NEW YORK STATE
MEDICAID PROGRAM

DENTAL

PRIOR APPROVAL GUIDELINES

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Section I - Purpose Statement

The purpose of this document is to assist the provider community to understand and comply with the New York State Medicaid (NYS-Medicaid) requirements and expectations for:

- Obtaining Prior Approval
- Field by Field Instructions for Prior Approval Form (eMedNY 361402)

This document is customized for Dental providers and it should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II - Instructions for Obtaining Prior Approval

Electronic prior approval requests and responses can be submitted on the HIPAA 278 transaction. The Companion Guide for the HIPAA 278 is available on the eMedNY HIPAA Support section. Click on eMedNY Companion Guides and Sample Files. Access to the final determinations will be available thru eMedNY eXchange messages or by mail. To sign up for eXchange visit www.emedny.org.

Prior approval requests can also be requested via ePACES. ePACES is an internet-based program available to enrolled Medicaid providers. For information about enrolling in ePACES, contact eMedNY at (800) 343-9000. A reference number will be returned to your ePACES screen, which can be later used to check the approval status on ePACES. Visit www.emedny.org for more information.

Paper prior approval forms, with appropriate attachments, should be sent to:

eMedNY, PO Box 4600, Rensselaer, NY 12144-4600.

A supply of the new Prior Approval forms is available by contacting eMedNY at the number above.

Expedited / Priority Shipping:
eMedNY, 327 Columbia Turnpike, ATTN: Box 4600 Rensselaer, NY 12144

This section of the manual describes the preparation and submission of the New York State Medical Assistance (Title XIX) Program Prior Approval Request Form (eMedNY 361402). It is imperative that these procedures are used when completing the forms. Request forms that do not conform to these requirements will not be processed by eMedNY.

Services that require Prior Approval are indicated by a line under the respective Procedure Code in the New York State Procedure Code and Fee Schedule Section of this Manual.

Receipt of prior approval does NOT guarantee payment. Payment is subject to client's eligibility and other guidelines.

Requests for prior approval should be submitted, and a determination received, before services are rendered. However, sometimes unforeseen circumstances arise that delay the submission of the prior approval request until after the service is provided. If this occurs, the prior approval request must be received by the department within 90 days of the date of service, accompanied by an explanation of why the service was provided without prior approval.

A prior approval request will not be processed after 90 days from the date of service unless the provider's request is delayed due to circumstances outside of the control of the provider. Such circumstances include the following:

- Litigation
- Medicare/third party insurer processing delays

- Delay in the Client's Medicaid eligibility determination
- Administrative delay by the department or other State agency

The request must give a detailed explanation for the delay. Requests submitted without an explanation will be returned, without action, to the provider.

To reduce processing errors (and subsequent processing delays), please do not run-over writing or typing from one field (box) into another. The displayed sample Prior Approval Request Form is numbered in each field to correspond with the instructions for completing the request.

Prior Approval Form (eMedNY 361402)

NYS MEDICAL ASSISTANCE TITLE XIX PROGRAM
ORDER/PRIOR APPROVAL REQUEST DENTAL SERVICES

1 ORDER DATE	2 CLIENT ID
M M D D C C Y Y	

DO NOT STAPLE IN BARCODE AREA

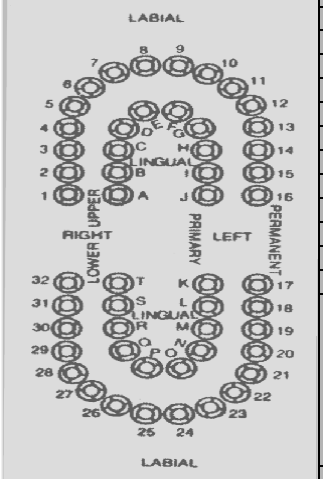
3 CLIENT NAME	4 CLIENT ADDRESS	5 CLIENT TELEPHONENUMBER	6 SEX	7 DATE OF BIRTH
			M I	M M D D C C Y Y

8 REFERRING PROVIDER NAME	9 REFERRING PROVIDER NUMBER	10 PROF CD	11 REFERRING PROVIDER ADDRESS/TELEPHONE

12 REQUESTING PROVIDER NAME	13 REQUESTING NUMBER	14 LOC CD	15 REQUESTING PROVIDER ADDRESS/TELEPHONE

16 SERVICING PROVIDER NAME	17 SERVICING PROVIDER NUMBER	18 PROF CD	19 SERVICING PROVIDER ADDRESS/TELEPHONE

20



Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. See charting system shown.

	21 PROCEDURE CODE	22 TOOTH NO. OR LETTER	23 SURFACE	24 DESCRIPTION	25 TIMES REQ.	26 AMT. REQ.
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

27 ARE X-RAYS INCLUDED? ☐ YES ☐ NO ☐ F.M.S. ☐ PANOREX

BITEWINGS How many? _____

PERIAPICALS How many? _____

28 If Prosthesis is this initial placement? ☐ YES ☐ NO

If no, enter date of prior placement M M / D D / C C Y Y

29 REMARKS FOR UNUSUAL SERVICES

	30 PROCEDURE CODE	31 MOD	32 DENT SITE	33 TIMES REQ.	34 TOTAL AMOUNT REQUESTED		PROCEDURE CODE	MOD	DENT SITE	TIMES REQ.	TOTAL AMOUNT REQUESTED		PROCEDURE CODE	MOD	DENT SITE	TIMES REQ.	TOTAL AMOUNT REQUESTED
1						13						25					
2						14						26					
3						15						27					
4						16						28					
5						17						29					
6						18						30					
7						19						31					
8						20						32					
9						21						33					
10						22						34					
11						23						35					
12						24						36					

35 PA REVIEW OFFICE CODE

☐ ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

Section III - Field by Field (eMedNY 361402) Instructions

ORDER DATE (Field 1)

Indicate the month, day and year on which the request is submitted.

Example: October 7, 2005 = 10072005

ORDER DATE							
1	0	0	7	2	0	0	5

CLIENT ID (Field 2)

Enter the Client's eight-character alphanumeric Welfare Management System (WMS) ID number.

Example:

CLIENT ID NUMBER							
A	A	1	2	3	4	5	W

Note: WMS ID numbers are composed of eight characters. The first two are alpha, the next five are numeric and the last is an alpha.

CLIENT NAME (Field 3)

Enter the last name followed by the first name of the client as it appears on the Medicaid ID Card.

CLIENT ADDRESS (Field 4)

Enter client's address including name of facility, where appropriate.

CLIENT TELEPHONE NUMBER (Field 5)

Enter client's telephone number, including the Area Code.

SEX (Field 6)

Place an X on M for Male or F for Female to indicate the client’s gender.

DATE OF BIRTH (Field 7)

Indicate the month, day and year of the Client's birth.

Example: April 5, 1940 = 04051940

DATE OF BIRTH
0 | 4 | 0 | 5 | 1 | 9 | 4 | 0

REFERRING PROVIDER NAME (Field 8)

If the Client was referred by another Provider, enter the referring Provider's name in this field. Otherwise, leave blank.

REFERRING PROVIDER NUMBER (Field 9)

If the Client was referred by another Provider, enter the referring Provider's Number.

PROF CD (Field 10)

Leave this field blank.

REFERRING PROVIDER ADDRESS/TELEPHONE (Field 11)

If a Referring Provider number is indicated in Field 9, indicate the referring provider’s address and telephone number in this field.

REQUESTING PROVIDER NAME (Field 12)

Enter the name of the individual provider or group who is requesting Prior Approval. Fill in first name, last name and degree.

Example: John Smith, D.D.S.

For a group, enter the name of the group in this field and the name of the practitioner rendering services in the “Servicing Provider Name” area (field 16).

REQUESTING NUMBER (Field 13)

Enter the Provider number of the individual provider or group who is requesting Prior Approval. For a group, enter the Provider number of the group in this field and the Provider number of the practitioner rendering services in the “Servicing Provider Number” area (field 17).

Note: A license number must not be entered in this field

LOC CD (Field 14)

Enter the Requesting Provider's 3-digit location code (example 003). This could be the service location where the client will be treated, but **MUST** be the location where the prior approval roster will be sent. If this is not completed, the default is the correspondence address on file for the Provider.

REQUESTING PROVIDER ADDRESS/TELEPHONE (Field 15)

Enter the full mailing address and telephone number, including zip code and area code, of the Requesting Provider, and where correspondence related to this request will be sent.

For a group, enter the address and telephone number of the group in this field and the address and telephone number of the practitioner rendering services in the "Servicing Provider Address/Telephone" area (field 19).

SERVICING PROVIDER NAME (Field 16)

For a group, enter the name of the provider that will actually be rendering services. Otherwise, leave blank.

SERVICING PROVIDER NUMBER (Field 17)

For a group, enter the Provider number of the provider that will actually be rendering services. Otherwise, leave blank.

Note: A license number must not be entered in this field.

PROF CD (Field 18)

Leave this field blank.

SERVICING PROVIDER ADDRESS/TELEPHONE (Field 19)

For a group, enter the address and telephone number of the provider that will actually be rendering services. Otherwise, leave blank.

TOOTH DIAGRAM (Field 20)

To be used to describe **PRESENT** oral conditions. Identify missing teeth with an X. Crowns are indicated by circling the correct tooth or teeth. Restorations are shown by shading in the correct surfaces of any teeth affected.

PROCEDURE CODE (Field 21)

Enter in this field the procedure codes(s) from the Dental Procedure Codes and Fee Schedule which **DO NOT REQUIRE PRIOR APPROVAL**, but relate to the overall treatment plan. Please be concise, but be sure to provide a COMPLETE TREATMENT PLAN for all procedures not requiring prior approval.

TOOTH NO. OR LETTER (Field 22)

For procedures requiring a tooth number: use the tooth-numbering system specified on the tooth diagram of the Prior Approval request form to identify the tooth number or letter to which each procedure code applies.

For procedures requiring a quadrant identification: use the two-letter designations 10 = Upper Right; 20 = Upper Left; 30 = Lower Left; 40 = Lower Right.

For procedures requiring an arch identification: use 01 = Upper; 02 = Lower.

SURFACE (Field 23)

For those procedures where tooth surface designation is applicable, indicate within this field each surface (M, I/O, D, F/B, L) to which the procedure will apply.

DESCRIPTION (Field 24)

Enter the description of the service requested. This description should be the same as found in the Procedure Code Section of this Manual as it relates to the appropriate procedure code.

For multiple extractions not requiring prior approval:
List each of the applicable procedure code(s) for the extraction(s) only once per request.

Enter the appropriate tooth numbers in the DESCRIPTION field to indicate that the procedure code will apply to more than one tooth.

Attempt to confine all numbers to one line of the DESCRIPTION.

When it is necessary to use more than one line to list all tooth numbers, DO NOT repeat the procedure code, times requested, and amount requested on the subsequent lines. DO NOT let tooth numbers run over from the DESCRIPTION into the TIMES REQUESTED column.

Example of correct listings of extractions:

	Procedure Code	Teeth No.or Letter	Surface	Description	Times Req.	Amount Requested
	D7140			Routine Extraction #6, 7, 8, 9, 10, 11,	10	450.00
				22, 23, 26, 27		

TIMES REQ. (Field 25)

Indicate with two digits the number of times the requested procedure is to be performed as part of this treatment plan (e.g., one occurrence = 01).

AMOUNT REQ. (Field 26)

Enter the total dollar amount requested for the specific procedure. The dollar amount should be sufficient to cover the total units requested.

ARE X-RAYS INCLUDED? (Field 27)

Check the box that indicates whether or not x-rays in support of the prior approval request are included. Also, indicate the type and, if appropriate, the number of x-rays included.

PROSTHESIS (Field 28)

Complete this field for any Client who requires a dental prosthesis. When the requested information does not apply, leave blank.

If a replacement for an existing prosthesis is being requested, enter the month, day and year the current prosthesis was placed, e.g., 01/15/1992. If the exact date of placement is not known, enter as much information as you have available. Describe the condition of the current prosthesis and document why it needs to be replaced in the “Remarks for Unusual Services” or on a separate sheet of paper.

REMARK FOR UNUSUAL SERVICES (Field 29)

Enter any prosthetic comments or other extenuating circumstances in support of the treatment plan in this area or on a separate sheet of paper. If there are separate attachments, indicate the type and number in this area.

PROCEDURES THAT REQUIRE PRIOR APPROVAL SECTION (Lines 1 – 36)

This section is used to indicate ALL procedure codes related to the treatment plan that require prior approval. Enter the procedure code, the site information (if appropriate), the times requested and amount requested. Each procedure must be listed separately.

ONLY PROCEDURES REQUIRING PRIOR APPROVAL SHOULD BE ENTERED IN THIS SECTION. Procedures that DO NOT require prior approval, but are part of the overall treatment plan should be entered in the "Examination and Treatment Plan" Section.

Up to 36 procedures can be accommodated on one prior approval request. If more than 36 procedures codes requiring prior approval need to be listed, attach additional prior approval requests with the Client's and Requesting Provider's information filled out and a notation in the "Remarks for Unusual Services" indicating the number and type of additional attachments.

Only those procedure codes entered in this section will be reviewed. If no procedure codes are entered, or none of the procedure codes listed requires prior approval, the request will automatically be rejected.

PROCEDURE CODE (Field 30)

Enter in this field the procedure codes(s) from the Dental Procedure Codes and Fee Schedule which REQUIRE PRIOR APPROVAL. Procedure codes requiring prior approval are indicated by a line below the procedure code (e.g.: **D1234**).

MOD (Field 31)

Used to indicate HIPAA "modifiers". Leave blank

DENT SITE (Field 32)

Enter the dental site information (tooth, quadrant, arch, etc.) associated with that procedure code, if applicable. Required site information is indicated in parenthesis following the procedure description in Dental Procedure Codes and Fee Schedule section.

TIME REQ (Field 33)

Indicate with ONE digit the number of times the requested procedure is to be performed.

TOTAL AMOUNT REQUESTED (Field 34)

Enter the total dollar amount requested for the specific procedure. The dollar amount should be sufficient to cover the total units requested and should be the "usual and customary" fee for the procedure.

PA REVIEW OFFICE CODE (Field 35)

Enter the appropriate code to ensure that the prior approval request is routed to the appropriate Business Location for review. This field is critical when a non-scannable attachment, such as x-rays or photographs, is submitted.

Enter code ‘A1’ for all dental prior approval requests.

For orthodontia, enter code ‘A1’ for all counties except New York City.