



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

275 E. Main Street, 6W-A  
Frankfort, KY 40621  
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**Janie Miller**  
Secretary

**Elizabeth A. Johnson**  
Commissioner

May 8, 2009

**TO:** Individual Dental Providers (60) Provider Letter A-156  
Group Dental Providers (61) Provider Letter A-18

**RE: Dental and EPSDT Dental  
New Processes and Procedures**

Dear Kentucky Medicaid Provider:

In an effort to streamline the prior authorization process for dental services, whether through traditional Dental or EPSDT Special Services Dental program, EDS will begin performing the medical necessity reviews for Prior Authorization beginning May 18, 2009. This process change is a result of the recommendations made by the Medicaid Advisory Council to streamline the dental service prior authorization process.

Services provided to Kentucky Medicaid members under the traditional Dental or EPSDT Special Services Dental programs must be medically necessary and clinically appropriate as outlined below in the excerpt from provider letter A-04, dated February 25, 2008.

"Medically-necessary" or "medical necessity" within the dental program means that the Dental Care and Services furnished must:

1. *Be necessary to protect, maintain or restore function (speech and mastication), appearance, growth and development of the oral-facial structures or to alleviate pain, infection, disfigurement, and dysfunction.*
2. *Be individualized, specific and consistent with the need and the symptoms, or confirmed diagnosis of the condition or injury under treatment and not in excess of the member's needs.*
3. *Be consistent with generally accepted professional dental standards.*
4. *Be reflective of the level of service that can be safely furnished and for which no equally effective or more conservative or less costly treatment is available.*
5. *Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or for the convenience of the provider.*

The Traditional Dental services that will be subjected to medical necessity review, per 907 KAR 1:026, are as follows:

Service Code	Service Code Description	Required Documentation
D0330-for members under the age of 6	Panoramic Film	MAP 9; Letter of Medical Necessity
D4341	Periodontal Scaling and Root Planing, per quad	MAP 9; Periodontal Charting, including pocket depths

Per 907 KAR 1:034, all requested service codes require prior authorization and medical necessity review for any member age 21 and under through the EPSDT Special Services Dental Program. The requests should include a completed MAP-9 form with tooth numbers, a completed EPSDT Special Services Dental Evaluation Form (MAP-005), x-rays and any other pertinent documentation. If you are submitting a request for External Bleaching (Procedure Code D9972-D9973), x-rays are not required, but "before" pictures must be included. Original x-rays or copies of x-rays which have good diagnostic quality will be acceptable.

The above referenced MAP forms can be found at the following websites:

- <http://www.kymmis.com/kymmis/Provider%20Relations/PriorAuthorizationForms.aspx> for the MAP 9
- <http://chfs.ky.gov/dms/epsdt.htm> for the MAP 005

Requests that do not include the above documentation will be addressed with a Lack of Information (LOI) process and will not be submitted to the dental consultant for review. The provider will receive a letter that outlines the missing information and the timeframe for submission of such information.

Effective May 18, 2009, requests for these procedures should be sent to:

EDS  
Attention: Dental Department  
PO Box 5350  
Frankfort, KY 40601  
Facsimile 1-877-298-6108 Option 4

Upon completion of the review by the dental consultant, an approval letter or a denial letter will be issued. If you have submitted original x-rays, rather than copies, those will be returned to you.

Note that the Dental and EPSDT Special Services Dental Program requires **pre-authorization**. Requests for authorization should be made prior to providing services, except in emergency situations or extenuating circumstances, such as retroactive member eligibility.

If a request is denied, you have the right to request reconsideration. The request for reconsideration must be in writing and postmarked within 30 days of the date of the denial letter.

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The written request must state clearly that you wish reconsideration and must be submitted to:

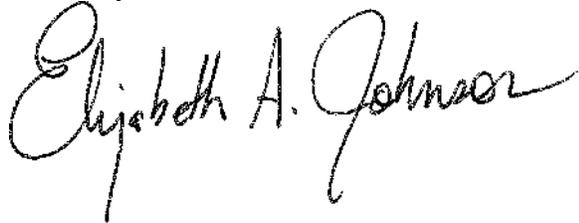
EDS  
Attn: Dental Reconsideration Coordinator  
PO Box 5350  
Frankfort, KY 40601

Within 30 days of your request we will send you a letter with our decision.

**Please note that all *non-dental* EPSDT Special Service requests as well as Orthodontic requests will continue to be reviewed by SHPS.**

We appreciate your continued cooperation and participation with the Dental and EPSDT Special Services Dental Program. If you have questions or need additional information please contact EDS at 877-298-6108, option 3 or DMS at 502-564-9444.

Sincerely,

A handwritten signature in black ink that reads "Elizabeth A. Johnson". The signature is written in a cursive, flowing style.

Elizabeth A. Johnson  
Commissioner

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