MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 07-57

Distribution: Dentists and Dental Clinics

Issued: October 1, 2007

Subject: Revised Dental Prior Authorization Form (MSA-1680-B)

Effective: November 1, 2007

Programs Affected: Medicaid, CSHCS

Effective for dates of service on and after November 1, 2007, the Michigan Department of Community Health (MDCH) has revised the Dental Prior Approval Authorization Request Form (MSA-1680-B). The form is used for both the Medicaid and/or Children's Special Health Care Services (CSHCS) programs.

The form is found on the MDCH website on the "Medicaid Provider Forms and Other Resources" webpage. The website address is www.michigan.gov/mdch, click on Providers >> Information for Medicaid Providers >> Medicaid Provider Forms and Other Resources, scroll down to find the form number, MSA-1680-B. The form is in a PDF format or a fill-in enabled Word document. Instructions are posted along with the form.

Paper forms are no longer maintained for distribution. For providers without internet access, a written request for up to ten copies of the form may be submitted to the following address:

Michigan Department of Community Health
MSA Policy Support Unit
PO Box 30479
Lansing, Michigan 48909-7979

The form has been revised to clarify and obtain information required for the Prior Authorization (PA) process. Changes include:

Provider Information

- A new field for the provider fax number

Beneficiary Information

- Beneficiary replaces the word, Recipient
- MI Health Card Number replaces Recipient ID Number
- Address information is deleted

Treatment Information

- New fields for CSHCS related diagnosis information for CSHCS beneficiaries
- Number of X-rays taken field has been expanded to include date taken
- New field for treatment plan enclosed has been added
- Prosthesis information fields have been added or revised
- Area of Oral Cavity replaces Surface
- Area for Prognosis of Dental Treatment and Pertinent Dental or Medical History has more space to write information
- Fields are changed to reflect easier use of the form

The request for the CSHCS diagnoses has been added for the CSHCS program. Dental providers treating CSHCS beneficiaries are now required to submit the beneficiary's CSHCS qualifying diagnosis on the MSA-1680-B form. This information will aid staff in identifying the services available for that diagnosis.

Dental providers do not have to submit a diagnosis for Medicaid beneficiaries who are not eligible for CSHCS.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

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 at 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.

Approved

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

www.michigan.gov/mdch

FAX: 517-335-0075

☐ Medicaid ☐ CSHCS

For MDCH Consultant Use Only

1. Prior Authorization No.

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

2. Provider Name (Last, First, Middle Initial)		9. Beneficiary Name (Last, First, Middle Initial)	
3. Provider Street Address	4. Provider County	10. Birth Date / /	11. Sex ☐ M ☐ F
5. City	State / ZIP Code	12. MI Health Card No.	13. Phone No. ( ) -
6. Provider Fax Number ( ) -	7. Provider Phone No. ( ) -	14. Does Patient Live in a Nursing or AIS Home? ☐ No ☐ Yes	If Yes, Facility Name
8. Provider Billing NPI No.		15. Is Patient Covered by Any Other Dental Plan? ☐ No ☐ Yes	If Yes, Plan Name
16. CSHCS Diagnosis – *ICD.9 Diagnosis Code and Description* .		17. CSHCS Diagnosis - *ICD.9 Diagnosis Code and Description* .	
18. Are X-Rays Enclosed? ☐ No ☐ Yes	Number of X-Rays and Date Taken / /	22. Indicate: Missing Teeth with an "X" - Teeth to Be Extracted with a " / ".	
19. Is Treatment for Orthodontics? ☐ No ☐ Yes	Treatment Plan Enclosed? ☐ No ☐ Yes		
20. Is this Initial Placement of Prosthesis? ☐ No ☐ Yes ☐ Max. ☐ Mand.			

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

21. 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				☐	☐	☐	☐	☐	☐

29. Address 5 Year Prognosis of Partial Dentures and/or Reason for Denture Replacement:

EXAMINATION AND TREATMENT RECORD

LINE	23. Tooth	24. Surface: M D O L I F	25. Area of Oral Cavity	26. Procedure Code	27. Consultant Use Only	28. Description of Service
1						
2						
3						
4						
5						
6						
7						
8						
9						

30. Other Pertinent Dental or Medical History:

31. 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

32. Consultant Remarks:

33. Review Action:

Approved ☐ Denied ☐

Returned ☐ No Action ☐

34. Consultant Signature Date

AUTHORITY: Title XIX of the Social Security Act

COMPLETION: Is Voluntary, but is required if payment from applicable program is sought.

MSA-1680-B (Rev. 09/07) Previous Edition Obsolete.

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