PRIOR AUTHORIZATION

Requests for Prior Authorization (PA) are made on the American Dental Association (ADA) Claim Form, the same claim form used for billing. Providers should complete this form for PA following the instructions found in this chapter. When requesting PA two identical copies of this form must be submitted with the appropriate mounted bitewing or periapical radiographs that support the clinical findings and justify the treatment requested.

Radiographs should be attached to each request for authorization. The Medicaid Dental Program or its designee will return all requests for PA that do not have adequate information or radiographs necessary to make the authorization determination. If radiographs are contraindicated or unobtainable the reason must be stated in the "Remarks" section of the claim forms submitted for PA and documented in the treatment record as well.

Staple together all claim forms and radiographs for a single beneficiary.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the beneficiary's record and provide that information to the Louisiana Department of Health (LDH) Medicaid Dental Program or its designee.

For ease of billing it is preferable to group services requiring authorization on a single claim form so that only one PA number need be issued per beneficiary.

All Adult Denture Program services (except for repairs) require PA. Adult Denture Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided in Appendix B. The procedure codes for services requiring PA are marked with an asterisk (*) and must be authorized by the Medicaid Dental Program or its designee before payment will be made.

It is the provider's responsibility to utilize the appropriate procedure code in a request for PA. Prior authorization of a requested service does not constitute approval of the fee indicated by the provider.

When requesting PA, the provider should list all services that are anticipated, even those not requiring authorization, in order for the Medicaid Dental Program or its designee to fully understand the general dental health and condition of the beneficiary for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be entered in the "Remarks" section of the claim form. If the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

If a cover sheet is used, be certain it includes the date of the request, the beneficiary's name, the beneficiary's Medicaid ID) #, the provider's name and the provider's Medicaid ID #. A copy of this cover sheet, along with a copy of the request for PA, must be kept in the beneficiary's treatment record. Without the complete treatment plan, appropriate radiographs, or explanations, it may not be possible for the LDH Medicaid Dental Program or its designee to determine approval of the isolated services.

Prior Authorization Reminders

If you have questions regarding this policy, you may contact the LDH Medicaid Dental Program or its designee (see appendix J).

At the completion of the PA review one of the following will occur:

A copy of the claim form and the radiographs will be returned to the provider (at the address listed on the claim form) and the other copy will be retained by the Medicaid Dental Program or its designee. A PA letter to the provider detailing the services that have been prior authorized. A PA number will be furnished on the PA letter to allow the provider to bill for services as they are completed. The beneficiary also receives a copy of the PA letter. An example of a PA letter can be found in Appendix H. The returned copy of the claim form and the PA letter must be filed in the beneficiary's treatment record.

In some cases, both copies of the claim form (and radiographs) may be returned requesting additional radiographs, additional information or with questions or suggestions concerning the proposed treatment. These cases have not been approved or denied. In order to complete the PA process, they must be returned with the requested information. If necessary, the provider may provide further explanations or reasons for treatment in the "Remarks" section of the claim form.

In other cases, the copy of the claim form and radiographs returned to the provider will have denied services lined out, a maximum fee stated, the number of requested services decreased, or other changes. In these cases, a PA letter will be sent to the provider detailing those services that have been prior authorized and list any denied services along with an explanation of those denials. A prior authorization number will be furnished to allow the provider to bill for services as they are completed. The beneficiary also receives a copy of the PA letter and in the case of a denial, the explanation of denied benefits will advise beneficiaries of their appeal rights. The returned copy of the claim form and the PA letter must be filed in the beneficiary's treatment record.

Provider should be certain that both copies of the claim form submitted for prior authorization are identical so that there is an accurate copy in the beneficiary's treatment record.

The Medicaid Dental Program or its designee reviews the dental PA requests in an expedient manner. However, some requests are held over for additional consultation.

NOTE: All Adult Denture Program prior authorization requests require a minimum of two weeks to process.

Failure to receive the returned claim form and radiographs and/or a Prior Authorization Letter (see Appendix I) within three-week's time should alert the provider that the claim form might have been misdirected. In these instances, contact the Medicaid Dental Program or its designee. If the claim form is returned to the provider but the radiographs that were included with the claim are not returned, the provider must immediately contact the Medicaid Dental Program or its designee. All contacts must be documented in the beneficiary's record.

To amend or request reconsideration of a PA, the provider should submit a copy of the PA letter and copies of the original claim form and supporting documentation with a statement of what is requested. The services indicated on a single PA letter should match the services originally requested on a single page of the claim submitted for PA. Requests for additional treatment must be submitted as a new claim for which a new PA will be issued. For administrative changes only, e.g. provider number or beneficiary identification number corrections, date of service changes, etc., a copy of the PA letter with the requested changes noted, may be sufficient.

If the provider proceeds with treatment before receiving PA, the provider should consider that the request may not be authorized for services rendered. However, providers may provide and bill for services that do not require PA while awaiting PA of those services that do.

Prior authorization is not a guarantee of Medicaid eligibility. When a beneficiary loses Medicaid eligibility, any authorization of services becomes void.

All PA requests should be sent to the **LDH Medicaid Dental Program or its designee** (see Appendix J for contact information).

The checklist available in Appendix G is provided to help prevent errors frequently made when completing a Medicaid dental PA request. We recommend that you print this form and use when completing Medicaid dental PA requests.