




STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Coverage Management Branch
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707

October 2, 2007

MEMORANDUM

QUEST MEMO
ADM-0702

TO: QUEST Health Plans

FROM:  Lois Lee, Acting Med-QUEST Division Administrator

SUBJECT: IMPLEMENTATION OF NEW DENTAL FISCAL AGENT

Effective September 1, 2007, Cyrca Dental assumed responsibility for managing the dental benefits for the Medicaid fee-for-service and QUEST populations. Cyrca Dental will process prior authorization requests, adjudicate claims and work with recipients and dental providers to coordinate dental care. ACS will process any claims for services rendered prior to July 1, 2007. CCMC will continue as the case management agency recruiting dentists and coordinating travel and translation for clients.

With the contracting of Cyrca Dental as the new third party administrator, the Med-QUEST Division made certain policy changes with regard to the dental program. Only the most recent CDT procedure codes will be accepted and all medical procedures which were previously allowed to be billed using CDT codes (mostly oral surgery codes) will no longer be processed by Cyrca. Dental procedures which are the responsibility of the QUEST medical plans (See attached Appendix M) should be billed to the QUEST plans or the Medicaid Fee-for-Service program, as appropriate. Medicaid fee-for-service and the QUEST plans will be responsible for processing hospital and anesthesia claims for services rendered in the hospital setting supporting a dental procedure. Dental providers seeking prior authorization for services must use the Cyrca Dental Prior Authorization form (copy attached). Cyrca Dental will be using this form to authorize dental services including those performed in the hospital. Cyrca Dental can provide a copy of the service authorization to the QUEST plan. If the QUEST plan wishes to have a copy, please provide the plan's contact name, fax number and phone number to Ms. Leslie Tawata at ltawata@cyrcachealth.com.

Attachments

**APPENDIX M
DENTAL PROCEDURES WHICH ARE THE
RESPONSIBILITY OF THE MEDICAL PLANS**

HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07340	Vestibuloplasty - ridge extension
D/07350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	Excision of Tumors:
D/07440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D/07441	Excision of malignant tumor - lesion diameter over 1.25 cm
	Removal of Cysts and Neoplasms:
D/07450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07451	Removal of benign odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07461	Removal of benign non-odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07465	Destruction of lesions by physical methods: electrosurgery, chemotherapy, cryotherapy or laser
	Excision of Bone Tissue:
D/07471	Removal of lateral exostosis – mandible or maxilla
D/07472	Removal of torus palatinus
D/07473	Removal of torus mandibularis
D/07490	Radical resection of mandible or maxilla
	Surgical Incision:
D/07511	Incision and drainage of abscess-intra oral soft tissue-complicated
D/07520	Incision and drainage of abscess - extraoral soft tissue
D/07530	Removal of foreign body, skin, or subcutaneous areolar tissue
D/07540	Removal of reaction - producing foreign bodies, musculoskeletal system
D/07550	Sequestrectomy for osteomyelitis
D/07560	Maxillary sinusotomy for removal of tooth fragment or foreign body

* HCPCS Codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
	Treatment of Fractures - Simple:
D/07610	Maxilla - open reduction (teeth immobilized if present)
D/07620	Maxilla - closed reduction (teeth immobilized if present)
D/07630	Mandible - open reduction (teeth immobilized if present)
D/07640	Mandible - closed reduction (teeth immobilized if present)
D/07650	Malar and/or zygomatic arch-open reduction
D/07660	Malar and/or zygomatic arch-closed reduction
D/07670	Alveolus - stabilization of teeth, open reduction, splinting
D/07680	Facial bones - complicated reduction with fixation and multiple surgical approaches
	Treatment of Fractures - Compound:
D/07710	Maxilla - open reduction
D/07720	Maxilla - closed reduction
D/07730	Mandible - open reduction
D/07740	Mandible - closed reduction
D/07750	Malar and/or zygomatic arch-open reduction
D/07760	Malar and/or zygomatic arch-closed reduction
D/07770	Alveolus - stabilization of teeth open reduction, splinting
D/07780	Facial bones - complicated reduction with fixation and multiple surgical approaches
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions:
D/07810	Open reduction of dislocation
D/07820	Closed reduction of dislocation
D/07830	Manipulation under anesthesia
D/07840	Condylectomy
D/07850	Surgical discectomy, with/without implant
D/07852	Disc repair
D/07854	Synovectomy
D/07856	Myotomy
D/07858	Joint reconstruction
D/07860	Arthrotomy
D/07870	Arthrocentesis
D/07872	Arthroscopy - diagnosis, with our without biopsy

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HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07873	Arthroscopy - surgical: lavage and lysis of adhesions
D/07874	Arthroscopy - surgical: disc repositioning and stabilization
D/07875	Arthroscopy - surgical: synovectomy
D/07876	Arthroscopy - surgical: discectomy
D/07877	Arthroscopy - surgical: debridement
D/07880	Occlusal - orthotic device, by report
	Other Oral Surgery - Repair of Traumatic Wounds:
D/07910	Suture of recent small wounds up to 5 cm
D/07911	Complicated suture up to 5 cm
D/07912	Complicated suture over 5 cm
D/07920	Skin grafts (identify defect covered, location and type of graft)
	Other Repair Procedures:
D/07940	Osteoplasty for orthognathic deformities
D/07941	Osteotomy – mandibular rami
D/07943	Osteotomy mandibular rami with bone graft; includes obtaining the graft
D/07944	Osteotomy, segmented or subapical, per sextant or quadrant
D/07945	Osteotomy, body of mandible
D/07946	Le Fort I (Maxilla - total)
D/07947	Le Fort I (Maxilla - segmented)
D/07948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft
D/07949	Le Fort II or Le Fort III - with bone graft
D/07950	Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible - autogenous or nonautogenous
D/07955	Repair of maxillofacial soft and hard tissue defects
D/07980	Sialolithotomy
D/07981	Excision of salivary gland, by report
D/07982	Sialodochoplasty
D/07983	Closure of salivary fistula
D/07990	Emergency tracheotomy
D/07991	Coronoidectomy
D/07995	Synthetic graft - mandible or facial bones, by report

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HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report
D/07997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D/07999	Unspecified oral surgery procedure, by report
Adjunctive General Services:	
D/09220	General anesthesia - first 30 minutes (limitation: nitrous oxide for unruly children or highly apprehensive adults; attach report or a note)
D/09221	General anesthesia - each additional 15 minutes
D/09420	Hospital calls (limitation: confinement must be approved; only under physician's request, no routine or follow-up visits)

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REQUEST FOR DENTAL AUTHORIZATION

CYRCA USE ONLY
PA No.:

- New Request Date Range: _____
- Extension Request Date Range: _____
- OP –Dental services performed in the hospital Date: _____

Check only ONE – Other Medically-Related Services Must Be Requested on a DHS 1144 Form.

NOTE: AN INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from date of approval unless otherwise noted by the consultant.

PLEASE PRINT INFORMATION CLEARLY

Medicaid Recipient Section																																																																																					
1. Medicaid I.D. Number:			2. Patient Name (Last, First, M.I.):					3. Gender: <input type="checkbox"/> M <input type="checkbox"/> F		4. Date of Birth: ____/____/____																																																																											
5. Patient Mailing Address (St., Apt. No., City, Zip Code):																																																																																					
Dental Service Section																																																																																					
6. Area of Oral Cavity	7. Tooth System	8. Tooth No(s) or Letters	9. Tooth Surfaces	10. Procedure Code	11. Description					A-Approved P-Pended D-Denied R-Revoked AC-Approved w/changes																																																																											
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12. Justification/Remarks:																																																																																					
13. Place of Treatment: <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other				14. Attachment: <input type="checkbox"/> Yes <input type="checkbox"/> No		15. If attachments: Note # of: Radiographs: _____ Oral Images: _____ Model(s): _____ Reports: _____																																																																															
16. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If treatment already commenced: Date appliance placed: _____ Total mos. of treatment remaining: _____						17. If prosthesis (crown, bridge, denture), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement: Date of prior placement: _____																																																																															
18. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates:						19. Is treatment result of <input type="checkbox"/> Auto accident? <input type="checkbox"/> Other accident? <input type="checkbox"/> Neither Brief description and dates:																																																																															
20. Identify all missing teeth with "x"																																																																																					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="16" style="text-align: center;">Permanent</td> <td colspan="6" style="text-align: center;">Primary</td> </tr> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td> <td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td> <td>T</td><td>S</td><td>R</td><td>Q</td><td>P</td><td>O</td><td>N</td><td>M</td><td>L</td><td>K</td> </tr> </table>												Permanent																Primary						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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K
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Dental Provider Section																																																																																					
21. Dentist Signature/Date:						22. NPI:			23. Medicaid Provider Number:																																																																												
24. Print Dentist Name:						25. Print Contact Name: (if different from Dentist):																																																																															
26. Dentist Mailing Address (St., Suite No., City, Zip Code):						27. Telephone Number:			28. Fax Number:																																																																												
Consultant Comments																																																																																					
Dental Consultant Signature/Date:																																																																																					

Prior Authorization Form Instructions

Note: X-Rays or reports may be required for certain procedures and should accompany the completed Prior Authorization form. Verify the requirements according to the Code Table provided by Medicaid.

1. **Medicaid Identification Number:** Enter patient's Medicaid I.D. number assigned by the State of Hawaii.
2. **Patient Name:** Enter patient's last name, first name and middle initial.
3. **Gender:** Check appropriate box to indicate patient's gender.
4. **Date of birth:** Enter patient's date of birth in MM/DD/YYYY.
5. **Patient's Mailing Address:** Enter patient's mailing address which may be different from the patient's residence address.
6. **Planned date or date range of procedure(s):** Enter the date or range of dates for the planned procedure(s).
7. **Area of oral cavity:** *Optional.* Use area of oral cavity code set form ANSI/ADA/ISO Specification No. 3950 "Designation System for Teeth and Areas of the Oral Cavity."
8. **Tooth system:** *Optional.* Enter applicable ANSI ASC X12 code list qualifier. Use **JP** when designating teeth using the ADA's Universal/National Tooth Designation System. Use **JO** when using the ANSI/ADA/ISO Specification No. 3950.
9. **Tooth no(s) or letter(s):** Designate tooth number when procedure code requested directly involves a tooth. If a range of teeth is being requested use a hyphen ("-") to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code requested.
10. **Tooth surface:** Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes without spaces: **B** = Buccal; **D** = Distal; **F** = Facial; **L** = Lingual; **M** = Mesial; and **O** = Occlusal.
11. **Procedure code:** Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.
12. **Description:** Use description of dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.
13. **Justification:** Briefly describe medical reason(s)/purpose of the procedure.
14. **Place of treatment:** Check place of treatment. If procedure is being performed in nursing home, check "other" box.
15. **Attachment:** Indicate whether there are attachments (e.g., report or x-rays)
16. **If attachments: Note # of:** Identify the number of attachments.

Dental Provider Section

17. **Dentist signature/date:** The dentist requesting the prior authorization (usually treating or rendering dentist) signature and date.
18. **NPI number:** The National Provider Identifier (HPI) issued to health care providers by the National Plan and Provider Enumeration System (NPPES).
19. **Medicaid provider number:** Medicaid provider number assigned by the Med-QUEST Division. This number is accepted until the NPI number is received.
20. **Print contact name:** Enter contact name to obtain additional information, if not dentist.
21. **Telephone no.:** Enter telephone number of dentist or contact name.
22. **Fax no.:** Enter fax number of dentist or contact name.

Cyrca Dental

Fax or mail the completed form using the information at the top of the form. If the prior authorization requires either X-Rays or other non-paper attachments, mail the form and attachments to the address on the top left of the form. Faxes of prior authorizations that require attachments will pend up to 30 days until the appropriate information is provided.

To be Completed by Medicaid

DO NOT COMPLETE. Cyrca Dental will make determination and fax or mail the determination using information on the form to the requesting dentist.