MSA-1680-B DENTAL PRIOR AUTHORIZATION REQUEST

Completion Instructions

For services requiring prior authorization (PA) for individuals enrolled in **Fee-for-Service Medicaid** and/or **Children's Special Health Care Services (CSHCS),** providers must request prior authorization (PA) through the Program Review Division. For beneficiaries enrolled in Medicaid Health Plans, Healthy Kids Dental or other managed care plans, providers must contact the assigned plan for authorization requirements.

PA Request Submission:

- **Providers are strongly encouraged to submit PA requests electronically through direct data entry into CHAMPS** through the CHAMPS Provider Portal at https://milogintp.michigan.gov.
    - **THIS FORM IS NOT REQUIRED IF the PA Request is submitted electronically AND the Supplemental Information section is fully completed.**
    - All other required supporting clinical documentation, including diagnostic dental images/radiographs if required by policy, must be uploaded to the request in CHAMPS. All documents must contain the beneficiary name and **mihealth** card number.
    - For complete information on standards of coverage, covered services, PA, documentation requirements, required modifiers, procedure codes and appropriate quantity amounts, refer to the Dental chapter of the MDHHS Medicaid Provider Manual, the Billing & Reimbursement for Professionals chapter, Michigan Medicaid Approved Policy Bulletins, and provider-specific databases located https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers/policyforms/policy-letters-and-forms for detail.
- Alternatively, providers may submit PA requests via fax to **FAX (517) 335-0075.**
- Providers are discouraged from mailing PA requests, but if necessary, requests may be mailed to

MDHHS, Dental Prior Authorization
P.O. Box 30170
Lansing, MI 48909

Refer to the **CHAMPS Provider Portal** located at https://milogintp.michigan.gov to enter PA request; refer to the Provider Communication section under the tracking number to upload required documentation, check the status of a PA, view PA determination letters, submit invoices for manually priced procedure codes when applicable, submit requests for changes to an approved authorization when necessary (requests for extension of an authorization period must be submitted within 15 days prior to the end of the authorization period), and other functions.

Questions regarding PA should be directed to the Program Review Division at **1-800-622-0276.**

Questions regarding navigating CHAMPS should be directed to the Provider Support Helpline at (800) 292-2550 or providersupport@michigan.gov.

Form Completion: Forms that are not legible will be returned for resubmission.

BOX #	INSTRUCTIONS
	THIS FORM IS NOT REQUIRED if PA Request is submitted in CHAMPS via Direct Data Entry at https://milogintp.michigan.gov and the Supplemental Information section is fully completed.
1	Enter the date the request is being faxed.
2 – 3	Enter the Medicaid enrolled provider's organization name and NPI. Previously referred to as Group NPI. If not a group practice, enter the Individual provider's name and NPI.

4	Enter the servicing location to which PA correspondence should be mailed, including determination letters and requests for additional clinical information.
5	Enter contact information for an individual in the provider's office that the Program Review Division can contact with questions regarding the PA request.
6	Enter the Medicaid enrolled rendering/servicing provider's name and NPI.
7 - 11	Enter the beneficiary's name, **mihealth** card number, phone number, date of birth, and sex. The information should be taken directly from the **mihealth** card and verified in CHAMPS.
12	Enter the beneficiary's diagnosis code(s) and description(s) that relate to the service being requested. For CSHCS covered services, dental providers are required to submit the beneficiary's CSHCS qualifying diagnosis related to the dental services being requested.
13 - 18	Indicate if an Expedited Review is being requested (due to medical necessity for provision of services within 10 calendar days). Standard reviews will be determined within 7 calendar days. If YES, questions 14-18 must be answered. If NO, skip to box #19. If the request does not meet expedited criteria, it will be processed as a standard review and the requesting provider will be notified via the Provider Communication section for this request in CHAMPS.
19	Indicate the dental service category being requested; if not listed, describe under Other. If CSHCS services are being requested, refer to the CSHCS Section, Dental Chapter of the MDHHS Medicaid Provider Manual.
20	Complete the dental chart for each tooth using the Charting Key. For CSHCS requests, additionally document whether each tooth is erupted, partially erupted, or unerupted, as well as the presence of supernumerary teeth. Refer to American Dental Association (ADA) guidelines for designation of supernumerary teeth.
21	If diagnostic images are required by policy, confirm that they are attached to the request. Additionally, enter the date the images were taken and specific tooth number(s) for crowns, dental implants, impacted teeth, bridges, and teeth extracted since the images were taken. To determine services requiring dental images/radiographs, refer to the Dental chapter of the MDHHS Medicaid Provider Manual, and Michigan Medicaid Approved Policy Bulletins located at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.
22 - 23	Complete for requests for periodontal services. Confirm attachment of a comprehensive periodontal charting, periodontitis staging and grading. Refer to American Academy of Periodontology (AAP) guidelines for periodontal diagnosis and classification. Thorough completion of sections 20, 22, 23 satisfies the requirement for inclusion of the beneficiary's clinical record.
24 - 25	Document any other pertinent dental or medical history. Use box #19 for additional PA related comments.
26 - 29	Complete one line for each CDT procedure code requested. For periodontal services, each quadrant must be entered on a separate line.
30	Printed/typed name, along with signature and date are required, attesting to the Provider Certification.

AUTHORITY: Title XIX of the Social Security Act COMPLETION: Is Voluntary, but is required if payment from applicable program is sought.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Michigan Department of Health and Human Services

MSA-1680-B DENTAL PRIOR AUTHORIZATION REQUEST

THIS FORM IS NOT REQUIRED if PA Request is submitted in CHAMPS via Direct Data Entry at https://milogintp.michigan.gov and the Supplemental Information section is fully completed.

All other required supporting clinical documentation required by policy must be uploaded to the request in CHAMPS. Refer to the Dental chapter of the Michigan Medicaid Provider Manual available online at https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers/policyforms/policy-letters-and-forms for detail.

THIS FORM IS REQUIRED FOR FAXED SUBMISSIONS TO FAX (517) 335-0075.

The provider is responsible for eligibility verification.
Authorization does not guarantee beneficiary eligibility or payment.
Forms that are not legible will be returned for resubmission.

1. Fax Submission Date: / /

2. Requesting Provider (Organization/Group) If not applicable, enter Individual. Name:	
3. Organization/Group NPI (If not applicable, enter Individual.)	
4. Provider's Address (for PA Correspondence) City State ZIP Code	
5. Provider Office Contact Information (for contact during PA request review, if needed): Name: Phone Number: ( ) - Email	
6. Rendering/Servicing Provider Name (Last, First, Middle Initial): Rendering/Servicing Provider NPI #	
7. Beneficiary Name (Last, First, Middle Initial):	
8. mihealth Card Number	9. Date of Birth / /
10. Beneficiary Phone Number: ( ) -	11. Sex ☐ M ☐ F
12. ICD Diagnosis Code and Description: .	
13. Is Expedited Review and Determination being requested? ☐ YES ☐ NO **If YES, questions 14-18 must be answered. If NO, skip to box #19** If the request does not meet expedited criteria, it will be processed as a standard review and the requesting provider will be notified via the Provider Communication section for this request in CHAMPS.	
14. If approved, will the service requested be rendered within ≤ 10 calendar days of the request submission date? ☐ YES ☐ NO	
15. If the service requested is not rendered within ≤ 10 calendar days will the patient's life, health, or ability to regain maximum function be seriously jeopardized? ☐ YES ☐ NO	
16. Is intervention within ≤ 10 calendar days necessary to correct a medical condition or avoid further damage/loss of function? ☐ YES ☐ NO	
17. Will the patient be discharged from the hospital/nursing facility as of today's date (date this form is being completed)? ☐ YES ☐ NO	
18. Explain need for Expedited Review and Determination. Supporting documentation submitted with this request must concur with this explanation for an expedited review to be granted.	

19. Dental Services Being Requested:

Under 21	☐ Yes	☐ No	Adult	☐ Yes	☐ No
CSHCS	☐ Yes	☐ No	Periodontics	☐ Yes	☐ No
Orthodontics	☐ Yes	☐ No	Other		

20. Complete the required dental chart using the charting key.

Charting Key:
C = Crown
V = Impacted
I = Implant
X = Missing
P = Pontic
/ = To be extracted

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**

CSHCS Requests Only – Indicate:
E = Erupted
PE = Partially Erupted
U = Unerupted
Document Presence of Supernumerary Teeth:

21. Are diagnostic images (if required by policy) attached? ☐ Yes ☐ No
Date Taken: / /
Indicate the specific tooth number(s) for crowns, dental implants, impacted teeth, bridges, and teeth extracted since images taken:

If request is for Periodontal Services, complete boxes # 20-23. Completion of boxes # 20-23 satisfies requirement for inclusion of clinical record.

22. Required current comprehensive periodontal charting attached? ☐ Yes ☐ No

Periodontal charting must include 6 measurements per tooth and all of the following applicable: probing depths ≥ 4mm, BOP and/or gingival inflammation, attachment loss, furcation, mobility.

23. Periodontal Diagnosis
[Refer to American Academy of Periodontology (AAP) guidelines for periodontal diagnosis and classification].
Stage (I, II, III, IV):
☐ Localized
☐ Generalized
☐ Molar/incisor pattern
Grade (A, B, C):
Address the 1 year prognosis of teeth in each quadrant being requested:

24. Other Pertinent Dental or Medical History:

25. Additional Provider Comments:

LINE	26. **CDT PROCEDURE CODE**	27. **TOOTH NUMBER(S)**	28. **QUADRANT** (1 quadrant per line)	29. **DESCRIPTION OF SERVICE**
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30. PROVIDER CERTIFICATION: The patient named above (parent/guardian/authorized representative as applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and/or State funds. I understand that any false claims, statements or documents, omission, or concealment of a material fact may lead to prosecution under applicable Federal and/or State law. I, as named provider or representative thereof, attest that the information provided on this form and attached supporting documentation is accurate and complete to the best of my knowledge and ability.

Name of Provider (or Provider's Representative)

completing this form (typed or printed): _____

Signature: _____ Date: ___/___/_____