MEDICAL SERVICES ADMINISTRATION

# Bulletin

**Distribution:** Dental 03-02

**Issued:** September 1, 2003

**Subject:** Chapter IV (Prior Authorization, Billing and Reimbursement)

**Effective:** October 1, 2003

**Programs Affected:** Medicaid, Children's Special Health Care Services (CSHCS)

This bulletin transmits the revised Chapter IV (Prior Authorization, Billing and Reimbursement for Dental Providers). As a part of the chapter revision process, previously issued policy bulletins have been incorporated. Rewording and clarification of existing policy and policy changes have been incorporated which reflect issues raised and clarifications requested by the provider community and within the Department of Community Health (DCH).

The attached Chapter IV is effective for dates of service on and after 10/01/2003. The revisions to this chapter allow for HIPAA compliance and further refine the uniform billing project goal of consistency of billing requirements between Medicaid and other payers.

In reviewing this chapter, please note the following:

- The Remittance Advice is updated and changes made for HIPAA compliance. The RA changes include the elimination of the tooth surface and number columns, the elimination of the source status codes, elimination of the proprietary edit codes and the conversion to the national Reason and Remark codes.

- Payments due to all providers enrolled with the MDCH under a specific TIN are consolidated and issued as one check or EFT.

The Department is in the process of redesigning it's provider manuals with the goal of producing a single all provider manual. As this process takes place, information may be shifted to different sections or chapters. As you review the chapter, pay particular attention to any topics you feel may be missing. We will verify that the information has been relocated to another part of the manual that will be distributed to you at a later date.

**Manual Maintenance**

Replace the current Chapter IV, Prior Authorization and Billing with the attached Chapter IV, Prior Authorization, Billing and Reimbursement.

Dental 00-03 is obsolete and should be discarded.

This bulletin may be discarded when manual maintenance is completed.

**Questions**

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov . When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

**Approval**

Paul Reinhart, Director
Medical Services Administration

# CHAPTER IV – BILLING & REIMBURSEMENT FOR DENTAL PROVIDERS

## TABLE OF CONTENTS

## SECTION 1 – GENERAL INFORMATION/BILLING

This chapter contains information needed to submit dental claims to the Michigan Department of Community Health (MDCH) for Medicaid and Children's Special Health Care Services (CSHCS). It also contains information about how claims are processed and how providers are notified of MDCH actions.

Dental providers must use the ASC X12N 837D 4010 A1 dental format when submitting electronic claims and the ADA 2000 claim form for paper claims.

### 1.1 CLAIMS PROCESSING SYSTEM

All claims submitted and accepted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through the CP system are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and combination of service edits. Electronic claims received by Wednesday may be processed as early as the next weekly cycle.

MDCH encourages providers to send claims electronically by file transfer or through the data exchange gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated.

### 1.2 REMITTANCE ADVICE

After claims have been submitted and processed through the CP System, a paper remittance advice (RA) is sent to each provider with adjudicated or pended claims. An electronic health care claim payment/advice (ASC X12N 835 4010A1) is sent to the designated primary service bureau for providers choosing an electronic RA. (Refer to the Remittance Advice Section of this chapter for additional information.)

### 1.3 ADDITIONAL RESOURCE MATERIAL

Additional information needed to bill may include:

| | |
|---|---|
| **Bulletins** | These intermittent publications provide updated policy information that supplements provider manuals. Bulletins are automatically mailed to enrolled providers affected by the bulletin and to subscribers of the manual(s). Recent bulletins can be found on the MDCH website. (Refer to Directory Appendix for contact information.) |
| **CDT-4 Codes** | Providers must purchase this manual from the American Dental Association. For ordering information and catalog, contact the ADA. (Refer to the Directory Appendix for contact information.) |
| **Companion Guide (Data Clarification Document)** | This document is intended as a companion to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim, ASC X12N 837D 4010A1. It contains data clarifications authorized by the Department of Health and Human Services and includes identifiers to use when a national standard has not been adopted and parameters in the implementation guide that provide options. |

| | |
|---|---|
| **Electronic Submission Manual** | This manual provides detailed instructions on obtaining approval for electronic billing and how to file electronic claims to MDCH. It is available on the MDCH website. (Refer to the Directory Appendix for contact information.) |
| **Medicaid Databases** | These list procedure codes, descriptions, fee screens, and other pertinent coverage, documentation, and billing indicators. The databases are only available on the MDCH website. (Refer to Directory Appendix for contact information.) |
| **Numbered Letters** | General program information or announcements are transmitted to providers via numbered letters. These can be found on the MDCH website. (Refer to Directory Appendix for contact information.) |
| **Provider Manuals** | These manuals include program policy and special billing information. Provider manuals and other program publications are available at a nominal cost from MDCH. (Refer to the Directory Appendix for information on ordering manuals and publications.) |

## SECTION 2 – GENERAL INFORMATION/PRIOR AUTHORIZATION (PA)

The Dental Prior Approval Authorization Request (MSA-1680-B) is a form designed to obtain authorization for those services that require PA, as indicated in the Dental Coverages and Limitations Chapter and the Dental Procedure Codes Appendix.

The dentist must remember the following:

- X-rays and/or the completed periodontal chart must be sent along with the PA form.
- The PA form only needs to include the procedure that requires PA.
- Assess the general oral health and provide a five-year prognosis on the prosthesis requested.
- The dentist should make liberal use of the Pertinent Dental History and Medical area on the request to better define symptomatology, treatment situations, etc. when the services requested or the accompanying documentation may leave unresolved questions. When health problems exist, they should be identified on the request along with any effect they might have upon the proposed plan of treatment.
- Any additional documentation submitted with the request must contain the beneficiary's name and identification (ID) number, date, and the dentist's name and ID number.

Additional information is generally required to be submitted with or indicated on the PA form. This is to enable staff to make an accurate determination regarding the proposed plan of treatment. The following list indicates those procedures by description and procedure code, and the additional information that is required.

### 2.1 PROCEDURE CODE REQUIRED INFORMATION

| | | |
|---|---|---|
| **Prosthodontics, Removable** | D5110-D5140 | Complete radiographic survey of mouth (teeth and edentulous areas). |
| | D5211-D5214 | Complete radiographic survey of mouth (teeth and edentulous areas). |
| | D5810-D5821 | Radiographs of mouth, justification, and explanation of proposed future treatment. |
| **Prosthodontics, Fixed** | D6210-D6245 | Radiographs of mouth. |
| | D6740-D6792 | Radiographs of mouth. |

## SECTION 3 – HOW TO FILE CLAIMS

Professional claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDCH.

### 3.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into the Claims Processing System, which results in faster payments and fewer claims that pend or reject. Claims can be submitted by file transfer or through the Data Exchange Gateway (DEG). Providers submitting claims electronically must use the ASC X12N 837D 4010 A1 dental format.

Complete information on submission of electronic claims is available on the MDCH website. (Refer to the Directory Appendix for contact information.) The MDCH Electronic Submission Manual and other resources such as Companion Guides (Data Clarification Documents) are on the website and are essential to successful electronic submissions. Information on the website is updated as version changes occur at the national level and the Department adopts those changes.

#### 3.1.A. AUTHORIZED BILLING AGENTS

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDCH must be an authorized billing agent. The authorization process is:

- Contact the MDCH Automated Billing Unit for an application packet (Refer to the Directory Appendix for contact information.);
- Complete and submit the forms in the application packet (an application and a participation agreement);
- Receive an ID number;
- Format and submit test files; and
- When test files are approved, providers receive authorization from MDCH to bill electronically.

When authorized as an electronic billing agent, any provider (including yourself) who wants claims submitted on their behalf must complete and submit the Billing Agent Authorization (MDCH-1343) form to MDCH. (Refer to the Directory Appendix for contact information.) This form certifies that all services the provider has rendered are in compliance with Medicaid guidelines. MDCH notifies each provider when the MDCH-1343 has been processed. After notification, approved billing agents can bill electronically for themselves or for other providers that have completed the MDCH-1343 indicating that the billing agent may bill on their behalf. More than one billing agent per provider can be authorized to submit the provider's claims electronically. Only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ANSI X12N 835 4010A1. Authorizations remain in effect unless otherwise indicated in writing by the provider.

Complete details for the electronic billing agent authorization process, test file specifications, electronic billing information and the transaction set for dental claims can be found in the Electronic Submitters Manual on the MDCH website. (Refer to the

Directory Appendix for contact information.) Any production claims for services rendered must be billed on paper until the authorization process is complete.

*Test claims are not processed for payment!*

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDCH. Billing agents prepare claims received from their clients, format to HIPAA compliant MDCH standards, and submit the files to MDCH for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice that reflects their individual claims. Billing agents will receive a remittance advice that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

### 3.1.B. Filing Claims with Comments, Additional Information or Attachments

If comments or additional information is required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report or other paper attachment is required and an electronic claim is submitted, refer to the Electronic Submission Manual for instructions for submitting paper attachments for electronic claims.

## 3.2 Paper Claims

The ADA Version 2000 claim form must be used when submitting paper claim forms. The MDCH Optical Character Reader (OCR) scans paper claims.

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned, print or alignment problems may cause misreads, thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops;
- Light print or print of different density;
- Breaks or gaps in characters;
- Ink blotches or smears in print;
- Worn-out ribbons.

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and/or problems with the compatibility of your equipment with MDCH scanners should be directed to the OCR Coordinator. (Refer to the Directory Appendix for contact information.)

### 3.2.A. Guidelines to Complete Paper Claim Forms

To assure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to do so can result in processing/payment delays or claims being returned unprocessed.

- Dates must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 10012003). Be sure the dates are within the appropriate boxes on the form.
- Use only black ink. Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- Upper case alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. DO NOT squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use White-Out or correction tape, including self-correcting typewriters.
- If a mistake is made, start over and prepare a "clean" claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat in 9" x 12" or larger envelopes. Do not fold the form.
- Put your return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely.
- Keep the file copy for your records.
- Mail Dental claim forms separately from any other claim type.

### 3.2.B. Providing Attachments with Paper Claims

When a claim attachment(s) is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID Number. Attachments must be on 8 ½ x 11" white paper and one -sided. Do not submit two-sided materials. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail unfolded claim forms with attachments in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required. Unnecessary attachments delay the processing of claims.

### 3.2.C. MAILING PAPER CLAIMS

All paper claim forms and claim forms with attachments must be mailed to MDCH. (Refer to the Directory Appendix for contact information.)

## SECTION 4 – ADA COMPLETION INSTRUCTIONS

### 4.1 DENTAL CLAIM FORM – ADA

**Dental Claim Form**

©American Dental Association, 1999 version 2000

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services — Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

**PATIENT**

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

**SUBSCRIBER / EMPLOYEE**

19. Subs./Emp. ID#/SS#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY)
29. Marital Status ☐Married ☐Single ☐Other
30. Sex ☐M ☐F

**OTHER POLICIES**

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY)
35. Sex ☐M ☐F
36. Plan/Program Name
37. Employer/School Name Address

38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)

40. Employer/School Name Address

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date (MM/DD/YYYY)

**BILLING DENTIST**

42. Name of Billing Dentist or Dental Entity
43. Phone Number ( )
44. Provider ID #
45. Dentist Soc. Sec. or T.I.N.
46. Address
47. Dentist License #
48. First visit date of current series
49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City
51. State
52. Zip Code
53. Radiographs or models enclosed? ☐Yes, How many? ☐No
54. Is treatment for orthodontics? ☐Yes ☐No — If service already commenced: Date appliances placed; Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither — Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

| Date (MM/DD/YYYY) | Tooth | Surface | Diagnosis Index # | Procedure Code | Qty | Description | Fee |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |
| | | | | | | | |

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Primary: A B C D E | F G H I J | T S R Q P | O N M L K

| | |
|---|---|
| Total Fee | |
| Payment by other plan | |
| Max. Allowable | |
| Deductible | |
| Carrier % | |
| Carrier pays | |
| Patient pays | |

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

©American Dental Association, 1999
J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746

### 4.2 DENTAL CLAIM FORM COMPLETION INSTRUCTIONS

The following boxes must be completed on the ADA Version 2000 claim form unless otherwise indicated.

If no instruction is given, the boxes are optional and you do not have to enter any information.

| | | |
|---|---|---|
| **1** | **Dentist's Statement of Actual Services** | Mark the box titled Dentist's statement of actual services. PA requests must continue to be submitted on the MSA-1680-B form. This is a mandatory field. |
| **2** | **Medicaid Claim and Prior Authorization (PA) Number** | Mark the box titled Medicaid Claim. If a Box requires PA, you must list the PA Number in the area provided. This is a mandatory field. |
| **3-7** | **For Provider's Use Only** | |
| **8-18** | **Patient/Beneficiary Information Section** | |
| **8-16** | **Patient Information** | Fill in the boxes with the patient/beneficiary information. Providers must enter Beneficiary Name in Box 8 and the Date of Birth in Box 12. Date of Birth must be an eight-figure configuration, e.g., 03152000. Box 13 is used by the dental office to identify beneficiary/patient and is the Provider Reference Number. Boxes 8 and 12 are mandatory. The other boxes are optional. |
| **17** | **Relationship to Subscriber/ Employee** | |
| **18** | **Employer/School** | |
| **19-41** | **Subscriber Information Section** | |
| **19** | **Subs/Emp. ID#/SSN** | Providers must enter the eight-digit Medicaid Beneficiary ID number of the patient identified in Box 8. Do not use the beneficiary's SSN. This is a mandatory field. |
| **20-21** | **Employer Name and Group Number** | |
| **22-30** | **Subscriber Information** | |
| **31** | **Is Patient Covered by Another Plan?** | This is necessary to determine Coordination of Benefits. This is a mandatory field. |
| **32** | **Policy Number** | Required when applicable. If "YES" in Box 31, fill in boxes 32-37. If "NO", skip boxes 32-37. |
| **33-37** | **Other Subscriber's Information** | |
| **38** | **Subscriber/ Employer Status** | |

| | | |
|---|---|---|
| **39-41** | **Patient and Employee Signatures Block** | |
| **42-57** | **Billing Dentist Section** | |
| **42** | **Name of Billing Dentist of Dental Entity** | Include the individual dentist's name for billing. This is a mandatory field. |
| **43** | **Phone Number** | |
| **44** | **Provider ID Number** | This is the unique provider type and provider number assigned by the Medicaid program for identification. This is a 9-digit field; the first two are the provider type and the last seven are the unique provider ID #. A space may be included between the provider type and ID number. For example, 12 7654321. This is a mandatory field. |
| **45** | **Dentist Soc. Sec. or TIN** | |
| **46, 50-52** | **Address, City, State, Zip Code** | |
| **47** | **Dentist License Number** | |
| **48** | **First Visit Date Current Series** | |
| **49** | **Place of Treatment** | |
| **53** | **Radiographs or Models Enclosed?** | |
| **54** | **Is Treatment for Orthodontics?** | |
| **55** | **Is Prosthesis for a Crown, Bridge or Denture, and is this Initial Placement?** | |
| **56** | **Is Treatment Result of Occupational Illness or Injury?** | |
| **57** | **Is Treatment Result of Auto Accident?** | Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for Coordination Of Benefits (COB). This is a mandatory field. |
| **58-61** | **Procedure Code and Claim Information Section** | |
| **58** | **Diagnosis Code** | |

<table>
<tr><td>59</td><td>Examination and Treatment Plans</td><td>Use the appropriate procedure codes. List the date, tooth, surface, procedure code, quantity, description and fee. Mandatory fields to be completed are date, tooth, surface, procedure code, quantity and fee.<br><br>Where applicable, the dentist must enter the appropriate code(s) indicating the tooth surface(s) being treated.<br><br><table><tr><td>B = Buccal</td><td>L = Lingual</td></tr><tr><td>D = Distal</td><td>M = Mesial</td></tr><tr><td>F = Facial</td><td>O = Occlusal</td></tr><tr><td>I = Incisal</td><td></td></tr></table><br>Payment Information<br><br>Each separate claim submitted must have the Total Fee box filled out even if there are multiple claims for a beneficiary.<br><br>▪ Do not put remarks in the Total Fee box, such as “See next page”, then total all of the claims and put the entire fee on the last claim. Each claim is scanned and reimbursed separately.<br><br>▪ The Total Fee box must include the total of all eight claim lines. This is a mandatory field.<br><br>▪ Do not include dollar signs ($), decimals (.), dashes (-) or spaces in the fee amount field. For example, if a procedure is $50, then the payment information should be entered as 5000.<br><br>▪ The Payment by other plan box must include the payment received by another third-party carrier, when applicable.<br><br>▪ The Maximum Allowable box should be left blank.<br><br>▪ The Deductible Box is used to submit the amount not paid by another third-party carrier when applicable. The amount should reflect the difference between the total fees and payment received from the other carrier. The program reimburses up to the programs fee screens.<br><br>▪ The boxes, Carrier %, Carrier pays and Patient pays should be left blank.</td></tr>
<tr><td>60</td><td>Identify All Missing Teeth</td><td></td></tr>
<tr><td>61</td><td>Remarks for Unusual Services</td><td>Use to indicate any information that may be helpful in determining the benefits for the treatment. Required when applicable, if the procedure performed requires documentation to be sent with claim.</td></tr>
<tr><td>62-66</td><td colspan="2">Signature Block Section</td></tr>
<tr><td>62</td><td>Signature</td><td>A signature is required. See the General Information for Providers Chapter of this manual for the provider certification requirements and acceptable signatures for the claim form.</td></tr>
<tr><td>63-66</td><td>Address</td><td>Enter address where treatment was performed.</td></tr>
</table>

## SECTION 5 – REPLACEMENT CLAIMS

### 5.1 GENERAL INFORMATION

Replacement claims (adjustments) must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDCH made payment. Reasons claims may need to be replaced include, but are not limited to:

- Return an overpayment;
- Correct information (except an incorrect provider ID number or an incorrect beneficiary ID number) submitted on the original claim;
- Report payment from another source after MDCH paid the claim; or
- Correct information (except a provider ID number or a beneficiary ID Number) that the scanner misread.

A replacement claim corrects the records on MDCH computer files and helps ensure that future claims you submit for a patient are processed correctly.

### 5.2 TO REPLACE A CLAIM MANUALLY

Providers must demonstrate the discrepancy on the RA by marking out the incorrect line and writing the correct information on the RA, using black ink. The corrected invoice and a copy of the original invoice should be submitted to the Miscellaneous Transactions Unit. (Refer to the Directory Appendix for contact information.)

Replacement claims are generated and submitted based on the information noted on the RA.

### 5.3 PAYMENT REFUNDS

Providers may refund payments to MDCH when the **entire amount paid for a claim** needs to be returned due to overpayment, either from a third party resource or due to an error. A copy of the RA with a check made out to "State of Michigan" in the amount of the refund should be sent to MDCH Cashier's Unit. (Refer to the Directory Appendix for contact information.)

Use of the replacement claim is the preferred method of refunding the entire amount of a previously paid claim.

*Do not submit a replacement claim and manually send a refund to the Cashier's Unit as this results in an incorrect refund amount.*

## SECTION 6 – CHANGES IN ELIGIBILITY AND ENROLLMENT (FFS/CSHCS)

### 6.1 GENERAL INFORMATION

Medicaid, State Medical Program or CSHCS beneficiaries may lose their eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (Fee-For-Service Medicaid or CSHCS) to a Medicaid Health Plan (MHP) or CSHCS Special Health Plan (SHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. (Refer to the Eligibility Chapter of this manual for additional information. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary.

*It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time of treatment and obtain the appropriate authorizations for payment.*

### 6.2 BILLING REQUIREMENTS

MDCH policy directs providers to bill the date of delivery for dentures and laboratory-processed crowns. However, when a beneficiary has a change in eligibility status and services have been started for root canal therapy, dentures and laboratory-processed crowns, the provider has 30 days from the loss or change in eligibility status to complete the services. The date of service on the claim form should be the date of the initial impression for dentures and laboratory-processed crowns.

# SECTION 7 – REMITTANCE ADVICE

## 7.1 PAYMENTS/CLAIM STATUS

MDCH processes claims and issues payments (by check or electronic funds transfer [EFT]) every week unless special provisions for payments are included in the provider enrollment agreement. A Remittance Advice (RA) is issued with each payment to explain the payment made for each claim. If no payment is due, but claims have pended or rejected, an RA is also issued. If claims are not submitted for the current pay cycle, no action is taken on previously pended claims, or no payment gross adjustments are processed in the pay cycle, an RA is not generated.

If the total amount approved for claims on any one RA is less than $5.00, a payment is not issued for that pay cycle. Instead, a balance is held until approved claims accumulate to an amount equal to or more than $5.00. Twice a year (usually June and December) all amounts of less than $5.00 are paid.

If a claim does not appear on an RA within 30 days of submission, a new claim should be submitted. The provider should verify that the provider ID# and beneficiary ID# are correct.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with the MDCH under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from the MDCH through EFT must register through the Department of Management and Budget's (DMB) website. (Refer to the Directory Appendix for DMB website information.)

## 7.2 REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

## 7.3 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ANSI X12N 835 version 4010A1 format. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format. Information regarding pended claims is reported electronically in the 277 Unsolicited Claim Status format.

The electronic RA has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems.
- It includes a MDCH trace number to identify the associated warrant or electronic funds transfer (EFT) payment.
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim.
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835 and/or 277U, regardless of how the claims were submitted (e.g. some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835/277U transaction must identify a primary service bureau to receive the 835/277U. All providers under the same corporate TIN must utilize the same primary service bureau. An addition of and/or change to the identification of the primary service bureau must be submitted to Provider Enrollment. The primary service bureau is the only one to receive the 835/277U remittance information for all claims regardless of submission source. No other service bureau submitting claims for that provider/group TIN receives information regarding claims submitted.

For more information regarding the 835 and 277U transactions issued by the MDCH, refer to the MDCH Companion Documents on the MDCH website. For general information about the 835 and 277U, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

### 7.4 PAPER REMITTANCE ADVICE

All providers with approved or pended claims receive a paper RA, even if they opt to receive the 835/277U transactions.

The following information is supplied on the paper RA Header:

- **Provider ID Number and Provider Type**: This is the Medicaid provider ID# from the provider's claim. The first two digits of the Provider ID# appear in the Provider Type box and the last seven digits appear in the Provider Number box.
- **Provider Name**: This is from the MDCH provider enrollment record for the provider ID# submitted on the claim.
- **Pay Cycle**: This is the pay cycle number for this RA.
- **Pay Date**: This is the date the RA is issued.
- **Page No**: Pages of the RA are numbered consecutively.
- **Federal Employer ID Number (EIN) or Social Security Number (SSN):** This is in small print in the upper right corner and is unlabeled. The number on the provider's claim must match the billing provider ID# on file with the MDCH, and it must be a valid number with the Michigan Department of Treasury. MDCH cannot issue a check if there is a discrepancy between the number on file with the MDCH and the Michigan Department of Treasury. Incorrect information should be reported to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

Claims appear on the RA in alphabetical order by the beneficiary's last name. If there is more than one claim for a beneficiary, they appear in Claim Reference Number (CRN) order under the beneficiary's name. The table below explains the fields of the RA:

| Field Name | Explanation |
|---|---|
| **Claim Header** | **Patient ID Number:** Prints the beneficiary's Medicaid ID number that the provider entered on the claim.<br><br>**Claim Reference Number (CRN):** A 10-digit CRN is assigned to each claim. If the claim has more than one service line, the same CRN is assigned to each line. The first four digits are the Julian Date the claim was received by MDCH. The fifth through tenth digits are the |

| | |
|---|---|
| | sequential claim number assigned by the MDCH.<br><br>Example: In CRN 3223112345, 3 is the year 2003, 223 is the Julian day of the year (August 11), and 112345 is the sequence number. The combination of Julian day and sequence makes a unique number that is assigned to each claim. When asking about a particular claim, the provider must refer to the CRN and Pay Date.<br><br>The 10-digit CRN is following by a two-character input ID (3223223445-XX). If a service bureau submitted the claim, this is the service bureau ID. If the provider submitted a paper claim, this is a scanner identifier. |
| **Line No.** | This identifies the line number where the information was entered on the claim. |
| **Invoice Date** | This identifies the date the provider entered on the claim or, if left blank, the date the claim was processed by the system. |
| **Service Date** | This identifies the service date entered on the claim line (admit date for inpatient service). |
| **Procedure Code** | This identifies the procedure code or revenue code entered on the service line. |
| **Qty** | This identifies the quantity entered on the service line. If the MDCH changed your quantity, an informational edit appears in the Explanation Code column. |
| **Amount Billed** | This identifies the charge for the entire claim. |
| **Amount Approved** | This identifies the amount the MDCH approved for the service line (amount approved for DRG represents the entire claim and it is not approved by claim line). Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from MDCH.<br><br>For example, when other resources made a payment greater than MDCH's usual payment. |
| **Claim Adjustment Reason Code** | Claim adjustment reason codes communicate why a claim or service line was paid differently than was billed. If there is no adjustment to a claim line, then there is no adjustment reason code. |
| **Claim Remark Code** | Claim remark codes relay service line specific information that cannot be communicated with a reason code. |
| **Invoice Total** | Totals for the Amount Billed and the Amount Approved print here. |
| **Insurance Information** | If Medicaid beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g. vision, medical) print below the last service line information. |
| **History Editing** | Certain edits compare the information on the claim to previously paid claims. In some cases, information about the previous claim prints on the RA. This information prints directly under the service line to which it relates. |
| **Page Total** | This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two RA pages, the page total includes only the paid lines printed on each RA page. |

### 7.5 Gross Adjustments

Gross adjustments are initiated by the MDCH. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on the RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used. Code definitions can be found in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDCH gross adjustment code that corresponds to the gross adjustment description.

| Code | Name | Explanation |
|---|---|---|
| GACR | Gross Adjustment Credit | This appears when the provider owes MDCH money. The gross amount is subtracted from the provider's approved claims on the current payroll. |
| GADB | Gross Adjustment Debit | This appears when MDCH owes the provider money. The gross adjustment amount is added to the provider's approved claims on the current payroll. |
| GAIR | Gross Adjustment Internal Revenue | This appears when the provider has returned money to MDCH by check instead of submitting a replacement claim. It is subtracted from the provider's YTD (Year To Date) Payment Total shown on the summary page of the RA. |

### 7.6 Remittance Advice Summary Page

The Summary Page is the last page of the RA and gives totals on all claims for the current payroll and year-to-date totals from previous payrolls. The table below explains the fields of the Summary Page:

| Field Name | Explanation |
|---|---|
| **This Payroll Status** | The total number of claims and the dollar amount for the current payroll. This includes new claims plus pended claims from previous payrolls that were paid, rejected, or pended on the current payroll. |
| **Approved** | Number of claims from this payroll with a payment approved for every service line. The dollar amount is the total approved for payment. |
| **Pends** | Number of claims from this payroll that are pending. The dollar amount is the total charges billed. |
| **Rejected** | Number of claims from this payroll with a rejection for every service line. The dollar amount is the total charges billed. |
| **App'd/Rejected** | Number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total approved. The amount next to Rejected Claim Lines is the total charge billed. |
| **Total Pends in System** | Number of new and unresolved pended claims in the system and related total charges. |

| | |
|---|---|
| **Previous YTD (Year to Date) Payment Total** | The total amount paid for the calendar year before any additions or subtractions for this payroll. |
| **Payment Amount Due This Payroll to Provider** | Payment Amount Approved, plus any balance due to the provider, minus any balance owed by the provider to MDCH. |
| **Payment Made This Payroll** | The amount of the check or EFT issued for this payroll. |
| **New YTD Payment Total This Payroll** | Total payment for the calendar year, including payments made on this payroll. |
| **Balance Owed or Balance Due** | One or more of the following messages prints if there is a balance owed or a balance due.<br>➢ **Balance Due to Provider by MDCH:** This appears if the payment amount approved is less than $5.00 or a State account is exhausted.<br>➢ **Balance Owed by provider to MDCH:** This appears when money is owed to MDCH, but you do not have sufficient approved claims from a particular State account (e.g., CC or SMP) to deduct what is owed.<br>➢ **Previous Payment Approved, Not Paid:** This appears if a balance is due from MDCH on the previous payroll.<br>➢ **Previous Payment owed by Provider to MDCH:** This appears when a balance is due from you on a previous payroll. |
| **Pay Source Summary** | Identifies the dollar amounts paid from the designated State accounts. |

### 7.7 PENDED AND REJECTED CLAIMS

When claims are initially processed, the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid, rejected or pended and lists edits that apply.

- **Rejections:** If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definitions of the codes to determine the reason for the rejection.
- **Pends:** If any service line pends for manual review, PEND prints in the Claim Adjustment Reason/Remark column of the RA. These pended claims do not print again on the RA until the claim:
  - Is paid or rejected;
  - Is pended again for another reason; or
  - Has pended for 60 days or longer.

When a claim is pended, the provider must wait until it is paid or rejected before submitting another claim for the same service.

*After a claim initially pends, it may pend again for a different reason. In that case, a symbol sign (#) prints in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.*

## SECTION 8 – JULIAN CALENDAR

| Day 'Month | January | February | March | April | May | June | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 32 | 60 | 91 | 121 | 152 | 182 | 213 | 244 | 274 | 305 | 335 |
| 2 | 2 | 33 | 61 | 92 | 122 | 153 | 183 | 214 | 245 | 275 | 306 | 336 |
| 3 | 3 | 34 | 62 | 93 | 123 | 154 | 184 | 215 | 246 | 276 | 307 | 337 |
| 4 | 4 | 35 | 63 | 94 | 124 | 155 | 185 | 216 | 247 | 277 | 308 | 338 |
| 5 | 5 | 36 | 64 | 95 | 125 | 156 | 186 | 217 | 248 | 278 | 309 | 339 |
| 6 | 6 | 37 | 65 | 96 | 126 | 157 | 187 | 218 | 249 | 279 | 310 | 340 |
| 7 | 7 | 38 | 66 | 97 | 127 | 158 | 188 | 219 | 250 | 280 | 311 | 341 |
| 8 | 8 | 39 | 67 | 98 | 128 | 159 | 189 | 220 | 251 | 281 | 312 | 342 |
| 9 | 9 | 40 | 68 | 99 | 129 | 160 | 190 | 221 | 252 | 282 | 313 | 343 |
| 10 | 10 | 41 | 69 | 100 | 130 | 161 | 191 | 222 | 253 | 283 | 314 | 344 |
| 11 | 11 | 42 | 70 | 101 | 131 | 162 | 192 | 223 | 254 | 284 | 315 | 345 |
| 12 | 12 | 43 | 71 | 102 | 132 | 163 | 193 | 224 | 255 | 285 | 316 | 346 |
| 13 | 13 | 44 | 72 | 103 | 133 | 164 | 194 | 225 | 256 | 286 | 317 | 347 |
| 14 | 14 | 45 | 73 | 104 | 134 | 165 | 195 | 226 | 257 | 287 | 318 | 348 |
| 15 | 15 | 46 | 74 | 105 | 135 | 166 | 196 | 227 | 258 | 288 | 319 | 349 |
| 16 | 16 | 47 | 75 | 106 | 136 | 167 | 197 | 228 | 259 | 289 | 320 | 350 |
| 17 | 17 | 48 | 76 | 107 | 137 | 168 | 198 | 229 | 260 | 290 | 321 | 351 |
| 18 | 18 | 49 | 77 | 108 | 138 | 169 | 199 | 230 | 261 | 291 | 322 | 352 |
| 19 | 19 | 50 | 78 | 109 | 139 | 170 | 200 | 231 | 262 | 292 | 323 | 353 |
| 20 | 20 | 51 | 79 | 110 | 140 | 171 | 201 | 232 | 263 | 293 | 324 | 354 |
| 21 | 21 | 52 | 80 | 111 | 141 | 172 | 202 | 233 | 264 | 294 | 325 | 355 |
| 22 | 22 | 53 | 81 | 112 | 142 | 173 | 203 | 234 | 265 | 295 | 326 | 356 |
| 23 | 23 | 54 | 82 | 113 | 143 | 174 | 204 | 235 | 266 | 296 | 327 | 357 |
| 24 | 24 | 55 | 83 | 114 | 144 | 175 | 205 | 236 | 267 | 297 | 328 | 358 |
| 25 | 25 | 56 | 84 | 115 | 145 | 176 | 206 | 237 | 268 | 298 | 329 | 359 |
| 26 | 26 | 57 | 85 | 116 | 146 | 177 | 207 | 238 | 269 | 299 | 330 | 360 |
| 27 | 27 | 58 | 86 | 117 | 147 | 178 | 208 | 239 | 270 | 300 | 331 | 361 |
| 28 | 28 | 59 | 87 | 118 | 148 | 179 | 209 | 240 | 271 | 301 | 332 | 362 |
| 29 | 29 | - - | 88 | 119 | 149 | 180 | 210 | 241 | 272 | 302 | 333 | 363 |
| 30 | 30 | - - | 89 | 120 | 150 | 181 | 211 | 242 | 273 | 303 | 334 | 364 |
| 31 | 31 | - - | 90 | - - - | 151 | - - - | 212 | 243 | - - - | 304 | - - - | 365 |

For leap year, one day must be added to number of days after February 28. The next three leap years are 2004, 2008 and 2012.

**Example:** claim reference # 3351203770-59
3 = year of 2003
351 = Julian date for December 17
203770 = consecutive # of invoice
59 = internal processing

## SECTION 9 – PA COMPLETION INSTRUCTIONS

### 9.1 DENTAL PRIOR AUTHORIZATION (PA) REQUEST (MSA-1680-B)

**DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST**
Michigan Department of Community Health

☐ Medicaid ☐ CSHCS

**Note:** **Approval refers to service only and does not authorize fees or patient eligibility, including age.**

**For MDCH Consultant Use Only**

1. Prior Authorization No.

2 | 3 | 4 | 5 | 6 | 7 | 8 | 9

| | | | |
|---|---|---|---|
| 10. Provider Name (Last, First, Middle Initial) | | | 17. Recipient Name (Last, First, Middle Initial) |
| 11. Provider Street Address | 12. Provider County | 18. Recipient Street Address | 19. Birth Date |
| 13. City / State | ZIP Code | 20. City / State | ZIP Code |
| 14. Prov. Type / 15. Provider ID No. | 16. Provider Phone No. | 21. Sex ☐ M ☐ F / 22. Recipient ID No. | 23. Recip. Phone No. |
| 24. Does Patient Live in a Nursing or AIS Home? ☐ No ☐ Yes ➢ | | If Yes, Facility Name | Facility Phone No. |
| 25. Is Patient Covered by Any Other Dental Plan? ☐ No ☐ Yes ➢ | | If Yes, Plan Name | |

26. Indicate Missing Teeth with an "X".

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

27. Are X-Rays Enclosed? ☐ No ☐ Yes ➢ If Yes, Number of X-Rays

28. Is Treatment for Orthodontics? ☐ No ☐ Yes

29. How Long Has Patient NOT Worn a Prosthesis?

30. How Long Has Patient Been Edentulous?

31. Other Pertinent Dental or Medical History:

**EXAMINATION AND TREATMENT RECORD**

| LINE | 32. Tooth | 33. Surface: M D O L I F | 34. Procedure Code | 35. Consultant Use Only | 36. Description of Service |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
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| 16 | | | | | |
| 17 | | | | | |
| 18 | | | | | |
| 19 | | | | | |
| 20 | | | | | |
| 21 | | | | | |
| 22 | | | | | |

37. Status of Current Prosthesis:

| | Part | Full | Date Inserted | Can Be Worn Yes | Can Be Worn No | Can Be Repaired Yes | Can Be Repaired No | Used Now Yes | Used Now No |
|---|---|---|---|---|---|---|---|---|---|
| Max | | | | | | | | | |
| Mand | | | | | | | | | |

38. Reason for Denture Replacement:

39. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.

Provider's Signature Date:

**For MDCH Consultant Use Only**

40. Consultant Remarks:

41. Request Approved As:
1 5 Presented
2 6 Amended
4 8 Disapproved
No Action

42. Consultant Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought

The Department of Community Health is an equal opportunity employer, services and programs provider.

MSA-1680-B (Rev. 05/03) Previous Edition May Be Used

### 9.2 COMPLETION OF MSA-1680-B FORM

The instructions pertain to the completion of the Dental Prior Approval Authorization Request. Michigan Department of Community Health (MDCH) requests that all PA forms be typewritten to facilitate processing the forms.

| | | |
|---|---|---|
| **1** | **Prior Authorization (PA)** | If the procedure is authorized, the consultant enters a PA Number in this box. The dentist must enter this number on the ADA 2000 Dental Invoice (Box 2) when submitting the charges for payment. |
| **2-9** | **Consultant Use Only** | These boxes are to be completed by staff upon review of the authorization request. |
| **10-16** | **Provider Information** | The dentist's name, provider type code, and seven-digit ID number must be entered as they appear on the DCH Provider Confirmation Form.<br><br>The dentist's telephone number (including area code), mailing address, and county must be entered in the appropriate boxes. |
| **17-23** | **Beneficiary Information** | The beneficiary's last name, first name, middle initial, and eight-digit beneficiary ID number must be entered exactly as they appear on the beneficiary's **mihealth** card or the Children's Special Health Care Services (CSHCS) letter. A beneficiary receiving CSHCS and Medicaid benefits has the same ID number for both programs. The beneficiary's mailing address, birth date, phone number, and sex must be entered in the appropriate box. |
| **24** | **Does Patient Live in a Nursing Facility?** | If the beneficiary resides in a nursing facility, the dentist must check "YES" and enter the name of the facility. |
| **25** | **Is Patient Covered by Another Dental Plan?** | If the beneficiary has other dental coverage, the dentist must check "YES" and enter the name of the insurance carrier, the policy number, etc. |
| **26** | **Tooth Chart** | The dentist must indicate the status of the beneficiary's teeth at the time of examination prior to treatment by indicating missing teeth with an "X." |
| **27** | **Are X-Rays Enclosed?** | "YES" or "NO" should be checked to indicate if x-rays are enclosed. If "YES", the dentist should indicate how many. |
| **28** | **Is Treatment for Orthodontic Purposes?** | Answer "YES" or "NO" in boxes provided. |
| **29-30** | **Prosthesis Questions** | Provide information for denture requests. |
| **31** | **Other Pertinent Dental or Medical History** | Provide additional documentation or information necessary for MDCH staff to make a decision for the procedure requested. |
| **32** | **Tooth Number or Letter** | If a procedure submitted for authorization involves treatment of a single tooth, the dentist must enter the appropriate tooth number or letter as indicated on the Tooth Chart. |

| | | |
|---|---|---|
| **33** | **Surface** | The appropriate tooth surface code(s) for each procedure submitted for authorization must be entered, as applicable. Restorative procedures must be identified by the specific tooth surface(s) involved.<br>M = Mesial<br>D = Distal<br>O = Occlusal<br>L = Lingual<br>I = Incisal<br>F = Facial<br>B = Buccal |
| **34** | **Procedure Code** | The appropriate code, as indicated in the Procedure Codes Appendix, must be entered for each procedure submitted for authorization. |
| **35** | **Consultant Use Only** | The dentist should not write or mark in this column. The Dental Consultant may enter a procedure code in this area. If the Consultant has entered a procedure code, this is the code the dentist must use for billing purposes. |
| **36** | **Description of Service** | Using current dental terminology, the dentist must enter the description of the procedure, treatment, or service submitted for authorization. The description for each procedure code must be limited to one line. Appropriate abbreviations may be used if necessary. |
| **37** | **Prosthesis Status** | This box must be completed for all beneficiaries who have worn partial or full dentures at any time. The dentist must complete this box even if denture services are not included in the present request.<br>The possession of maxillary and/or mandibular prosthesis must be indicated by:<br>▪ Checking “PARTIAL” or “FULL”;<br>▪ Entering the date of insertion;<br>▪ Checking “YES” or “NO” to indicate if prosthesis is usable or repairable;<br>▪ “YES” or “NO” must be checked to indicate if the beneficiary is wearing maxillary and/or mandibular prosthesis; and<br>▪ Where applicable, the dentist must indicate how long the beneficiary has not worn or been without either or both prostheses. |
| **38** | **Reason for Denture Replacement** | The dentist must indicate the reason why the prosthesis is requested; provide an oral health assessment along with a five-year prognosis for the prosthesis. |
| **39** | **Provider Certification** | The dentist must sign and date this certification to validate the Dental Prior Approval Authorization Request. All unsigned requests are returned to the dentist for signature. |
| **40-41** | **Consultant Use Only** | These boxes are to be completed by the Dental Consultant upon review of the treatment plan. The Consultant indicates:<br>▪ The plan is approved as presented;<br>▪ Approved as amended; |

| | | |
|---|---|---|
| | | ▪ Disapproved; or<br>▪ Returned with no action taken.<br>If the plan is authorized, a PA Number is entered in Box 1. The dentist must enter this number on the ADA 2000 Dental Invoice (Box 2) when submitting the charges for payment.<br>If the plan is disapproved, the dentist may submit a new, revised treatment request for authorization.<br>If the request is returned with no action, the dentist may resubmit the same form and any materials originally accompanying it, addressing the Consultant's requests for additional information or treatment coverage concerns. |

### 9.3 MAILING ADDRESS

Mail completed PA requests to MDCH Prior Authorization Section– Dental. (Refer to the Directory Appendix for contact information.)

### 9.4 REORDERING PA REQUEST FORMS

The Dental Prior Approval Request Authorization (MSA-1680-B) form is available on the MDCH website, or may be requested from the MDCH. (See the Directory Appendix for website and forms ordering information.) Please allow at least four to six weeks for processing a forms order.

All requests for forms must include the following information:

- Provider name,
- Provider ID number,
- Billing address;
- Name of contact person; and
- Telephone number.