Prior Authorization Process for Dental Services

On behalf of Indiana Medicaid

Acentra HEALTH

Agenda

General Prior Authorization Requirements and Provider Responsibilities

Overview of IHCP Dental Covered Services and Required Documentation

Tips for Reducing Pends and Administrative Denials

Prior Authorization Review Process

Post Submission Actions for Authorization Revisions, Administrative Review and Peer to Peer

Conclusion and Q&A

General Prior Authorization Requirements

Submitting via Portal

Submitting requests through the portal is the preferred PA method

- The portal Case Wizard provides step-by-step guidance through the case submission process and prompts you if there are any issues.
- Communicate with clinical reviewers using case Notes.
- Allows you to have multiple accounts assigned under your login.

Submitting via Fax

- Prior Authorization Dental Request Form:
  - Member Identification number
  - Provider NPI both “Requesting” and “Rendering” (if different)
  - *CPT; HCPCS; along with dates of service (DOS)
  - Diagnosis code
  - Form must be signed
- Submit all relevant documentation at the time of submission

Submitting via Phone

- Provider must provide all the information from the Prior Authorization Dental Request Form. Then submit all relevant documentation either via portal, fax or mail.

*__Abbreviations__: Dates of service (DOS), National Provider Identifier (NPI), Current Procedural Terminology (CPT), Current Dental Terminology (CDT), Revenue code (REV), & Healthcare Common Procedure Coding System (HCPCS)

The dental form and instructions are found on the IHCP provider website: Medicaid: Providers: Provider References.

Provider Responsibilities

Submitting Timely Requests

A request is considered timely when the it is submitted prior to the start of services (unless submitted late due to retrospective Medicaid eligibility).

Prior Authorization Check List

- ✓ Verify the Member's eligibility with Indiana Medicaid FFS via the IHCP provider portal.
- ✓ Check the IHCP Fee Schedule prior to submission to ensure a prior authorization is required
- ✓ Complete all required forms and submit documentation with request for authorization.
- ✓ Ensure that the request is not a duplication of services.

Provider Responsibilities for Retrospective Review

Retrospective review occurs when the entire date span of the request is in the past, prior to the date of submission. This is considered under the following circumstances:

- Pending or retroactive member eligibility.
- Provider unaware that the member was eligible for services at the time services were rendered. A PA is granted in this situation only when certain conditions are met.

Retrospective Review Process

- Retrospective review requests will NOT be pended for additional information.
  - It is important that all information and documentation is provided at the time you are submitting the retrospective review request.

- When submitting a retrospective PA review request, always provide detailed information and documentation to explain why the retro request is required.

PRIOR AUTHORIZATION FOR

Dental Services

Dental Covered Services – IHCP

The following services are subject to prior authorization (PA) for medical necessity:

- Periodontal surgery
- Space maintenance for children under 3 years of age or if permanent teeth are missing
- Orthodontics
- Dentures (complete and partial)
- Repairs and relines of dentures (complete and partial)
- Frenectomy (buccal/labial or lingual frenectomy procedures) for members 1 year of age or older
- General anesthesia for members 21 years of age or older
- Intravenous (IV) sedation for members 21 years of age or older

Documentation Requirements

- Depending on the type of service requested, various supporting documents must be included with the PA request, such as a current treatment plan, progress notes and medical documentation.
  - Providers must clearly sign the treatment plan (or plan of care) that accompany the PA request. Electronic or stamped signatures are allowable. Signing providers must be within the scope of practice for their applicable licensure.
  - Certain types of supporting documentation must be included using the correct IHCP forms.
  - **All dental requests** must include the dental form filled out in its entirety. Orthodontic requests do not require Dental form but must have a treatment plan.

    INDIANA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Dentures

- CPT code: D5110- Maxillary Complete Denture
- CPT code: D5120- Mandible Complete Denture

- CPT code: D5211- Maxillary Resin Partial Denture
- CPT code: D5212- Mandible Resin Partial Denture

- CPT code: D5213- Maxillary Cast-Metal Partial Denture
- CPT code: D5214- Mandible Cast-Metal Partial Denture

- CPT code: D5225- Maxillary Flexible-Base Partial Denture
- CPT code: D5226- Mandible Flexible-Base Partial Denture

- CPT code: D5282- Maxillary Removable Unilateral Partial Denture-one piece case mental
- CPT code: D5283- Mandible Removable Unilateral Partial Denture-one piece case mental

Medical Necessity Documentation

Information should include but not limited to:

- Which teeth are missing and/or planned to be extracted
- Recent tooth loss or extractions
- Any information about bone or tissue changes due to shrinkage
- Weight loss
- Bone loss in the upper or lower jaw
- Recent sickness or disease
- Changes due to physiological aging
- How long the member is edentulous and unable to masticate properly (fewer than eight posterior teeth are in occlusion

Additional criteria and information can be found in the Dental Services reference module:
Dental Services

Orthodontics

The IHCP covers orthodontic procedures only for members 20 years old and younger and only for cases of craniofacial deformities, whether congenital or acquired. Prior authorization is required for all orthodontic services.

The IHCP reimburses for a maximum of two phases of orthodontic treatment**: one limited treatment** (D8010, D8020, D8030 or D8040) and **one comprehensive treatment** (D8070, D8080 or D8090).

Members meet the criteria for medical necessity for orthodontic care when it is part of a case involving treatment of craniofacial anomalies, malocclusion caused as the result of trauma, or a severe malocclusion or craniofacial disharmony.

Medical Necessity Documentation

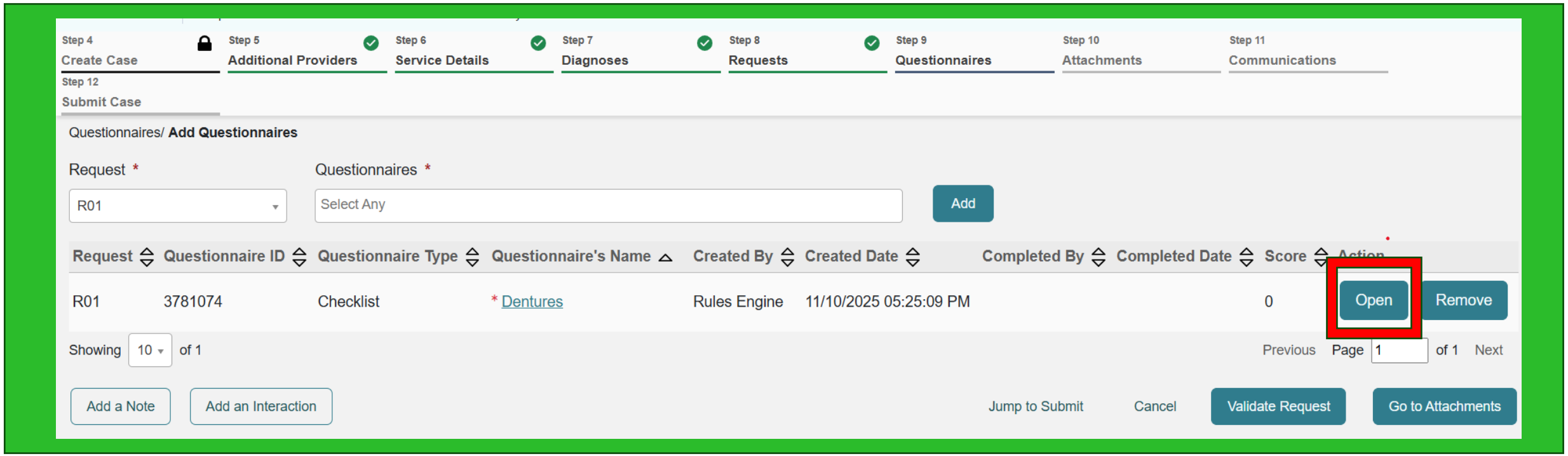
The member's diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions. Diagnostic records required to establish medical necessity include:

- Panoramic radiograph
- Cephalometric radiograph
- Intraoral and extraoral photos
- Members with malocclusions associated with a craniofacial anomaly must be diagnosed by a member of a craniofacial anomalies team recognized and endorsed by the American Cleft Palate-Craniofacial Association (ACPA), presumably an orthodontist, and treated by an orthodontist who may or may not be a member of a recognized craniofacial anomalies team.
- Members with malocclusions not associated with a craniofacial anomaly may be diagnosed and treated by any orthodontist, whether a member of a recognized craniofacial anomalies team or not. The treating provider is not required to be associated with a recognized craniofacial anomalies team.

Additional criteria and information can be found in the Dental Services reference module:
Dental Services

The Questionnaire Section

On the questionnaire section, the **Dentures** questionnaire will be populated. Click open to answer the questions.



Common Reasons for Denials and Voids

ADMINISTRATIVE DENIALS:

- Dental form or other necessary documentation not received with your PA request.

MEDICAL NECESSITY DENIALS:

- Exceeding the benefit limitation

COMMON REASONS FOR VOIDS:

- The request is a duplicate of another authorization submitted to Acentra Health.
- The requested service(s) does not require a Prior Authorization per IHCP Fee Schedule.
- Prior authorization incorrectly submitted to Acentra Health.
  - Member eligibility can be updated anytime, be sure to check on IHCP Provider Portal prior to submitting any PA request.

Tips to Reduce Pends and Denials

- Upload or provide all required documentation at the time of submission.
- Include all required forms (i.e. Dental form) and service specific documentation when submitting request.
- Verify:
  - All required forms are filled out completely and contain proper signatures as required.
  - The request has not been previously submitted.
  - The member is not receiving services from a different provider.
- Provide any missing documentation within 30 days of Acentra Health requesting additional information. (This does not apply to retrospective review requests).

Prior Authorization Review Process

After submission of a request, one of the following four (4) actions will occur:

1. **<u>Approval</u>**: Request met criteria either at nurse review level or medical director review.
   - ➢ PA requests, via portal, may be immediately approved through Rules Driven Authorization process if all criteria has been met.
2. **<u>Pended request for additional information</u>**: Information is requested for determination that was not included with the original submission.

Prior Authorization Review Process Cont.

3. **<u>Administrative Denial</u>**: Denial of services due to the following:
   - Untimely Request
   - Requested information not received

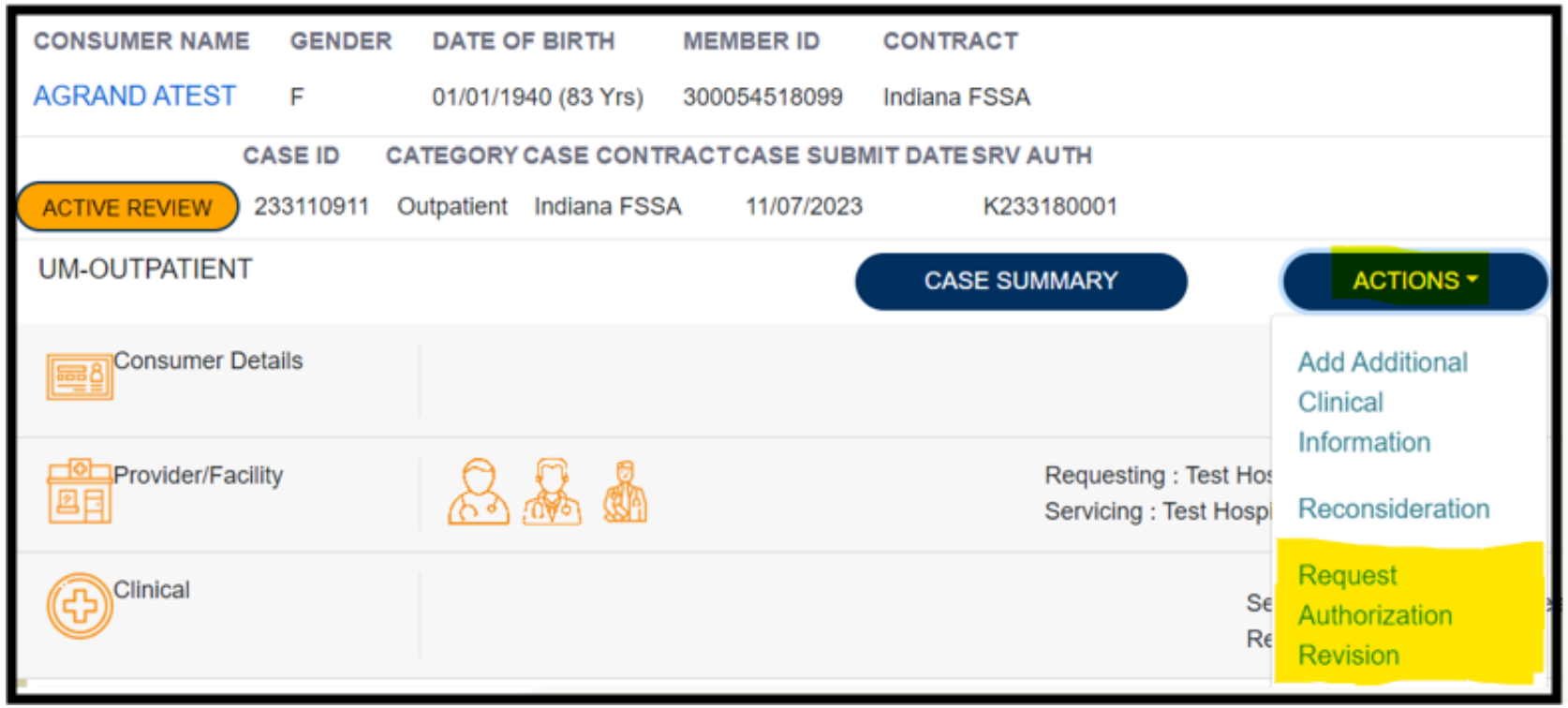
4. **<u>Medical Necessity Denial</u>**: Physician has determined that medical necessity has not been met. The Physician may partially approve or fully deny a request.

POST SUBMISSION

ACTIONS

Authorization Revision Requests

- If a date extension is required due to delay in treatment, you may request a date extension by requesting an Authorization Revision.



Assuming a PA From Another Provider

- Complete the **Authorization Revision Request form** and fax it to 800-261-2774 or call customer service at 866-725-9991 for assistance.

- Provide all relevant information including but not limited to:
  - Member information
  - Originating provider information
  - Authorization number
  - Procedures on the PA request
  - Date PA will be assumed

Administrative Review

- If an administrative denial or medical necessity denial is issued, the provider can request an Administrative Review (also known as Reconsideration). The provider MUST submit a request for administrative review to Acentra Health within ***7 business days plus 3 calendar days*** of the date provided on the initial adverse determination letter.

- To request an Administrative Review:
  - Click Actions button in the Atrezzo portal and select Administrative Review
  - Fax in a written request using the prior authorization revision request form

NOTE: It is important to reference the IHCP Prior Authorization reference module for details of what is required to initiate an administrative review: https://www.in.gov/medicaid/providers/files/modules/prior-authorization.pdf

Peer to Peer

- Providers may request a Peer to Peer on a medical necessity adverse determination. Requests for peer to peer must be completed within ***7 business days plus 3 calendar days*** of the date provided on the initial adverse determination letter.

- To request Peer to Peer Review:
  - Click the Actions button in the Atrezzo portal to select Peer to Peer. Enter the ordering provider's full name, phone number, and three dates and times of availability.
  - Call Customer Service at 866-725-9991
    - Once an agreeable date and time have been identified, a representative will contact (via telephone) the provider with the confirmed date and time. A note will also be placed in the case that is visible to the provider.

Provider Resources

- **Provider Education and Training materials:** (Videos, Handbooks, Quick Guides and FAQs) are located at https://inmedicaidffs.acentra.com/training-and-education/

- **Provider Communication and Support email:** INPriorAuthIssues@Acentra.com

  Provider registration issues. Prior Auth submission issues. Assistance with account.

- **Dedicated Customer Support Line:** Call (866) 725-9991, our Customer Service agents are available weekdays, from 8:00 a.m. to 5:00 p.m., EST.

  Request a clinical call back. Check case status. Reset Log In. Submit prior auth requests.

Conclusion and Q&A

Thank you for your time!

Provider Relations Assistance: INPriorAuthIssues@acentra.com

Provider Education Website: https://inmedicaidffs.acentra.com

Acentra Health Customer Service: Phone: 866-725-9991

Fax: 800-261-2774