PRIOR AUTHORIZATION

Requests for prior authorization (PA) are made on the ADA Dental Claim Form, the same claim form used for billing. Providers should complete this form for prior authorization following the instructions found within this chapter. When requesting prior authorization, two identical copies of the 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 dental consultants at the LSU School of Dentistry 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.

Providers should staple together all claim forms and radiographs for a single recipient.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the recipient record and provide that information to the PAU.

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

EPSDT Dental Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided in Appendix A. **The procedure codes for services requiring PA are marked with an asterisk** (*) and must be authorized by the dental consultants at the LSU School of Dentistry 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 dental consultants reviewing the case to fully understand the general dental health and condition of the recipient 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, please be certain it includes the date of the request, the recipient's name, the recipient'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 recipient's treatment record. Without the complete treatment plan, appropriate radiographs, or explanations it may not be possible for the consultant to approve isolated services.

Prior Authorization Requirements for Multiple Permanent Tooth Restorations

Providers must use their recipient records in order to determine if the second or subsequent restoration performed on the same recipient, same permanent tooth within 12 months from the date of the original restoration due to pulpal necrosis (root canal) or traumatic injury is eligible for reimbursement by Medicaid. This policy applies to the same billing provider or another Medicaid provider located in the same office as the billing provider.

If the requested code is eligible for reimbursement as a second or subsequent restoration due to pulpal necrosis (root canal) or traumatic injury for the same permanent tooth, a PA is required. The PA request must provide the following:

- An indication in the "Remarks" section of the ADA Dental Claim Form (Block 35) that this is the second or subsequent restoration in a 12-month period, same tooth (provide tooth number); and
- An indication in the "Remarks" section of the ADA Dental Claim Form (Block 35) as to whetherthe restoration is necessary due to pulpal necrosis (root canal) or traumatic injury; and
- Submit a copy of the entire treatment record.
  NOTE: The reason that the tooth requires a second or subsequent restoration must be well documented in the recipient's record; and
- Submit all pertinent radiographs that were taken. If radiographic copies are sent, they must be labeled right/left and be of good diagnostic quality.

Prior Authorization Reminders

All codes that are to be submitted for payment as a second or subsequent restoration in a 12-month period for the same recipient and same permanent tooth, requires PA including codes D2140 and D2330 which normally does not require PA. The PA number must be entered in the appropriate block on the claim for payment.

If the above-referenced guidelines are not followed when the PA request is submitted, the claim will receive a 515 denial and the provider will be responsible for resubmitting the required information to the Medicaid Dental PAU (see Appendix K for contact information) in order to have the claim reconsidered for payment.

If you have questions regarding this policy, you may contact the LSU Dental School, Medicaid Dental Prior Authorization Unit.

At the completion of the prior authorization 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 PAU. The FI will send a PA letter to the provider detailing the services that have been prior authorized. A prior authorization number will be furnished on the PA letter to allow the provider to bill for services as they are completed. The recipient also receives a copy of the PA letter. An example of a PA Letter can be found at the end of this section. The returned copy of the claim form and the PA letter must be filed in the recipient'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 prior authorization process, they must be returned to the dental consultants 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, the FI will send a PA letter 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 recipient also receives a copy of the PA letter and in the case of a denial, the explanation of denied benefits will advise recipients of their appeal rights. The returned copy of the claim form and the PA letter must be filed in the recipient'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 recipient's treatment record.

The dental consultants review the dental PA requests in an expedient manner. However, some requests are held over for additional consultation.

Failure to receive the returned claim form and radiographs and/or a Prior Authorization Letter within two weeks time should alert the provider that the claim form might have been misdirected. In these instances, please contact the dental consultants at the LSU School of Dentistry. 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 dental consultants at the LSU School of Dentistry. All contacts with the LSU School of Dentistry must be documented in the recipient'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 recipient 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 recipient Medicaid eligibility. When a recipient loses Medicaid eligibility, any authorization of services becomes void.

All dental PA requests should be sent to the **LSU School of Dentistry Medicaid Dental Prior Authorization Unit (PAU)** (see Appendix K for contact information).

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

NOTE: Claim forms for payment should be submitted to the FI (see Appendix K for contact information).