OUTPATIENT HOSPITAL DENTAL SERVICES
FREQUENTLY ASKED QUESTIONS (FAQ)
November 2020

MISSISSIPPI DIVISION OF MEDICAID

DIVISION OF MISSISSIPPI MEDICAID

Is a prior authorization required for dental services done in an outpatient hospital setting?

Yes. The Division of Medicaid's policy requires an authorization for all dental services rendered in an outpatient hospital setting. Refer to Admin Code, Part 204 Dental Services Rule 1.11.

Who is responsible for obtaining the prior authorization?

The dentist must obtain the prior authorization prior to performing dental services in the outpatient hospital setting. Prior authorization can be obtained by contacting DOM's UM/QIO by visiting https://ms.allianthealth.org/ or via phone at 1-888-224-3067.

What documentation is required for outpatient dental authorization requests?

Effective October 1, 2020, dental providers must submit a dental scoring tool for dental services provided in an outpatient hospital setting or Ambulatory Surgical Center (ASC), for fee-for-service (FFS) Medicaid beneficiaries, when requesting a prior authorization (PA) from DOM's Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions.

The form is located on the Alliant Health Solutions - MS Prior Authorization Portal (https://ms.allianthealth.org) in the Help/Support Section under PA FORMS, and is listed as "Dental in OR and ASC." The completed form must be included with all prior authorizations to avoid a technical denial.

- The dental scoring tool can be accessed at the following link:
- https://ms.allianthealth.org/docs/help/Dental%20in%20OR%20and%20ASC.pdf

Should you have any questions regarding this form, please contact Alliant Health Solutions at 888-224-3067.

What must be done once the prior authorization is obtained?

The authorization must be shared with the hospital facility prior to the service being rendered. The dentist and hospital must include the treatment authorization number (TAN) on their claim submitted for reimbursement.

What happens if prior authorization is not obtained by the Dentist for services rendered in an outpatient hospital setting?

Failure to obtain prior authorization will result in denial of payment.

As a facility, can the Code on Dental Procedures and Nomenclature (CDT Code) be billed for dental services?

Yes. The authorization gives the hospital the ability to bill for the same CDT code(s) as the dentist for services rendered.

Are multiple units of a CDT code allowed to be billed by the hospital?

If the prior authorization is approved for multiple units of a specific CDT code, the hospital is allowed to bill multiple units. Each unit should be billed on a separate line, and multiple discounting will apply. Effective July 1, 2019, the highest allowed dental procedure is priced at 100% of the allowed or published fee, and each additional dental procedure code will be priced at 25% of the allowed or published fee.

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Envolve Dental

magnolia health

Is a prior authorization required for dental services done in an outpatient hospital setting?

Dental Services that qualify for treatment in a facility must receive prior authorization from Envolve Dental. Requested outpatient hospital and/or ambulatory surgical center settings must be participating in-network providers with Magnolia Health Plan.

Who is responsible for obtaining the prior authorization?

The dentist operator that will render the services at the outpatient hospital or ambulatory surgical center is responsible for obtaining prior authorization. To request authorization, the requesting dentist operator must include all the following:

- A completed Magnolia Health Outpatient Medicaid Prior Authorization Fax Form with detailed information about the facility;
- All requested dental procedure codes, including D9999 to request the use of an outpatient hospital or ambulatory surgical center facility; and,
- All required documentation listed in the Envolve Dental Clinical Policy – ENVD.UM.CP.0009 that supports medical necessity and meets the clinical criteria needed to evaluate the request for services. Clinical policy ENVD.UM.CP.0009 may be found on the Envolve Dental Provider Web Portal at https://pwp.envolvedental.com.

What must be done once the prior authorization is obtained?

- Upon approval of a prior authorization request, Envolve Dental will send an automated fax approval letter to the requesting dentist operator.
- Envolve Dental will fax the Magnolia Health Outpatient Form to Magnolia Health with the dental service authorization number.
- Magnolia Health will issue a facility/anesthesia authorization number and fax it to the approved hospital or surgical facility and the operator dentist who initiated the request.
- The requesting dentist operator calls the facility to schedule the services.

What happens if prior authorization is not obtained by the Dentist for services rendered in an outpatient hospital setting?

Failure to obtain prior authorization will result in denial of payment unless a qualifying urgent/emergent need is present. If a qualifying urgent/emergent need is present, post-service review will be allowed to not delay the member's care.

As a facility, can the Code on Dental Procedures and Nomenclature (CDT Code) be billed for dental services?

Yes, facilities may bill CDT codes for dental services provided in an Outpatient hospital setting. The highest allowed CDT code is reimbursed at 100%, and all other CDT codes are reimbursed at 25%. Ambulatory Surgical Centers (ASC) may not bill for CDT codes.

Are multiple units of a CDT code allowed to be billed by the hospital?

Yes, multiple units of a CDT code are allowed to be billed by the hospital if the prior authorization is approved for multiple units of a specific CDT code. When multiple units are submitted, the highest allowed D-code is reimbursed at 100%, and all other D-codes are reimbursed at 25%.

How does a Magnolia MississippiCAN dental service rendered in an outpatient hospital setting policy differ from DOM?

MississippiCAN dental services are rendered the same, whether provided in a private dental office setting or in an outpatient hospital/ambulatory surgical center setting. Services rendered in a dental office setting that involve intravenous sedation require the same criteria for prior authorization review that must be submitted for requesting services in an outpatient hospital or ambulatory surgical center. This includes submission of all supporting documentation (i.e. completed and signed Sedation Evaluation Tool for Dental Procedures) for medical necessity as required by the Envolve Dental Sedation Clinical Policy (ENVD.UM.CP.0009) located on the Envolve Dental Provider Web Portal at https://pwp.envolvedental.com. The Envolve Dental Sedation policy may be different from DOM's procedures.

For more information regarding Magnolia Envolve Dental policy please visit
https://dental.envolvehealth.com/

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Is a prior authorization required for dental services done in an outpatient hospital setting?

Yes, dental services done in an outpatient hospital or ambulatory surgical setting requires prior authorization.

Who is responsible for obtaining the prior authorization?

Dentists are responsible for obtaining prior authorization from **Avesis for Dental Treatment in an Outpatient Hospital or Ambulatory Surgical Center setting** by submitting a request using **ADA code D9999** with the required **Molina Mississippi Hospital Worksheet** and all services that are requested to be performed on the ADA Claim form.

1. Dentists can download the Molina Mississippi Hospital Worksheet
2. Prior Authorization request should be submitted on the Avesis Provider Portal. To gain access, contact your Avesis Provider relations Representative.

If **approved**, Avēsis is to submit the Molina Mississippi Hospital Worksheet to Molina, including the Avēsis dental approval to review and determine the approval of the Outpatient Hospital or Ambulatory Surgical Center facility.

1. Provider will notify the facility of approval.
2. The facility will request prior authorization for the rendering of sedation services by one of the following methods:
   - Access Molina Provider Portal at https://provider.molinahealthcare.com/, or
   - Download the Prior Authorization Form at:https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx
   - Choose PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE. Complete the prior authorization form and fax to 855-591-3566.
3. If denied, the provider and member have options listed for the appeals process on the notification received.

What must be done once the prior authorization is obtained?

The hospital facility must also request a prior authorization from Molina for the rendering of sedation services as this service is a medical benefit. The dentist and hospital must include the applicable treatment authorization number (TAN) on their claim submitted for reimbursement.

What happens if prior authorization is not obtained for services rendered in an outpatient hospital setting?

Failure to obtain prior authorization will result in denial of payment.

As a facility, can the Code on Dental Procedures and Nomenclature (CDT Code) be billed for dental services?

YES. Molina pays "D codes" in an outpatient setting. These are HCPCS level II codes that are usually submitted to dental payors on a dental claim form for professional reimbursement. In March of 2019 we started paying the facility for their portion of the "D code procedure" that would be due to the facility granted the dental physician obtained the appropriate authorization from Avesis and the in accordance with the dental physician's approved procedure the facility obtained the appropriate authorization from Molina. A "D code" is not a CPT code, Molina does reimburse the facility accordingly when the D code is approved to be performed in a Molina provider facility. Some facilities use the CPT code crosswalk to some D codes.

Are multiple units of a CDT code allowed to be billed by the hospital?

Yes. When dental services are performed in an outpatient hospital setting, the medical (Anesthesia) service is covered under the medical benefits, not dental. Molina requires an approval from Avesis that the dental procedure is necessary before Molina approves hospital anesthesia on the medical PA. Avesis pays the dental benefits and Molina pays medical. If a claim is submitted and Molina does not show that Avesis has approved dental procedure, Molina will deny the medical anesthesia claim. Avesis would pay claims billed with CDT codes. Molina claims will pay the CPT and CDT coded claims for the anesthesia and facility services. Molina uses the 100/25/25 percent reimbursement methodology when reimbursing outpatient facility claims that include approved multiple units of D codes.

How does a MississippiCAN dental service rendered in an outpatient hospital setting policy differ from DOM?

Molina follows *Admin Code, Part 204 Dental Services Rule 1.11* for dental services rendered in an outpatient hospital setting.

For more information regarding Molina Avesis Dental policy please visithttps://www.molinahealthcare.com/providers/ms/medicaid/home.aspx

United Healthcare Dental

UnitedHealthcare

How does a UnitedHealthcare MississippiCAN dental service rendered in an outpatient hospital setting policy differ from DOM?

For information specific to UnitedHealthcare MississippiCAN Dental Policy for services rendered in an outpatient hospital setting see below.

UnitedHealthcare https://www.uhcprovider.com/en/policies-protocols/dental-policies.html

How do I submit outpatient dental authorizations to UnitedHealthcare?
Prior authorization requests can be submitted on the Provider Web Portal or through regular mail.

- Provider Web Portal
  - uhcproviders.com
    - Select *Authorizations*
    - Select *Submit Authorizations*
- Regular Mail
  - UnitedHealthcare
    P.O. Box 1313
    Milwaukee, WI 53201

Will outpatient dental authorizations from UnitedHealthcare expire?

Approved authorizations are valid for 6 months.

What documentation is required by UnitedHealthcare for outpatient dental authorization requests?

- Criteria Scoring Form
  - To obtain the current version, please visit uhcprovider.com
    - Select *Policies and Protocols* at the bottom of the page
    - Under Additional Resources, select *Dental Clinical Policies and Coverage Guidelines*
    - Select *Dental Care Services in an Operating Room or Ambulatory Surgery Center–Dental Coverage Guideline*

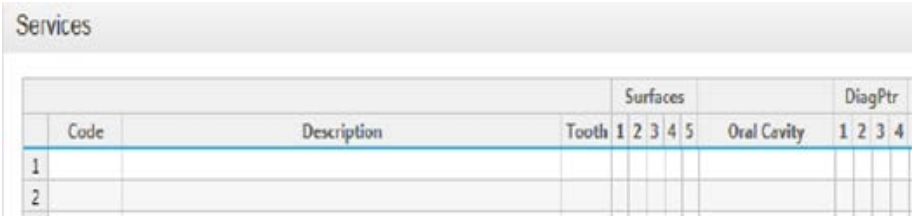
- Select *Dental Care Services in an Operating Room or Ambulatory Surgery Center: Criteria Scoring*
- Cases with fewer than **<u>24</u>** total points will be denied.
- All sections of the form must be completed. Missing information may result in a denied authorization.

- ADA Dental Claim Form
- Provider Narrative of the Planned Treatment
- Physician Letter/Consult
  - Only required if documenting 15 points on the Criteria Scoring Form for a medically compromising condition or behavioral health/disability/special needs condition (see screenshot below). This must originate from a licensed physician, not the requesting dentist.

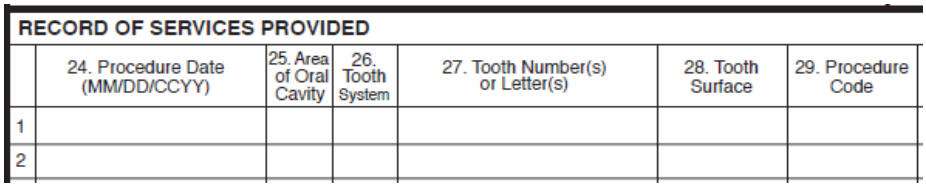
Co-Morbidities [2,3]	Points	Co-Morbidities
Medically compromising condition – documented by a physician	15	
Behavioral health/disability/special needs condition – documented by a physician	15	

How do I enter the planned services for UnitedHealthcare outpatient dental authorization requests?

- Code D9999 must be included for all outpatient dental authorization requests. Code D9999 is a "trigger code" that UnitedHealthcare uses to identify outpatient dental authorizations. D9999 must be approved for UnitedHealthcare to pay the associated claims. Note: Dental anesthesia codes are not necessary. Those services should be billed with the facility charges using the appropriate CPT/medical codes.
  - <u>Provider Web Portal Authorization Requests</u> **–** Type D9999 and all planned dental codes into the **Services** section on the Provider Web Portal (see screenshot below).



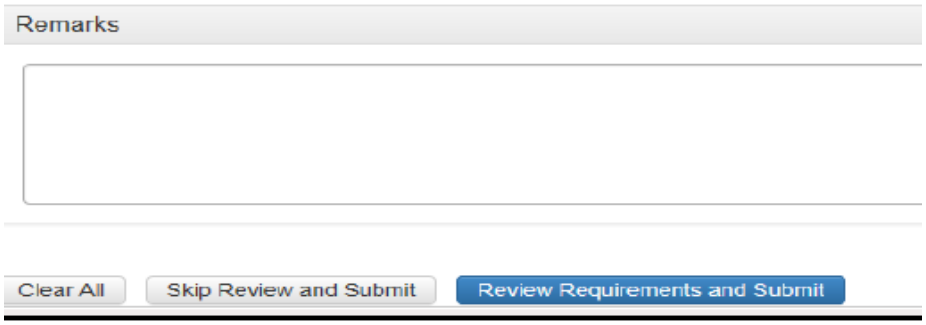
- Mailed Paper Authorization Requests – Enter D9999 and all planned dental codes into the **Record of Services Provider** section on an ADA Dental Claim Form (see screenshot below).



RECORD OF SERVICES PROVIDED						
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code
1						
2						

Where do I document the facility information on UnitedHealthcare outpatient dental authorization requests?

- The facility name and address must be documented as outlined below. This information is required for the facility to receive payment.
  - Provider Web Portal Authorization Requests – Type the facility name and address in the **Remarks** section on the Provider Web Portal (see screenshot below). This information must be entered in the Provider Web Portal, not in an attached document.



  - Mailed Paper Authorization Requests – Enter the facility name and address into box **35. Remarks** on an ADA Dental Claim Form (see screenshot below).