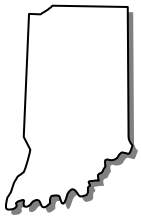
INDIANA HEALTH COVERAGE PROGRAMS



P R O V I D E R B U L L E T I N

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To: **All Dental, Federally Qualified Health Center, and Rural Health Clinic Providers**

Subject: **McArty v. Roob – Denture Prior Authorization Requirements**

Overview

McArty v. Roob is a lawsuit recently filed against the state of Indiana that challenges the State's alleged policy of refusing to provide Medicaid payment for dentures or denture services solely because six years have not passed since the recipient member last received any such services.

Under an agreement approved by the court, Indiana Medicaid has agreed not to deny Medicaid coverage for medically necessary dentures, partial dentures, and associated repairs and relines, based on the fact that the Medicaid member on whose behalf the request for services is made, received such services within the last six years, when the services are otherwise covered. In addition, Indiana Medicaid has agreed to review all prior authorization (PA) requests for dentures, partial dentures, and associated repairs and relines that were denied on or after June 13, 2006, if the provider resubmits the *Indiana Prior Review and Authorization Request* form with documentation showing medical necessity.

Under the terms of the agreement, the State is permitted to deny coverage of these services if the member is no longer eligible for Medicaid or if the State determines that the request is not medically necessary. The court also allows Medicaid to require the member to use the most cost-effective treatment instead of the specifically requested treatment, as long as the cost-effective procedures meet the medically necessary needs of the member. Indiana Medicaid is requesting that dental providers work with members that meet this criterion and resubmit the prior authorization request for consideration.

Under the agreement, a service is "medically necessary" when it meets the definition of "medically reasonable and necessary service" as defined in *405 IAC 5-2-17*. Indiana Medicaid determines medical necessity by reviewing documentation submitted by the provider to support the functional and medical needs of the patient. When submitting the *Indiana Prior Review and Authorization Request* form, the dentist should complete all applicable information and include all descriptions necessary to create a complete clinical picture of the patient and the need for the request. The request should include any information about bone and/or tissue changes due to shrinkage; any recent tooth loss; any weight loss; any bone loss in the upper or lower jaw; any recent sickness or disease; or any changes due to physiological aging. If the member's primary source of nutrition is parenteral and/or enteral nutritional supplements, a plan of care to wean the member from the nutritional supplements must be included with the request. The dentist must also include its office telephone number on the PA request in case the PA analyst has questions. Prior authorization is not required for members younger than 21 years of age; however, the provider must maintain documentation to support medical necessity in the patient's medical record.

Annual Dental Cap

The provision of dentures, relines, and repairs counts toward the annual $600 dental cap for members who are 21 years of age or older. If the member requires additional dental services, beyond the $600 of dental services covered under the dental cap for that calendar year, providers can hold the member responsible for the additional payment. In this case, the provider does not file the additional claims with the Indiana Health Coverage Programs (IHCP). The following guidelines must be met for IHCP providers to hold a member responsible for payment:

- The service rendered must be determined to be non-covered by the IHCP or a covered service for which the member has exceeded the program limitations for the particular service.
- The member must understand **before receiving the service** that the service is not covered by the IHCP and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP will not cover the service.

Providers can use a consent form for adult dental services that specifies a member only has $600 of dental services, and that all additional dental services are not covered after the $600 annual dental cap is exhausted. The member should sign the form to acknowledge this and indicate the understanding that he or she is financially responsible for all services agreed to after the cap is exhausted, and that reimbursement is not available from the IHCP.

Providers can bill the member using the usual and customary charge for any services provided after the cap has been exhausted. However, if a service is partially paid by the IHCP because of the cap limit, the member can only be billed for the difference between what the IHCP would have reimbursed to the provider and what the IHCP actually paid.

Verifying Eligibility

Providers must verify member eligibility prior to delivering services. Providers are encouraged to use one of the Eligibility Verification Systems (EVS), such as the automated voice-response system (AVR), the OMNI swipe machine, or Web interChange to confirm if a member has reached the dental cap.

Audit *6236 – Dental services are limited to $600 per member 21 years old and older*, identifies whether a member has met his or her cap. To verify eligibility using the AVR, providers must use the billing provider number for the dental office. Providers may also call Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 to verify how much of the dental cap has been met. However, providers must remember that the information provided by Customer Assistance only reflects services paid up to the point in time of the call. The IHCP does not reserve services for a provider or guarantee payment of services.

Additional Information

Questions about the information in this bulletin may be directed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

If you need additional copies of this bulletin, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/banner_results.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.