MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST
Instructions for MSA-1680-B

The Dental Prior Approval Authorization Request form (MSA-1680-B) must be used by dental practices and community-based dental clinics (e.g., local health departments, Federally Qualified Health Centers) to request prior authorization (PA) for individuals enrolled in **Medicaid Fee-for-Service** and/or **Children's Special Health Care Services (CSHCS)**. For beneficiaries enrolled in Healthy Kids Dental, Medicaid Health Plans, or Integrated Care Organizations, providers must contact the assigned plan for authorization requirements.

The status of a PA request may be reviewed in CHAMPS. Additionally, providers will receive a PA determination letter. Approved services must be completed before the PA period ends. To request an extension, the provider must submit a copy of the determination letter and required documentation within 15 days prior to the end date of the current authorization. If the original PA is over one year old, a new PA request must be submitted.

For complete information on covered services, PA and documentation requirements, 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.

Form Completion: MDHHS requires that the MSA-1680-B be typewritten.

BOX #	INSTRUCTIONS
1 - 5	If submitting a request via CHAMPS direct data entry (DDE), the provider may skip #1 – 5, and start form at box #6.
1 - 2	Enter the Medicaid enrolled provider's organization name and NPI. Previously referred to as Group NPI.
3	Enter the servicing location to which PA correspondence should be mailed, including determination letters and requests for additional clinical information.
4 - 5	Enter the Medicaid enrolled rendering/servicing provider's name and NPI.
6	Enter contact information for an individual in the provider's office that the Program Review Division can contact with questions regarding the PA request.
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.
13	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.
14	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.
15	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.
16 – 17	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 16 – 17 satisfies the requirement for inclusion of the beneficiary's clinical record.
18 – 19	Document any other pertinent dental or medical history. Use box #19 for additional PA related comments.
20 – 23	Complete one line for each CDT procedure code requested. For periodontal services, each quadrant must be entered on a separate line.
24	Printed name, signature and date are required, attesting to the Provider Certification. Signature of a licensed dentist or dental therapist is required.

Form Submission:

PA request forms for all eligible Medicaid and CSHCS beneficiaries must be submitted via direct data entry, faxed, or mailed to:

Michigan Department of Health and Human Services, Dental Prior Authorization
P.O. Box 30154
Lansing, MI 48909
Fax: (517) 335-0075

If submitting electronically, the completed MSA-1680-B must be uploaded along with the supporting clinical documentation required and diagnostic dental images/radiographs if required by policy.

The status of a PA request can be checked via the **CHAMPS Provider Portal** located at https://milogintp.michigan.gov. Questions regarding PA should be directed to the Program Review Division at **1-800-622-0276.**

Michigan Department of Health and Human Services

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

Submit in CHAMPS via Direct Data Entry (DDE) https://milogintp.michigan.gov or FAX: 517-335-0075

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

NOTE: IF SUBMITTING VIA CHAMPS DIRECT DATA ENTRY, SKIP TO BOX #6

1. Requesting Provider Name (Organization/Group) If not applicable, enter Individual.	2. Organization NPI (previously known as Group) If not applicable, enter Individual.
3. Provider's Servicing Location (for PA correspondence) Street Address	City State ZIP Code
4. Rendering/Servicing Provider Name (Last, First, Middle Initial)	5. Rendering/Servicing Provider NPI
6. Provider Office Contact Information Name: Phone Number: ( ) - Email	
7. Beneficiary Name (Last, First, Middle Initial)	12. ICD Diagnosis Code and Description:
8. **mihealth** Card Number	9. Beneficiary Phone Number ( ) -
10. Date of Birth / /	11. Sex ☐ M ☐ F

13. Dental Services Being Requested

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

14. 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**

For CSHCS Requests Only Additionally Indicate:
E = Erupted
PE = Partially Erupted
U = Unerupted

Document Presence of Supernumerary Teeth:

15. 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 # 16 - 17

16. 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.

Completion of boxes #16 – 17 satisfies requirement for inclusion of clinical record.

17. 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:

18. Other Pertinent Dental or Medical History:

19. Additional Provider Comments:

LINE	20. **CDT PROCEDURE CODE**	21. **TOOTH NUMBER(S)**	22. **QUADRANT** (1 quadrant per line)	23. **DESCRIPTION OF SERVICE**
1				
2				
3				
4				
5				
6				
7				
8				

24. 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. Signature of a licensed dentist or dental therapist is required.

Provider's Name (typed/printed): Provider's Signature: Date:

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.