CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Dental or Orthodontia Services form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***prior authorization*** requests are denied. Requests are considered only when completed and received before the service is provided.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- This form may be submitted by mail to the following address:

TMHP-CSHCN Services Program Authorization Department
12365-A Riata Trace Pkwy., Ste. 100
Austin, TX 78727

- This form may be submitted by fax to 1-512-514-4222.
- Submit only the prior authorization form. Do not submit instruction pages.
- **Refer to:** The "Dental" chapter in the current *CSHCN Services Program Provider Manual*.

Prior Authorization Request Submitter Certification Statement

Description
Read the certification statement and select "We Agree."

Client Information

Field Description	Guidelines
First name*	Enter the client's first name as indicated on the CSHCN Services Program eligibility form
Last name*	Enter the client's last name as indicated on the CSHCN Services Program eligibility form
CSHCN Services Program number*	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form
Date of birth*	Enter the client's date of birth as indicated on the CSHCN Services Program eligibility form
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP
Diagnoses	Enter the diagnosis code(s) relevant to the need for dental or orthodontia services

Dental Procedures

Field Description	Guidelines
CDT Code(s)*	Enter the current dental terminology (CDT) code dental procedures
TID*	Enter the tooth identification (TID)
SID *	Enter the surface identification (SID)
POS	Enter the place of service (POS)
Anticipated date of service*	Enter the anticipated date of service

Orthodontia Procedures

Field Description	Guidelines
CDT code(s) for each orthodontic procedure*	Enter the Current Dental Terminology (CDT) code for each orthodontic procedure
Estimated month of placement for each appliance	Indicate the estimated month of placement for each appliance
Estimated number of adjustments for each appliance	Enter the estimated number of adjustments for each appliance

Dentist Information and Required Signature

Field Description	Guidelines
Requesting Provider name*	Enter the dentist's name
Provider contact name	Enter the dentist's contact name
Tax ID*	Enter the dentist's Tax ID
NPI*	Enter the dentist's national provider identifier (NPI)
Taxonomy code*	Enter the dentist's s taxonomy code
Benefit code*	Enter CSN benefit code
Telephone	Enter the dentist's telephone number
Fax	Enter the dentist's fax number
Address/City/State/ZIP + 4*	Enter the dentist's address, city, state, and ZIP + 4
Requesting Provider signature	Dentist must sign in this field
Date	Enter the date the form is signed

Additional Requirements

Providers requesting prior authorization for diagnostic, some therapeutic procedures, and surgeries (most oral and maxillofacial) must complete the "Dental Procedures" section of the prior authorization request form.

- The TMHP-CSHCN Services Program may require the submission of X-rays, photographs, models, etc., for specific prior authorized services.

- All prior authorization requests must include specific rationale for the requested service, including documentation of medical necessity and appropriateness of the recommended treatment.

- Additional documentation, including current periapical radiographs, must be maintained in the client's medical or dental record and submitted to the CSHCN Services Program on request.

<u>Diagnostic Services</u>

- Prior authorization is required for diagnostic services not adequately described by other procedure codes where an unspecified procedure code is necessary. Prior authorization is not required for any other diagnostic service.

<u>Orthodontia Services</u>

- Prior authorization is required for all orthodontic services except for the initial orthodontic visit. Providers requesting prior authorization for orthodontia services must complete the "Orthodontia procedures" section of the form.

- The following documentation must accompany an orthodontia authorization request:
  - Prior authorization must be requested using both the CDT procedure code and the remarks codes for orthodontia services
  - The date of service the documentation was obtained
  - A complete orthodontia treatment plan including all procedures required to complete full treatment, such as extractions, orthognathic surgery, upper and lower appliances, monthly adjustments, appliance removal if needed, and special appliances
  - Copy of the completed and scored Handicapping Labiolingual Deviation (HLD)index calculation

- Revisions to initial treatment plans must be submitted to the CSHCN Services Program Authorization Department separately from this form.

Therapeutic Services

- Prior authorization requests must be submitted with documentation supporting medical necessity and appropriateness of the recommended treatment.

- Additional documentation, including current periapical radiographs, must be maintained in the client's medical record and submitted to the CSHCN Services Program on request.

Fixed Prosthodontics:

- Prior authorization is required for fixed prosthodontics for CSHCN Services Program clients 16 years of age or older.

- The following documentation must accompany an authorization request for fixed prosthodontics:
    - Documentation supporting that the mouth is free of disease; no untreated periodontal or endodontic disease, or rampant caries
    - Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown, except when a Maryland bridge is placed
    - Tooth Identification (TID) System noting only permanent teeth
    - Documentation supporting that a removable partial is not a viable option to fill the space between the teeth
    - Appropriate pretreatment radiographs of each involved tooth, such as periapical views must be maintained in the client's medical record and submitted to the CSHCN Services Program on request. Panoramic films are inadequate to detect caries or tooth structure necessary to evaluate the request

CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form and Instructions

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **512-514-4222**.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *CSHCN Services Program Provider Manual*.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's CSHCN Services Program enrollment and/or personal exclusion from the CSHCN Services Program.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in *the CSHCN Services Program Provider Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form and Instructions

Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

Client Information:

First name*:	Last name*:
CSHCN Services Program number*: 9-____________________-00	Date of birth*:
Address/City/State/ZIP:	
Diagnoses:	

Dental Procedures:

CDT Code(s)*	Tooth Identification (TID)*	Surface Identification (SID)*	Place of service (POS)

Anticipated date of service*: __________________________________

Has client received 4 or more (in any combination) crowns, inlays, or onlays? (Indicate yes or no)	☐ Yes	☐ No

Orthodontia Procedures:

CDT code(s) for each orthodontic procedure*:

Estimated month of placement for each appliance*:

Estimated number of adjustments for each appliance:

Dentist Information and Required Signature:

Requesting provider name*:	Provider contact name:	
Tax ID*:	NPI*:	
Taxonomy code*:	Benefit code*: **CSN**	
Telephone:	Fax:	
Street Address*:		
City:	State:	ZIP + 4*:
Provider signature:	Date:	