

FREQUENTLY ASKED QUESTIONS FOR DENTAL SERVICES

Q. When do dental providers need to start using the new Utilization Management Contractor (UMC) Prior Authorization forms?

A. The new forms are currently available and effective 4/1/11 **ONLY** the new forms will be accepted. The forms can be found at:

http://www.wvmi.org/corP/web_sites/links_wvmedicaid.aspx.

Q. What dental and orthodontic services now require prior authorization?

A. A list of the services requiring prior authorization can be found on the Bureau for Medical Services website at: <http://www.dhhr.wv.gov/bms/>

Q. Dental providers have spoken to BMS about the new requirement that crowns and other services now require prior authorization and have expressed concerns about young children who need this service at the time of examination (and while they are under anesthesia) and cannot wait for prior authorization. Is there a provision for these circumstances?

A. Yes, a provision has been made for these situations. The following retrospective review policy will apply in instances where the dental practitioner's judgment determines that providing service immediately and not awaiting prior authorization is medically necessary and appropriate:

- Retrospective review is available for Medicaid members in instances where it is in the dental practitioner's opinion that a procedure that requires prior authorization is medically necessary and per recommended dental practices delaying the procedure may subject the member to unnecessary or duplicative service if delivery of the service is delayed until prior authorization is granted. In these instances, a request for prior authorization **MUST** be made by the provider within 10 business days of the date the service is performed. If the procedure does **NOT** meet medical necessity criteria upon review by the Utilization Management Contractor (UMC) then the prior authorization request will be **DENIED** and the provider cannot be reimbursed for the service. Prior authorization is also available for medical necessity review before the service is provided.

Q. On the Orthodontic treatment prior authorization request form, there is not a place to put the treatment plan that is requested, how should this information be sent?

A. The treatment plan should be attached and faxed with the request. When the APS Healthcare, Inc. Direct Data Entry (DDE) system becomes available this document can be attached to the DDE request when it is submitted.

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Q. On all of the request forms, there is not a place for the provider's Medicaid ID number; it just has a place for their NPI. WVMI uses the Medicaid ID number, not the NPI, how should this be handled?

A. Until providers are notified to begin using their assigned NPI on UMC Request forms they are to continue to put their Medicaid ID Number in this field. There is sufficient space to accommodate this number.

Q. Several of the forms do not have a place for tooth number. Will these be updated? Also, how are requests for the same procedure on multiple teeth handled?

A. The tooth chart in the General Dentistry request should be utilized in all instances to indicate the tooth number(s) for requested procedures and should be submitted with the appropriate UMC form for the requested procedure. Duplicative information does not need to be completed on this form, when another form is applicable to the procedure for which the dental provider is requesting prior authorization. Multiple teeth can be indicated on the same form.

Q. On all request forms, there is not a place for the physician to sign and date. Are forms still required to be signed and dated?

A. Signature is required on the Treatment Plan/Plan of Care when it is requested/required as an attachment. UMC Request Forms do not require signature and with the advent of the DDE request system the provider will register and have a unique log-on and password which will identify them, their practice, and their assigned users.

Q. On all request forms, it asks for a Diagnosis/Current Dental Terminology (CDT) codes, what needs to be put here?

A. The upcoming DDE system has fields for BOTH Current Procedural Terminology (CPT) and CDT codes **AND** primary and secondary diagnosis. The CPT/CDT code is required and a primary diagnosis is now required per the updated manual.

Q. Frequency/Duration of Services, most procedures are done through one visit, how should this be completed?

A. If a procedure only requires a single visit, "1" should be the response in the frequency/duration field. If multiple visits are required to complete the requested service, then the number of visits should be noted in this field.

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