

BULLETIN

Bulletin Number: MMP 24-14

Distribution: Dentists, Dental Clinics, Dental Health Plans, Medicaid Health Plans, Integrated Care Organizations, Federally Qualified Health Centers, Tribal Health Centers, Local Health Departments, Program of All-Inclusive Care for the Elderly (PACE) Providers

Issued: May 1, 2024

Subject: Changes to Dental Frequency Verification Process

Effective: June 1, 2024

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, MI Health Link

This policy applies to Medicaid Fee-for-Service (FFS). Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs) must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. MHPs and ICOs may develop prior authorization (PA) requirements and review criteria that differ from Medicaid requirements. For beneficiaries enrolled in an MHP or ICO, the provider must check with the beneficiary's health plan for PA requirements.

Changes to Dental Frequency Verification Process

Effective June 1, 2024, the previous Dental Frequency Verification Process that required providers to obtain a service request number through emailing Provider Support will end. Service request numbers approved prior to June 1, 2024 will no longer be valid for claims submitted on or after June 1, 2024. Providers must utilize the new Dental Frequency Verification function located in the Community Health Automated Medicaid Processing System (CHAMPS) to ensure the beneficiary is eligible for a crown, complete denture or partial denture per the five-year rule prior to rendering service.

Providers can access instructions to the verification process here: [Dental Frequency Verification](#).

It is the provider's responsibility to verify the five-year rule before providing service and retain documentation of the screenshot in CHAMPS and the date of the response in the beneficiary's dental record. Failure to complete the verification process may result in denied claims.

Frequency verification approval does not guarantee beneficiary eligibility or payment. Prior to rendering services, the provider is responsible for verifying the beneficiary's Medicaid eligibility

on each date of service. Refer to the Beneficiary Eligibility chapter of the MDHHS Medicaid Provider Manual, Verifying Beneficiary Eligibility section for additional information.

The provider cannot bill the beneficiary for services rendered. Refer to the General Information for Providers chapter of the [Michigan Department of Health and Human Services \(MDHHS\) Medicaid Provider Manual](#), Billing Beneficiaries section for additional information.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved

A handwritten signature in black ink that reads "Meghan E. Groen". The signature is fluid and cursive, with the first name "Meghan" and last name "Groen" clearly legible.

Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration