the beneficiary representative have 90 days from the postmark date of the QIO reconsideration letter to ask for a fair hearing. Information on how to request a fair hearing will be included in the QIO denial letter.

VI. Customer Service

A The QIO Prior Authorization Unit will respond to provider and beneficiary inquiries regarding prior authorization requests.

B If the QIO Prior Authorization Unit is unable to adequately answer billing provider and/or beneficiary inquiries, the QIO Director of DC Medicaid Programs will respond.

C If neither the QIO Prior Authorization Unit, nor the QIO Director of DC Medicaid Programs, is able to adequately answer provider or beneficiary inquiries, the DHCF

Contracting Officer's Technical Representative will respond.

Responsible Approving Manager:	Date:
DHCF Approval:	Date: