ND HEALTH ENTERPRISE MMIS
PHASE III TRAINING

DENTAL SERVICE AUTHORIZATIONS

JANUARY 2016
Service Authorization – Dental

• ND Medicaid’s new system is now referred to as ND Health Enterprise MMIS
• This system went live October 5, 2015
• Previous system will be referred to as ND Legacy MMIS
• Prior Authorizations will now be referred to as Service Authorizations
Dental Service Authorizations can be submitted via:

- Web portal
- Electronic 278
- ADA Dental Claim Form Version 2006 or 2012 Only

All applicable documentation will be required regardless of the route of submission to the department (Radiographs, Periodontal Charts, Health Tracks Comprehensive Orthodontics Screening Form SFN 61 available at: http://www.nd.gov/eforms/ )
Service Authorization – Dental

• 278 Transactions:
  – Contact your software vendor and tell them you are interested in sending a 278 transaction
  – ND Medicaid cannot support the 837-D “Pre-treatment electronic dental claim”
Service Authorization – Dental

• Paper Service Authorizations may be returned if missing information such as:
  – Member Number
  – NPI
  – Missing or Invalid CDT Code
  – Quadrant, Tooth Number, or Tooth Surface Information
• Providers will log into the ND Health Enterprise MMIS Portal

Choose Providers:
Service Authorization – Dental

Enter Provider Login User name and Password:
Service Authorization – Dental

• To create a service authorization, providers will click on Authorizations:
• Providers will then choose to Submit an Dental Authorization:

Service Authorization – Dental

- Providers will see that their submitter ID is noted at the top of the service authorization and that no Service Authorization ID has been issued. This will be issued when the authorization has been submitted to the Department. Providers will see the service level is Dental and that this is a request:
Providers will then enter Member/Recipient Information. All fields marked with an asterisk are required fields.
• The Requesting Provider Field will be populated with the ND Medicaid enrolled provider ID information:
Service Authorization – Dental

• Event Provider defaults to Yes. If the Event Provider differs from the Requesting Provider this can be changed to No.

• This needs to be changed if the Requesting Dental Office will not be the Billing Dental Office and there will be an individual servicing provider.

• In most cases, you will need to select NO and enter in the requesting/treating dentist information and this will have to match the claim information being billed.
Service Authorization – Dental

• Health Care Services Review Information:
  – Request Category (what type of review?)
  – Certification Type (initial, extension)
  – Service Type (Dental Care)
  – Level of Service (emergency, elective, or urgent)

• A Valid Value must be chosen for each of these and is dependent on the type of authorization being sent
• Providers must complete the Dates of Service field. ND Medicaid must receive requested begin and requested end dates (i.e. 01/01/2016 through 12/31/2016)
Providers are able to send any additional notes for the reviewer to consider when reviewing the service authorization:
Service Authorization – Dental

- Providers are able to submit diagnosis codes. This is not a required field, however must match the claim when the claim is billed.

<table>
<thead>
<tr>
<th>Seq #</th>
<th>Diagnosis Code</th>
<th>Diagnosis Date</th>
<th>Diagnosis Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td></td>
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<tr>
<td>2</td>
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<tr>
<td>12</td>
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</tr>
</tbody>
</table>
Providers are required to submit at least one line item for a service authorization to be considered. Each additional service requires an additional line item:

<table>
<thead>
<tr>
<th>Service Level</th>
<th>Certification Issue Date</th>
<th>Certification Action</th>
<th>Review Decision Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>SV3 (Dental Service)</td>
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</tr>
</tbody>
</table>

- **Service Qualifier**: ADA

- **Service From Description**: 

- **Requested Begin Date**: 

- **Requested End Date**: 

- **Requested Amount**: 

- **Requested Unit(s)**: 

- **Approved Begin Date**: 

- **Approved End Date**: 

- **Approved Amount**: 

- **Approved Unit(s)**: 

- **Service Description**: Dental
<table>
<thead>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Service Qualifier</th>
<th>Service Code From</th>
<th>Service Code To</th>
<th>Service To Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA</td>
<td>D5110</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requested Begin Date</th>
<th>Requested End Date</th>
<th>Requested Amount</th>
<th>Requested Unit(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>02012015</td>
<td>03012015</td>
<td>1000.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approved Begin Date</th>
<th>Approved End Date</th>
<th>Approved Amount</th>
<th>Approved Unit(s)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Service Description**

- **Dental**
For each detail line that is submitted, opening the dental expandable field set allows additional information to be submitted (prosthesis information, oral cavity codes, and tooth number/surface information). This may be required on the service authorization depending on what is being requested.
All service authorization line items must contain:

- A CDT procedure code
- From and Through dates of service
- Either Requested Units **or** Requested Amount
  - If Units are requested, then a unit of measure is also required
After entering all line item information, the line item MUST BE SAVED.

To add an additional line – click the Add Service Line Item button and enter in additional services:

If each line item is not saved, the data will be lost.
• To submit your service authorization to the Department:
  – First Click SAVE at the bottom of the screen (this will give you a message at the top of the screen stating: System successfully saved the information.)
  **it may also tell you if you have any problems with your service authorization so they can be resolved
  – Second Click Submit at the bottom of the screen
After the service authorization has been submitted a confirmation page will be shown on the screen. This confirmation page has very important information including:

- Service Authorization ID Number
- Member ID Number
- Provider ID Number
- Service Authorization Status
- Submission Date and Time
Service Authorization – Dental

• It is very important to print your confirmation page and keep a copy for your records
• The confirmation page will be required to be sent with any documentation that the Department may need
• The Department also utilizes SFN 177 which is currently available at: www.nd.gov/eforms for attachments that may be necessary
A service authorization confirmation page looks like this:

- You can print the submission page, choose to submit another service authorization, or choose to go back to the service authorization Main Page.

<table>
<thead>
<tr>
<th>Svc Cd</th>
<th>Description</th>
<th>Requested Cost/Units</th>
<th>SA Line Item Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Dentures complete maxillary</td>
<td>1000.0</td>
<td>Pended</td>
</tr>
</tbody>
</table>

Mailing Address

Please send additional documentation to the following address:

ND Department of Human Services  
500 E Boulevard Avenue  
Department 325  
Bismarck, ND 58505-0250
Providers can also edit and view both saved and pended service authorizations
- Choose authorizations
- View/Edit Authorizations
- Enter in the search criteria in the box below and edit the pended authorization as necessary
• Checking Status on the web portal – what do the HIPAA Values Mean??
  – A1: Certified in total means the service authorization has been approved
  – A2: Certified partial means the service authorization has been partially approved (one line approved, one line pended or denied)
  – A3: Not Certified means the service authorization has been denied
  – A4: Pended means the service authorization remains pended
  – A6: Modified means the service authorization team has reviewed the service authorization and it is in process
Frequency List-existing approvals:

• A service authorization will need to be submitted for all recipients previously approved for the frequency list.
• If previously approved for the frequency list, a note on the submission or in Box 35 of the service authorization stating previously approved for frequency list will be sufficient.
• The recall of the visits will need to be noted on the service authorization, if this is not indicated, the authorization will be allowed at 2 per year.
• All applicable codes will need to be present on the service authorization to prevent claim denials (i.e. exams, prophy’s, etc.)
Frequency List-approvals for new patients:

• A service authorization will need to be submitted for all recipients for requests for frequency list

• A note on the submission or in Box 35 of the service authorization stating “request for frequency” will be required and the medical or mental health condition will also be required.

• Documentation may be attached and probing depths may be required depending on the services being requested (D4910).

• The recall of the visits will need to be noted on the service authorization, if this is not indicated, the authorization will be allowed at 2 per year

• All applicable codes will need to be present on the service authorization to prevent claim denials (i.e. exams, prophy’s, etc.)
DD List-existing approvals:

- A service authorization will need to be submitted for all recipients previously approved for the DD list.
- If previously approved for the DD list, please submit a service authorization with all applicable codes including code D9920 and the service authorization will be entered into the Health Enterprise system.
- The recall of the visits will need to be noted on the service authorization, if this is not indicated, the authorization will be allowed at 2 per year.
- All applicable codes will need to be present on the service authorization to prevent claim denials (i.e. exams, prophy’s, etc.)
DD List-approvals for new patients:

- An initial service authorization will need to be submitted for all new recipients for requests for DD recipients, code D9920 – “extra time”

- SFN 64 - Request for Extra Time – Individuals with DD will be required for new individuals and this form can be found at: [http://www.nd.gov/eforms/Doc/sfn00064.pdf](http://www.nd.gov/eforms/Doc/sfn00064.pdf). Please see the dental manual for additional information, pg. 7.

- The recall of the visits will need to be noted on the service authorization, if this is not indicated, the authorization will be allowed at 2 per year

- All applicable codes will need to be present on the service authorization to prevent claim denials (i.e. exams, prophy’s, etc.)
• For all Frequency list and DD list recipients:
  – These service authorizations will be approved for a 5 year timeframe
  – The codes being authorized will need to match the claim
  – The service authorization number issued must be on the claim for payment
Open Line Question & Answer

We are opening the phone line in order to field any questions you may have. In order to get your question in queue, please perform the following;

• **Press star*, then pound#** to move into the call queue.

• The operator will advise you when you have the floor.

• Additionally, you are not limited to the number of questions you can ask. However, you will again need to please **press star*, then pound#** to have the floor.
Thank you