Comagine Health



District of Columbia Department of Health Care Finance

Utilization Review Quality Improvement Organization Provider Manual

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Section 1. Purpose of Comagine Health Care Management Program

The purpose of the Care Management program is to ensure that appropriate medical services are provided in accordance with state and federal regulations, statutes, and policies to recipients of the District of Columbia (DC) Department of Health Care Finance (DHCF) state Medicaid Plan (fee for service).

1.1 History of Peer Review

The Federal government has expended significant dollars in developing and supporting review of care in facilities. In fact, this type of review was required by law in 1972 for Medicaid and Medicare programs. Comagine Health has been in existence since 1974, providing utilization management, care coordination, case management, quality assurance services and special studies for Medicare, Medicaid, and private sector entities.

1.2 Corporate Background and Experience

Comagine Health is one of the nation's leading healthcare consulting and care management organizations, helping to transform care and improve care delivery and patient outcomes. We work with clients throughout the public and private sectors to advance the quality, efficiency, and value of healthcare for millions of Americans every day.

Programs offered include traditional utilization management services, such as pre–service, concurrent, retrospective review, coding validation, and medical consultation. Services designed for the managed care arena include the early identification of high–risk patients, specialty referral management services, consumer advocacy services and audits of access to care.

1.3 Organizational Mission and Vision

Mission: Together, with our partners, we work to improve health and to create a better health care system so that people and communities will flourish.

Vision: Health care reimagined, together.

At Comagine Health, we believe in partnership and in community. Together, we work on initiatives and implement programs aimed at impacting and aligning key levers or strategies to produce outcomes that improve health and create a better health care system through systemwide quality improvement, care management, research and evaluation, and data solutions.

1.4 Utilization Management and Medical Necessity

Utilization management is the evaluation of medical necessity, appropriateness, and efficiency of healthcare procedures and facilities under the applicable health benefit plan. Sometimes utilization management is referred to as utilization review or UR.

Medical necessity, or medically necessary, is defined as health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. The service shall, or is reasonably expected to:

- Prevent the onset of an illness, condition, or disability,
- Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability, and
- Assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the recipient and those functional capacities that are appropriate for individuals of the same age.

Section 2. Communications with Comagine Health

Comagine Health's review process is flexible and is set up to handle review requests received via the internet (preferred) and secure fax. Comagine Health offers secure web-based review capability using the internet to create a two-way link, via the Comagine Health Provider Portal, which can be used to exchange care management data and get your questions answered, thus facilitating real-time, online approvals. Comagine Health also maintains toll-free, dedicated phone and fax numbers for Medicaid providers to use to request and review services.

Comagine Health's regular business hours are 8:30 am to 5:00 pm Eastern Time, Monday through Friday; excluding scheduled holidays (please refer to Appendix A: Contact Information). Comagine Health staff members are available to handle review requests received from 8:30 am to 5:00 pm on regular business days.

2.1 Contacting Comagine Health by Phone

To reach Comagine Health's customer service for questions about reviews you may also call (800) 251-8890. In the event your call is after business hours, or an attendant is not available, your call will be directed to Comagine Health's 24-hour voice mail system.

During regular business hours, Comagine Health monitors the voice mail system, checking messages and ensuring callbacks are handled in a timely manner. Messages left after 5:00 pm, or on weekends, or holidays are retrieved on the next business day and calls are returned by 12:00 pm Eastern Time.

2.2 Contacting Comagine Health via the Provider Portal (Preferred)

Providers submitting web-based review requests will need to obtain a User ID and password to log in and access the Comagine Health Provider Portal. Registered, trained providers can log in and directly enter information and attach documents required for the admission (i.e., prior-authorization, long-term care reviews, service reviews and retrospective reviews).

For more information on how to submit web-based review submissions, please visit: https://comagine.org/program/dc-medicaid-um/providers (scroll down to 'Comagine Health Provider Portal' for links, Quick Start Guides, FAQs, and training videos) or contact Comagine Health at (800) 251-8890.

2.3 Contacting Comagine Health by Fax

Providers who submit infrequent requests may fax review requests to Comagine Health at the numbers specified below (the preferred method of submitting a review is electronically via the Comagine Health Provider Portal and reviews submitted in the Portal are prioritized). Faxed submissions (only one patient per fax) must be legible and include all required demographic, clinical information, and forms.

Completed medical necessity reviews may be faxed as indicated below. Please do not send the entire medical record via fax; only the required pertinent clinical documentation to complete a review.

Toll-Free Fax Number: 1 (800) 731-2314 (for Providers who submit reviews infrequently)

A fax cover sheet with a confidentiality disclaimer is recommended.

The following are suggestions for submitting your fax:

- No bold font
- No italics
- No underlining
- Not all caps
- If possible, no special characters, i.e., * or = (quotes are OK)
- Normal spacing (i.e., looks like a normal document not written in a column that takes up a horizontal third of the page)
- Typed is preferred over handwritten

Please complete the **719A** and other DC DHCF forms completely as required by the review type. Forms not completely filled out will be returned to the provider and if not completed, a technical denial will be issued.

2.4 Comagine Health's Communication of Review Determinations

Our secure Comagine Health Provider Portal Dashboard offers immediate feedback from Comagine Health concerning the request for review— Processed, Pending Submission (draft), Pending Decision, or pending for Further Information Required (from the provider). For requests submitted through the preferred web-based review system, an internet-based notification of the final determination is posted for the provider. Providers using the web-based system for their request submissions will not need to wait for the transmission of a fax or mailed document to learn of the final determination.

For those requests that are not submitted through the web-based review system, Comagine Health will communicate the determination and the Prior Authorization number (i.e., the certification number) to the provider via fax. Comagine Health will send letter notifications for all adverse determinations and appeal reviews within five business days after the determination is given. These notifications will be sent to the recipient, (or if a minor, to the parent or guardian), and the requesting provider.

Section 3. Compliance with URAC's Utilization Review Standards

Comagine Health complies with URAC health utilization management (UM) standards when performing utilization reviews (UR). These standards provide a process for conducting a utilization review that is clinically sound and respects recipients' and providers' rights. URAC standards ensure that only appropriately trained, qualified clinical personnel conduct and oversee the utilization review process; that a reasonable and timely appeals process is in place; and that medical decisions are based on valid clinical criteria. Some frequently asked questions about making utilization review decisions are answered in the following section.

3.1 Frequently Asked Questions about Utilization Review Decisions

1. Who makes the utilization review decision?

URAC (formerly known as Utilization Review Accreditation Committee). Health Utilization Management Accreditation requires Comagine Health to use a three-step process to determine if a proposed medical treatment or service is medically necessary:

- **Initial Clinical Review**: A licensed clinical reviewer conducts this first step of the review process using InterQual criteria, organization policies, American Society of Addiction Medicine (ASAM) criteria, the DC's DHCF regulations, criteria and review protocols, or additional guidance. If the clinical information provided does not meet medical necessity criteria and review protocols for approved services, or if, in the clinical reviewer's judgment, a physician should review the case, it is referred for peer clinical review.
- **Peer Clinical Review**: A licensed physician qualified to render a clinical opinion about the proposed treatment or service performs a peer clinical review by reviewing all available information and then making a decision about certifying care or services. When a non-certification decision is made by the physician reviewer, a Comagine Health reconsideration process is available.
- **Comagine Health Reconsideration (appeal) Process**: A provider or recipient may initiate a written request for reconsideration within 21 business days from the date of the non-certification notice for all review types except for Nursing Home Medical Eligibility Reviews. A written request for reconsideration for Nursing Home Medical Eligibility Reviews must be made within 30 business days of the date of the non-certification notice. Requests may also be made via telephone, followed by a written request. The process may be expedited, if requested (please refer to Section 16).

2. What recourse is there when we disagree with a Comagine Health determination?

Comagine Health's written notice of non-certification decision contains instructions for initiating a reconsideration request to Comagine Health or an appeal of the non-certification determination to the District for the recipient. Please refer to Section 16 of this manual for details on the reconsideration and appeal process. If, after reconsideration review, the recipient still disagrees with the Comagine

Health determination, their reconsideration letter will outline the steps that must be taken to request a Fair Hearing with the DC Medicaid.

3. What is considered an urgent review?

An urgent review is performed when a case involves urgent care and the application of the time periods for making non–urgent care determinations (a) could seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function, or (b) in the opinion of a physician with knowledge of the recipient's medical condition would subject the recipient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

4. How are review timelines determined?

The number of days allotted for each type of review for the DC's Fee for Service Medicaid program is based on the District's Fee for Service Medicaid Program review protocols. Review timelines differ by review type and by urgent reviews and non-urgent reviews. If the review requires additional information, additional time is allotted. A table of review timeliness is shown in following pages under question 5 of this section.

When additional information is required to complete the review, the timeline is three (3) business days. When this occurs, it is the provider's responsibility to provide Comagine Health with the additional information requested to complete the review. If the information is not received within three business days, the review will be completed with the information already received or a technical denial will be issued, putting the case at risk of potential non-certification. If the District's required forms are not filled out, a technical denial will be issued.

5. What are the time frames for Comagine Health Utilization Management Review Decisions per District Requirements?

When all necessary clinical information has been received and no referral for clinical physician review is needed, the timeframes for completion of reviews are as follows:

Table 1. Review Timeframes

Review Type	Timeframes for Completion from Date All Information Required/ Submitted to Comagine Health
Prior Authorization Review for Acute Care Hospital	6 days
Specialty hospital admission	3 business days
Pre-Admission Review	3 days
Outpatient services and eyewear	6 days
Home Health & private duty nursing	6 days

Review Type	Timeframes for Completion from Date All Information Required/ Submitted to Comagine Health
Direct and transfer Admission for all Acute Care Hospital	Within 24 hours of admission
Retrospective Reviews for Acute Care	14 business days
Outpatient Medical Services and Surgical Procedure	6 days
Durable Medical Equipment	6 days
Eyewear and Contact Lens	6 days
Out of State Nursing Home Placement	3 business days
Hospice	6 days
Nursing Facility Add-on	6 business days
Continued Stay Reviews	24 hours (or 1 business day)
Retrospective Reviews	6 business days
Level of Care Review - ICF/IDD	3 business days
Plan of Care	6 business days
EPD Waiver Program Medical Review	6 business days
LTC Assessment Reconsideration	20 business days
CASSIP Disability Determinations	6 business days
Katie Beckett/TEFRA	6 business days
Individual reviews for selected medical and surgical procedures	6 days
State Plan	5 business days
Dental and Orthodontic Service	6 days
SUD Residential Treatment Facilities Admission review	3 days
SUD Residential Treatment Facilities Continued Stay Reviews	3 business day of the last certified day

6. What if Comagine Health requests additional information?

When additional information is required to complete the review, the timeline is adjusted accordingly. When this occurs, Comagine Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the additional information required to complete the review.

Should additional information be required to complete the review, Comagine Health will notify the requesting provider and pend the review for three business days awaiting additional information. If the information requested is not received within two business days, the review will be processed with the information already provided or a technical denial will be issued.

For instances in which required forms are not completed or there is late notification, a technical denial will be issued per District requirements. Technical denials are not eligible for reconsideration/appeals, however a new review may be requested with required, completed forms and relevant clinical information, if the required District review submission timelines have not expired.

Section 4. HIPAA

Comagine Health provides care management services on behalf of its clients and is considered a "Business Associate" of these clients under the Health Insurance Portability and Accountability Act (HIPAA) "Administrative Simplification" regulations governing patient health information. These regulations include the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") and the Security Standard ("Security Rule") and in accordance with the requirements of the DC.

Section 5. Provider Billing Concerns

5.1 Claim Discrepancies

Providers are encouraged to thoroughly examine discrepancies in claims for accuracy prior to contacting Comagine Health. Xerox Business Services, LLC, the fiscal agent for DC DHCF, has an inquiry telephone line for this purpose. Providers may contact the fiscal agent at (202) 906-8319 (inside DC metro area) or (866) 752-9233 (outside DC metro area).

Providers may call Comagine Health to investigate a discrepancy that has caused or has the potential to cause a claim to fail. A discrepancy may occur when adjustments are made after an authorization has been completed by Comagine Health and different information is submitted during the billing process. The Provider is responsible for ensuring that submitted information is consistent from authorization through the billing process. Examples of such discrepancies are as follows:

- The date(s) on the Comagine Health review does not match the certified admission or discharge date on the claim. Admitting or principal diagnosis codes and/or modifiers on the Comagine Health review do not match the code(s) on the claim.
- Incorrect recipient Medicaid Identification number indicated on the
- Comagine Health review.
- The Prior Authorization number (11 numeric characters) used for billing does not match.
- The Provider number (nine numeric characters) used for billing does not match.

5.2 Contingency for Payment

Comagine Health certification indicates only that admission is medically necessary. This certification (approval) does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in DC.

Section 6. Eligibility

The District's Medicaid utilization review program has been established to provide a way to authorize medically necessary services. The Federal and State Medicaid program was established and is regulated by Federal and District Codes.

There are times when DC Medicaid recipients could be covered under another insurance or program, and the requirements for review may vary. If another insurer is the primary, a review with Comagine Health will not be required.

6.1 Provider Responsibility for Eligibility Verification

Providers are responsible for verifying recipient eligibility prior to submitting a review request to Comagine Health for prior authorization (PA) of admission, continued stay, or retrospective review. The following information is available to assist the provider in the eligibility verification process.

Prior to submitting a review request to Comagine Health, remember to verify eligibility first.

Verify recipient eligibility for Medicaid benefits and services at the beginning of each month or at each visit/care encounter. Recipients may be enrolled in programs with restricted services. Certain services require prior approval for reimbursement. Please refer to the fee schedule to confirm if a PA is required. This information may be obtained from the Interactive Voice Response (IVR) system by calling (202) 906-8319 (in District) or (866) 752-9231 (outside DC metro area).

The IVR will prompt you to enter your provider number. This is the nine-digit number assigned to you through the Medicaid program. The system will then prompt you to enter the recipient number. This nine-digit code is listed on the patient's Medical Assistance Card.

Section 7. Utilization Review Methods of Submission

7.1 Submission Methods

Comagine Health will accept review requests submitted by providers:

- Over the internet (Comagine Health Provider Portal is the preferred method of review submission), or
- Via Fax (only for providers who submit reviews infrequently or for out-of-state providers).

Include demographics in your submission, any forms required by the District (entirely completed), and relevant clinical information to substantiate the reason the service is being requested.

Table 2. Submission Methods

Submission Mode	Description
Internet (preferred)	The Comagine Health Provider Portal is the preferred method of review submission. Providers log in to web-based review system and directly enter prior authorization information for admission, concurrent (continued stay), or retrospective review request instead of sending records for shorter stays. For information on how to submit web-based review submissions, please visit: https://comagine.org/program/dc-medicaid-um/providers (scroll down to 'Comagine Health Provider Portal' for links, Quick Start Guides, FAQs, and training videos) or contact Comagine Health at (800) 251-8890.
Fax	Providers may request prior authorization for admission, concurrent (continued stay), or retrospective reviews by faxing the request to Comagine Health's secure, HIPAA-compliant toll-free fax number: 1 (800) 731-2314. (Please only send one Medicaid recipient request per fax; faxes containing more than one request will be returned.) Include a cover sheet regarding confidentiality, and your admission information from the medical record.

Section 8. Process for Utilization Review Submissions

Comagine Health has adopted a browser-based product that uses the internet to create a two-way link between healthcare providers and Comagine Health Utilization Management Review to facilitate the prior authorization review process. The web based Comagine Health Provider Portal review system allows providers to submit utilization review requests to Comagine Health using a secure internet connection and is available to the provider 24 hours a day, seven days a week. Reviews submitted during non-office hours will be processed as received on the next business day (please refer to Appendix A).

8.1 Responsibility

Providers are responsible for verifying eligibility prior to submitting all review requests as required by the District's Medicaid Program utilization review policies and regulations. Providers are responsible for submitting all reviews to Comagine Health in a timely manner as required by DC, DHCF. Providers are also responsible for submitting reviews to Comagine Health for recipients who are covered by other Third-Party Liability (TPL) resources for admission and continued stay if utilizing DC Medicaid Fee for Service as a form of primary reimbursement.

8.2 Requirements

Use of the Comagine Health Provider Portal, web-based review system, requires internet access and establishment of provider logon information for each user. Training is conducted by Comagine Health via Zoom sessions. If you are interested in receiving training, please see Comagine Health's website at: https://comagine.org/program/dc-medicaid-um/providers scroll down to 'Comagine Health Provider Portal' for links, Quick Start Guides, FAQs, and training videos) or contact Comagine Health at (800) 251-8890.

8.3 Process and Procedures

8.3.1 Submission

If you have already received Comagine Health Provider Portal web-based review submission training from the Comagine Health team, submit your review requests via the internet at the following web address: https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin

For assistance with use of the web-based review submission once registration and training have occurred, please contact the Comagine Health DC Office at (800) 251-8890 or email your inquiry to dcmedicaid@comaginehealth.org. If you do not have internet access the preferred method of review submission is via fax.

Operational hours for Comagine Health DC Medicaid utilization reviews are: 8:30 am to 5:00 pm Eastern Time Monday through Friday except for designated holidays (please refer to Appendix A).

The provider may submit the prior authorization review request to Comagine Health via the web-based review system (preferred method) or fax for providers who submit infrequently or are out of state providers.

8.3.2 How to Reach Comagine Health

Comagine Health Provider Portal:
https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin

Phone: 1 (800) 251-8890

Fax: 1 (800) 731-2314 (for all providers who submit reviews infrequently or are out of state)

8.3.3 Required Review Documentation

The provider will submit all required, completed DHCF forms, depending on the review type, in addition to any relevant clinical information required to substantiate the service request.

Additional requirements for clinical documentation and/or other necessary information to complete the review process are available within this manual. The requirements of the DC DHCF Policies and Transmittals are available on the DHCF website at http://dhcf.dc.gov/page/dhcf-our-providers.

8.3.4 Medical Necessity Screening

Once the information for the specific review period has been received, Comagine Health's clinical reviewer will assess the medical information to determine whether the condition of the recipient meets medical necessity for the services and level of care requested. If the Criteria, Federal and District regulations are met, the Comagine Health clinical reviewer will issue a Prior Authorization number and the review will be certified (please refer to https://www.changehealthcare.com/clinical-decision-support/interqual for information about InterQual criteria, Appendix C for the DHCF's Nursing Facility Level of Care Assessment form, and Appendix D for DHCF's Dental Criteria Guidelines).

8.3.5 Second-Level Peer Review

Cases that clinical reviewers have determined do not meet criteria are referred to a Comagine Health physician reviewer (medical director or physician consultant). The physician reviewer will review the clinical information and either certify the admission or issue a potential non-certification. In the event of a potential non-certification, the attending physician will be given an opportunity to discuss the review with the Comagine Health physician reviewer. Following the discussion, Comagine Health will either certify or non-certify the medical review.

8.3.6 Adverse Determinations

If the Comagine Health physician reviewer issues an adverse determination of the medical review, a Comagine Health representative will notify the appropriate facility by web-based review system or by

fax. Comagine Health will send the non-certification letter within five business days to the following parties: the recipient, guardian, or parents of recipient (if minor) and the requesting provider.

The adverse determination will be documented in the non-certification (denial) letter containing justification for the non-certification as well as an explanation of the right to request a reconsideration review to Comagine Health's initial adverse determination and recipient appeal rights with the DC Office of Administrative Hearing (OAH).

Comagine Health will not send letter notifications on certified (approved) reviews. Certified reviews and prior authorization numbers can be found on the Comagine Health Provider Portal for reviews submitted via the web. Providers who faxed their reviews will receive notification of their certified reviews and prior authorization numbers via fax.

Comagine Health will send letter notifications for all non-certified reviews and Comagine Health reconsideration reviews. These notifications will be sent to the recipient, guardian, or parent of recipient (if minor) and the requesting provider or facility.

The DC DHCF will not reimburse providers for services that have not been approved by Comagine Health, except for adverse determinations that are reversed as a result of a reconsideration review performed by Comagine Health or a recipient Fair Hearing by the District.

8.3.7 Procedures for Admissions or Continued Stay (Concurrent) Review - Due on Weekends and Holidays

In those instances where the concurrent review date falls or is due on Saturday, Sunday, or a holiday, the concurrent review will take place on the preceding Comagine Health business day. Adverse determinations can be retrospective to the first day the recipient was not meeting the level of care criteria or protocols.

8.3.8 Late Submission Review Requests

Late review requests will result in a technical denial and authorization for services moving forward only if the review was not submitted timely.

Reviews for continuing services are due on or before the last day of service authorized. The required timeframe for submitting all review documentation to Comagine Health for all Acute Care Hospitals in the State is within 24 hours of the actual admission.

In the event of an emergency transfer, it is the responsibility of the receiving hospital to obtain authorization for the emergency admission within the timeframes outlined.

8.3.9 Chart Requests

At the direction of the DC, DHCF, Comagine Health may request the chart of a recipient to verify quality of care or accuracy of the information provided. The chart request may be made telephonically, through the web-based review system, or in writing.

Section 9. Prior Authorization

The most effective form of utilization review is prior authorization which takes place before the recipient receives a service. The biggest advantage is that inappropriate health care services can be avoided rather than contested after an expense is incurred.

The DC's Medicaid utilization review program has been established to provide a way to prior authorize before services are rendered. The Federal and State Medicaid program was established as a prior authorization system and is regulated by Federal and State codes. Providers are required to submit clinical reviews in a timely manner with complete documentation to substantiate the service request for the recipient.

9.1 Responsibility

Providers are responsible for obtaining the prior authorization review from Comagine Health in advance of delivering the services to the recipient.

Prior to submitting a review request to Comagine Health, remember to verify eligibility first.

Receiving providers are to submit review information to Comagine Health. The applicable portions of the 719A form pertaining to the service being requested must be completed (the provider is to retain the original copy of the 719A form). Only the relevant clinical information to satisfy the District's Fee for Service Medicaid Program utilization review protocols and InterQual criteria is required to complete the review process.

Providers will be notified of incomplete 719A forms or incomplete clinical information and be given up to three business days to submit additional information to complete the review. Notification of an incomplete review submission will occur via the web portal for web submission (preferred), via fax for fax submission. If the 719A form remains incomplete after three business days a technical denial will be issued. If clinical information remains incomplete after three business days, a non-certification may result when referred to the physician reviewer.

Comagine Health has five days to complete the review, once all the relevant information has been received to complete the review process.

9.2 Requirements

All of the services listed below must be prior authorized by Comagine Health in order to be reimbursed by the DC:

- Acute Care Hospitals
- Acute Care Hospitals Bordering Counties

- Acute Care Hospital Surgical
- Community Support Services
- Collaborative Care Model (CoCM)
- Gastric Bypass Surgery
- Outpatient Medical and Surgical Procedures
- If a PA requirement is noted on the fee schedule
- Specialty Hospital admission
- Home Health and Private Duty Nursing Services
- Hospice (Outpatient and Inpatient) Services
- Eyewear and Contact Lenses
- Dental and Orthodontic Services
- Specific Durable Medical Equipment, Prosthetics, Orthotics,
- Medical Supplies (DME/POS)
- Out of State Nursing Home Placement
- Intellectual and Developmental Disabilities Waiver
- EPD Waiver Program Services
- SUD Residential Treatment Facility

Authorization for services will remain valid for 12 months.

9.3 Information Needed for the Review

Comagine Health representatives require all the information below for clinical reviews.

Please refer to Appendix B for the 719A form.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address, phone number and fax number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or surgery/service date
- Justification for the hospitalization or service request, and pertinent history
- Anticipated discharge date
- Documentation to justify the medical necessity of the service at the requested level of care, including pertinent test results, labs, medications, and treatment
- Discharge planning details to include placement (provider)

- Prior authorization request dates of service must be within 6 months from the physician's signature date

9.4 Eyewear and Contact Lenses

Eyewear and contact lens requests may be submitted via the Comagine Health Provider Portal including the required prescription documentation and the completed 719A form (the provider is to retain the original copy of the completed 719A form).

9.5 Dental and Orthodontic Services

Dental and Orthodontic Service requests may be submitted via the Comagine Health Provider Portal. Please include all the required documentation with your submission:

- Submit only services requiring prior authorization
- Complete all appropriate sections on the 719A form (retain the original copy of the 719A form)
- Attach electronic radiographs as required
- Please refer to Appendix D for the DHCF approved Dental Criteria Guidelines

9.6 Specific Durable Medical Equipment (DME)

- Specific DME requests may be submitted via the Comagine Health Provider Portal submitting the complete required documentation:
- Submit requests only for services requiring prior authorization:
  - prosthetic devices not included in the fee schedule
  - medical supplies and equipment in excess of specific limitations
  - cost, rental or lease equipment, specific procedure codes, and
  - repair of purchased equipment should not exceed 75% of the purchase price of the equipment
- Completed 719A form (please refer to Appendix B).
- The provider is to retain the original copy of the 719A form
- For DME and items not included in the fee schedule
  - Beneficiaries enrolled in IDD (Intellectual & Developmental Disability) waiver will have Comagine Health notify the provider and refer the request with supporting documentation to DHCF for review within three days of the completed 719A.
  - Beneficiaries enrolled in Fee for Service Medicaid will have Comagine Health notify the provider and refer the request with supporting documentation to DHCF for review within six days of the completed 719A.
- Notification of authorization will be provided via the Comagine Health Provider Portal or fax depending on the method of review submission.

9.7 Out of State Nursing Home Placement

May be appropriate when there is no appropriate nursing home bed available in the DC and requires that the following additional information be submitted for an initial admission review. All forms must be fully completed:

- Cover Page for Request for Out-of-State Nursing Facility Placement

- Request for Out-of-State Placement
- **Proof of Contact In-State Nursing Facilities is the responsibility of the requesting facility/provider** (a minimum of 1 DC facility must be contacted and deny placement within 48 hours of submission to Comagine Health)
- Copy of the Level of Care (LOC) approval letter from the DHCF contractor
- Copy of the Request for Medicaid Nursing Facility Level of Care, DHCF Form 1728 or the completed InterRAI by the DHCF contractor
- Copy of the Pre-admission Screening and Annual Resident Review (PASRR)
- Beneficiary Agreement
- Copy of the beneficiary history and physical as well as the discharge summary, if completed, and
- If the beneficiary requires specialized care (such as tracheostomy, dialysis, etc.), submit a copy of the most recent physician orders and or relevant clinical notes (DHCF transmittal #17-09)

9.8 Timeframes for submission of Prior Authorization Reviews

Requests for Prior-Authorization require at least six days' advanced notice before the anticipated service delivery date. If additional information is required, the review timeline may take longer than six days due to Comagine Health awaiting additional information from the provider.

9.9 Timeframes for Pended Reviews

When a review has been submitted and is pended awaiting clinical/required relevant information, Comagine Health will notify the provider via web-based review system fax or phone. The provider has no more than three business days to submit the requested information before Comagine Health will proceed to review with the information already submitted. This may result in an adverse determination due to lack of documentation to support the review's certification.

9.10 Medical Necessity Review Process

During the prior authorization review, Comagine Health's clinical reviewer will review the medical record and evaluate the medical necessity for admission at the requested level of care. When Medical Necessity Criteria and review protocols are met, the Comagine Health Clinical Reviewer will issue a Prior Authorization number, and the review will be authorized.

9.11 Transfer (Admission) Reviews

Transfers between hospitals require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes inter-facility transfers, such as discharge from acute inpatient to acute rehabilitation, for example, and discharges to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following special considerations apply:

- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.

- All transfer requests must be submitted by the receiving facility via the Comagine Health Provider Portal or fax submission for providers who submit infrequently.

Section 10. Specialty Hospital

The DC Medicaid utilization review program Specialty Hospital reviews allow for review in advance of services being provided. Providers are required to submit clinical reviews in a timely manner with complete relevant clinical documentation to substantiate the service request for the recipient.

10.1 Responsibility

Providers are responsible for obtaining the Specialty Hospital review from Comagine Health in advance of delivering the services to the recipient. Receiving providers are to submit review information to Comagine Health. The applicable portions of the 719A form pertaining to the service being requested must be completed. Only the relevant clinical information to satisfy the District's Medicaid Program utilization review protocols and InterQual criteria is required to complete the review process.

Prior to submitting a review request to Comagine Health, remember to verify eligibility first.

Providers will be notified of incomplete 719A forms or incomplete clinical information and be given up to three business days to submit additional information to complete the review. Notification of an incomplete review submission will occur via the web portal for web submission (preferred), and via fax for fax submission. If the 719A form remains incomplete after three business days a technical denial will be issued. If clinical information remains incomplete after three days, a non-certification or technical denial may result when referred to the physician reviewer.

Comagine Health has three business days to complete the review, once all the information has been received to complete the review process.

10.2 Requirements

All inpatient services at the following hospitals listed below must complete Specialty Hospital review and be approved by Comagine Health in order to be reimbursed by the DC.

- Specialty Hospital of Washington (Capitol Hill, Hadley, or other long term acute care hospital)
- National Rehabilitation Hospital or other rehabilitation hospital
- Hospital for Sick children (or other pediatric specialty hospital)
- Psychiatric Institute of Washington or other psychiatric inpatient facility

Authorization for services will remain valid for 12 months.

10.3 Information Needed for the Review

Comagine Health representatives require all the information below for clinical reviews. Please refer to Appendix B for the 719A form.

- Recipient name
- Recipient birth date and age

- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address, phone number and fax number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or surgery/service date
- Justification for hospitalization and pertinent history
- Anticipated discharge date
- Relevant clinical documentation to justify the medical necessity of the service at the requested level of care, including pertinent test results, labs, medications, and treatment
- Discharge planning details to include placement (provider)

10.4 Timeframes for Submission of Specialty Hospital Reviews

Requests for Specialty Hospital review require a minimum of three (3) days' advanced notice prior to the anticipated date of the service delivery. If additional information is required, the review timeline may take longer than three (3) days when Comagine Health is awaiting additional information from the provider.

10.5 Medical Necessity Review Process

During the Specialty Hospital review, Comagine Health's clinical reviewer will review the submitted medical information and evaluate the medical necessity for admission at the requested level of care. When Medical Necessity Criteria and review protocols are met, the Comagine Health clinical reviewer will issue a Prior Authorization number, and the review will be authorized.

10.6 Transfer (Admission) Reviews

Transfers between hospitals require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes inter-facility transfers, such as discharge from one level of care to another and to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following considerations apply:

- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.
- All transfers require the receiving facility to submit a request for authorization prior to the transfer.

Section 11. Acute Care Hospital Reviews

The DC's Medicaid utilization review program Acute Care Hospital reviews allow for review of services being provided within DC acute care hospitals, those in bordering counties, and surgical reviews. Providers must submit clinical reviews promptly with complete relevant documentation to substantiate the service provided for the recipient.

11.1 Acute Care Hospital Surgical

Comagine Health will review acute care services associated with surgical procedures, transplants, medical procedures and testing on behalf of the DC DHCF. These reviews should follow the same general requirements and information necessary for review as the other Acute Care Hospital reviews.

11.2 Responsibility

Providers are responsible for obtaining the prior authorization for the Acute Care Hospital review from Comagine Health within two business days of the onset of service delivery to the recipient. For surgical reviews, providers are responsible for obtaining the prior authorization from Comagine Health within six business days of the onset of service delivery to the recipient. In either case, late review submission or submission without relevant clinical information will result in a technical denial.

Prior to submitting a review request to Comagine Health, remember to first verify eligibility.

Providers will be notified of incomplete 719A forms or incomplete relevant clinical information and be given up to three business days to submit additional information to complete the review. Notification of an incomplete review submission will occur via the web portal for web submissions (preferred) or via fax for fax submissions. If the 719A form remains incomplete after three business days a technical denial will be issued. If clinical information remains incomplete after three days, adverse determination may result when referred to the physician reviewer.

Comagine Health has 24 hours/one business day to complete the review, once all the relevant clinical information has been received to complete the review process.

11.3 Requirements

All unscheduled admissions for inpatient services within the District and in bordering counties must be authorized by Comagine Health in order to be reimbursed by the DC.

- Receiving providers are to submit review information to Comagine Health for all reviews within two business days of admission.
- The applicable portions of the 719A form pertaining to the service being requested must be completed.

- Only the relevant clinical information to satisfy the District's Medicaid Program utilization review protocols and InterQual criteria is required to complete the review process.

11.4 Information Needed for the Review

Comagine Health representatives require all the information below for clinical reviews. Please refer to Appendix B for the 719A form.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address, phone number and fax number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or surgery/service date
- Justification for hospitalization and pertinent history
- Anticipated discharge date
- Documentation to justify the medical necessity of the service at the requested level of care, including pertinent test results, labs, medications, and treatment
- Discharge planning details to include placement (provider)

11.5 Timeframes for Submission of Acute Care Hospital Reviews

The required timeframe for submitting all review documentation to Comagine Health for direct and transfer admissions is within two business days of the actual admission. Submission deadlines depend on the day the patient was admitted, for example:

- The following Monday for a Thursday admission
- The following Tuesday for Saturday and Sunday admissions
- The following Wednesday for a Monday admission
- The following Thursday for a Tuesday admission
- The following Friday for a Wednesday admission

In the event of an emergency transfer, it is the responsibility of the receiving hospital to obtain authorization for the emergency admission within the timeframes outlined above.

Late review submission or submission without relevant clinical information will result in a technical denial.

11.6 Medical Necessity Review Process

During the Acute Care Hospital review process, Comagine Health's Clinical Reviewer will review the submitted clinical information and evaluate the medical necessity for admission at the requested level of care. When Medical Necessity Criteria and review protocols are met, the Comagine Health Clinical Reviewer will authorize the review, and a prior-authorization number will be issued.

11.7 Transfer (Admission) Reviews

Transfers between hospitals require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes inter-facility transfers, such as discharge from one level of care to another as well as discharges to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following special considerations apply:

- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.
- All transfers require the receiving facility to submit a request for authorization prior to the transfer.

Section 12. Continued Stay (Concurrent) Utilization Reviews

The continued stay review process evaluates whether the patient needs an extension of inpatient services and meets medical necessity for the level of care. During the continued stay review, the Comagine Health Clinical Reviewer evaluates what services have already been provided to the patient and the plan for continuing in-patient treatment. Providers should submit reviews in a timely manner, on or preceding the last review date authorized.

A continued stay (concurrent) review takes place during the time in which a recipient is receiving inpatient treatment at the acute care or residential care facility. If the first review was submitted before the recipient is discharged from the facility, the subsequent reviews will be considered continued stay reviews through the patient's discharge date.

12.1 Responsibility

Providers are responsible for checking Medicaid eligibility prior to seeking authorization of services from Comagine Health. Once eligibility has been established, submission via the Comagine Health web-based portal is the preferred method for submitting a review request. Providers are responsible for obtaining certification for continued stay (concurrent extensions) from Comagine Health. The clinical reviewer will review all of the appropriate detailed clinical information for the requested review period to satisfy InterQual Criteria or DHCF's criteria before the continued stay review will be certified. The provider is responsible for ensuring that the information submitted in the continued stay review request is accurate for the review period and documented in the medical record.

12.2 Requirements

The continued stay request is to be received in advance of the next review date provided during the previously certified review.

- BridgePoint (Capitol Hill and National Harbor)
- National Rehabilitation Hospital (or other rehabilitation hospital)
- Hospital for Sick children (or other pediatric specialty hospital)
- Continued stay Acute Care Hospitals
- Psychiatric Institute of Washington (or other inpatient psychiatric facility)

12.3 Process and Procedures

The provider will submit the continued stay review request to Comagine Health via the web-based system (preferred method) or by fax.

12.4 Procedures for Continued Stay Review - Due on Weekends and Holidays

In those instances where the concurrent review date is due on Saturday, Sunday, or a holiday, the concurrent review will take place prior to the next review date. Adverse determinations can be retrospective to the first day the recipient was not meeting the level of care criteria or protocols.

12.5 Information Needed for the Review

- Clinical information provided must specifically substantiate the medical necessity of the continued stay request and the length of stay requested.
- Information should also be provided to indicate progress with discharge planning and goals to meet discharge readiness.

12.6 Continued Stay Review Process

Once the information for the review has been received, the Comagine Health clinical reviewer will assess the documentation submitted using InterQual Criteria or DHCF Criteria to determine whether the condition of the recipient meets criteria for the level of care and the type of services requested.

During the prior authorization review, the next review date is set for continued stay review. Comagine Health will establish the date when a concurrent review will be due if the recipient has not been discharged before this date. Providers are responsible for submitting current relevant clinical information for continued stay review if the client has not been discharged. Providers are to contact Comagine Health and submit the next continued stay review within the following timeframes.

12.7 Timeframes for Continued Stay Review Submissions

Comagine Health has 24 hours, or one (1) business day to complete the continued stay review if and when all relevant clinical information is submitted to complete the review.

12.8 Timeframes for Pended Reviews

When a review has been submitted and is pended awaiting clinical/required information, Comagine Health will notify the provider via the Comagine Health Provider Portal, fax, or phone, depending on the mode of submission. The provider has no more than two calendar days to submit the requested information before Comagine Health proceeds with the information already submitted. This may result in an adverse determination due to lack of documentation to support certification of the review.

Section 13. Substance Use Disorder

The DC Medicaid utilization review program Substance Use Disorder (SUD) Residential Treatment Facility (RTF) allows review within 48 hours of admission. Providers are required to submit clinical reviews in a timely manner with complete documentation to substantiate the level of care request for the recipient.

13.1 Responsibility

Providers are responsible for checking Medicaid eligibility prior to seeking authorization of services from Comagine Health. Once eligibility has been established, submission via the Comagine Health web-based portal is the preferred method for submitting a review request. Providers are required to submit clinical reviews in a timely manner with complete documentation to substantiate the level of care request for the recipient. Within 48 hours of the individual presenting at the SUD residential treatment provider, the accepting SUD residential treatment provider shall perform the Continuum Assessment, in accordance with DBH's Chapter 63, and submit the initial clinicals.

Providers will be notified of incomplete clinical information or missing documents and be given up to two business days to submit additional information to complete the review. Notification of an incomplete review submission will occur via the web portal for web submission (preferred), and via fax for fax submission. If the information or document remains incomplete after three business days a technical denial will be issued. If clinical information remains incomplete after three business days, a non-certification or technical denial will be issued.

Comagine Health has three business days to complete the review, once all the information has been received to complete the review process.

13.2 Requirements

The SUD residential treatment provider shall include the following documents in the request for authorization:

- A completed Continuum Assessment which will include:
  - Documentation of an active moderate to severe Substance Use and/or Addictive Disorder per the DSM-V,
  - An individualized, comprehensive biopsychosocial assessment of the patient's Substance Use and/or Addictive Disorder,
  - An evaluation by a Qualified Provider (i.e., Physicians; Psychologists; Licensed Independent Clinical Social Workers; Licensed Independent Social Workers; Licensed Professional Counselors; Licensed Marriage and Family Therapists; and Advanced Practice Registered Nurses) confirming medical necessity of the requested services,
  - A medical history detailing the individual's medical conditions, and
  - For level 3.3 ONLY, description of cognitive deficits of moderate to severe intensity.

- Within 48 hours of the individual presenting at the SUD residential treatment provider, the accepting SUD residential treatment provider shall perform the Continuum Assessment, in accordance with DBH's Chapter 63, and submit the initial clinicals (described below) to DHCF's contracted Quality Improvement Organization (QIO), beginning July 1, 2021. Authorization requests should be submitted to the QIO via the Provider Portal (https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin).

- Additional medical information, including:
  - Comprehensive urine toxicology screen results,
  - Pregnancy test results for women (If a woman refuses a pregnancy test, the refusal must be documented and submitted to the QIO. The QIO may require additional information.), and
  - The glucose level to validate medical clearance for admission into the SUD residential treatment provider.

13.3 Prior Authorization Process

Authorization for services will remain valid for 12 months.

Prior Authorization Review & Documentation Timeline Summary

Level 3.1, 3.3, & 3.5 SUD Residential Treatment	***Level 3.7 WM SUD Residential Treatment***
By Day 7 – Co-Triage, Continuum Assessments, and SUD Plan of Care, MCO Approval Letter if transitioning & Clinical Summary Progress	*By Day 3 – Co-Triage, Continuum Assessments, and SUD Plan of Care, MCO Approval Letter if transitioning & Clinical Summary of Progress*
Day 14 – Clinical Summary of Progress (for the most recent 14 days, or less, of treatment)	*By Day 5 – Updated Clinical Summary of Progress, Continuum Assessment, and Plan of Care*
Day 28 – Updated Clinical Summary of Progress, Continuum Assessment, and Plan of Care (for the most recent 28 days, or less, of treatment)	*Every 5 days following – Clinical Summary of Progress and any documentation updates (i.e. Continuum or SUD Plan of Care)*
Every 14 days following –Clinical Summary of Progress and any documentation updates (i.e. Continuum or SUD Plan of Care)	

Co-occurring Capable (BH by an External Org)	***Co-occurring Capable (BH by an External Org)***
Behavioral Health Assessment (Only to be submitted once (unless updated) with the initial Continuum and enhanced by Day 15 if needed)	*See 3.1,3.3 & 3.5*
Behavioral Health Plan of Care (Only to be submitted once (unless updated) with the initial Continuum and enhanced by Day 15 if needed)	
For MCO to FFS Transitions (>15 days in any month)	

Co-occurring Capable (BH by an External Org)	*Co-occurring Capable (BH by an External Org)*
3 Days prior to transition – Submit Clinical Documents including Continuum Assessment, Current Treatment Plan, and Clinical Summary of Progress to Comagine Health *along with MCO Approval Letter*	

13.4 Medical Necessity Review Process

During the SUD Residential Treatment Facility review, Comagine Health's clinical reviewer will review the clinical information submitted and evaluate the medical necessity for admission at the requested level of care. Medical Necessity Criteria and review protocols are met, the Comagine Health clinical reviewer will issue a Prior Authorization number, and the review will be authorized.

13.5 Transfer (Admission) Reviews

Transfers between Facility's require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes discharges to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following considerations apply:

- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.
- All transfers require the receiving facility to submit a request for authorization prior to the transfer.

Section 14. Retrospective Reviews

A retrospective review for medical necessity is indicated after services have been rendered, the client has been discharged, and subsequent eligibility has been established.

Prior to submitting a review request to Comagine Health, remember to first verify active eligibility dates were present during the time the services were provided.

Providers are required to submit a request for a retrospective review within the allotted timeframe of 12 months after discharge and/or that billing was initiated within the 12 months after discharge. The provider is responsible for ensuring that the information submitted in the review is accurate for the review period and documented in the medical record.

14.1 Process and Procedures

The provider will submit the Subsequent Eligibility Admission review request to Comagine Health via the web-based system.

14.2 Submitting Retrospective Reviews Via Web-based Review System

- Subsequent Eligibility Admissions will be initiated by the provider. Providers should include sufficient relevant clinical information for the clinical reviewer to complete the review. Please do not send the entire medical chart for review. The entire review may be submitted into the web-based system in seven-day (one week) increments with attached:
  - Admission Summary
  - Physician orders and notes
  - Discharge Summary
  - Review summary of progress toward meeting discharge goals for days of stay and for longer lengths of stay each week, until last week of discharge, then daily clinical information submitted

14.3 Information Needed for the Review

Comagine Health representatives require all the information below for clinical reviews. Please refer to Appendix B for the 719A form.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address, and phone number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or surgery/service date
- Justification for hospitalization and pertinent history
- Anticipated discharge date
- Documentation to justify the medical necessity of the service at the requested level of care, including pertinent test results, labs, medications and treatment
- Discharge planning details to include placement (provider)

14.4 Medical Necessity Screening

The Comagine Health clinical reviewer will review the information provided for the retrospective review and will apply the appropriate InterQual Criteria. If the criteria, Federal and District regulations are met, Comagine Health will issue a retrospective authorization number. Comagine Health certification indicates that the admission was medically necessary.

14.5 Timeframes for Retrospective Review Submissions

Comagine Health has 14 business days to complete acute care stay review if all required information is submitted to complete the review.

Section 15. Long Term Care Reviews

The Long-Term Care Reviews determine that the services and environment for delivery of those services are medically appropriate to allow the consumer to live with a permanent or chronic condition.

15.1 Responsibility

The Comagine Health clinical reviewer will receive and review all the appropriate detailed level of care assessment form (please refer to Appendix D) information for the requested services before services are delivered. The provider is responsible for ensuring that the relevant clinical information submitted in the review is accurate for the review period and present in the documented medical record.

Prior to submitting a review request to Comagine Health, remember to verify eligibility first.

15.2 Requirements

Providers are responsible for submitting the long-term care review service requests and required documents as indicated by DC policy:

- EPD Level of care (LOC) determinations (require DC Care Connect (DCCC) entry)
- EPD Waiver program medical reviews (require DCCC entry)
  - Approved LOC for the certification/recertification period of request
  - Completed Case Management Conflict Free Personalized Care Plan
- Level of care (LOC) determinations
  - Pre-admission Screening and Resident Review (PASRR) must be included with LOC requests for Nursing Home Placement and Nursing Home Reviews
- Nursing Facility Reviews (Nursing Home)
  - Pre-admission Screening and Resident Review (PASRR)
  - 1728 DHCF LOC Request or InterRAI Assessment
  - 1728 DHCF LOC or InterRAI assessment Approval Letter from the DHCF contractor
  - Current or Up to Date Completed Minimum Data Set (MDS)
  - Physician Certification/Recertification every 60 days
  - Supporting Clinical Documents
- Nursing Facility continued stay reviews (Nursing Home)
  - Pre-admission Screening and Resident Review (PASRR)
  - 1728 DHCF LOC Request or InterRAI assessment form
  - 1728 DHCF LOC or InterRAI Approval Letter from the DHCF contractor
  - Current or Up to Date Completed Minimum Data Set (MDS)
  - Physician Certification/Recertification every 60 days
  - Supporting Clinical Documents

15.3 Information Needed for the Review

Comagine Health representatives require all the information below for clinical reviews. Please refer to Appendix D for Form 1728, which must be attached to the Comagine Health Provider portal (preferred mode of submission) during the review process or faxed to Comagine Health at 800-731-2314. Incomplete forms will be returned to the provider, and two business days will be given to complete the form. Forms that are incomplete will result in technical denial.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address, and phone number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or service date
- Justification for the services and pertinent history
- Anticipated discharge date
- Discharge planning details to include placement (provider)

15.4 Submitting Level of Care Reviews via the Comagine Health Provider Portal

- Level of Care Reviews (LOC) may be submitted via the Comagine Health Provider Portal, and the 1728 form may be attached to your review request in the web-based system. The provider is to retain the original copy of the form.
- If you do not have internet access, you may fax your review request to 800-731-2314, including the 1728 form.
- Comagine Health will review the LOC request within three business days of receipt and issue a determination.
- Approval notifications will be visible via the Comagine Health Provider Portal or faxed for those review requests received via fax.
- If the Comagine Health physician reviewer non-certifies the LOC requested, the determination status will immediately be posted in the web-based review system, and an adverse determination letter will be mailed out within five business days to the following parties: the recipient and the requesting provider/facility. The letters will contain justification for the adverse determination with an explanation of the right to request reconsideration to Comagine Health and a description of the recipient appeal procedure to the District. Please refer to Reconsideration and Appeals, Section 16.

- DHCF will not reimburse providers for services that have been non-certified by Comagine Health, except for non-certifications that are reversed because of an appeal review by Comagine Health, a provider appeal, or recipient Fair Hearing by the State.

15.5 EPD Waiver Program Medical Reviews

- Level of Care Reviews (LOC) must be submitted in DC Care Connect (DCCC). A completed paper or electronic interRAI assessment and level of need document must be included in your review request from the provider agency or Aging and Disability Resource Center (ADRC) in DCCC. The provider is to retain the original copy of the documentation.
- Once the LOC is approved Comagine Health sends the information to DHCF's Long Term Care Division (LTCD) and Case-management agency via DCCC. DHCF's LTCD will then send a transmittal to the Economic Security Association (ESA) to determine financial eligibility (for the initial LOC approval).
- This process within ESA can take up to 45 days.
- Once Comagine Health is tasked from DHCFs Long Term Care Division or Provider agency, Comagine Health will conduct a review of the Personalized Care Plan within six business days according to DHCF's Policy and Procedures to make a determination of services requested.
- Recertification for the LOC review; a task request is submitted from the provider agency via DCCC to Comagine Health. The provider is to retain the original copy of the documentation.

15.6 Nursing Facility Reviews

- **Nursing Facility Reviews** will be performed at the Nursing Home facility by a Comagine Health Clinical Review Specialist.
  - A minimum of one week's advanced notice will be provided prior to visiting the facility to perform reviews.
  - Reviews will be conducted within 30 days of admission to a nursing facility
  - The recipient records subject to review will be faxed, or sent via secure email, in advance to the Nursing Home facility with the review date notice.
  - For readmissions to the nursing home, review will be conducted within 18 days, prior to expiration of the bed hold
  - Documentation to justify the level of care as well as the presence of a completed Pre-admission Screening and Resident Review (PASRR), if required.
  - The Nursing Home facility will have all individual medical records (electronically or hard copy) available for review when the Comagine Health Clinical Review Specialist arrives at the facility.
- **Continued Stay Reviews** will be performed at the Nursing Home facility by a Comagine Health Clinical Review Specialist:
  - At least one week's advanced notice will be provided prior to visiting the facility to perform reviews.
  - Reviews will be conducted 30 days from the nursing home admission date, 6 months from the initial nursing home review and then annually
  - The recipient records reviewed will be faxed or sent via secure email to the Nursing Home facility with the review date notice.

- Documentation to justify the level of care and a completed Pre-admission Screening and Resident Review (PASRR), if required.
- The Nursing Home facility will have all individual medical records (electronic or hard copy) available for review when the Comagine Health Clinical Review Specialist arrives at the facility.

- **Approval Determinations**
  - Comagine Health will send letter notifications for approved review requests.
  - Notification of the approval determination will be provided via fax or via secure email within 5 business days of the approval determination being made for Nursing Home facility onsite review.

15.7 Second-Level Peer Review

- Cases that clinical reviewers have determined do not meet criteria are referred to a Comagine Health Medical Reviewer
- The physician reviewer will review the clinical information and either certify the admission or issue a non-certification.

15.8 Adverse Determinations

- If the Comagine Health physician reviewer non-certifies the medical review, a Comagine Health representative will notify the appropriate facility by fax or secure email. Comagine Health will send the adverse determination letter within five business days to the following parties: the recipient, guardian, or parents of recipient (if minor) and the requesting provider.
- The adverse determination letter will contain justification for the non-certification and an explanation of the right to request reconsideration review to Comagine Health's initial non-certification determination as well as recipient appeal rights with the District.
- Comagine Health will send a letter notification for all non-certified reviews and Comagine Health reconsideration reviews. These notifications will be sent to the recipient and the requesting provider or facility within five business days of the determination being made.
- If the beneficiary and or the facility wishes to request reconsideration, the reconsideration request must be made within 30 business days from the date the non-certified notification was sent.

The DC DHCF will not reimburse providers for services that have been non-certified by Comagine Health, with the exception of adverse determinations that are reversed as a result of a reconsideration review performed by Comagine Health or a recipient Fair Hearing by the DC Office of Administrative Hearing (OAH).

Section 16. Utilization Review Reconsiderations and Appeals

Comagine Health offers a process in all cases involving adverse determination. When a reconsideration review determination is to non-certify a review request, Comagine Health will generate written

notification of the adverse decision within one business day of the date the decision is made. Comagine Health's non-certification notification will include rights for an appeal review. Comagine Health's reconsideration process features a second opinion by a physician who specializes in the services under review.

URAC requires that appeal reviews be conducted by individuals who:

- Are clinical peers
- Hold an active, unrestricted license to practice medicine or a health profession
- Are board-certified
- Are in the same profession and in a similar specialty as typically manages the condition
- Are neither the individual who made the original non-certification nor the subordinate of such individual
- Have no conflicts of interest with the patient, attending physician, or facility being reviewed.

There are two types of reconsiderations potentially available - expedited or standard. Instructions on how to initiate each type of appeal are included in the adverse determination letter Comagine Health sends.

16.1 Expedited Reconsideration

16.1.1 Definition

Expedited reconsideration is an appeal of an adverse determination in a case involving urgent care.

16.1.2 Process and Procedures

A request for an expedited reconsideration may be made by the Comagine Health Provider Portal or fax within two business days of the date that appears at the top of the Non-Certification Letter if the recipient has not yet been discharged. If an expedited appeal request is filed after two business days, Comagine Health will respond to that request through the standard appeal process.

How to Request an Expedited Appeal from the Comagine Health DC Office

Requests for expedited appeals should be directed as follows:

Provider Portal: https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin

Fax: (800) 731-2314

Upon receipt of the request for an expedited appeal, the following will occur:

- Comagine Health will notify all appropriate parties of the request.
- Comagine Health will, if needed, request that any additional medical information necessary for the appeal review be submitted to us within two hours.

- The case will be referred to a Comagine Health physician reviewer who is licensed and/or accredited in the appropriate specialty or subspecialty who is not the same individual who initially reviewed and non-certified the review.
- The physician reviewer will review the medical information.
- If the physician reviewer reverses the non-certification decision, the Comagine Health representative will issue a certification number and length of stay (if applicable) and will notify all appropriate parties telephonically and in writing.
- If the physician reviewer modifies the decision or upholds the adverse determination, the requesting physician or facility will be notified telephonically and in writing.
- The DC MMIS will be updated electronically accordingly if decision is either reversed or modified.
- Notification with the review outcome, including clinical rationale will be sent to the recipient, attending physician as appropriate, and facility.

If the recipient, attending physician, or facility disagrees with the expedited outcome, a standard appeal may be filed.

16.2 Standard Reconsideration

16.2.1 Definition

Standard reconsideration is an appeal of adverse determination. It is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals.

16.2.2 Process and Procedures

A request for a standard reconsideration must be made through the Comagine Health Provider Portal or fax within 21 days (for all review types with the exception of Medical Eligibility Nursing Home Reviews and Dental Reviews) of the date shown on the Non-certification Letter. A request for a standard reconsideration for Medical Eligibility Nursing Home Reviews and Dental Reviews must be made within 30 business days of the date shown in the non-certification letter. Requests may also be made via telephone, followed by a written request.

How to Request a Standard Appeal from the Comagine Health DC Office

Requests for standard appeals should be directed as follows:

Provider Portal: https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin

Fax: (800) 731-2314

Any request for reconsideration of an adverse determination will be reviewed by a Comagine Health physician/practitioner consultant licensed and/or accredited in the appropriate specialty or subspecialty as the attending physician but will not be the same individual(s) who initially non-certified the review or the expedited appeal, if applicable.

Comagine Health will issue the reconsideration decision within 14 days of receipt of the request for a standard appeal; and issue a notice of determination within five (5) days of the decision to the recipient and the provider. All appropriate parties will be notified in writing of Comagine Health's determination to uphold, reverse, or modify the initial non-certification decision.

Comagine Health's reconsideration decision will take precedence over the initial adverse determination or the expedited appeal decision, if applicable. For example, if the appeal review certifies more facility days than the original review, then more facility days will be recommended for certification.

16.3 DC DHCF Fair Hearing Rights for Recipients

The DC, DHCF Fair Hearing procedure is the process by which recipients can contest the Comagine Health non-certification decision. Recipients may request a fair hearing by phone or in writing to the Fair Hearing representative at DC Office of Administrative Hearings within 90 days of the date on Comagine Health's adverse determination or reconsideration determination letter non-certifying the service.

For Nursing Home denials, if a recipient requests a fair hearing within thirty (30) calendar days of the postmark date on the date of notice, the DC Medicaid program will continue to pay for the nursing facility costs while your appeal is pending.

Recipients may still request a hearing after thirty (30) calendar days of the postmark date on this notice, but the request must be filed no later than ninety (90) calendar days of the postmark date of the notice letter. If the request is filed after the thirty (30) calendar day period, the DC Medicaid program will not pay for the nursing facility costs during the appeal. The request must state the rationale for requesting a Fair Hearing.

The address and phone number to request a fair hearing:

Office of Administrative Hearings
One Judiciary Square
441 4th Street, NW
Suite 450 North
Washington, DC 20001
Telephone: (202) 442-9094
Fax: (202) 442-4789

You may also call, write, or visit the Office of the Health Care Ombudsman at:

441 4th Street, NW, 2nd Floor
Washington, DC 20001
Telephone: (202) 724-7491 or 1-877-685-6391

Fax: (202) 535-1216

Section 17. Potential Quality of Care Reviews

Comagine Health is committed to promoting optimum quality of care for all recipients and therefore will use the Centers for Medicare & Medicaid (CMS) Physician Reviewer Assessment Form (PRAF) "C" Category of Concern codes to assess quality of care in various settings while performing reviews (please refer to Appendix E) .

The facility and attending physician are responsible for delivering the utmost quality of care for their patients. The Comagine Health clinical reviewer is responsible for identifying potential quality of care concerns regarding DC Medicaid recipients. Potential quality of care concerns may be identified during all types of reviews, including retrospective chart reviews.

17.1 Process

If the Comagine Health clinical reviewer identifies a potential quality of care concern, when performing a review, the situation will be handled in one of two ways:

- If the clinical reviewer determines that the recipient's quality of care is currently being compromised, a Comagine Health physician (medical director or P/PC) will be consulted. If the Comagine Health physician concurs that there is a potential quality of care concern, Comagine Health will refer the case to DHCS for further action.
- If the clinical reviewer determines that there is a potential quality of care concern, but the recipient's care is not currently being compromised, a Comagine Health physician (medical director or P/PC (physician reviewer) will be consulted. If the Comagine Health physician concurs that there is a potential quality of care concern, Comagine Health will refer the case to DHCF for further action and obtain the records if requested.

Section 18. Miscellaneous Reviews

Miscellaneous reviews are received directly from the DHCF by Comagine Health. These ad hoc reviews require a specialized clinician (networks of clinicians) to render expert opinion.

18.1 Process

Comagine Health will review and provide an expert opinion on individual cases subject to review by another entity but referred to us by the Contract Administrator for the purpose of determining whether the service under review was reasonable, medically necessary, and appropriate. Individual reviews will be performed by a Medical Reviewer (RN or Physician) with the components of the review to be determined by the individual case. Comagine Health will prepare an individual letter with outcomes documented for each individual review. This letter, which is the written report of findings, will also serve as the Special Cases Report that is submitted to the DHCF Contract Administrator within 48 hours of review of special cases.

Appendixes

Appendix A: Contact Information and Business Hours

Comagine Health District of Columbia Office
PO Box 34800
Washington, DC 20043
Phone: 1 (800) 251-8890
Fax Number: 1 (800) 731-2314

Business Hours:
Monday through Friday,
8:30 am to 5:00 pm Eastern Time

Holiday Schedule:
New Year's Day, Martin Luther King Jr. Day, Presidents' Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day, Christmas Day

Comagine Health District of Columbia Office Leadership
Folasade "Sade" Akinkuowo, RN, MSN, CCM
QIO Project Director, Comagine Health, District of Columbia
Phone: 1 (800) 949-7536, ext. 2995
fakinkuowo@comagine.org

Foster C. "Bud" Beall Jr., MA
Vice President, Care Management, Comagine Health
Office Phone:1 (800) 949-7536 ext. 2041
bbeall@comagine.org

DC, DHCF
Cavella Bishop, MBA, BSN, RN-BC, CCM
Program Manager for Clinicians, Pharmacy, and Acute Provider Services
Department of Health Care Finance
One Judiciary Square
441 4th St., NW Suite 900S
Washington, DC 20001
Office Phone: 1 (202) 724-8936

Appendix B: DC DHCF 719A Form

Government of the District of Columbia
Department of Health Care Finance
Fee-For-Service Medicaid Program

719A Prior Authorization Request

Patient			Prescribing Provider		Servicing Provider	
Beneficiary Name			Provider Name		Provider Name	
DCID Number			Provider Number	NPI	Provider Number	NPI
Address City, State, Zip			Address City, State, Zip		Address City, State, Zip	
Telephone Number	DOB	SEX	Telephone Number		Telephone Number	
Other Health Insurance Coverage			Requested Service		Beneficiary Location	
			Surgery ☐ DME ☐		Home ☐	
			Medical ☐ Pharmacy ☐		ICF/MR ☐	
			Dental ☐ Eyewear ☐		Nursing Home ☐	
			Hospice ☐ Other ☐		Hospital ☐	
Discharge Date:			Home Health: ☐ Skilled Nurse ☐PT ☐OT ☐SLP ☐HHA ☐Private Duty		Office ☐	

Requested Service Data					
Diagnosis Code	Procedure Code	Description of Services, DME and Supplies	Time Required	Frequency or Units	Estimated Charges

Justification

For Dental Use only

DENOTE THE TEETH ALREADY MISSING BY "X", TO BE EXTRACTED BY "/", X-RAYS TAKEN BY "V"

Q1				FACIAL								FACIAL					Q2	
01	02	03	PRIMARY TEETH	04	05	06	07	08	09	10	11	12	13	PRIMARY TEETH	14	15	16	RIGHT
R																	L	
I				A	B	C	D	E	F	G	H	I	J				E	
G				LINGUAL								LINGUAL					F	
H				T	S	R	Q	P	O	N	M	L	K				T	
T																		
32	31	30		29	28	27	26	25	24	23	22	21	20		19	18	17	
Q4				FACIAL								FACIAL					Q3	

For DME, Home Health, Private Duty Use Only

Requesting Physician Certification: I certify that I have documented that a Face-to-Face encounter, related to the primary reason the beneficiary requires Home Health or DME services, occurred on _____ between the beneficiary and the allowed prescriber (listed below).

☐Primary Physician ☐ Nurse Practitioner ☐ Certified Nurse Mid-Wife ☐ Physician Assistant ☐ Acute or Post-Acute Physician

Name of allowed prescriber:_____ Title:_____ Date:_____

Durable Medical Equipment Face to Face Regulations

☐ **Any HCPCS code for the following types of DME:** ++Transcutaneous Electrical Nerve Stimulation (TENS) unit ++Rollabout Chair ++Traction-cervical ++Oxygen and Respiratory equipment ++Hospital beds and accessories

☐ Any item of DME that appears on the DMEPOS Fee Schedule with a price ceiling at or greater than $1,000.

☐ Any other item of DME that CMS adds to the list of Specified Covered Items

Signature of the Requesting Provider: I Certify that the services requested are medically indicated and necessary for the health of this patient and that the foregoing information is true, accurate, and complete.	DATE
Signature:_____ Title:_____	

719A June 2018

Appendix C: DC DHCF Form 1728 - Request for Nursing Facility Level of Care

Government of the District of Columbia
Department of Health Care Finance

Nursing Facility Level of Care
Form 1728

SECTION A: BENEFICIARY							
Last Name: First: MI:	Medicaid ID:	SSN:		Birth date:	Gender: ❑ M ❑ F		
Permanent Street Address:	City:	ST:	ZIP:	Phone:			
Present Location of Beneficiary (if different than above):				Date of Request:			

SECTION B: LEVEL OF CARE		
❑ Nursing Facility	❑ Adult Day Treatment	❑ Elderly & Individuals w/Physical Disabilities (EPD) Waiver
Reason		
❑ Return from hospital after Medicaid bed-hold expired* ❑ Transfer from EPD Waiver to NF ❑ Annual reassessment ❑ Initial NF placement ❑ Conversion from other payor source to Medicaid. Start: _____ ❑ Transfer from NF	❑ Initial assessment	❑ Initial assessment ❑ Annual reassessment ❑ Transfer from NF to EPD Waiver

**If Medicaid bed-hold days <18 days no level of care required*

SECTION C: LEGAL REPRESENTATIVE ❑ POA ❑ LEGAL GUARDIAN ❑ NA				
Name:	Street Address:	City:	ST:	ZIP:

SECTION D: BENEFICIARY FUNCTIONAL STATUS			
Activities	**Independent** (needs no help)	**Supervision or Limited Assistance** (needs oversight, encouragement or cueing or highly involved, but requiring assistance)	**Extensive Assistance or Totally Dependent** (may help, but cannot perform w/o help from staff or cannot do for self at all)
ADLs:			
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Overall Mobility	❑	❑	❑
Eating	❑	❑	❑
Toilet Use	❑	❑	❑
IADLs:			
Medication Management	❑	❑	❑
Meal Preparation	❑	❑	❑
Housekeeping	❑	❑	❑
Money Management	❑	❑	❑
Using Telephone	❑	❑	❑
Beneficiary ventilator dependent? ❑ Yes ❑ No	List additional supporting documents here:		

Name of Person Completing Form:	Title:	Phone:	Date:
Signature:			

SECTION E: CLINICIAN ATTESTATIONS & AUTHORIZATIONS

❑ Physician ❑ Physician Assistant ❑Nurse Practitioner	Street Address:	City:	ST:	ZIP:
Phone: / NPI #:	Date:	Signature:		

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud	Print Name:	Title:
	SIGN HERE	Date:

SECTION F: QUALITY IMPROVEMENT ORGANIZATION AUTHORIZATIONS

Level of Care: ❑ Nursing Facility ❑Adult Day Treatment ❑ EPD Waiver	Certification Period (for EPD only):	Date:
Authorized Signature:	Comments:	

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud	Print Name:	Title:
	SIGN HERE	Date:

To submit this form electronically after completion, visit the Qualis Health Provider Portal at www.qualishealth.org. Then select one of the choices in the Healthcare Professional Drop-Down Menu: DC Medicaid or Provider Resources. You can obtain additional assistance in registering for the Qualis Health Provider Portal by contacting ProviderPortalHelp@qualishealth.org.

Revised Oct 19, 2015

Appendix D: Dental Utilization Review Criteria Guidelines

DENTAL GRID

Introduction

The following criteria will help to standardize the provider's and consultant's exercise of professional judgment. If the clinical condition of the patient reflects the criteria required by and such information is fully documented by the provider, the consultant may grant approval if in his/her professional judgment the service request is reasonable and consistent with the dental needs of the patient and conforms to the intent of the program.

Without sufficient acceptable diagnostic information, the consultant has no option but to deny approval or defer a decision. The necessity for the consultant to obtain adequate information and, thereby, to make a judgment on dental necessity is an integral part of the prior authorization process.

Code	Description	Criteria and Benefits	Required Documentation	Comments
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION – PROBLEM FOCUSED, BY REPORT	A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dento-facial anomalies, complicated perio-prosthetic conditions, complex temporo-mandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc. A benefit once per six months per patient per provider. The following procedures are not a benefit when provided on the same date of service with D0160: a. periodic oral evaluation (D0120), b. limited oral evaluation-problem focused (D0140), c. comprehensive oral evaluation- new or established patient (D0150), d. re-evaluation-limited, problem focused (established patient; not post- operative visit) (D0170), e. office visit for observation (during regularly scheduled hours-no other services performed (D9430). f. Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician (Dental provider who billed for D0160 cannot also bill for D9310 on the same date of service.	1. Written documentation for prior authorization shall include documentation of findings that supports the existence of one of the following: a. dento-facial anomalies, b. complicated perio-prosthetic conditions, c. complex temporo-mandibular dysfunction, d. facial pain of unknown origin, e. severe systemic diseases requiring multi-disciplinary consultation.	Plans generally include an age restriction: extensive oral evaluation cannot be adequately completed on a patient under the age of 3. D0145 is used for reimbursement purposes. A comprehensive oral evaluation-new or established patient (D0150), detailed and extensive oral evaluation (D0160), or comprehensive periodontal evaluation (D0180) is allowed for the same patient and by the same dentist at a subsequent date, after the patient reaches three years of age. The dental provider may bill once per six months per same provider.

Code	Description	Criteria and Benefits	Required Documentation	Comments
		Limitation: Either one comprehensive oral evaluation (D0150), one detailed and extensive oral evaluation (D0160), or one comprehensive periodontal evaluation (D0180) is allowed		
D0364	**CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW- LESS THAN ONE WHOLE JAW**	Cone Beam CT is covered for the following indications: 1. Evaluation prior to one of the following oral surgery indications: A. Removal of maxillo-facial tumor, cyst, neoplasm or other pathologic entities that, due to their size and/or anatomic location, appear to encroach, impinge or are invested in/on critical anatomic structures (i.e., inferior alveolar nerve, maxillary sinus); B. Arthroplasty of Temporomandibular (TM) fossae or condyle, TM joint replacement; C. Developmental mid-face syndromes such as cleft palate, Treacher-Collins syndromes, etc.; D. Surgical reconstruction of severe oral-facial trauma (such as those resulting from motor vehicle accidents, gunshot wounds, boating accidents or other disfiguring trauma). **In addition, when Cone Beam CT is requested prior to an oral surgery (a-d above), one of the following criteria must also be satisfied:** E. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach; -OR- F. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure. 2. Evaluation prior to orthognathic surgery when coverage criteria under the orthognathic surgery coverage policy are met AND information obtained by a CB/CT Scan is considered critical in determining surgical plan for the avoidance of disruption, invasion or fracture of a surrounding critical oral-facial structure.	Written documentation for prior authorization which includes rationale for request and A. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach; -OR- B. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure.	**Cone Beam CT** refers to a tomographic imaging beam that is concentrated to a narrow field of the body, as in the case of dental views. Multi-dimensional images of the hard tissue of the jaw are created to assist the dentist in diagnosis and treatment planning for the patient. Cone beam CT provides an image of hard tissue that has no distortion and is anatomically correct. Views may include cross-sectional axial, coronal, sagittal, cephalometric, or panoramic. Indications that are not covered (list may not be all inclusive) 1. Cone beam CT is not covered when used in conjunction with non-covered dental procedures. 2. Cone beam CT is not covered for other medically related dental indications not listed as covered. CT to assist with the dental implant evaluation and placement of the implant. (D0364-D0367).

Code	Description	Criteria and Benefits	Required Documentation	Comments
		3. Diagnosis for patients who present with contradictory or nonspecific clinical signs and symptoms associated with untreated or previously endodontically treated teeth. 4. Treatment of teeth with the potential for extra canals and suspected complex morphology, such as mandibular anterior teeth, and maxillary and mandibular premolars and molars, and dental anomalies. 5. Identification and localization of calcified canals. 6. Clinical examination and 2-D intraoral radiography are inconclusive in the detection of vertical root fracture. 7. Evaluation of the nonhealing of previous endodontic treatment to help determine the need for further treatment, such as nonsurgical, surgical or extraction. 8. Nonsurgical retreatment to assess endodontic treatment complications, such as overextended root canal obturation material, separated endodontic instruments, and localization of perforations. 9. Presurgical treatment planning to localize root apex/apices and to evaluate the proximity to adjacent anatomical structures.		
D0365	**CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MANDIBLE**	**See D0364**	• Written documentation for prior authorization which includes rationale for request	**See D0364**
D0366	**CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW ONE FULL DENTAL ARCH – MAXILLA, WITH OR WITHOUT CRANIUM**	**See D0364**	• Written documentation for prior authorization which includes rationale for request	**See D0364**
D0367	**CONE BEAM CT CAPTURE WITH**	**See D0364**	• Written documentation for prior authorization which includes rationale for request	**See D0364**

Code	Description	Criteria and Benefits	Required Documentation	Comments
	INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM			
D0470	**STUDY MODELS/ DIAGNOSTIC CASTS**	Also known as diagnostic models or study models. Benefits are available for diagnostic casts when taken as an initial diagnostic aid in determining a patient's total treatment plan. Diagnostic casts are for the evaluation of orthodontic benefits only. A benefit: a. once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment). b. for patients under the age of 21. c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly). **Limitation:** Fees for working models, such as those utilized for preparation of crowns, bridges, periodontal surgical stents, occlusal guards, nightguards etc. are not considered diagnostic in nature and are included in the fees for those procedures. The patient cannot be billed separately for such working models. If definitive prosthetic treatment (crown, bridge, dentures) is completed within 12 months after date of service of diagnostic casts, the fee for diagnostic casts will be deducted from the definitive treatment fee. **Rationale:** Diagnostic models are considered part of the overall treatment rendered.	1. Diagnostic casts are required to be submitted for orthodontic evaluation and are reimbursed only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned. 2. Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. 3. Photographs submission via the Comagine Health Provider Portal is preferred.	There are other situations for which study models/diagnostic cases are needed: D8080 (adolescent orthodontia) and D8999 (unspecified orthodontic procedure by report) may require study models. Oral Surgery (D7140-D7960) guidelines state: "For Procedure D7320 (alveoloplasty on an edentulous quadrant.) If radiographs are not sufficient to justify a need, (i.e., for soft tissue procedures) additional diagnostic material (photographs or models) and/or a statement of justification must be presented." **Bridges are a non-covered benefit without prior authorization from the District of Columbia Department of Health Care Finance (DHCF).**

Code	Description	Criteria and Benefits	Required Documentation	Comments
RESTORATIVE (PROCEDURES D2000-D2999)				
General Policies, Procedure D2799: 1. D2799 (Interim Crown-Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression).				
D2799	**Provisional Crown-Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression) is a covered benefit under DC Medicaid.**	1. D2799 Is not to be used as a temporary crown for routine crown restoration procedures. 2. D2799 is placed for an extended period of time (generally 6 months or more) to allow for other treatment and/or completion of diagnosis prior to the final impression/restoration.	1. Pre-operative radiograph of the tooth. 2. Full Mouth series of radiographs. 3. Narrative of Medical necessity must include how long the Interim crown will be utilized as an interim crown. 4. Requires a tooth number.	

ENDODONTICS (PROCEDURES D3110-D3450)

General Policies, Procedures D3110-D3450:

1. Includes those procedures which provide complete root canal filling on permanent teeth and pulpotomies (pulpectomies) on both deciduous and permanent teeth. Root canal therapy is covered if dentally necessary. It is dentally necessary when pathology is present, when the tooth is nonvital or the pulp has been compromised by caries, trauma, or accident which may lead to the death of the pulp, and the criteria set forth in this manual.
2. The prognosis of the affected tooth, other remaining teeth, and the type of final restoration allowable will be evaluated in considering root canal therapy.
3. Authorization and reimbursement for root canal treatment includes, but is not limited to, any of all of the following procedures:
   a. Any incision and drainage or open and medicating procedure necessary in relation to the root canal therapy.
   b. Vitality test.
   c. Radiographs required during treatment including final treatment radiographs.
   d. Culture.
   e. Medicated treatment.
   f. Final filling of canal(s).
   g. Final treatment radiographs(s).
4. The initial opening into the canal, sealing of the access opening, all treatment visits and routine post-operative visits are included in the fee for the completed endodontic treatment.
5. Necessary postoperative care within a ninety (90)-day period is included in the reimbursement fee.
6. Necessary retreatment within a two (2)-year period is included in the fee for completed endodontic treatment. The time limitation does not apply when the re-treatment procedure is performed by a different provider/office.
7. Root canal therapy is not a benefit when extraction is appropriate for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.
8. Root canal treatment must be completed prior to the request for reimbursement.
9. The date of service on the reimbursement request should reflect the final treatment date.
10. Cement bases, and insulating liners are considered part of restorations and are included in the fee for the completed restoration(s).
11. Permanent restoration for an endodontically treated tooth is a benefit when the coverage criteria specified in this manual for the particular restoration are met.
12. A non-resorbable filling material and a resorbable paste or cement should be used (silver points are not acceptable).
13. Radiographs are taken as part of the root canal therapy are part of and included in the fee for the completed endodontic therapy.

ROOT CANAL THERAPY (PROCEDURES D3310-D3348)

General Policies, Procedures D3310-D3348:

1. Retreatment procedures D3346 (anterior), D3347 (bicuspid), and D3348 (molar), are benefits with prior authorization for any permanent tooth and subject to criteria for coverage set forth in this manual.
2. Periapical preoperative diagnostic radiographs of the involved tooth (teeth), additionally sufficient radiographs or other diagnostic material to establish the integrity of the remaining teeth and arches are required for prior authorization of permanent root canal therapy or retreatment of a previous root canal.
3. Root canal therapy is a benefit for permanent teeth when dentally necessary and the final post-treatment restoration of the treated tooth will afford acceptable retention longevity; and:
   a. Missing teeth do not jeopardize the integrity or masticatory function of the dental arches; and
   b. The tooth is necessary to maintain adequate masticatory function; and
   c. Periodontal condition of the tooth and the remaining teeth must be no more involved than Periodontal Case Types II and III, as defined in General Policies - Periodontics procedures D4210 (Gingivectomy or Gingivoplasty) and D4920 (unscheduled dressing change).
4. Root canal therapy (D3310-D3330) may be performed without prior authorization.
5. All endodontic treatment procedures include the removal of posts, silver point and previous root canal filling material, and any procedures necessary to prepare the canals for placement of the canal filling.
6. Radiographs taken as part of the root canal therapy are part of and included in the reimbursement for the root canal therapy.

ENDODONTIC RETREATMENT (PROCEDURES D3346-D3348)

This procedure may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. A request for endodontic re-treatment must meet **at least one** of the following criteria:

The existing root canal fill is inadequate (poorly condensed, overfilled, underfilled).

- Apical pathology or a draining fistula.
- Lingering pain from percussion or temperature.
- Teeth must exhibit a minimum of 50% bone support

D3346	**RETREATMENT OF PREVIOUS ROOT CANAL ANTERIOR**	An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated. Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment. Provide the date of the previous root canal obturation if performed by the same provider.	

			If a fistula is present, an oral photograph of the respective tooth must be provided. 3. Periodontal Charting 4. Requires a tooth number.	
D3347	**RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID**	An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated. Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment. Provide the date of the previous root canal obturation for the respective tooth if performed by the same provider. If a fistula is present, an oral photograph of the respective tooth must be provided. 3. Periodontal charting. 4. Requires a tooth number.	
D3348	**RETREATMENT OF PREVIOUS ROOT CANAL - MOLAR**	An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated. Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment. Provide the date of the previous root canal obturation for the respective tooth if performed by the same provider. If a fistula is present, an oral photograph of the respective tooth must be provided. 3. Periodontal Charting. 4. Requires a tooth number.	

APEXIFICATION/ RECALCIFICATION (PROCEDURES D3351-D3353)

General Policies, Procedures D3351-D3353:

1. Apexification/Apexogenesis is defined as a technique for encouraging continued root formation and apical closure in teeth with incomplete apical development when the pulp is affected by trauma or caries.
2. Final obliteration of the root canal(s) may be accomplished when a radiograph indicates sufficient apical formation. The criteria for authorizing root canal treatment also apply to apexification and must be present prior to the initial pulpotomy treatment.
3. Not reimbursed when procedure D3351 (apexification/recalcification, pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.), D3352 (apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.), or D3353 (apexification/recalcification, final visit), and a completed root canal treatment are performed on the same tooth on the same day.

D3351	**APEXIFICATION/ RECALCIFICATION/ PULPAL REGENER-ATION - INITIAL VISIT (APICAL CLOSURE/ CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)**	Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy). A benefit: a. once per permanent tooth. b. for patients under the age of 21. Not a benefit: a. for primary teeth. b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. c. on the same date of service as any other endodontic procedures for the same tooth. This procedure includes initial opening of the tooth, performing a pulpectomy, preparation of canal spaces, placement of medications and all treatment and post treatment radiographs.	1. Radiographs for prior authorization – submit periapical radiographs. 2. Requires a tooth number. 3. If an interim medication replacement is necessary, use apexification/ recalcification- interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) (D3352). 4. Upon completion of apexification/ recalcification, prior authorization for the final root canal therapy shall be submitted along with the post-treatment radiograph to demonstrate sufficient apical formation.	

APICOECTOMY/PERIRADICULAR SERVICES (PROCEDURES D3410-D3473)

General Policies, Procedures D3410-D3503:

1. Apicoectomy/Periradicular Services, procedures D3410, D3421, D3425, and D3426 do not require prior authorization. D3471-D3473 require prior authorization.
2. Apicoectomy/Periradicular surgery, procedures D3410, D3421, D3425, and D3426 are defined as the excision of the apical portion of the root of a previously endodontically treated tooth to remove the diseased tissue.
3. These procedures may be indicated when an abnormality or blockage of the root end prevents the cleaning and sealing of the apical portion of a root canal through a coronal approach and the tooth remains symptomatic. They may also be indicated if the tooth is asymptomatic as clinically indicated. This occurs most commonly when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, or when a canal wall has been perforated or "shelved" during canal enlargement.
4. Procedure D3426 (apicoectomy/ each additional root) is reimbursed for a maximum of three (3) roots per tooth.
5. Not a benefit in conjunction with root canal therapy.

D3428	**BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY- PER TOOTH, SINGLE SITE**	1. Periradicular surgery requires bone removal to access the root area being treated and can hinder the long-term prognosis for the tooth. 2. A bone graft (D3428) is placed to enhance the healing process for the tooth. 3. Involves the use of non-autogenous graft to stimulate bone growth when periradicular pathology has led to the deformity of bone. 4. D3428 includes any non-autogenous graft material. 5. Periradicular surgery (D3471, D3472, and D3473) for the respective tooth must be approved.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment. 3. Requires a tooth number.	
D3429	**BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY-EACH ADDITIONAL CONTIGUOUS TOOTH IN THE SAME SURGICAL SITE**	1. SEE D3428 2. D3428 must be approved for the respective tooth. 3. D3429 is utilized when an additional bone graft is placed in a tooth contiguous to the graft placed on the tooth approved for D3428. 4. D3429 can only be used for a tooth contiguous to the tooth approved for D3428. 5. Periradicular surgery (D3471, D3472, and D3473) for the respective tooth must be approved.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment. 3. Requires a tooth number.	

D3432	**GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE, IN CONJUNCTION WITH PERIRADICULAR SURGERY**	1. D3432 is used for the regeneration of tissue associated with periradicular surgery and is requested as a separate procedure. 2. A barrier membrane is placed to stabilize the periradicular surgery site so that new bone can mature and heal without interference from the healing soft tissue. 3. This type of barrier membrane is resorbed and does not require a second surgery for removal. 4. Periradicular surgery (D3471, D3472, and D3473) for the respective tooth must be approved.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment. 3. Requires a tooth number.	
D3471	**SURGICAL REPAIR OF ROOT RESORPTION-ANTERIOR**	For surgery on root of anterior teeth. There is evidence of external root resorption on the respective tooth. D3471 does not include retrograde filling material placement. A benefit for permanent teeth only. Not a benefit: a. To the original provider within 90 days of root canal therapy except when a medical necessity is documented. b. To the original provider within 24 months of a prior Apicoectomy/Periradicular surgery, same root. c. The same date of service as procedures D3410, D3421, D3425, or D3426. The fee for this procedure includes all treatment and post treatment radiographs.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment. 3. Requires a tooth number.	
D3472	**SURGICAL REPAIR OF ROOT RESORPTION-PREMOLAR**	For surgery on root of premolar teeth. There is evidence of external root resorption on the respective tooth. D3472 does not include retrograde filling material placement.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale	

		A benefit for permanent teeth only. Not a benefit: a. To the original provider within 90 days of root canal therapy except when a medical necessity is documented. b. To the original provider within 24 months of a prior Apicoectomy/Periradicular surgery, same root. c. The same date of service as procedures D3410, D3421, D3425, or D3426. The fee for this procedure includes all treatment and post treatment radiographs.	and the identity of the root that requires treatment. 3. Requires a tooth number.	
D3473	**SURGICAL REPAIR OF ROOT RESORPTION-MOLAR**	For surgery on root of molar teeth. There is evidence of external root resorption on the respective tooth. D3473 does not include retrograde filling material placement. A benefit for permanent teeth only. Not a benefit: a. To the original provider within 90 days of root canal therapy except when a medical necessity is documented. b. To the original provider within 24 months of a prior Apicoectomy/Periradicular surgery, same root. c. The same date of service as procedures D3410, D3421, D3425, or D3426. The fee for this procedure includes all treatment and post treatment radiographs.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment. 3. Requires a tooth number.	

OTHER ENDODONTIC PROCEDURES				
D3921	**DECORONATION OR SUBMERGENCE OF AN ERUPTED TOOTH**	1. The purpose of decornation or submergence of an erupted tooth and then retention of the root is to preserve ridge height and width of bone surrounding the retained root until the patient is ready for the placement of an implant or prosthesis that depends on adequate bone for support. 2. A Decoronation or submergence procedure is performed to remove the clinical crown and gutta percha from the roots wherein the remaining root structure and surrounding bone is not affected. 3. After an appropriate interval, the remaining root is removed, and the implant or prosthesis is placed. 4. The procedure is performed when an extraction is contraindicated due to the risk of medication or radiation induced osteonecrosis.	1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Narrative to support the medical necessity to preserve the alveolar bone to maintain adequate width and height of the alveolus for the respective tooth for future implant placement. 3. Requires a tooth number.	

PERIODONTICS (PROCEDURES D4000-D4999): General Policies and Procedures

Radiographs must be **less than one (1) year old** and of diagnostic quality, showing the entire treatment site.

Required Periodontal Charting:

- **Must be dated within 1 year of request and include the patient's full name.**
- **Current periodontal charting taken (no more than 12 months old) w/4-6 probing depths per tooth**

General policy for all periodontal surgical procedures - Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three months, as well as any surgical reentry, except soft tissue grafts, for 24-36 months depending on the procedure. When a surgical procedure is billed within three months of the initial surgical procedure by the same dentist/dental office, the fee for the surgery is DISALLOWED. In the absence of documentation of extraordinary circumstances, the fee for additional surgery by the same dentist/dental office for 24 months is DISALLOWED.

Periodontal procedures shall be a benefit for patients aged 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented.

Current periapical radiographs of the involved areas and arch radiographs are required for periodontal scaling and root planing procedures (D4341 and D4342)) for prior authorizations. A panoramic radiograph alone is non-diagnostic for periodontal procedures.

Gingivectomy or gingivoplasty (D4210 and D4211) are a benefit once per quadrant in a 36-month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit a minimum of one 5mm+ pocket and radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.

Gingivectomy or gingivoplasty (D4210 and D4211) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by- case basis.

Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, reimbursement shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing.

Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.

PERIODONTICS (PROCEDURES D4210-D4920)

General Policies, Periodontal Procedures D4210-4920:

1. Periodontal Definitions.
   a. Type I-Gingivitis; inflammation of the gingiva, characterized clinically by gingival hyperplasia, edema, retractability, gingival pocket formation, pocket depth less than 4mm and no bone loss.
   b. Type II-Early periodontitis; progression of gingival inflammation into the alveolar bone crest and early bone loss resulting in moderate pocket formation (4-6mm).
   c. Type III- Moderate periodontitis; a more advanced state with increased destruction of periodontal structures associated with moderate-to-deep pockets (5-8mm), moderate-to-severe bone loss and tooth mobility.
   d. Type IV-Advanced periodontitis; further progression of periodontitis with severe destruction of the periodontal structures with increased pocket depth, usually greater than 7-8mm with increased tooth mobility.
   e. Type V-Refractory periodontitis; continues demonstration of numerous sites of periodontitis where loss of attachment is progressing, even after traditional therapy has been completed and good home care is evident.

2. Periodontal care shall be limited to those patients:
   a. Who exhibits generalized periodontal pocket depths in excess of 4-5 mm.
   b. Who has a minimum of one isolated pocket 5 mm or greater in depth per quadrant, and
   c. Where the isolated pockets of 5 mm or greater in depth have failed to respond to conservative treatment, including emergency treatment of periodontal abscesses.

3. Subgingival curettage, in the generally accepted sense, is a surgical service involving removal of the epithelial lining, granulation tissue, and other pocket contents, and includes the planing of the root surface to remove deposits and smoothing of the root surfaces. It is performed for patients with generalized pocket depths within the range of more than 4-5 mm and a minimum of one isolated pocket over 5 mm in depth per quadrant. This procedure is usually performed with local anesthesia.

4. Periodontal services shall be approved on an ordered schedule initially encompassing only the direct, least invasive measures.

5. In order to make a fair evaluation of prior authorization requests for periodontal procedures the following information shall be included with the request:
   a. Diagnostic radiographs dated within 1 year of the request.
   b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition to charting missing and tooth treatment planned for extraction. Additional documentation of recession is also a consideration, as it points to one aspect of the preexisting condition of the hard and soft tissue.

6. Guidelines for Reviewing Periodontal Treatment.
   a. Case Type I is essentially gingivitis, little or no bone loss. Prophylaxis shall be adequate to control these cases. Authorization for sub-gingival curettage, muco-gingival or osseous surgery for these cases shall not be granted.
   b. Case Types II and III (Early to moderate periodontitis, deep pockets (4-6 mm+), moderate to severe bone loss. The major emphasis of periodontal care covered under the DDSGP shall be the treatment of Case Types II and III, provided in an ordered schedule of services. Generally, initial treatment shall be limited to nonsurgical services such as sub-gingival curettage, followed by an evaluation period of a minimum of four (4) weeks.
   c. Case Type IV (deep pockets, severe bone loss, advanced mobility patterns) and Case Type V treatment plans shall not be authorized or rendered.

GINGIVECTOMY OR GINGIVOPLASTY (PROCEDURES D4210-D4212)

General Policies, Procedures D4210-D4211:

1. Gingivectomy or gingivoplasty procedures D4210 and D4211, are benefits in the treatment of moderate to deep gingival pockets (4-5 mm), moderate to severe bone loss, and include the removal of the soft tissue side of the pocket, eliminating the pocket, and creating a new gingival contour.

2. The quadrant shall be indicated on the request for prior authorization.

3. Procedures D4210/D4211 (gingivectomy or gingivoplasty) may be allowable when an isolated pocket(s) has not responded to conservative treatment.
   a. Any combinations of gingivectomy or gingivoplasty (procedures D4210 or D4211), gingival flap procedures including root planing procedures (D4240/D4241) are benefits once in thirty-six (36) months in the same quadrant.
   b. This procedure requires periodontal charting of the patient's entire dentition.

4. Procedures D4210/D4211 (gingivectomy or gingivoplasty) may be allowable where a drug-induced hyperplasia is exacerbated in isolated areas.

5. These surgical procedures are directed at correction of the soft tissue around the tooth. Gingivectomy is the excision of the soft tissue wall of the periodontal pocket when the pocket is uncomplicated by extension into the underlying bone. Gingivoplasty is the procedure by which gingival deformities (particularly enlargements) are reshaped and reduced to create normal and functional form.

6. When muco-gingival procedures and osseous surgery are performed in the same quadrant and in the same treatment episode, the procedure code for the most inclusive procedure is appropriate for the quadrant.

D4210	**GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT**	It is performed to eliminate supra-bony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240). Do not count tooth bounded spaces for D4210, D4341; count only "diseased teeth/periodontium." A tooth bounded space is the edentulous area bounded by two qualifying teeth. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space.	1. Quadrant , current periodontal charting (no more than 12 months old) with 6 points per tooth and narrative describing condition of the tissue. 2. Full Mouth Series of radiographs. 3. Photographs for prior authorization- submit photographs of the involved areas. 4. Written documentation for prior authorization – shall include a definitive periodontal diagnosis.	

		A benefit: a. for patients aged 13 or older except in unusual circumstances b. once per quadrant every 36 months This procedure cannot be prior authorized within 30 days following periodontal scaling and root planning (D4341 and D4342) for the same quadrant.	5. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudo-pockets as a result of gingival hyperplasia, which is demonstrated on a photograph. 6. Requires a quadrant number.	
D4211	**GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH, OR TOOTH BOUNDED SPACES PER QUADRANT**	It is performed to eliminate supra-bony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Crown lengthening involving soft tissue only is appropriately coded as D4211. A benefit: a. for patients aged 13 or older. b. once per quadrant every 36 months. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planning (D4341 and D4342) for the same quadrant.	1. Quadrant, current periodontal charting (no more than 12 months old) with 6 points per tooth or narrative describing condition of the tissue 2. Full Mouth Series of radiographs. 3. Photographs for prior authorization- submit photographs of the involved areas. 4. Written documentation for prior authorization – shall include a definitive periodontal diagnosis. 5. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudo-pockets as a result of gingival hyperplasia, which is demonstrated on a photograph. 6. Requires a quadrant number. 7. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).	Benefit exceptions for individuals <age 13 will be considered in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care.
D4212	**GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURES PER TOOTH**	When rendered on the same date as the preparation of a crown or other restoration it is included in the global fee for the restoration. Gingivectomies for restorative access should ideally be followed by an appropriate healing period before placing the restoration.	1. Current periodontal charting (no more than 12 months old) with 6 points per tooth or narrative describing condition of the tissue. 2. Full Mouth Series of radiographs. 3. Photographs for prior authorization- submit photographs of the respective teeth for the request.	

			4. A current and complete periodontal evaluation chart is required for prior authorization. 5. Narrative of Medical necessity. 6. Requires a tooth number.	
OTHER PERIODONTAL SURGERY (PROCEDURES D4240- D4261)				
D4240	**GINGIVAL FLAP PROCEDURE INCLUDING ROOT PLANNING – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT**	A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, a need to maintain esthetics, a need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Scaling and root planing procedures (D4341, D4342) do not precede this procedure. Scaling and root planing are included with D4240. One D4240 per quadrant per 24 months	1. Current periodontal charting (no more than 12 months old) with 6 points per tooth and narrative describing condition of the tissue. 2. Full Mouth Series of radiographs. 3. Photographs for prior authorization- submit photographs of the involved areas. 4. Narrative of Medical necessity. 5. Requires a quadrant number.	
D4241	**GINGIVAL FLAP PROCEDURE INCLUDING ROOT PLANNING – ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT**	A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, a need to maintain esthetics, a need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Scaling and root planing procedures (D4341, D4342) do not precede this procedure. Scaling and root planing are included with D4241. One D4241 per quadrant per 24 months	1. Current periodontal charting (no more than 12 months old) with 6 points per tooth and narrative describing condition of the tissue. 2. Full Mouth Series of radiographs. 3. Photographs for prior authorization- submit photographs of the involved areas. 4. Narrative of Medical necessity. 5. Requires a quadrant number.	
D4249	**CLINICAL CROWN LENGHTENING-HARD TISSUE**	This procedure is performed to allow a restorative procedure on a tooth with little or no tooth structure to be exposed in the oral cavity.	1. Full Mouth Series of radiographs. 2. Photographs for prior authorization- submit photographs for the respective teeth.	

		This procedure requires 1. Reflection of a full thickness flap, and removal of bone. 2. Removal of bone to expose more tooth structure. 3. To be rendered in a healthy periodontal environment. 4. A healing period of at least six (6) weeks prior to the crown preparation for the tooth. Once per lifetime per tooth.	3. Current periodontal charting (no more than 12 months old) with 6 points per tooth or narrative describing condition of the tissue. 4. Narrative of Medical necessity. 5. Requires a tooth number.	
D4260	**OSSEOUS SURGERY (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant**	This procedure is performed to treat teeth with periodontal pocketing and bone loss to more effectively remove the plaque buildup that causes inflammation and continued attachment/bone loss. The procedure also removes some of the bone to create easier to clean contours and reposition the gingival flaps more apically. This procedure requires 1. Reflection of a full thickness flap. 2. Removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). 3. To be rendered in a healthy periodontal environment. 4. A healing period of at least six (6) weeks prior to the crown preparation for the tooth.	1. Full Mouth Series of radiographs. 2. Current periodontal charting (no more than 12 months old) with 6 points per tooth and a narrative describing condition of the tissue. 3. Narrative of Medical necessity. 4. Requires a quadrant.	
D4261	**OSSEOUS SURGERY (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant**	This procedure is performed to treat teeth with periodontal pocketing and bone loss to more effectively remove the plaque buildup that causes inflammation and continued attachment/bone loss. The procedure also removes some of the bone to create easier to clean contours and reposition the gingival flaps more apically. This procedure requires 1. Reflection of a full thickness flap.	1. Full Mouth Series of radiographs. 2. Current periodontal charting (no more than 12 months old) with 6 points per tooth and narrative describing condition of the tissue. 3. Narrative of Medical necessity. 4. Requires a quadrant.	

		2. Removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). 3. To be rendered in a healthy periodontal environment. 4. A healing period of at least six (6) weeks prior to the crown preparation for the tooth.		

BONE REPLACEMENT GRAFT PER QUADRANT (D4263-D4267)

General Policies, Procedures D4263-D4264:

1. A diagnosis of Type III or Type IV periodontal disease is required for D4263 to be considered for prior authorization.
2. When bone loss results in deep, narrow pockets, a bone replacement graft may be placed to treat the bony defect.
3. Bone replacement grafts procedures (D4263 and D4264) are limited to periodontal defects associated with a natural tooth.
4. If the bone replacement graft is placed in an extraction site or implant removal site for the purpose of socket preservation D7953 is to be requested.
5. If the bone replacement graft is placed for ridge augmentation in edentulous areas D7950 is to be requested.

D4263	**BONE REPLACEMENT GRAFT FIRST SITE IN QUADRANT**	This procedure involves the use of osseous auto grafts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring or the placement of biologic materials to aid osseous tissue regeneration or barrier membranes. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes.	1. Diagnostic radiographs. 2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. 3. Requires tooth number	
D4264	**BONE REPLACEMENT GRAFT EACH ADDITIONAL SITE IN QUADRANT**	This procedure involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring or the placement of biologic materials to aid osseous tissue regeneration or barrier membranes. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved.	1. Diagnostic radiographs. 2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. 3. Requires tooth number(s).	
D4265	**BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION, PER SITE**	This procedure is used after laying a gingival flap (D4240/D4241) and/or during osseous surgery (D4260/D4261), biologic materials may be placed in a periodontal defect to aid in the regeneration of soft and osseous tissue.	1. Diagnostic radiographs. 2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. 3. Narrative of Medical necessity. 4. Describe the location of the area being treated with the biologic materials. 5. Identify the specific material used for periodontal regenerative procedures. 6. Requires tooth number(s).	

D4266	**GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE**	This procedure can be used for periodontal defects around natural teeth. A barrier membrane for guided tissue regeneration (GTR) is placed to prevent the fast-growing gingiva from attaching to the root before the new bone can mature and attach to the root. The resorbable barrier membrane (D4266) is integrated into the regeneration site and/or resorbed or broken down by the body in the healing process. This type of barrier membrane does not require a second surgery for removal.	1. Diagnostic radiographs and intra-oral photos to document the need for GTR. 2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. 3. A diagnosis of moderate to severe periodontal disease with 5mm pocket depths or greater with treatable bony defects. 4. Narrative of Medical necessity. 5. Identify the specific material used for the guided tissue regenerative procedure. 6. Requires tooth number(s).	There is a 24-month exclusion period for the delivery of the same procedure to treat the same area of the mouth.
D4267	**GUIDED TISSUE REGENERATION, NATURAL TEETH – NON- RESORBABLE BARRIER, PER SITE**	This procedure can be used for periodontal defects around natural teeth. A barrier membrane for guided tissue regeneration (GTR) is placed to prevent the fast growing gingival from encroaching on the surgical site until new bone has had time to fill in the periodontal defect. The non-resorbable barrier membrane (D4267) requires a second surgery to remove it four to six weeks after placement.	1. Diagnostic radiographs and intra-oral photos to document the need for GTR. 2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. 3. A diagnosis of moderate to severe periodontal disease with 5mm pocket depths or greater with treatable bony defects. 4. Narrative of Medical necessity 5. Identify the specific material used for the guided tissue regenerative procedure. 6. Requires tooth number(s).	There is a 24 month exclusion period for the delivery of the same procedure to treat the same area of the mouth. The removal of the non-resorbable barrier is included in the reimbursement rate for D4267.

PERIODONTAL SCALING AND ROOT PLANING (D4341-D4342)

General Policies, Procedures D4341-D4342: Please refer to Transmittal 10-26 for exception for the special needs population.

1. Periodontal scaling and root planing procedures D4341 and D4342, require prior authorization and shall be authorized by quadrant, the following information shall be included with the Prior Authorization Request:
   a. Diagnostic radiographs.
   b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition charting of missing teeth and teeth treatment planned for extraction.
2. Each quadrant requested must have a minimum of one (1) 5 mm or greater pocket.
3. When justified, a maximum of five (5) quadrant treatments may be authorized in a twelve (12)-month period.
4. Procedures D1110-D1120, prophylaxis, adult & child, are not reimbursed for the same date of service as scaling and root planing procedures D4341/D4342.
5. Periodontal scaling and root planing procedures D4341/D4342 are not reimbursed for the same date of service as any surgical periodontal procedure.
6. Generally, periodontal scaling and root planing procedures D4341/D4342 is performed prior to the provision of either procedures D4210/D4211, gingivectomy or gingivoplasty, or procedures D4260/D4261 osseous and muco-gingival surgery.
7. The full mouth periodontal charting should also show 4mm and above pocket depths and bone loss seen on the x-rays (BWX/PA) with the presence of calculus on the root surface in multiple quadrant(s).

D4341	**PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT**	This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. A benefit: a. for patients aged 13 or older. b. when there is a minimum of one 4mm+ pocket on each diseased tooth. c. once per quadrant every 12 months. Exception for special needs population may require procedure more than once a year. Gingivectomy or gingivoplasty (D4210 and D4211) cannot be prior authorized within 30 days following this procedure for the same quadrant. Prophylaxis (D1110 and D1120) are not reimbursed for the same date of service	1. Full mouth periodontal charting including 4 to 6 probing depths per tooth; indication of furcation involvement, mobility, or bleeding upon probing. Consideration should also be given to include recession if documented. 2. Radiographs for prior authorization – submit periapical radiographs of the involved areas and arch radiographs. 3. Written documentation for prior authorization – shall include a definitive periodontal diagnosis. 4. A current and complete periodontal evaluation chart is required for prior authorization. 5. Requires a quadrant number. 6. If three or fewer diseased teeth are present in the quadrant, use periodontal scaling and root planning (D4342).	Benefit exceptions for individuals <age 13 will be considered in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care. **Please refer to Transmittal 10-26 (link below)** due to exceptional circumstances granted to the special needs' population for D4341: https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/7033

D4342	**PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH PER QUADRANT**	This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. A benefit: a. for patients aged 13 or older. b. when there is a minimum of one 4mm+ pocket on each diseased tooth. c. once per quadrant every 12 months. Exception for special needs population may require procedure more than once a year. Gingivectomy or gingivoplasty (D4210 and D4211) cannot be prior authorized within 30 days following this procedure for the same quadrant. Prophylaxis (D1110 and D1120) are not reimbursed for the same date of service	1. Full mouth periodontal charting including 4 to 6 probing depths per tooth; indication of furcation involvement, mobility, or bleeding upon probing. Consideration should also be given to include recession if documented. 2. Radiographs for prior authorization – submit periapical radiographs of the involved areas and arch radiographs. 3. Written documentation for prior authorization – shall include a definitive periodontal diagnosis. 4. A current and complete periodontal evaluation chart is required for prior authorization. 5. Requires a quadrant number.	Benefit exceptions for individuals <age 13 will be considered in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care.

IMPLANTS AND IMPLANT SUPPORTED PROSTHETICS

General Policies, Procedures D6010-D6113

Dental implants are an accepted method for tooth replacement. The therapeutic goal of dental implants is to support restorations that replace a missing tooth or teeth so as to provide the member comfort and function and to assist in the ongoing maintenance of the remaining intraoral and perioral structures.
The first dental implant was a titanium implant in a human volunteer in Sweden by Dr. Per-Ingvar Branemark, a Swedish Orthopedic Surgeon in 1965.

There are three types of dental implants, the endosseous, subperiosteal and transosteal. Dental Implants can be performed as delayed procedures (over months or years) or immediate (at the time of tooth extraction).

An abutment is a connection to a dental implant that is a manufactured component usually made of machined high noble metal, titanium, titanium alloy or ceramic. A custom abutment is fabricated for a specific member using a casting process and usually is made of noble or high noble metal.

Surgical stents are highly recommended for more accurate placement of dental implants.

Factors influencing the selection of /patients for dental implants include age, general and dental health and individuals with special needs.

Candidates for dental implants must be age 18 or older and not pregnant.

When a tooth or teeth adjacent to the site of the requested dental implants requires restoration, the tooth or teeth should be treated prior to requesting the dental implant. If the tooth or teeth demonstrate significant disease treat the diseased tooth or teeth prior to submitting for the dental implant request. If there is injury to the tooth or teeth, and/or multiple missing teeth, more conservative treatment shall be considered as an alternative to dental implants to treat the condition and replace all missing teeth.

IMPLANTS AND IMPLANT SUPPORTED PROSTHETICS

Implants: (Implant Readiness)

A. Before requesting implants, periodontal health and dental health (endodontic, extractions, crowns and filings) must be completed.
Pre-screening and determining eligibility for the implants using periodontal charting, x-rays and a narrative stating why this procedure is necessary.

B. All extraction sites for implants must be healed and radiopaque.

C. Additional requirements for the Implant Site:

1. Bone grafting: D7953 Bone Replacement Graft/ridge preservation is allowed to restore bone height for extraction sites that are a candidates for implant placement.
2. The implant site - no ridge augmentation is needed.
3. Bone grafting at the time of implant placement is not recognized because the implant site should be ready/healing of the bone.

D. **Second molar implants** will be determined by the review of the clinical narrative and supporting documentation for the request.

E. CT scan **(D0365/66/67)** are allowed to assist the provider in the evaluation of the implant site and placement.

I. Single dental implants are **medically appropriate** when a functional deficit exists.

II. Dental implant bodies are **medically appropriate** to anchor a removable denture, not a fixed prosthesis, if the traditional removable dentures cannot be worn or are painful. Coverage is limited to four upper dental implant bodies in the maxilla or two lower dental implant bodies in the mandible for the edentulous patient.

III. Dental implants are **not medically appropriate** in the following situations:

- Presence of local or systemic conditions that may interfere with the normal healing process and subsequent tissue homeostasis.

- Inadequate quality or quantity of alveolar bone and soft tissues.
- The patient currently has active periodontal disease and poor hygiene.
- Replacement of a second molar if used to extend the functional first molar occlusion, unless the patient has an opposing tooth to prevent the extrusion of the opposing tooth, or an Orthodontic problem,
- Replacement of wisdom teeth (1, 16,17 and 32).
- When maintenance of the tooth/teeth is/are not considered. By this, it is meant that placement of dental implants in an area which is not truly of functional benefit to the patient or in an arch which should actually be edentulated altogether should not be covered. In this case, it will be up to the Comagine dental reviewer to determine if the patient can reasonably and successfully (or at least adequately) function with non-implant-borne dentures.
- When the teeth are not in occlusion (meeting of the upper and lower teeth when the jaw is closed and the tooth/teeth surfaces come in contact). There is the possibility that the dental implant would be placed in a site unopposed (i.e. not in occlusion) with *natural* dentition but would be functioning against a *denture tooth* in the opposing arch.

IV. Four (4) dental implants per arch will be authorized for the partially edentulous patient; for the completely edentulous, four (4) in the maxilla and two (2)in the mandibular area. When more than four (4) teeth are missing in the same arch, consideration must be given to a removable partial denture as an alternative benefit.

V. There must be at least 3 mm of inter-dental space between dental implants and naturally existing teeth to maintain periodontal health and form.

VI. If stents are required for dental implant placement, one stent per arch will be allowed.

VII. Dental implants will be re-evaluated via intraoral radiographs or CT scans **prior** to the authorization of abutments or crowns four to six months after dental implant placement.

VIII. After abutments or crowns are seated, a final intraoral radiograph, intraoral photo, or CT scan must be reviewed by Comagine Health dental reviewers before any further services in that area can be authorized.

IX. If an anterior tooth has been extracted due to trauma, gross caries or endodontic failure, with good general and periodontal health and controllable risk factors , an anterior dental implant is justified and will be authorized.

X. If bone grafting and augmentation is necessary, there must be a 4-6 months interval with good quality/contrast X-Rays or CT Scan for review by Comagine dental reviewers.

1. Candidates for implants must be age 18 or older and not pregnant.
2. Stable periodontal health and overall dental health in the entire mouth must be demonstrated.
3. Documentation submitted must demonstrate absence of radiographic and clinical calculus, pre-and post-periodontal charting and treatment, and an adult prophylactic/preventive procedure date not to exceed 6 months prior to the request for implant restoration.
4. Tooth (teeth) to be replaced must have an opposing occlusion.
5. Authorization to replace wisdom teeth (1,16,17 and 32) will not be approved.
6. Dental implants that fail shall not be replaced. (**).
7. Four (4) implants per arch shall be authorized for the partially edentulous patient, and for the completely edentulous, four (4) in the maxilla and two (2) in the mandibular.
8. There must be at least 3 mm of inter-dental space between implants and naturally existing teeth.
9. If stents are required for dental implant placement, one stent per arch shall be allowed.
10. Dental implants will be re-evaluated with X-rays and or CT scans prior to the authorization of abutments or crowns after 4-6 months.

11. If bone graft augmentation is necessary, there must be a 6-month interval before a dental implant can be placed and good quality/contrast x-rays or CT scans must be submitted for review.
12. The optimal dimensions of available alveolar bone for most forms of implant placement are: 5mm in width, 13-15 mm in height and 5 mm in length.
13. All requests for dental implants, implant abutments, and implant crowns shall be reviewed by dentists
14. Other Contraindications for dental implants shall include:
    a. Treatment including but not limited to long-term steroid therapy, radiation therapy to a potential implant site, chemotherapy, hemodialysis, heart surgery (within the last six months), recent Myocardial Infarction, (within past 6 months) or hyperbaric oxygen treatment for osteoradionecrosis.
    b. Concomitant use of anticoagulants or medications that contraindicates implant success, such as bisphosphonates
    c. Known illicit drug use (e.g., Crack, methamphetamine, heroin, cocaine or other drugs that can be smoked and/or applied to the intraoral tissues)
    d. Uncontrolled metabolic disorders, chronic renal disease, or a severe systemic disease (including but not limited to leukemia and collagen disorders such as systemic lupus erythematosus and scleroderma).
    e. Uncontrolled bulimia, GERD, or other conditions causing acid reflux
    f. Presence of intra- and peri-oral piercings
    g. Unstable psychiatric or chronic illness as noted above included poorly controlled diabetes mellitus with a current Hemoglobin A1c(HgbA1c>7%).
    h. Any history of dental implant failure or intraoral bone graft failure

Medical and Dental health history

- The patient must have generally healthy, well maintained and stable dentition.
- Medical History
- Documentation provided should show absence of radiographic and clinical calculus, a full-mouth periodontal charting, and an adult oral prophylaxis procedure, the date not to exceed 6 months prior to request for implant restoration.
- Initial documentation should clearly indicate any areas of current facial anesthesia, paresthesia, or dysesthesia as might be encountered in a patient with a past history of trauma, oral-maxillofacial surgical procedures, tumors, anatomical anomalies, etc.
- Tooth (teeth) to be replaced must have an opposing occlusion
- The patient must have no dental habits or oral conditions that preclude the placement of implants, including but not limited to:
  - bruxism, craze lines,
  - severe ulceration or erosive lesions,
  - temporomandibular joint disorder or myofascial pain disorder,
  - history of facial fractures (which may preclude the placement of implants; however this will be considered on a case by case situation).
- The patient should have no history of dental implant failure or intraoral bone graft failure.

PRE-SURGICAL SERVICES				
D6190	**RADIOGRAPHIC/ SURGICAL IMPLANT INDEX, BY REPORT**	A radiographic index or a surgical guide used to assist in surgical implant placement.	1. Full mouth radiographs (Panorex or full mouth series of x-rays) including Periapicals of the site requesting dental implant, 2. Full-mouth periodontal charting, unless patient is completely edentulous 3. Requires tooth (implant site) number 4. Clinical justification for the dental implants, including the reasons conventional removable dentures cannot be used to replace the missing teeth. 5. **Narrative to include the name and contact information of the dental provider who will restore the dental implant.**	One unit per arch.

SURGICAL SERVICES				
D6010	**SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT**	Includes second stage surgery and placement of healing cap Coverage is only for replacement of missing natural teeth. Implants done solely to restore a space beyond the normal complement of natural teeth are not covered.	1. Date of last dental cleaning listed on 719a form box 13 2. Full mouth radiographs (Panorex or CSX) including Periapicals of site requesting dental implant, 3. Full-mouth periodontal charting, unless patient is completely edentulous 4. Requires a tooth (implant site) number 5. Clinical justification for the dental implants, including the reasons conventional removable dentures cannot be used to replace the missing teeth. 6. **Narrative to include the name and contact information of the dental provider who will restore the dental implant.** 7. Requests for edentulous patients must indicate date denture or partial denture was completed and any realignments within 2 years. NOTE: if requests for implants is due to ill-fitting dentures patient must have been in dentures for 2 years and had at least 2 realignments.	All radiographs submitted must be free of tartar and show mouth is stable with no decay or extractions needed. A. Dental implants are **not medically appropriate** in the following situations: o Presence of local or systemic conditions that may interfere with the normal healing process and subsequent tissue homeostasis. o Inadequate quality or quantity of alveolar bone and soft tissues. o The patient currently has active periodontal disease and poor hygiene. o Replacement of a second molar if used to extend the functional first molar occlusion, unless the patient has an Orthodontic problem. o Replacement of wisdom teeth (1, 16,17 and 32). o When maintenance of the tooth/teeth is/are not considered. By this, it is meant that placement of dental implants in an area which is not truly of functional benefit to the patient or in an arch which should be edentulated altogether should not be covered. In this case, it will be up to the Comagine dental reviewer to determine if the patient can reasonably and successfully (or at least adequately) function with non-implant-borne dentures.

				○ When the teeth are not in occlusion (meeting of the upper and lower teeth when the jaw is closed and the tooth/teeth surfaces come in contact). There is the possibility that the dental implant would be placed in a site unopposed (i.e. not in occlusion) with *natural* dentition but would be functioning against a *denture tooth* in the opposing arch. B. Four (4) dental implants per arch will be authorized for the partially edentulous patient; for the completely edentulous, four (4) in the maxilla and two (2)in the mandibular area. C. When more than four (4) teeth are missing in the same arch, consideration must be given to a removable partial denture as an alternative benefit. D. There must be at least 3 mm of inter-dental space between dental implants and naturally existing teeth to maintain periodontal health and form. E. If stents (D6190) are required for dental implant placement, one stent per arch will be allowed. F. Dental implants will be re-evaluated via intraoral radiographs, intraoral photos, or CT scans **prior** to the authorization of abutments or crowns four to six months after dental implant placement. G. After abutments or crowns are seated, a final intraoral radiograph or CT scan must be reviewed by Comagine Health dental reviewers before any further services in that area can be authorized.

				H. If an anterior tooth has been extracted due to trauma, gross caries or endodontic failure, with good general and periodontal health and controllable risk factors , an anterior dental implant is justified and will be authorized. I. If bone grafting and augmentation is necessary, there must be a 4-6 months interval with good quality/ contrast X-Rays or CT Scan for review by Comagine dental reviewers
D6100	**SURGICAL REMOVAL OF IMPLANT BODY**	One unit per dental implant site.	1. Periapical radiograph of the implant. 2. Requires a tooth (implant site) number. 3. Delivery date of implant if known. 4. Clinical narrative to support the removal of the implant body. 5. Photo(s) of the implant body with required documentation.	
D6101	**DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE**	• The implant site must have healed for at least six months and be fully osseous integrated. • Implant must have good crown/root ratio • Must not have more than two threads above the alveolar crest • Implant must not be closer than 1-1.5mm to adjacent roots	1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites. 2. Pre-op radiographic images of defect of the implant and narrative 3. Intraoral Photo of the bony defect area 4. Requires tooth (implant site)number 5. Clinical narrative to debridement of the implant 6. The implant site must have healed for at least six months 7. Evidence of a bony defect surrounding the dental implant.	One unit per implant site
D6102	**DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE**	• The implant site must have healed for at least six months and be fully osseous integrated. • Direct loading will be considered • Implant must have good crown/root ratio • Must not have more than two threads above the alveolar crest • Implant must not be closer than 1-1.5mm to adjacent roots	1. A Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites. 2. Pre-op radiographic images of defect and narrative. 3. Intra Oral Photo of the bony defect area. 4. Requires tooth (implant site) number. 5. Clinical narrative to support the debridement of the implant	One unit per implant site

D6103	**BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration**	• The implant site must have healed for at least six months and be fully osseous integrated. • Direct loading will be considered • Implant must have good crown/root ratio • Must not have more than two threads above the alveolar crest • Implant must not be closer than 1-1.5mm to adjacent roots	1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites. 2. Pre-op radiographic images of defect and narrative. 3. Intra Oral Photo of the bony defect area. 4. Clinical narrative to support the bone graft for the implant. 5. Requires a tooth (implant site) number.	
D6104	**BONE GRAFT AT TIME OF IMPLANT PLACEMENT**	Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately. Criteria as for D6101 Not allowed on same day as other bone grafting procedures.	1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/ panorex needs to be high quality) for the implant site, as well as contralateral and opposing sites. 2. Pre-op radiographic images of defect and narrative. 3. Intraoral Photo of bony defect area. 4. Requires tooth (implant site) number.	
D6105	**REMOVAL OF IMPLANT BODY NOT REQUIRING BONE REMOVAL OR FLAP ELEVATION**	The non-surgical removal of an implant body that does not require flap elevation and bone removal at the implant site.	1. Periapical radiograph of the implant. 2. Requires tooth (implant site) number. 3. Delivery date of implant if known. 4. Clinical narrative to support the removal of the implant body. 5. Photo(s) of the implant body with required documentation.	One unit per dental implant site.
D6106	**GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER IMPLANT**	This procedure is used for peri-implant defects A barrier membrane for guided tissue regeneration (GTR) is placed around an implant that has osseous defects due to peri-implantitis. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft. This type of barrier membrane does not require a second surgery for removal.	1. Diagnostic radiographs and intra-oral photos to document the need for GTR. 2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. 3. Narrative of Medical necessity. 4. Identify the specific material used for the guided tissue regenerative procedure. 5. Requires tooth (implant site) number.	There is a 24-month exclusion period for the delivery of the same procedure to treat the same area of the mouth.

D6107	**GUIDED TISSUE REGENERATION, NON-RESORBABLE BARRIER, PER IMPLANT**	This procedure is used for peri-implant defects A non-resorbable barrier membrane is placed for guided tissue regeneration (GTR) around an implant that has osseous defects due to peri-implantitis. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft. This type of barrier membrane requires a second surgery for removal.	1. Diagnostic radiographs and intra-oral photos to document need for GTR. 2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. 3. Narrative of Medical necessity 4. Identify the specific material used for the guided tissue regenerative procedure. 5. Requires tooth (implant site) number.	There is a 24-month exclusion period for the delivery of the same procedure to treat the same area of the mouth. The removal of the non-resorbable barrier is included in the reimbursement rate for D6106.
IMPLANT SUPPORTED PROSTHETICS				
D6056	**PREFABRICATED ABUTMENT INCLUDES MODIFICATION AND PLACEMENT**	A connection to an implant that is a manufactured component, usually made of machined high noble metal, titanium, titanium alloy or ceramic. Modification of a prefabricated abutment may be necessary and is accomplished by altering its shape using dental burrs/diamonds.	1. Periapical radiograph of fully integrated implant. 2. Requires a tooth (implant site) number. 3. Arch radiograph showing placed integrated implant. 4. Intraoral photo of the healed tissue surrounding the healing cap of the implant.	
D6058	**ABUTMENT SUPPORTED PORCELAIN / CERAMIC CROWN**	A single crown restoration that is retained, supported and stabilized by an abutment on an implant.	1. Periapical radiograph of integrated implant with abutment, and arch radiograph with the abutment placed. 2. Requires a tooth (implant site) number 3. Intraoral photo of healed abutment, which shows healthy gingiva surrounding abutment. 4. Periodontal charting, if the patient has any remaining teeth present (i.e.: edentulous patients do not require periodontal charting). 5. If an implant provisional crown was approved **(D6085)** then intraoral photos and x-rays of the implant provisional crown must be included.	.
D6082	**IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS**	A single crown restoration that is retained, supported and stabilized by an implant.	1. Periapical radiograph of fully integrated implant 2. Requires a tooth (implant site) number. 3. Arch radiograph showing placed integrated implant.	

			4. Intra oral photo of the healed tissue surrounding the healing cap of the implant.	
D6083	**IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS**	A single crown restoration that is retained, supported and stabilized by an implant.	1. Periapical radiograph of fully integrated implant. 2. Requires a tooth (implant site) number. 3. Arch radiograph showing placed integrated implant. 4. Intra oral photo of the healed tissue surrounding the healing cap of the implant.	
D6084	**IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS**	A single crown restoration that is retained, supported and stabilized by an implant.	1. Periapical radiograph of fully integrated implant. 2. Requires a tooth (implant site) number. 3. Arch radiograph showing placed integrated implant. 4. Intra oral photo of the healed tissue surrounding the healing cap of the implant.	
D6085	**INTERIM IMPLANT CROWN**	One unit per dental implant site.	1. Periapical radiograph of fully integrated implant. 2. Requires a tooth (implant site) number 3. Arch radiograph showing placed integrated implant. 4. Intra oral photo of healed tissue surrounding healing cap of implant. 5. Narrative of Medical necessity to include how long the Interim crown will be utilized as an interim crown.	
D6110	**IMPLANT SUPPORTED REMOVABLE COMPLETE DENTURE FOR EDENTULOUS ARCH- MAXILLARY ARCH**	Removable complete maxillary denture that attaches to abutments Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture If beneficiary has received a maxillary denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments.	1. Intraoral (IO) photo showing healthy gingiva surrounding abutment. 2. Periapical radiograph of integrated implant with the abutment placed.	
D6111	**IMPLANT SUPPORTED REMOVABLE COMPLETE DENTURE FOR EDENTULOUS ARCH- MANDIBULAR ARCH**	Removable Mandibular complete denture that attaches to abutments Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture	1. Intraoral (IO) photo showing healthy gingiva surrounding the abutment. 2. Periapical radiograph of integrated implant with the abutment placed.	

		If beneficiary has received a mandibular denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments.		
D6112	**IMPLANT SUPPORTED REMOVABLE PARTIAL DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY ARCH**	Removable Maxillary partial denture that attaches to abutments Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture If beneficiary has received a maxillary partial denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments.	1. Intraoral (IO) photo showing healthy gingiva surrounding the abutment. 2. Periapical radiograph of integrated implant with the abutment placed. 3. Full mouth periodontal charting.	
D6113	**IMPLANT SUPPORTED REMOVABLE PARTIAL DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR ARCH**	Removable Mandibular partial denture that attaches to abutments Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture If beneficiary has received a mandibular partial denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments.	1. Intraoral (IO) photo showing healthy gingiva surrounding abutment. 2. Periapical radiograph of integrated implant with the abutment placed. 3. Full mouth periodontal charting.	

OTHER IMPLANT SERVICES				
D6081	**SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP**	Prior Authorization is required. D6081 is billed one unit per dental implant site and once per calendar year	1. Full mouth periodontal charting including 4 to 6 probing depths per tooth and implant site; and bleeding sites. Consideration should also be given to include recession if documented. 2. A current and complete periodontal evaluation chart is required for prior authorization. 3. Radiographs for prior authorization – submit periapical radiographs of the involved areas. 4. Written documentation for prior authorization – shall include a definitive periodontal diagnosis. 5. Intra-oral photos of the implant site. 6. Requires a tooth (implant site) number.	The dental provider cannot bill for D6081 on the same date of service for the following scenarios: 1. D1110 and D4910 are billed. 2. D4341, D4342,D4240, D4241, are billed for the same quadrant. 3. D6101 has been reimbursed for the same dental implant site in a calendar year.
D6096	**REMOVE BROKEN IMPLANT RETAINING SCREW**	One unit per dental implant site. The implant retaining screw is broken and the remaining screw fragment could not be removed using standard and conventional techniques.	1. Periapical radiograph of the broken implant screw. 2. Requires a tooth (implant site) number. 3. Clinical narrative to support the removal of the broken implant retaining screw. 4. Photo(s) of the fractured implant screw.	

ORAL SURGERY (PROCEDURES D7140-D7960)

General Policies, Procedures D7140-D7960:

1. Diagnostic periapical radiographs are required for all surgical procedures that are submitted for authorization and/or reimbursement except:
   a. For procedures performed on soft tissue structures.
   b. For Procedure D7320 (alveoloplasty on an edentulous quadrant.) If radiographs are not sufficient to justify a need, (i.e., for soft tissue procedures) additional diagnostic material (photographs or models) and/or a statement of justification must be presented.
2. Submitted periapical radiographs should show all aspects of a suspected pathologic area or neoplasm, the entire crown and apices of all teeth to be excised or extracted. In those cases where the radiograph of the crown of the tooth is not complete but there is sufficient evidence presented to substantiate the need for the surgical procedure, the surgical procedure may be allowed.
3. Oral surgery services to correct longstanding abnormalities of the mandible or maxilla, e.g., prognathia or retrognathia, or skin grafts for denture retention purposes or interosseous implants for procedures is not a benefit.
4. Extraction of asymptomatic teeth is not a benefit. The following includes, but is not all inclusive of, conditions which may be considered symptomatic when documented:
   a. Fully bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length.
   b. Teeth, which are involved with a cyst, tumor, or other neoplasm.
   c. Unerupted teeth, which are distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth.

d. Misaligned tooth (teeth), which cause the exacerbation of periodontal disease in adjacent teeth/areas.

e. Extractions of primary teeth required to minimize malocclusion or misalignment when there is inadequate space to allow normal eruption of the permanent tooth (teeth).

f. Perceptible radiologic pathology that fails to elicit symptoms.

g. Extractions that are required to complete dentally necessary orthodontic dental services.

5. Routine postoperative visits (within 30 days following surgical procedure) are considered part of, and included in, the global fee for the surgical procedure.
6. Extractions of asymptomatic deciduous teeth that appear by radiographic evaluation ready to exfoliate naturally are not a benefit.
7. The fees for oral surgery procedures include local anesthesia and routine postoperative visits.
8. The fee for extractions includes the excision of associated minor cystic or inflamed tissue.
9. The charge for a stent in conjunction with oral surgery is part of and included in the fee for the surgery.

D7251	**CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL**	Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	1. Written documentation for prior authorization which includes rationale for the request. 2. Panorex. 3. Requires a tooth number.	

BIOPSY OF ORAL TISSUE (D7285-D7286)

General Policies, Procedures D7285-D7286:

1. Procedures D7285 (biopsy of oral tissue, hard) and D7286 (biopsy of oral tissue, soft) are benefits as an independent procedure for collecting tissue specimen(s).
2. D7286 does not require prior authorization.
3. Not a benefit in conjunction with the extraction of a tooth or root or excision of any body part or neoplasm in the same area or region on the same day.
4. Please indicate the area of the lesion and submit operative and pathology reports.

D7285	**BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)**	For removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery. A benefit: a. for the removal of the specimen only. b. once per arch, per date of service regardless of the areas involved. Not a benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.	1. Radiographs for prior authorization – submit a pre-operative radiograph. 2. A pathology report from a certified pathology laboratory is required for prior authorization. 3. Requires an arch number.	If during the listed endodontic or oral surgery procedures, the provider finds an unexpected or unanticipated lesion that in his/her professional judgment necessitates excision and biopsy, this should be allowed by special report. The processing of the biopsy (i.e. Laboratory and pathologist fees) are a benefit through the patient's Medicaid; this information is given to the laboratory processing the specimen. The medical portion will have codes in place so that these secondary fees can be covered.

ALVEOLOPLASTY (D7310-D7350)

General Policies, Procedures D7310-D7320:

1. Alveolectomy (alveoloplasty) is a collective term for the operation by which the shape and condition of the alveolar process is improved for preservation of the residual bone.
2. Tuberosity reductions are considered to be included as part of the global fee for an alveoloplasty or multiple extractions in the same quadrant.
3. Some form of alveolectomy is indicated in almost every case of multiple extractions and frequently in single extractions as well. Normally alveolectomy procedures necessary in conjunction with the extraction of teeth are included as part of the extraction procedures.

D7310	**ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT**	The alveoloplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.	1. Radiographs for prior authorization–submit radiographs of the involved areas. 2. Requires a quadrant number. 3. Clinical narrative to support the request for the alveoloplasty.	
D7320	**ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT**	No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.	1. Radiographs for prior authorization– submit radiographs of the involved areas if photographs do not demonstrate the medical necessity. 2. Photographs for prior authorization-submit photographs of the involved areas. 3. Requires a quadrant number. 4. Clinical narrative to support the request for the alveoloplasty.	
D7340	**VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)**	Benefit allowance includes sutures, local anesthesia and routine post-operative care. Benefits are allowed once in a 60-month (5 year) period per arch Not a benefit: a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch. b. on the same date of service with extractions (D7111- D7250) same arch.	1. Radiographs for prior authorization – submit radiographs. 2. Photographs for prior authorization – submit photographs. 3. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment. 4. Requires an arch number.	

D7350	**VESTIBOULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)**	Benefit allowance includes sutures, local anesthesia and routine post-operative care. Benefits are allowed once in a 60-month (5 year) period per arch Not a benefit: a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch. b. on the same date of service with extractions (D7111- D7250) same arch.	1. Radiographs for prior authorization – submit radiographs. 2. Photographs for prior authorization – submit photographs. 3. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment. 4. Requires an arch number.	

EXCISION OF CYST (D7450-D7461)				
General Policies, Procedures D7450-D7461: 1. The appropriate procedure number shall be determined by the measurement of the cystic image on the diagnostic x-ray presented unless otherwise documented by report. 2. Prior authorization will not be made without an adequate radiograph of the neoplasm in question. 3. Please identify the area of the lesion and provide the operative and pathology reports. 4. Biopsy D7286 on same day for same area is not a covered service. 5. Postoperative care within a thirty (30)-day period following surgery shall be included in the fee for the services.				**The processing of the biopsy (i.e. Laboratory and pathologist fees) are a benefit through the patient's Medicaid; this information is given to the laboratory processing the specimen. The medical portion will have codes in place so that these secondary fees can be covered.**
D7451	**REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM**		1. Radiographs for prior authorization–submit a radiograph of the cyst or tumor. 2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history. 3. A pathology report from a certified pathology laboratory is required for prior authorization.	
D7460	**REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM**		1. Radiographs for prior authorization- submit a radiograph of the cyst or tumor. 2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history. 3. A pathology report from a certified pathology laboratory is required for prior authorization.	

EXCISION OF BONE TISSUE (D7471-D7490)

General Policies, Procedures D7471-D7490:

1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring at the midline of the hard palate.
2. Not a benefit if the condition is:
   a. Asymptomatic; or
   b. Will be bypassed by a dental prosthesis.
3. The extent and severity of this procedure is difficult to diagnose using x-rays only, therefore justification by models, photos, narrative, or other diagnostic modalities may be required.

D7471	**REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)**	A benefit: a. once per quadrant. b. for the removal of buccal or facial exostosis	1. Photographs for prior authorization–submit pre-operative photographs. 2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment. 3. Requires a quadrant number.	
D7472	**REMOVAL OF TORUS PALATINUS,**	1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, and overgrowth which develops in the midline of the roof of the mouth. 2. A benefit once per lifetime. 3. Not a benefit if the condition is: a. Asymptomatic; or b. Will be bypassed by a dental prosthesis.	1. Photographs for prior authorization – submit pre-operative photographs. 2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment. 3. The extent and severity of this procedure is difficult to diagnose using x-rays only. Justification by models, photos, narrative, or other diagnostic modalities may be required.	
D7473	**REMOVAL OF TORUS MANDIBULARIS**	1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring on the lingual aspect of the mandible. 2. A benefit once per Quadrant per date of service 3. Not a benefit if the condition is: a. Asymptomatic; or b. Will be bypassed by a dental prosthesis.	1. Photographs for prior authorization – submit pre-operative photographs. 2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment. 3. Requires a quadrant number.	

			4. The extent and severity of this procedure is difficult to diagnose using x-rays only. Justification by models, photos, narrative, or other diagnostic modalities may be required.	

SURGICAL INCISION (D7509-D7530)

General Policies, Procedures D7509 - D7530:

1. D7509 – Marsupialization of Odontogenic Cyst is a covered benefit that requires prior authorization
2. D7510 – Incision and Drainage of Abscess-Intra-Oral Soft Tissues is a covered benefit and does not require prior authorization.
3. D7511 – Incision and Drainage of Abscess- Intra-Oral Soft Tissue-Complicated is not a covered benefit.
4. D7520 – Incision and Drainage of Abscess-Extra-Oral Soft Tissue is a covered benefit and does not require prior authorization
5. D7530 – Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue is a covered benefit and does not require prior authorization

D7509	**MARSUPIALIZATION OF ODONTOGENIC CYST**	This procedure involves an incision into a large maxillary or mandibular cystic lesion and making a window, typically removing a portion of the cyst for biopsy and creating a longer-term opening from the outside similar to a pouch, allowing for decompression or drainage.	1. Submit a radiograph of the cyst . 2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history. 3. Requires tooth number or quadrant number.	

OTHER ORAL SURGERY PROCEDURES (D7840-D7999)

Procedure D7961: Buccal/ Labial Frenulectomy - Separate Procedure not Incidental to Another Procedure.

1. A benefit where it is documented that:
   a. A short labial frenum interferes with the mobility of the central portion of the lip.
   b. A hypertrophy of the frenum and papilla palatina interferes with the proper fitting and retention of a prosthetic appliance.
   c. A hypertrophy of the frenum and overextension to the papilla palatine produces a diastema in children; or
   d. Where attachment of frenum displaces interdental papilla or marginal gingival with consequent periodontal disease.
   e. Where a restriction of the labial frenum is negatively impacting infant feeding.
2.
2. Appropriate diagnostic material must be submitted in order to process for the prior authorization.
3. Routine postoperative care (within 30 days of surgical procedure) is considered part of and included in the global fee for the procedure.
4. Not reimbursed when provided in conjunction with vestibuloplasty, alveoloplasty with ridge extension, or excision of hyperplastic tissue.

Procedure D7962 Lingual Frenectomy (Frenulectomy) – Separate Procedure not Incidental to Another Procedure.

1. A benefit where it is documented that:
   a. An unusually strong lingual frenum that is affecting speech and mastication.
   b. A benefit in cases of ankyloglossia where there is interference with proper mastication.
   c. The lingual frenum interferes with the normal use or function of a prosthetic appliance.
   d. The lingual frenum exhibits a restriction that is negatively impacting infant feeding.
2. Appropriate diagnostic material must be submitted in order to process for the prior authorization.
3. Routine postoperative care (within 30 days of surgical procedure) is considered part of and included in the global fee for the procedure.
4. Not reimbursed when provided in conjunction with vestibuloplasty, alveoloplasty with ridge extension, or excision of hyperplastic tissue.

Procedure D7970: Excision of Hyperplasic Tissue – Per Arch

1. D7970 is used to remove hyperplastic tissue.
2. Reimbursed when inflammatory hyperplasic tissue interferes with normal mastication or in an edentulous area where the inflammatory hyperplasic tissue interferes with normal use or function of a prosthetic appliance.

D7840	**CONDYLECTOMY**	Surgical removal of all or portion of the mandibular condyle (separate procedure). Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.	1. Radiographs for prior authorization – submit an appropriate imaging. 2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.	
D7850	**SURGICAL DISCECTOMY, WITH/ WITHOUT IMPLANT**	Excision of the intra-articular disc of a joint. Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/ computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.	1. Radiographs for prior authorization – submit appropriate imaging. 2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history. 3. An operative report shall be submitted.	
D7860	**ARTHROTOMY**	Cutting into joint (separate procedure). Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/ computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.	1. Radiographs for prior authorization – submit appropriate imaging 2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history. 3. An operative report shall be submitted .	
D7940	**OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES**	Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or a deformity that may be addressed via surgical correction. Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.	1. Radiographs for prior authorization – submit appropriate imaging. 2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, and the proposed treatment. 3. An operative report shall be submitted for prior authorization.	

D7950	**OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA – AUTOGENOUS OR NONAUTOGENOUS, BY REPORT**	This procedure is for ridge augmentation or reconstruction to increase height, width and/or volume of residual alveolar ridge. D7950 is not for grafting procedures for the following: 1. Periodontal disease 2. In conjunction with an extraction 3. Implant removal 4. Other disease conditions.	1. Diagnostic radiographs and intra-oral photos to document need for the graft. 2. Narrative of Medical necessity. 3. Identify the specific material used for the guided tissue regenerative procedure. 4. Requires the specific arch for the graft.	
D7953	**BONE REPLACEMENT GRAFT**	Osseous autograft, allograft or non-osseous graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g. clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Membrane, if used, should be reported separately.	1. Radiographs for prior authorization – submit a pre-operative photograph. 2. Written documentation shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed. 3. Requires a tooth number or quadrant number.	
D7956	**GUIDED TISSUE REGENERATION, EDENTULOUS AREA- RESORBABLE BARRIER, PER SITE**	This procedure is for placing a resorbable barrier membrane for bone regeneration in edentulous areas, such as ridge augmentation or sinus lifts. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft. This type of barrier membrane does not require a second surgery for removal.	1. Diagnostic radiographs and intra-oral photos to document the need for GTR. 2. Tooth (implant site) number(s). 3. Narrative of Medical necessity. 4. Identify the specific material used for the guided tissue regenerative procedure.	There is a 24 month exclusion period for the delivery of the same procedure to treat the same area of the mouth.
D7957	**GUIDED TISSUE REGENERATION, EDENTULOUS AREA- NON- RESORBABLE BARRIER, PER SITE**	This procedure is for placing a non-resorbable barrier membrane for bone regeneration in edentulous areas, such as ridge augmentation or sinus lifts. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft. This type of barrier membrane requires a second surgery for removal.	1. Diagnostic radiographs and intra-oral photos to document the need for GTR. 2. Tooth (implant site) number(s). 3. Narrative of Medical necessity. 4. Identify the specific material used for the guided tissue regenerative procedure.	There is a 24-month exclusion period for the delivery of the same procedure to treat the same area of the mouth. The removal of the non-resorbable barrier is included in the reimbursement rate for D7957.
D7961	**BUCCAL/LABIAL FRENULECTOMY –**	Surgical removal or release of mucosal and muscle elements of a buccal or labial frenum that is associated with a pathological condition, , a speech concern identified by a licensed speech-language pathologist, or interferes with proper oral development, infant feeding, or treatment.	1. Photographs for prior authorization – submit a pre-operative photograph. 2. Written documentation for prior authorization – shall include the rationale demonstrating the medical necessity and	

		A benefit once per arch per lifetime	the specific area the treatment to be performed. 3. Requires the specific arch.	
D7962	**LINGUAL FRENULECTOMY**	Surgical removal or release of mucosal and muscle elements of a lingual frenum that is associated with a pathological condition, a speech concern identified by a licensed speech-language pathologist, or interferes with proper oral development, infant feeding, or treatment. A benefit once per arch per lifetime	1. Photographs for prior authorization – submit a pre-operative photograph. 2. Written documentation for prior authorization – shall include the rationale demonstrating the medical necessity and the specific area the treatment to be performed.	
D7970	**EXCISION OF HYPERPLATIC TISSUE-PER ARCH**	Excision of hyperplastic tissue caused by an ill-fitting denture.	1. Photographs for prior authorization – submit a pre-operative photograph. 2. Written documentation for prior authorization – shall include the rationale demonstrating the medical necessity and the specific area the treatment to be performed. 3. Requires an arch number.	
D7972	**SURGICAL REDUCTION OF FIBROUS TUBEROSITY**	A benefit once per quadrant per date of service. This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service	1. Photographs for prior authorization–submit a pre-operative photograph. 2. Written documentation– shall include the rationale demonstrating the medical necessity and the actual or proposed prosthodontic treatment. 3. Requires a quadrant number.	
D7979	**NON-SURGICAL SIALOLITHOTOMY**	A sialolith is removed from the gland or ductal portion of the gland without surgical incision into the gland or the duct of the gland, for example via manipulation, ductal dilation, or any other non-surgical method.	1. Photographs –submit a pre-operative photograph. 2. Written documentation– shall include the patient's symptoms and rationale demonstrating the medical necessity for the procedure. 3. Requires a quadrant number.	

ORTHODONTIC GENERAL POLICIES (D8000-D8999)

1. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.

2. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

3. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

4. The Handicapping Labio-Lingual Deviations (HLD) Index is a quantitative, objective method for evaluating prior authorization requests for comprehensive orthodontic treatment. The HLD Index form allows for identification of certain automatic qualifying conditions and provides a single score, based on a series of measurements, which represent the presence, absence, and degree of handicap. The HLD Index form must be submitted with all PA requests for comprehensive orthodontic treatment.

5. The beneficiary's orthodontia provider shall demonstrate that the beneficiary meets at least one of the following criteria:

   a. The beneficiary has an adjusted score greater than or equal to fifteen (15) on the Handicapping Labio-Lingual Deviation (HLD) Index.

   b. Exhibits one (1) or more of the following Automatic Qualifying Conditions that causes dysfunction due to a handicapping malocclusion and is supported by evidence in the beneficiary' treatment records:

      1. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
      2. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
      3. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate where tissue laceration and/or clinical attachment loss are present,
      4. A crossbite of individual anterior teeth causing clinical attachment loss where recession of the gingival margin is present,
      5. An overjet greater than 9 mm or reverse overjet (mandibular protrusion) is greater than 3.5 mm,
      6. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

   c. Has otherwise established a medical need for orthodontic treatment by demonstrating two (2) or more of the conditions below and justified the need in an accompanying narrative prepared by the ordering or referring dentist, orthodontist, primary care physician, speech pathologist, or behavioral health provider:

      1. A speech pathology that has proven non-responsive to medical treatment without orthodontic treatment, which has been diagnosed by a licensed speech therapist;
      2. Dysfunctional masticatory capacity as a result of the existing relationship between the maxillary and mandibular arches;
      3. Significant facial asymmetry.
      4. Severe maxillary, mandibular, or bi-maxillary protrusion or other physical deviation; or
      5. Other conditions that affect the medical, social, or emotional function of the patient as demonstrated by objective evidence provided by the patient's primary care physician or behavioral health provider.

6. If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

D8080	**COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION**	These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. A benefit: a. for handicapping malocclusion, cleft palate and facial growth management cases. b. **for patients under the age of 21.** c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). d. once per patient per lifetime. All appliances (such as bands, arch wires, headgear, and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted. This procedure includes the replacement, and repair of brackets, bands and arch wires by the original provider.	1. The following shall be submitted together for prior authorization: a. Completed DC HLD Scoring sheet. b. comprehensive orthodontic treatment of the adolescent dentition (D8080), and c. diagnostic casts (D0470). 2. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted: a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.	DHCF reimburses the dental providers a global fee for the entire orthodontic case. D8680 Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainers) does not require prior authorization. One per lifetime
D8091	**COMPREHENSIVE ORTHODONTIC TREATMENT WITH ORTHOGNATHIC SURGERY**	These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as	1. The following shall be submitted together for prior authorization: a. Completed DC HLD Scoring sheet. b. Comprehensive orthodontic treatment with Orthognathic surgery (D8091),	DHCF reimburses the dental providers a global fee for the entire orthodontic case. D8680 Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainers) does not require prior authorization.

		comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. A benefit: a. for handicapping malocclusion, cleft palate and facial growth management cases. b. **for patients under the age of 21.** c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). d. once per patient per lifetime. All appliances (such as bands, arch wires, headgear, and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted. This procedure includes the replacement, and repair of brackets, bands and arch wires by the original provider.	c. Classification of craniofacial abnormalities and/or malocclusion, and c. diagnostic casts (D0470). 2. Supporting documentation of the medical necessity for correction of maxillary and mandibular skeletal deformities associated with masticatory malocclusion. The documentation must demonstrate that the skeletal deformities are contributing to significant dysfunction and preclude adequate treatment through dental therapeutics and orthodontics alone. 3. Skeletal, facial, or craniofacial deformity defined by study models and pre-orthodontic imaging such as cephalometric radiographs and cephalometric diagrams with standard computer-generated measurements. 4. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted: a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.	One per lifetime
D8695	**REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER**	D8695 should not be reported by the current treating dentist when the removal of the oral appliances is a part of the normal sequence of treatment or when the appliances are removed after the completion of treatment.	1. Written documentation for prior authorization– shall include the rationale demonstrating the reason for the premature removal of the appliance and	

	THAN COMPLETTION OF TREATMENT		indicate that the dentist who removed the appliances and they are not the dentist that placed the orthodontic appliance. 2. Intraoral photos.	
D8703	**REPLACEMENT OF LOST OR BROKEN RETAINER-MAXILLARY**	The replacement of lost or broken maxillary retainer previously place post-orthodontics.	1. Written documentation for prior authorization– shall include the rationale demonstrating the reason the retainer needs to be replaced.	Two per lifetime
D8704	**REPLACEMENT OF LOST OR BROKEN RETAINER-MANDIBULAR**	The replacement of lost or broken mandibular retainer previously place post-orthodontics.	1. Written documentation for prior authorization– shall include the rationale demonstrating the reason the retainer needs to be replaced.	Two per lifetime
D8999	**UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT**	Used for procedure that: 1. Is not adequately described by a CDT code. 2. Has a CDT code that is not a benefit, but the patient has an exceptional medical condition to justify the medical necessity. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.	1. Prior authorization is required for non-emergency procedures. 2. Radiographs for prior authorization -submit radiographs if applicable for the type of procedure. 3. Photographs for prior authorization -submit photographs if applicable for the type of procedure. 4. Written documentation for prior authorization– describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment. 5. Documentation shall include the medical condition and the specific CDT code associated with the treatment. (describe procedure in narrative format).	

ADJUNCTIVE GENERAL POLICIES (D9000-D9999)

Anesthesia (D9210-D9248)

1. General anesthesia **(D9222, and D9223)** is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.
2. Inhalation of Nitrous Oxide/Analgesia, Anxiolysis (D9230) does not require prior authorization.
3. Deep sedation/general anesthesia **(D9222, and D9223)** shall be considered for prior authorization when it is documented why local anesthesia is contraindicated. Such contraindications shall include but are not limited to the following:
   a. a severe mental or physical handicap,
   b. extensive surgical procedures,
   c. an uncooperative child,
   d. an acute infection at an injection site,
   e. a failure of a local anesthetic to control pain.
4. The administration of deep sedation/general anesthesia **(D9222 and D9223),** and nitrous oxide (D9230),) is a benefit in conjunction with Medicaid covered associated procedures. Prior authorization shall be denied if any associated procedures by the same provider are denied.
5. Providers who administer general anesthesia **(D9223)** shall have valid anesthesia permits
6. Anesthesia time for general anesthesia is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.
7. Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

ADJUNCT PROCEDURES (PROCEDURES D9000-D9999)				
1. General anesthesia is an excluded benefit unless provided in conjunction with authorized oral surgery procedures, such as the surgical extraction of impacted teeth, procedures D7220-D7240. 2. This procedure is only reimbursed to providers holding a valid general anesthesia permit; please include the general anesthesia permit number on the claim form.				
D9222	**DEEP SEDATION/ GENERAL ANESTHESIA – FIRST 15 MINUTES**	Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration. Not a benefit: a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), b. when any associated procedures on the same date of service by the same provider are denied.	1. Written documentation for prior authorization–shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. 2. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for prior authorization. 3. The quantity is for the first 15-minutes , that are necessary to complete the treatment shall be indicated on the 719A Form. 4. Copy of Anesthesia license on file, if not on file submit a copy.	
D9223	**DEEP SEDATION/ GENERAL ANESTHESIA – EACH ADDITIONAL 15 MINUTES**	Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration. **[The difference between general anesthesia and intravenous sedation is that the patient cannot support his/her own airway while under general anesthesia.]** **Drugs typically used:** Fentanyl, Versed or Valium, Sodium Bretival	1. Written documentation for prior authorization–shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. 2. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for prior authorization. 3. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the 719A Form . 4. Copy of Anesthesia license on file, if not on file submit a copy.	Exception for Howard University Hospital Dentistry, anesthesia services are administered under hospital, not required to submit anesthesia license information with requests.

		General anesthesia is allowed with these services: (when the procedure is a covered benefit): Apicoectomy (D3410-D3426). Retrograde filling (D3430). Root amputation (D3450). Hemisection (D3920). Surgical extractions (D7210-D7241). Root recovery (D7250). Coronectomy (D7251). Other oral surgery procedures (D7260-D7291). Alveoloplasty (D7310-D7321). Vestibuloplasty (D7340-D7350). Removal of tumors, cysts and neoplasms (D7410-D7461). Excision of bone tissue (D7471-D7490). Surgical Incision (D7509- D7560). Treatment of fractures-simple (D7610-D7680). Treatment of fractures-compound (D7710-D7780). Reduction of dislocation of temporo-mandibular joint (D7810-D7877). Repair of traumatic wounds (D7910). Excision of hyperplastic tissue (D7970). Placement of Implant D6010 Special needs patients that is combative during exam/treatment (must be part of waiver program) **Not a benefit:** a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230). b. when all associated procedures on the same date of service by the same provider are denied.		
D9420	**HOSPITAL OR AMBULATORY SURGICAL CENTER CALL**	Care provided outside the dentist's office to a patient who is in hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes. Not a benefit: a. for an assistant surgeon. b. for time spent compiling the patient history, writing reports or for postoperative or follow up visits.	1. The operative report for prior authorization – shall include the total time in the operating room or ambulatory surgical center. 2. A benefit for each hour or fraction thereof as documented on the operative report. 3. Documentation of past dental treatment notes, radiographs, IO photos may be requested.	

D9944	**OCCLUSAL GUARDS – HARD APPLIANCE, FULL ARCH**	Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. ~ Allowed in cases of bruxism only. ~ Occlusal guards submitted in conjunction with TMJ therapy are not covered.	1. Intraoral photographs and radiographs of occlusal / incisal wear. 2. Arch radiographs. 3. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity for the appliance. 4. Requires the specific arch.	
D9945	**OCCLUSAL GUARDS – SOFT APPLIANCE, FULL ARCH**	Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. ~ Allowed in cases of bruxism only. ~ Occlusal guards submitted in conjunction with TMJ therapy are not covered.	1. Intraoral photographs and radiographs of occlusal / incisal wear. 2. Arch radiographs. 3. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity for the appliance. 4. Requires the specific arch.	
D9946	**OCCLUSAL GUARDS – HARD APPLIANCE, PARTIAL ARCH**	Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. ~ Allowed in cases of bruxism only. ~ Occlusal guards submitted in conjunction with TMJ therapy are not covered.	1. Intraoral photographs and radiographs of occlusal / incisal wear. 2. Arch radiographs. 3. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity for the appliance. 4. Requires the specific arch.	
D9947	**CUSTOM SLEEP APPLIANCE FABRICATION AND PLACEMENT**	The patient does not have a contraindication to the use of an oral appliance. Dental conditions that interfere with or will not support an oral appliance. Examples include braces, retainers, the largely edentulous patient, active periodontal disease, anatomical defects, or other related conditions. Patients that do not have the manual dexterity to place and remove the sleep apnea appliance. The patient is allowed one oral sleep apnea appliance within a 60-month period.	1. A prescription for the sleep apnea appliance from a physician who is board certified by the AASM or sleep board eligible. 2. Written documentation that the patient is unable to use Continuous Positive Airway Pressure (CPAP) machine or demonstrate non-compliance with CPAP. 3. Clinical narrative to include the description of the sleep appliance and the expected outcome. 4. Full mouth series of radiographs or panorex. 5. Periodontal charting. 6. Medical and dental history.	General symptoms alone such as snoring, trouble sleeping, nighttime wakening, or falling asleep during the day are not sufficient for diagnosing sleep apnea in the absence of a sleep study (PSG-polysomnography.) **Sleep Apnea is not a dental condition. Therefore, ordering and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or primary snoring is conducted by the physician board certified by the American Academy of Sleep Medicine (AASM) or sleep board eligible.**

		Any adjustment or repair of the sleep apnea appliances are included in the first six (6) months of wear after delivery. If the sleep appliance is lost or broken, the dental provider will need to submit supporting documentation with a clinical narrative, photos if applicable, for review.	7. The qualified dentist to provide the sleep apnea appliance (D9947) must have at least one of the following: certification in dental sleep medicine by a non-profit organization, designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, or documentation of recognized continuing education in dental sleep medicine (e.g., American Dental Association Continuing Education Recognition Program [ADA CERP] or Academy of General Dentistry Program Approval for Continuing Education [AGD PACE]) provided by a dental sleep medicine focused non-profit organization or accredited dental school in the last two years. 8. Requires the specific arch.	
D9951	**OCCLUSAL ADJUSTMENT-LIMITED**	The reshaping of the occlusal surfaces of teeth to create a harmonious contact relationship between the maxillary and mandibular teeth. D9951 is not indicated when the procedure only involves the occlusal (bite) adjustment in the post-delivery for a direct or indirect restoration or a fixed or removable prosthesis. If the occlusal adjustment is required within a short period of completion of a restorative procedure, it considered a part of the global fee for the restorative procedure.	1. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity. 2. The specific teeth requiring occlusal adjustment.	
D9952	**OCCLUSAL ADJUSTMENT-COMPLETE**	D9952 may require study casts to be mounted on an articulator to analyze occlusal disharmony. D9952 is indicated to achieve functional relationships and masticatory efficiency in conjunction with restorative, orthodontia, orthognathic surgery, or jaw trauma. D9952 is for a comprehensive series of visits, not a single visit. D9952 is reimbursed once per lifetime.	1. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity. 2. The specific teeth requiring occlusal adjustment. 3. If needed in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma.	

D9953	**RELINE CUSTOM SLEEP APNEA APPLIANCE (INDIRECT)**	This procedure is utilized to indirectly reline an appliance that is specifically custom fabricated to treat sleep apnea.	1. The qualified dentist to reline the sleep apnea appliance (D9947) must have at least one of the following: certification in dental sleep medicine by a non-profit organization, designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, or documentation of recognized continuing education in dental sleep medicine (e.g., American Dental Association Continuing Education Recognition Program [ADA CERP] or Academy of General Dentistry Program Approval for Continuing Education [AGD PACE]) provided by a dental sleep medicine focused non-profit organization or accredited dental school in the last two years. 2. Clinical narrative to document an ill-fitting sleep apnea device. 3. Full Mouth series of radiographs or panorex. 4. Photos of the sleep apnea appliance.	Not reimbursed to the provider of placement within six (6) months of the sleep apnea appliance placement.
D9959	**UNSPECIFIED SLEEP APNEA SERVICES, BY REPORT**	This procedure is utilized to report a procedure not adequately described by an existing sleep apnea code.	1. The qualified dentist rendering the sleep apnea procedure (D9959) must have at least one of the following: certification in dental sleep medicine by a non-profit organization, designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, or documentation of recognized continuing education in dental sleep medicine (e.g., American Dental Association Continuing Education Recognition Program [ADA CERP] or Academy of General Dentistry Program Approval for Continuing Education [AGD PACE]) provided by a dental sleep medicine focused non-profit organization or accredited dental school in the last two years.	General symptoms alone such as snoring, trouble sleeping, nighttime wakening, or falling asleep during the day are not sufficient for diagnosing sleep apnea in the absence of a sleep study (PSG-polysomnography.) **Sleep Apnea is not a dental condition. Therefore, ordering and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or primary snoring is conducted by the physician board certified by the American Academy of Sleep Medicine (AASM) or sleep board eligible.**

			2. The dental provider must submit the following: a. clinical narrative outlining the specific nature of the treatment, b. dental records to document prior placement of sleep apnea device, c. the materials and techniques used, d. the time and resources required, e. the clinical justification for the procedure. 3. Full mouth series of radiographs or panorex. 4. Periodontal charting. 5. Medical and dental history.	

Appendix E: CMS PRAF "C" Category of Concern Codes for Quality Review

Centers for Medicare and Medicaid Services
PRAF "C" Category of Concern Codes

The quality review process involves the use of the Centers for Medicare & Medicaid (CMS) Physician Reviewer Assessment Form (PRAF) "C" Category of Concern codes to screen for quality of care. These codes can be applied to any setting of care, including acute inpatient, long term care, residential treatment center care, and outpatient services.

CATEGORY	DESCRIPTION AND USE
C01	Apparently did not obtain pertinent history and/or findings from examination. This category is used for a failure to provide an accurate history; this is also for failure to include information obtained by the performance of an appropriate physical exam.
C02	Apparently did not make appropriate diagnoses and/or assessments. This category is used for a failure to perform an appropriate assessment and establish a diagnosis.
C03	Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see CO6 or CO9) and procedures (see C07 or C08) and consultations (see Cl3 and C14)]. This category is used for a lack of organized, appropriate diagnostic and management plans related to the condition for which the patient was admitted; incomplete, inappropriate, or lack of treatment plan for principal diagnosis.
C04	Apparently did not carry out an established plan in a competent and/or timely fashion (e.g. omissions, errors of technique, unsafe environment). This category is used for failure to take necessary precautions; lack of appropriate equipment maintenance; medication errors; technical and/or procedural errors; failure to follow physician's orders; delayed completion or reporting of studies.
C05	Apparently did not appropriately assess and/or act on changes in clinical/other status results. This category is used for failure to recognize clinical changes which occur in the patient's condition; this category also applies if the clinical changes are noted but not acted on.
C06	Apparently did not appropriately assess and/or act on laboratory tests or imaging study results. This category is used for a failure to provide ongoing monitoring and evaluation of the patient's laboratory or imaging studies by failing to evaluate and/or act on diagnostic studies.
C07	Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed. This category is used for failure to document accepted indications for a procedure.
C08	Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09). This category is used for failure to perform a medically necessary procedure that is indicated by the patient's condition.

CATEGORY	DESCRIPTION AND USE
C09	Apparently did not obtain appropriate laboratory tests and/or imaging studies. This category is used for failure to order diagnostic (laboratory and/or imaging) studies that are deemed appropriate for the patient's condition.
C10	Apparently did not develop and initiate appropriate discharge, follow-up, and rehabilitation plans. This category is used for a lack of follow-up arrangements or plans for conditions continuing to require treatment and/or monitoring prior to or following discharge; failure to develop a plan that reflects an appropriate transition of care; failure to identify additional needed resources; failure to provide appropriate teaching; failure to transmit pertinent information.
C11	Apparently did not demonstrate that the patient was ready for discharge. This category is used for failure to assure that the patient is stable enough for discharge to the setting into which the patient is being discharged.
C12	Apparently did not provide appropriate personnel and/or resources. This category is used for lack of sufficient staff to handle patient load; lack of credentialed staff for provision of offered services; equipment unavailable to carry out treatment plan.
C13	Apparently did not order appropriate specialty consultation. This category is used for those cases in which a specialty consultation that would have been necessary to adequately assess and treat the patient was not ordered. If there is a distinct clinical management concern over and above failure to order the consultation, cite that category as well, even if it is C.03.
C14	Apparently, specialty consultation process was not completed in a timely manner. This category is used when a specialty consultation is not ordered in a timely manner or is not completed in a timely manner. If the only issue is the delay, do not additionally cite C.03. If there is a distinct clinical management concern over and above the delay in ordering or completing the consultation, cite that category as well, even if it is C.03.
C15	Apparently did not effectively coordinate across disciplines. This category is used when there is poor communication and coordination between specialists or clinicians that adversely impacts the patient's care.
C16	Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection). This category is similar to category C04 but is more specific to patient safety and protection from injury.
C17	Apparently did not order/follow evidence-based practices. This category of concern is used when there is a specific aspect of the treatment plan that doesn't follow current guidelines and evidence-based practices.
C18	Apparently did not provide medical record documentation that impacts patient care. This category is used for poor or missing documentation that makes it difficult to follow the plan of care and patient progress.
C40	Apparently did not follow-up on patient's noncompliance (NOTE: Only applies to MA or Managed Care patient). This category is used when there is no follow-up on patient compliance with a previously prescribed treatment plan for a patient enrolled in an MA or Managed Care Plan.

CATEGORY	DESCRIPTION AND USE
C99	Other quality concern not elsewhere classified. This category is used in exceptional cases. The vast majority of cases should be able to fit into the above listed categories.

Appendix F: Letter – Denial

Comagine Health

PO Box 34800
Washington, DC 20043-4800
www.comagine.org

Office: 1.800.251.8890
Toll Free: 1.800.731.2314

<<Member_Name>>
<<Member_Full_Address>>

If you do not speak and/or read English, please call 800-251-8890 between 8:00 AM and 5:00 PM. A representative will assist you.

Si usted no habla y / o lee Inglés, por favor llame al 800-251-8890 entre 8:00 a.m.-5:00 p.m. Un representante le asistirá. - **SPANISH**

如果您不会说或读英语，请在早上8点钟到下午5点钟之间致电800- 251-8890，
我们的工作人员会协助您. - **CHINESE**

አንግሊዘኛ ማንበብ ወይንም መጻፍ ካልቻሉ በዚህ ቁጥር 800-251-8890
ከ 8:00 a.m. እስከ 5:00 p.m. ባለ ግዜ ውስጥ ይደውሉ አርዳታ እንሰጣለን። - **AMHARIC**

만일 당신이 영어로 말을 할수 없거나 읽을 수 없을 경우, 오전 8시에서 오후 5시 사이에
800-251-8890 으로 전화를 하십시요. 담당자가 도와 드릴 겁니다. - **KOREAN**

Nếu ban không nói và / hoặc đọc tiếng Anh, xin gọi 800-251-8890, 8:00-5:00. Một đại diện sẽ giúp ban. - **VIETNAMESE**

DC MEDICAID
PLEASE READ CAREFULLY
THIS IS A LETTER ABOUT A DENIAL DECISION

<<Notice_Date>>

<<Member_Name>>
<<Member_Full_Address>>

Patient Name:	<<Member_Name>>	Medicaid ID#:	<<Insurance_ID>>
Date of Birth:	<<Member_DoB>>		
Facility:	<<Admitting_Name>>	Prior Authorization#:	<<Reference_ID>>
Physician Name:	<<Treating_Name>>		
Admit Date:	<<Admit_Date>>	Discharge Date:	<<Discharge_Date>>
Approved Day(s):	<<IP_Stay_Total_Approved_Days>>		
Approved Procedure(s):	<<Approved_Procedures>>		
Denied Day(s):	<<IP_Stay_Total_Denied_Days>>		
Denied Procedure(s)	<<Denied_Procedures>>		
Diagnosis:	<<Diagnosis>>		

In order to promote high quality health care, Comagine Health has been designated by the D.C. Department of Health Care Finance (DHCF) to review and determine medical necessity of certain medical admissions and surgical procedures provided to D.C. Medicaid beneficiaries. Your request for the medical procedure described above has been denied.

The final decision regarding medical treatment is between you and your physician. Comagine Health will notify D.C. Medicaid, your attending physician and the hospital (facility) of this denial. D.C. Medicaid program will not pay for services denied by Comagine Health.

WHY IS THIS HAPPENING?

Each review is completed by a physician reviewer, using available clinical information. Based on the information available at the time of the review, a determination was made to deny (not pay for) your request for _____. This determination was based on the following: **{Insert the appropriate InterQual criteria or other clinical rationale}**.

WHAT SHOULD I DO IF I DISAGREE WITH THIS DECISION?

If you disagree with this decision, you may request Comagine Health to reconsider its determination. Your request must be submitted in writing **within 21 calendar days** to:

Comagine Health
Attn: Care Management Department
10700 Meridian Ave N, Suite 300
Seattle, WA 98133
Toll Free: (800) 251-8890
Fax: (800) 731-2314

Please keep a copy of this letter and the envelope in which this letter was sent in the event there are questions about when your request for reconsideration was made.

ARE THERE ANY OTHER ACTIONS I CAN TAKE?

Yes, you may also ask for a fair hearing from the Office of Administrative hearing or the Office of the Health Care Ombudsman.

REQUESTING A FAIR HEARING

You may ask for a **fair hearing** from the Office of Administrative Hearings or the Office of Health Care Ombudsman. You have **90 days** from the postmark date of this letter to ask for a fair hearing. You can **call, write, or visit** the Office of Administrative Hearings or the Office of Health Care Ombudsman to ask for a fair hearing.

The contact information for the Office of Administrative Hearings is:

Office of Administrative Hearings
One Judiciary Square
441 4th Street, NW Suite 450 North
Washington, DC 20001
Phone: (202) 442-9094
Fax: (202) 442-4789

The contact information for the Office of Health Care Ombudsman is:

Office of Health Care Ombudsman
441 4th Street, NW, 2nd Floor
Washington, DC 20001
Telephone: (202) 724-7491
Fax: (202) 535-1216

WHAT IF I NEED HELP ASKING FOR A FAIR HEARING?

For assistance with requesting a fair hearing, you may be able to get free legal services. See the lists below of legal services in the District of Columbia.

Legal Resources

1. **Legal Aid Society of the District of Columbia**
1331 H Street NW, Suite 350
Washington, DC 2000
(202) 628-1161

2041 Martin Luther King Jr Ave SE
Suite 201
Washington, DC 20020
(202) 628-1161

2. **Neighborhood Legal Services**
64 New York Ave, NE Suite 180
Washington, DC 20002
(202) 832-6577

4609 Polk St NE
Washington, DC 20019
(202) 832-6577

3. **University Legal Services, Protection and Advocacy Program**
220 I Street NE, Suite 130

Washington, DC 20002
(202) 547-0198 (voice)
(202) 547-2657 (TTY)

WHAT HAPPENS AFTER I ASK FOR A FAIR HEARING?

The Office of Administrative Hearings will send you a letter with your hearing date.

WHAT HAPPENS AT THE FAIR HEARING?

The Office of Administrative Hearings will send you a letter which describes the hearing process. This information will be included in the letter with your hearing date.

You may bring a friend, relative, advocate or lawyer who is not an employee of the District of Columbia to assist you at your fair hearing. You may also bring witnesses and any other documents you would like to present.

If you have any questions regarding this letter, please contact Comagine Health at (800) 251-8890.

Sincerely,



Doug Boenning, MD
Medical Director for the Comagine Health Clinical Review Team

cc: <<Admitting_Name>>
<<Treating_Name>>

Appendix G: Letter – Reconsideration Upheld, Inpatient

Comagine Health

PO Box 34800
Washington, DC 20043-4800
www.comagine.org

Office: 1.800.251.8890
Toll Free: 1.800.731.2314

<<Member_Name>>
<<Member_Full_Address>>

If you do not speak and/or read English, please call 1-800-251-8890 between 8:00 a.m. and 5:00 p.m. A representative will assist you.

Si usted no habla y / o lee Inglés, por favor llame al 800-251-8890 entre 8:00 a.m.-5:00 p.m. Un representante le asistirá. - **SPANISH**

如果您不会说或读英语，请在早上8点钟到下午5点钟之间致电800- 251-8890，
我们的工作人员会协助您. - **CHINESE**

አንግሊዘኛ ማንበብ ወይንም መጻፍ ካልቻሉ በዚህ ቁጥር 800-251-8890
ከ 8:00 a.m. እስከ 5:00 p.m. ባለ ግዜ ውስጥ ይደውሉ እርዳታ እንሰጣለን። - **AMHARIC**

만일 당신이 영어로 말을 할수 없거나 읽을 수 없을 경우, 오전 8시에서 오후 5시 사이에
800-251-8890 으로 전화를 하십시요. 담당자가 도와 드릴 겁니다. - **KOREAN**

Nếu ban không nói và / hoặc đọc tiếng Anh, xin gọi 800-251-8890, 8:00-5:00. Một đại diện sẽ giúp ban. - **VIETNAMESE**

DC MEDICAID
PLEASE READ CAREFULLY
THIS IS A LETTER ABOUT AN UPHELD RECONSIDERATION DECISION

<<Notice_Date>>

<<Member_Name>>
<<Member_Full_Address>>

Patient Name:	<<Member_Name>>	Medicaid ID#:	<<Insurance_ID>>
Date of Birth:	<<Member_DoB>>		
Facility:	<<Admitting_Name>>		
Physician Name:	<<Treating_Name>>		
Admit Date:	<<Admit_Date>>	Discharge Date:	<<Discharge_Date>>
Denied Day(s):	<<IP_Stay_Total_Denied_Days>>		
Denied Procedure (s):	<<Denied_Procedures>>		
Diagnosis:	<<Diagnosis>>		

We have received your request for a reconsideration. In order to promote high quality health care, Comagine Health has been designated by the D.C. Department of Health Care Finance (DHCF) to review and determine medical necessity of certain medical admissions and surgical procedures provided to D.C. Medicaid beneficiaries. The decision after reconsideration is to uphold the original denial.

The final decision regarding medical treatment is between you and your physician. Comagine Health will notify D.C. Medicaid, your attending physician and the hospital (facility) of this denial. D.C. Medicaid program will not pay for services denied by Comagine Health.

WHY IS THIS HAPPENING?

Each review is completed by a physician reviewer, using available clinical information. Based on the information available, the decision was based on the following: **{Insert the appropriate InterQual criteria or other clinical rationale}**. A copy of the clinical criteria used for the decision will be provided upon your request.

ARE THERE ANY OTHER ACTIONS I CAN TAKE?

Yes, you may also ask for a fair hearing from the Office of Administrative hearing or the Office of the Health Care Ombudsman. Insert information from the Comagine Health letter.

REQUESTING A FAIR HEARING

You may also ask for a **fair hearing** from the Office of Administrative Hearings or the Office of Health Care Ombudsman. You have **90 days** from the postmark date of this letter to ask for a fair hearing. You can **call, write, or visit** the Office of Administrative Hearings or the Office of Health Care Ombudsman to ask for a fair hearing.

The contact information for the Office of Administrative Hearings is:

Office of Administrative Hearings
One Judiciary Square
441 4th Street, NW Suite 450 North
Washington, DC 20001
Phone: (202) 442-9094
Fax: (202) 442-4789

The contact information for the Office of Health Care Ombudsman is:

Office of Health Care Ombudsman
441 4th Street, NW, 9th Floor
Washington, DC 20001
Telephone: (202) 724-7491
Fax: (202) 535-1216

WHAT IF I NEED HELP ASKING FOR A FAIR HEARING?

For assistance with requesting a fair hearing, you may be able to get free legal services. See the lists below of legal services in the District of Columbia.

Legal Resources

1. **Legal Aid Society of the District of Columbia**
   1331 H Street NW, Suite 350
   Washington, DC 2000
   (202) 628-1161

   900 Delaware Ave S
   Washington, DC 20024
   (202) 628-1161

   2041 Martin Luther King Jr Ave SE
   Washington, DC 20020
   (Advocates for Justice and Education in the Anacostia Professional Building the:"Big Char:")
   (202) 628-1161

2. **Neighborhood Legal Services**
   4609 Polk St NE
   Washington, DC 20032
   (202) 832-6577

   680 Rhode Island Ave NE
   Washington, DC 20002
   (202) 832-6577
   (202) 269-5100

   2811 Pennsylvania Ave SE
   Washington, DC 20020
   (202) 832-6577

3. **University Legal Services, Protection and Advocacy Program**
   220 I Street NE, Suite 130

Washington, DC 20002
(202) 547-0198 (voice)
(202) 547-2657 (TTY)

WHAT HAPPENS AFTER I ASK FOR A FAIR HEARING?

The Office of Administrative Hearings will send you a letter with your hearing date.

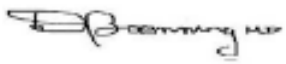
WHAT HAPPENS AT THE FAIR HEARING?

The Office of Administrative Hearings will send you a letter which describes the hearing process. This information will be included in the letter with your hearing date.

You may bring a friend, relative, advocate or lawyer who is not an employee of the District of Columbia to assist you at your fair hearing. You may also bring witnesses and any other documents you would like to present.

If you have any questions regarding this letter, please contact Comagine Health at (800) 251-8890.

Sincerely,



Doug Boenning, MD
Medical Director for the Comagine Health Clinical Review Team

cc: <<Admitting_Name>>
<<Treating_Name>>

Appendix H: Letter – Prior Authorization for EPD Waiver Services

Comagine Health

PO Box 34800
Washington, DC 20043-4800
www.comagine.org

Office: 1.800.251.8890
Toll Free: 1.800.731.2314

<<Member_Name>>
<<Member_Full_Address>>

Si usted no habla y / o lee Inglés, por favor llame al 800-251-8890 entre 8:00 a.m.-5:00 p.m. Un representante le asistirá. - **SPANISH**

如果您不会说或读英语，请在早上8点钟到下午5点钟之间致电800- 251-8890，
我们的工作人员会协助您. - **CHINESE**

አንግሊዘኛ ማንበብ ወይንም መጻፍ ካልቻሉ በዚህ ቁጥር 800-251-8890
ከ 8:00 a.m. እስከ 5:00 p.m. ባለ ግዜ ውስጥ ይደውሉ እርዳታ እንሰጣለን። - AMHARIC

만일 당신이 영어로 말을 할수 없거나 읽을 수 없을 경우, 오전 8시에서 오후 5시 사이에
800-251-8890 으로 전화를 하십시요. 담당자가 도와 드릴 겁니다. - **KOREAN**

Nếu ban không nói và / hoặc đọc tiếng Anh, xin gọi 800-251-8890, 8:00-5:00. Một đại diện sẽ giúp ban. - **VIETNAMESE**

<<Group_Name>>
PLEASE READ CAREFULLY
THIS IS A LETTER ABOUT PRIOR AUTHORIZATION FOR EPD WAIVER SERVICES

<<Notice_Date>>

<<Admitting_Name>>
<<Admitting_Full_Address>>

Patient Name:	<<Member_Name>>	**Medicaid ID#:**	<<Insurance_ID>>
Date of Birth:	<<Member_DoB>>	**Prior Authorization#:**	<<Reference_ID>>
Facility:	<<Facility>>		
Physicians Name:	<<Treating_Name>>		
Start Date:	<<Service_Start_Date>>	**End Date:**	<<Service_End_Date>>
Approved Service(s):	<<Approved_Procedures>>		
Approved Unit(s):	<<Total_Approved_Units>>		
Diagnosis:	<<Diagnosis_Code>> - <<Diagnosis_Description>>		

RE: Prior Authorization for EPD Waiver Services

Dear <<Admitting_Name>>,

Your authorization request on behalf of Medicaid Beneficiary, <<**Member_Name**>>, **Medicaid ID** # <<**Insurance_ID**>> has been approved for the following services.

Servicing Provider: <<Admitting_Name>>
Authorization #: <<Reference_ID>>

Thank you,

Comagine Health
Utilization Review Team

cc: Authorization #: <<Reference_ID>>

Appendix I: Comagine Health Provider Portal Quick Start Guides

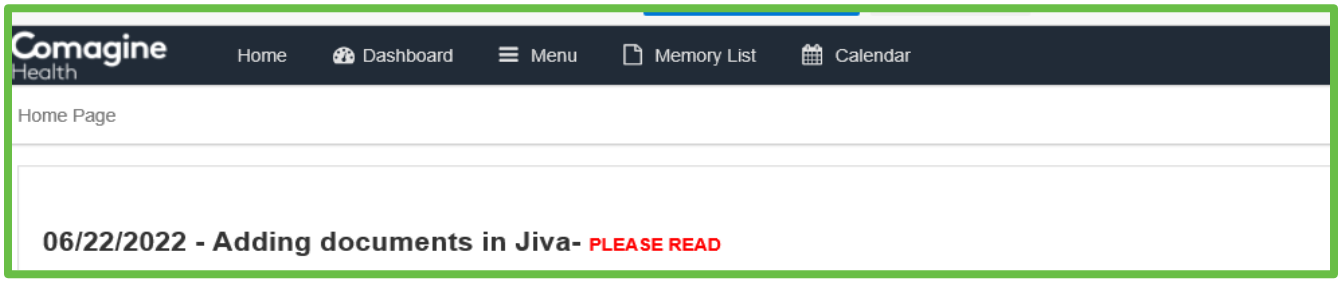
To support the use of the Comagine Health Provider Portal (CHPP), we have created Quick Start Guides for the different submissions through the portal. This section contains selected examples; the entire set are posted on our website at https://comagine.org/program/dc-medicaid-um/providers.

I.1 Acute Care Hospitals

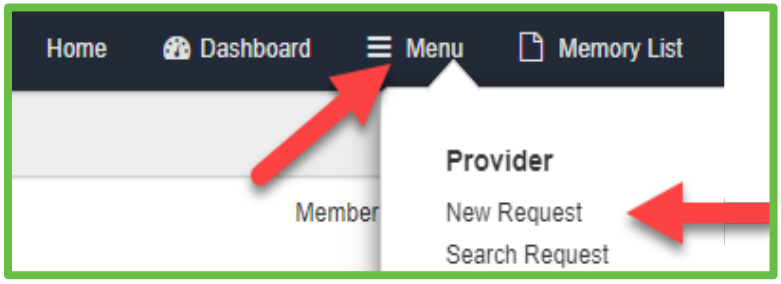
The following are the steps for submitting Acute Care Hospital Prior Authorization (PA) requests via the CHPP. Please note that Acute Care Hospital requests must be submitted **within 48 hours** of admission and Comagine Health does not review emergency room admissions.

Steps

1) **Main View:**
   A. **Home (Splash) Page** – Where Comagine Health posts provider announcements.
   B. **Dashboard Menu (New Request or Search Request)** – Where work can be managed individually (through the To Do tab) or as a team (through Team tab).
   C. **Menu** – To start a New Request or Search for a request.
   D. **Memory List** – Keeps a running list of the episodes viewed so they can be found easily while in the CHPP. Should be cleared out at the end of each session.

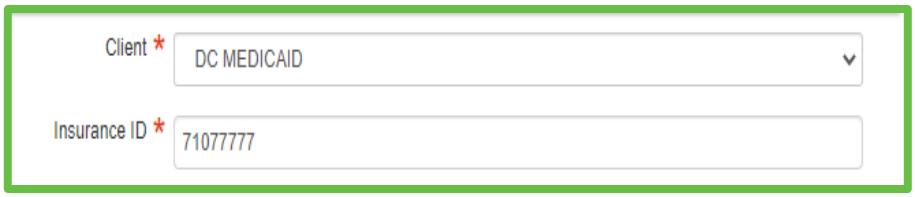


2) **Submit a New Request:**
   A. Click on **Menu** and select **New Request.**

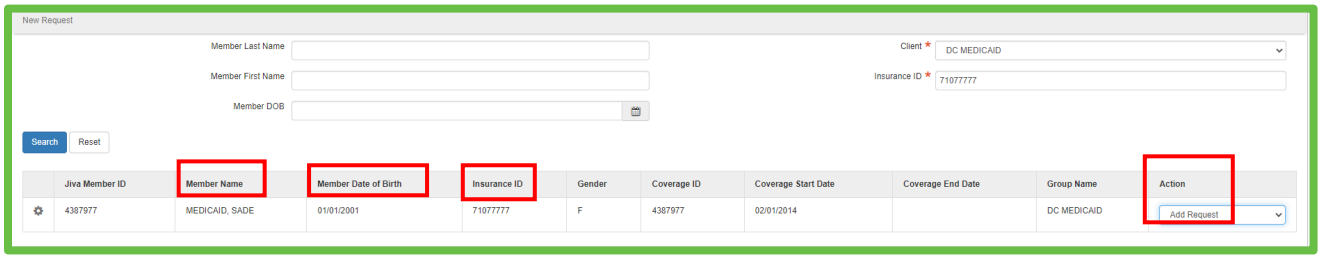


   B. **Client:** Select **DC MEDICAID**
   C. **Insurance ID**, enter **Medicaid ID number**, starting with 7.

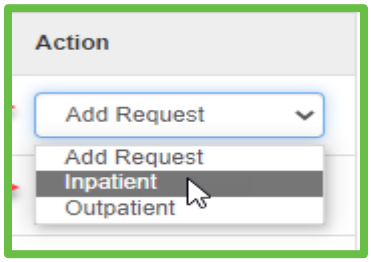
D. Click on **Search.**



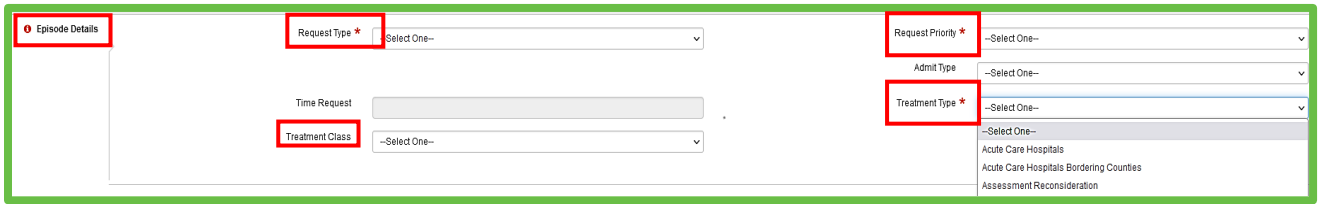
3) Medicaid Recipient Search:
   A. Verify correct **member name, date of birth,** and **insurance ID.**



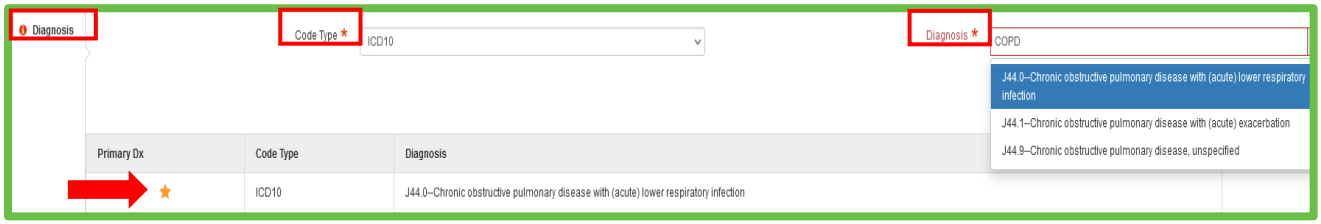
4) Under **Action,** click where it says **Add Request** and select **Inpatient** (IP) from the drop-down menu.



5) Fill out the **Episode Details** with the red asterisk, including the Treatment Class. For **Inpatient** requests complete:
   A. Request Type*: Select Prior Authorization.
   B. **Time Request:** Does not need to be filled in.
   C. **Treatment Class**: Select **Currently Admitted**, **Discharged (Retros only)**, **Future Admission** or **N/A** (this field MUST be completed even though an asterisk is not present).
   D. **Request Priority***: Will auto-populate with **Non-Urgent.**
   E. For Treatment Type*: Select Acute Care Hospitals.



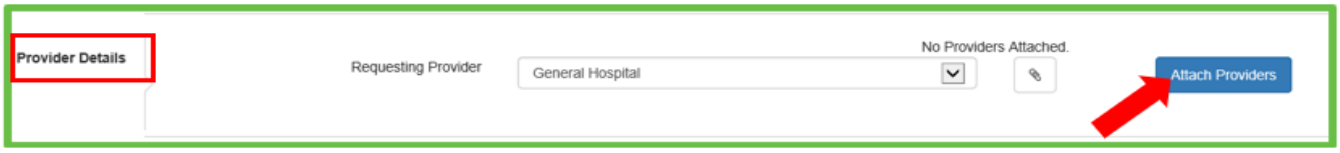
6) Fill out the **Diagnosis** section:
   A. For the **Code Type***: **ICD10** will auto-populate.
   B. Under **Diagnosis***: Only enter one diagnosis at a time.
      - The diagnosis codes will appear in a drop-down menu as you start typing, and you can then select it.
      - Example: J44.0 will appear below and can be selected by clicking on it.
      - If there are multiple diagnoses, the primary diagnosis (Primary Dx) can be amended by selecting the **yellow star** on the **Primary Dx** line.



7) Complete the **Provider Details** section:
   A. To add an organization, click the **paperclip icon** beside the **Requesting Provider** drop-down menu underneath **Provider Details.**

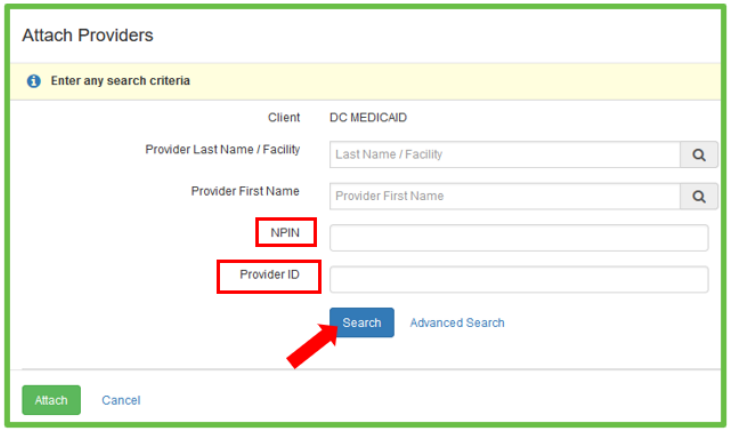
- This entry is required for users to access the case via the CHPP and receive updates on status from Comagine Health.

   B. After adding the organization, please select **Attach Providers** by clicking on the blue **Attach Providers** button to the right of the paperclip.



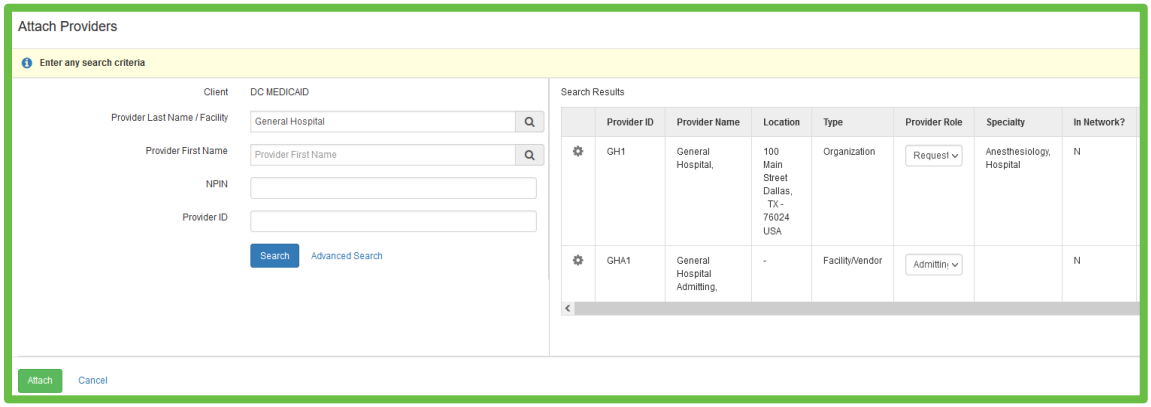
   C. Once selected, you will see the screen below. You can do a basic **Search** or **Advanced Search** for providers. Enter the DC Medicaid **Provider ID** that starts with zero, or the National Provider Identification Number (**NPIN**).

- For facility/vendors and Individual selections, searching for the Medicaid **Provider ID** or the **NPIN** may help narrow requests rather than searching by last name.



- An errant search will trigger you to call Comagine Health for assistance. You may do so or attempt your search again using different parameters.

D. Click **Search.** The search results for the agency will appear on the right.



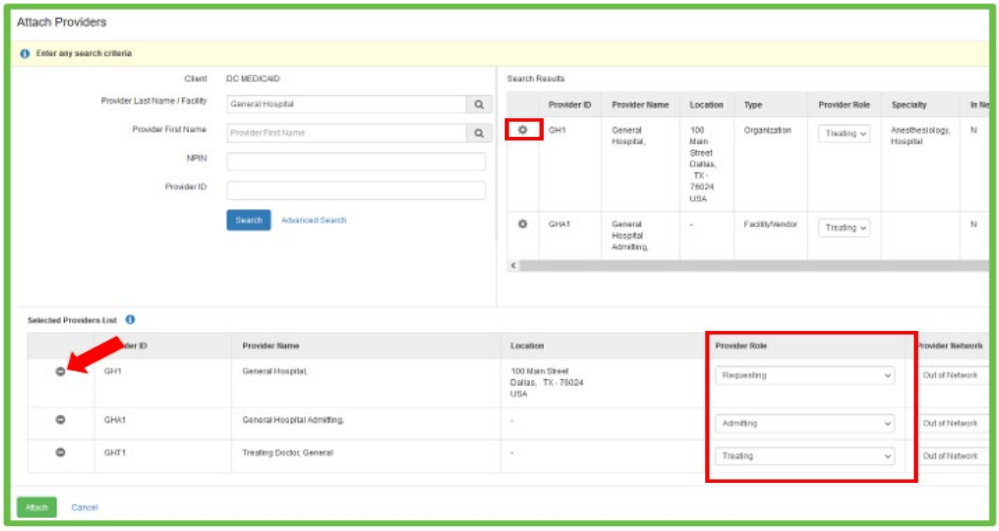
E. Each provider entry must be paired with a specific **provider role** selected from the drop-down contained inside the **Provider Role** column within the search result itself. Tip: Disregard the **Provider Network** drop-down.

- Facility/vendor is always paired with **Admitting.**
- Individual is always paired with **Treating.**
- Organization is always paired with **Requesting.**

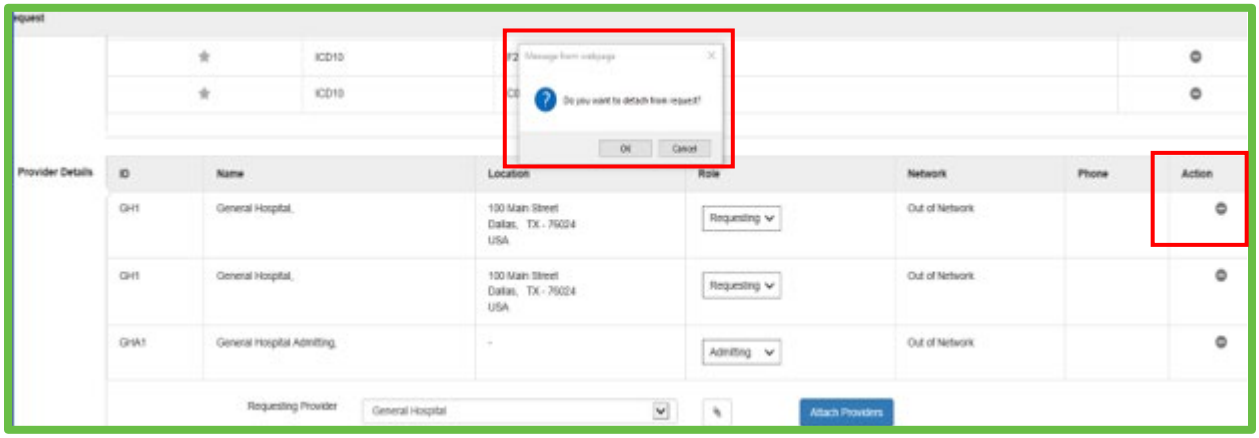
F. Click on the **gear icon (⚙)** under search results and choose **Multiple Attach**.

- The list of providers will appear under **Selected Provider's List**
- The entry will remain there while you complete additional searches to complete your entries.
- When all entries are selected and you are ready to attach, select **Attach** from the bottom left of the screen.
- If you prefer selecting **Single Attach** instead of **Multiple Attach**, this will allow you to attach one provider at a time. You will have to recomplete step C - forward for any additional entries.

G. Once all providers have been selected, click the green **Attach** button to save all providers.

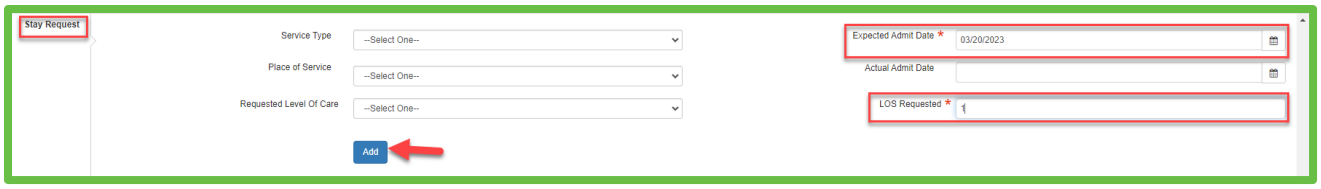


H. If a provider is selected in error, click the icon under **Action** to detach the provider; a pop-up message will ask, "Do you want to detach from request?" Click **OK**.



8) Complete the **Stay Request** section for Inpatient (IP) admits only**:**

A. **Service Type**: Leave blank.
B. **Place of Services**: Leave blank.
C. **Requested Level of Care:** N/A (May be useful).
D. **Expected Admit Date***: Enter the date.
E. **Actual Admit Date**: Enter the date.
F. **LOS Requested** *: Enter number of days requested. For example, one day.
G. Click the blue **Add** button.

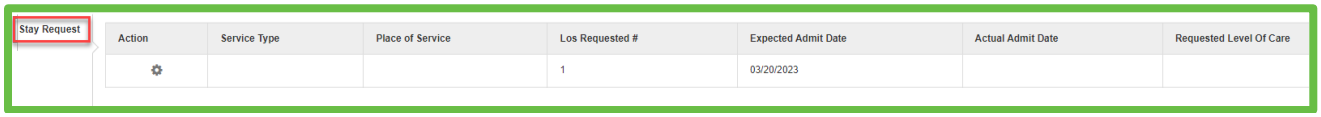


9) To **edit** a **Stay Request**:

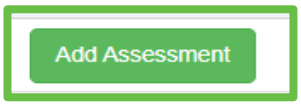
A. Click on the **gear icon** ⚙ under **Action.** A new screen will open for edits.

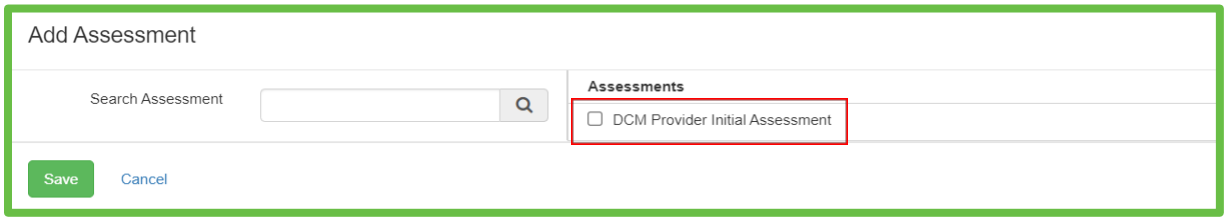
10) To **remove** a **Stay Request**:

a. Click on the **gear icon** ⚙ under **Action** and select **Remove.** A box will open to confirm you want to remove it, click **OK** to remove.



11) **Add Assessments.** Click on the **Add Assessment** tab.





A. Select and complete the DCM Provider Initial Assessment.

- There are three questions in the **DCM Provider Initial Assessment.**
- Enter **contact name**, **contact phone number,** and **contact fax.**
- **Always** select **Complete** when finished with an assessment and not just **Save.**



12) In the **Documents** section:

A. Click on the blue **Add Documents** button.



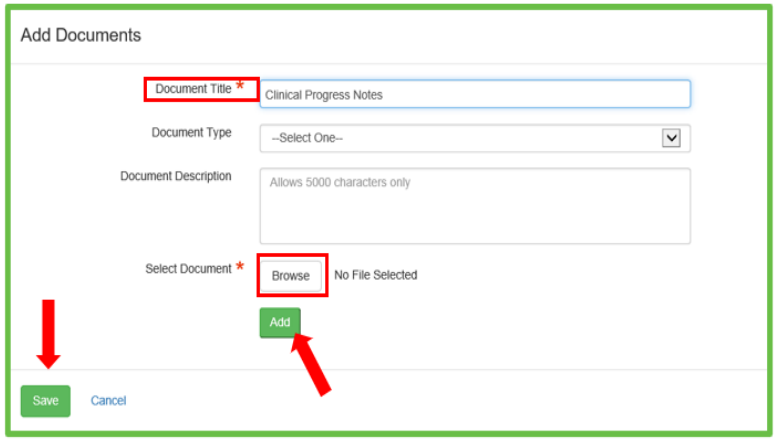
B. **Document Title*:** Enter the name of the document being uploaded.

C. **Document Type and Description:** Can be left blank.

D. **Select Document*:** Choose **Browse** and locate your document to upload.

- Tip: Please only use PDF or DOC files.
- Tip 2: TIFF files will not be accepted and Comagine Health will ask for clinicals to be resubmitted in either PDF or DOC format.

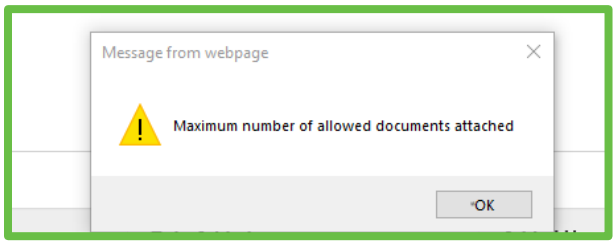
E. Once you have selected the document to be added, click the green **Add** button.



F. If you have multiple documents, please complete step A through E for each document.

G. Once all documents have been uploaded, select **Save**.

H. The maximum number of allowed documents attached is four (4). If the number of uploaded documents exceeds four an error message will appear (see below). Click **OK**. If you need to add more than this, you may either combine documents into one attachment, or attach additional documents after the request has been submitted. The process for this is outlined below in Step 15.



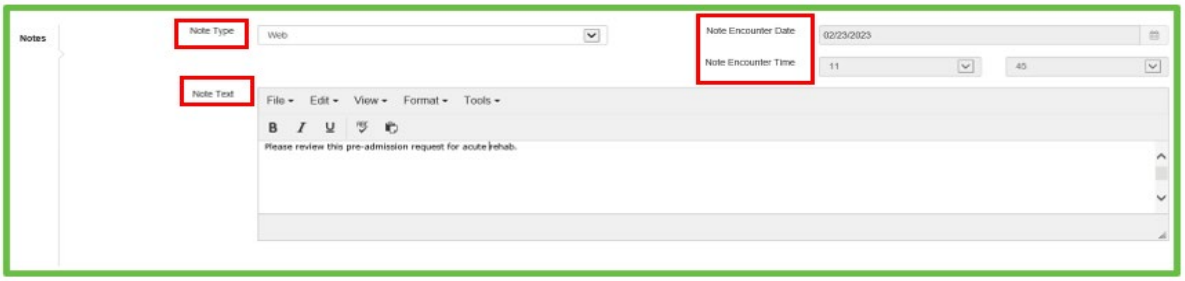
12) Under the **Notes** section, enter the following information:

A. **Note Type:** Will auto-populate to **Web**.

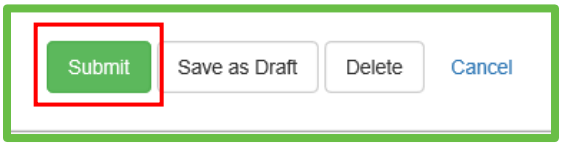
B. **Note Text:** Add notes according to the request (i.e., additional information submitted).

C. **Note Encounter Date and Note Encounter Time:** Will auto-populate the date and time.

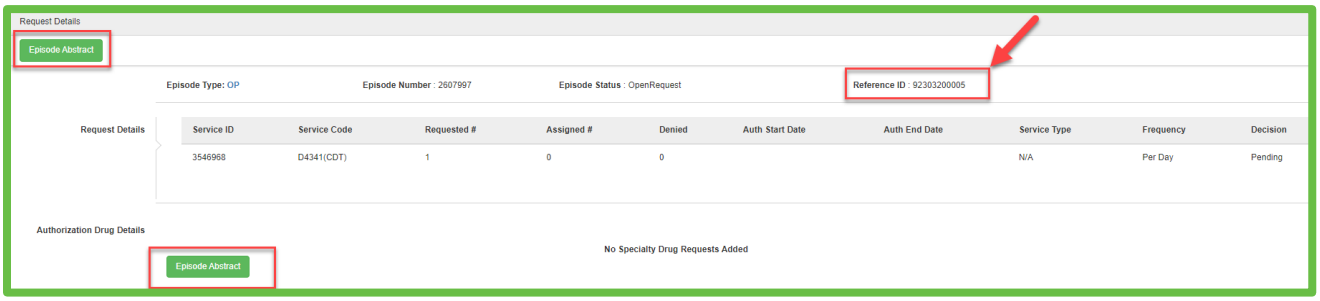
D. Click **Save.**



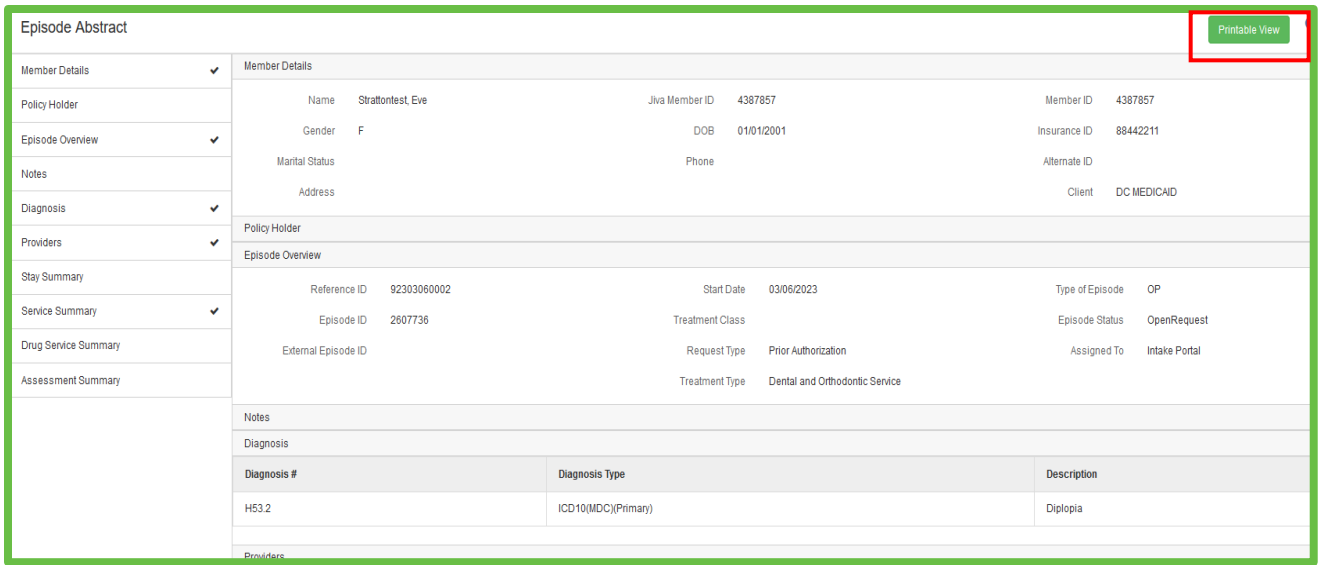
13) **Submit, save, or delete**.
    A. **Submit:** Episode will be submitted to Comagine Health. Review to ensure your entered information is correct and click **Submit**. It will ask you to confirm – click **OK**.
    B. **Save as Draft:** Episode will not submit to Comagine Health; but will be saved for later edits.
    C. **Delete:** The request will be deleted.



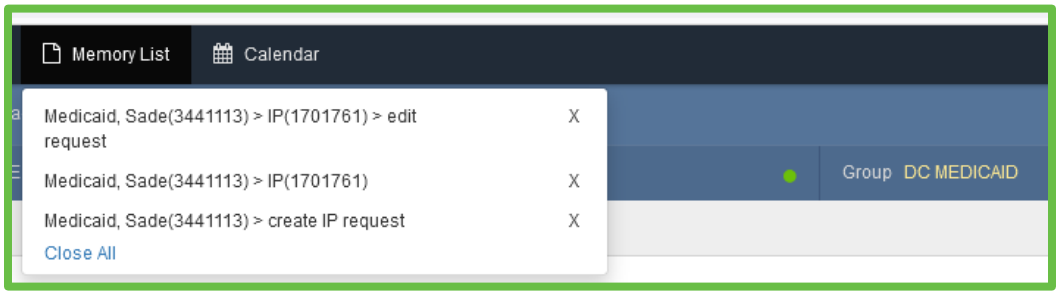
14) Make a note of the CHPP **Reference ID** number for your records to locate the episode faster.
    A. Selecting **Episode Abstract** here allows you to review what was submitted; however, you cannot edit from here.



    B. You can print by selecting **Printable View.**

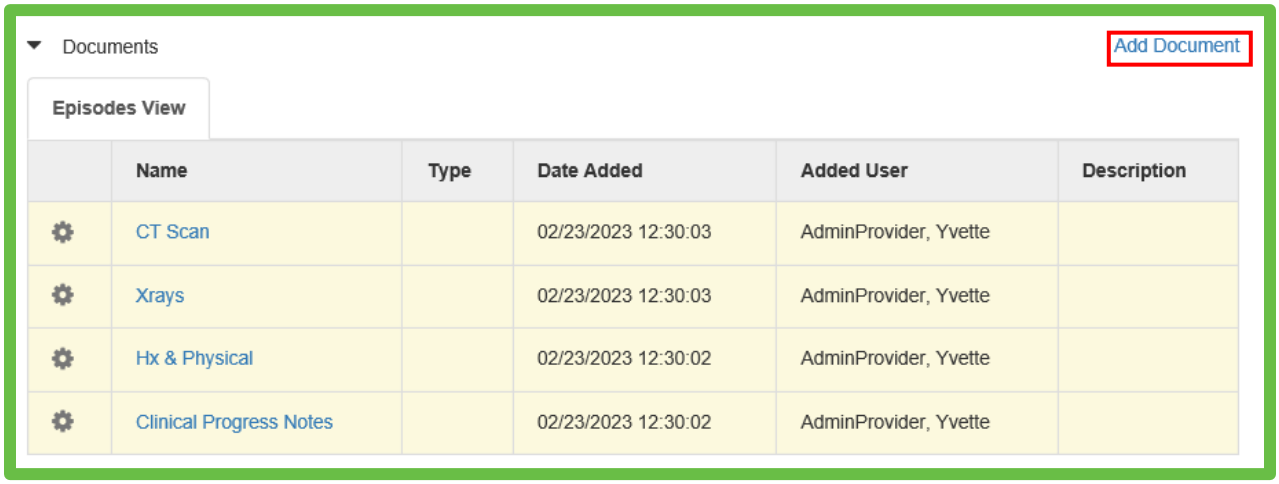


15) If additional documents need to be submitted, locate the submitted episode by clicking on **Memory List** at the top of the screen, or by completing a search by clicking **Menu** and then **Search Request.**

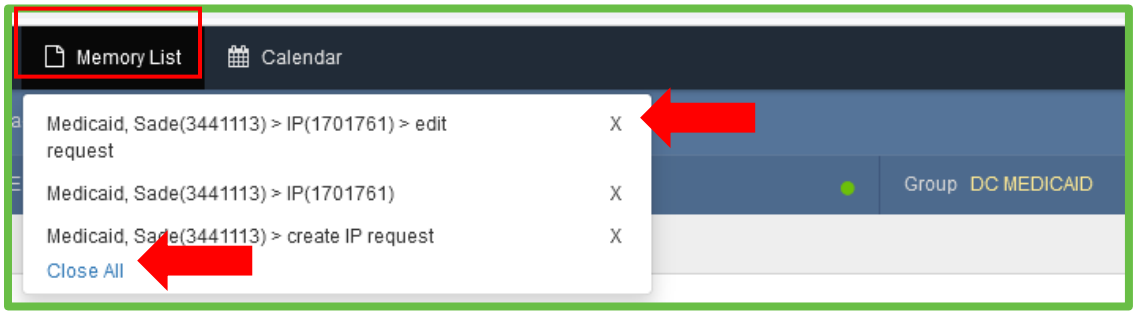


A. Either select the episode you were working on in the **Memory List** or search for the **Reference ID** in the **Search Request.**

B. Click on **Add Document** and follow Step 11 above to add additional documents.



16) **Always go to the Memory List and close out of all episodes**. This will ensure Comagine Health has access to review your submission. Click on the **x** next to the episodes or click **Close All** to clear the Memory list.



For CHPP Technical Assistance: 1-800-251-8890

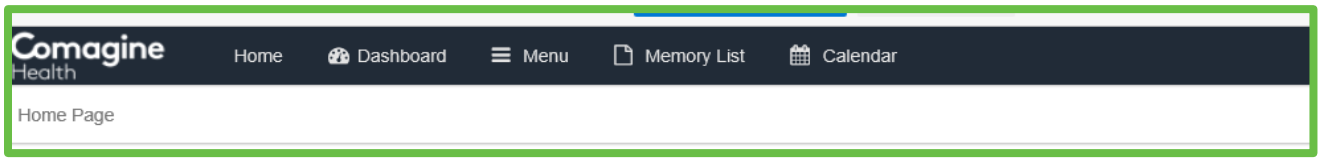
CHPP Log-On Link:
https://comaginepp.zeomega.com

I.2 Specialty Hospital

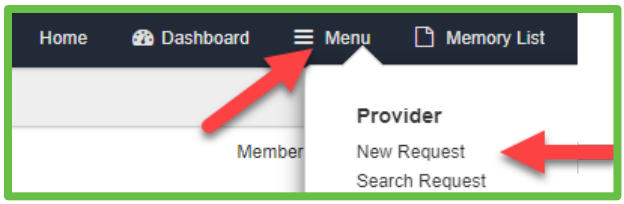
The following are the steps for submitting Long-Term Acute Care Hospital (LTACH) Pre-Admission requests via the CHPP.

Steps

1) Main View:
   A. **Home (Splash) Page** – Where Comagine Health posts provider announcements.
   B. **Dashboard Menu** (**New Request** or **Search Request**) – Where work can be managed individually (through the **To Do** tab) or as a team (through **Team** tab).
   C. **Menu** – To start a **New Request** or **Search** for a request.
   D. **Memory List** – Keeps a running list of the episodes viewed so they can be found easily while in the CHPP. Should be cleared out at the end of each session.



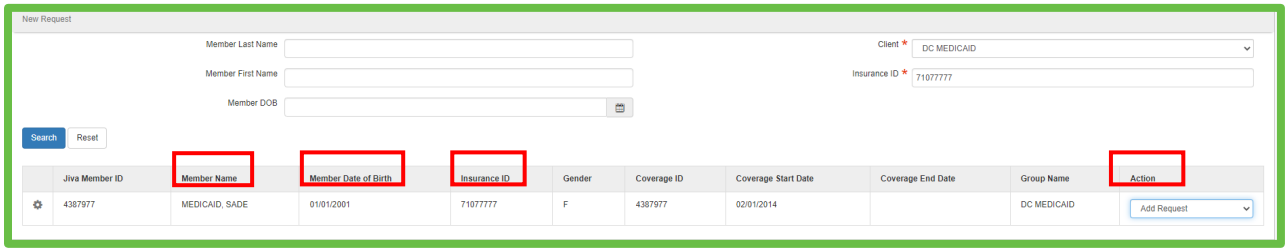
2) Submit a New Request:
   A. Click on **Menu** and select **New Request**.



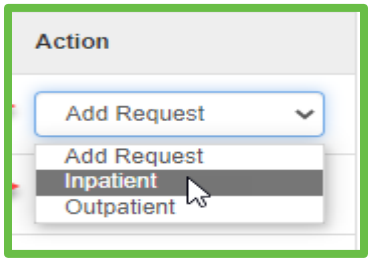
B. Client: Select DC MEDICAID.
C. **Insurance ID**: Enter **Medicaid ID Number**, which starts with 7.
D. Click on **Search**.



3) Medicaid Recipient **Search**:
   A. Verify correct Member Name, Member Date of Birth, and Insurance ID.



4) Under **Action**, click where it says **Add Request** and select **Inpatient** (IP) from the drop-down menu.



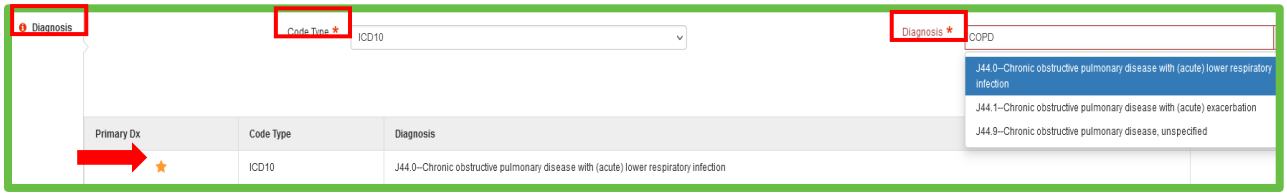
5) Fill out the **Episode Details** with the red asterisk, including the Treatment Class. For **Inpatient** requests, complete:
   A. **Request Type***: Pre-Admission.
   B. **Time Request**: Does not need to be filled in, and automatically populates to 1 day.

C. **Treatment Class**: Select **Currently Admitted**, **Discharged** (Retros only), **Future Admission**, or **N/A** (this field MUST be completed even though an asterisk is not present).
D. **Request Priority***: Will auto-populate with Non-Urgent.
E. **Treatment Type***: Select Specialty Hospital of Washington.



6) Fill out the **Diagnosis** section:
A. **Code Type***: ICD10 will auto-populate.
B. **Diagnosis***: Only enter one diagnosis at a time.

- The diagnosis codes will appear in a drop-down menu as you start typing, and you can then select it.
- Example: J44.0 will appear below, and you select it by clicking on it.
- If there are multiple diagnoses, the primary diagnosis (Primary Dx) can be amended by selecting the **yellow star** on the **Primary Dx** line.

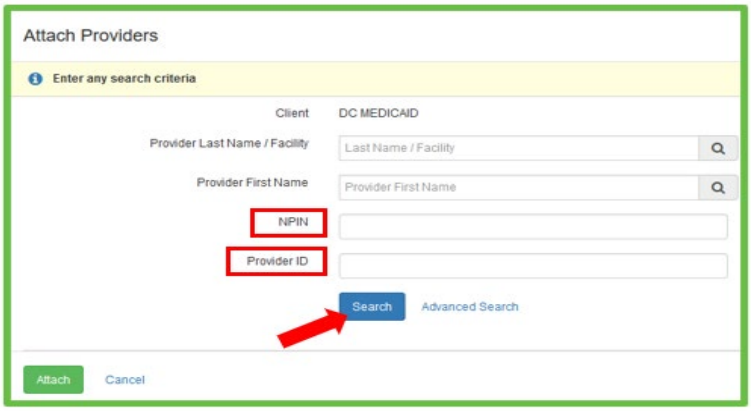


7) Complete the **Provider Details** section:
A. To add your Organization, click the **paperclip icon** beside the **Requesting Provider** drop-down underneath **Provider Details**. This entry is required for users to access the case via the Provider Portal and receive updates on status from Comagine Health.
B. After adding your Organization, select **Attach Providers** by clicking on the blue **Attach Providers** button to the right of the paperclip.

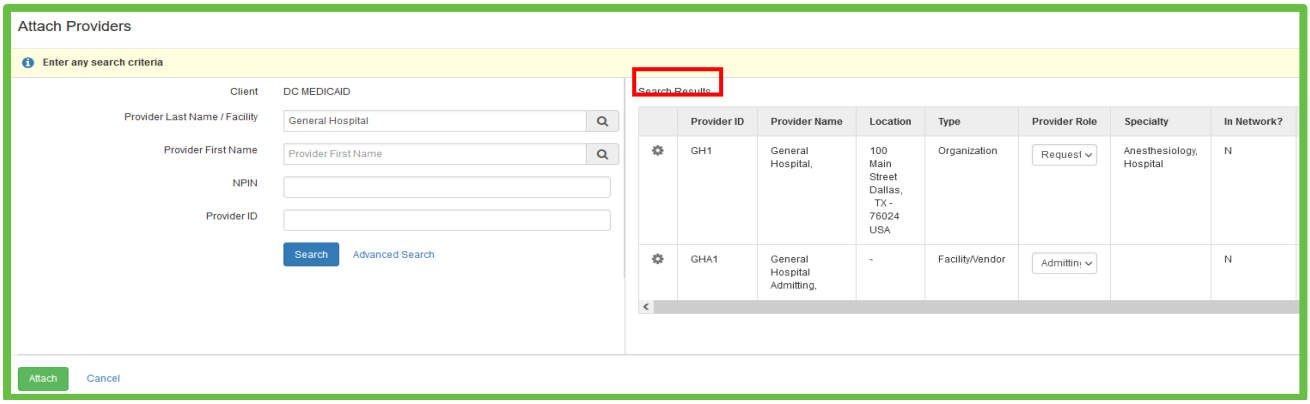


C. Once selected, you will see the screen below. You can do a basic **Search** or **Advanced Search** for providers. Enter the **DC Medicaid Provider ID** that starts with a zero, or the **National Provider Identification Number (NPIN)**.

- For facility/vendors and individual selections, searching for the Medicaid **Provider ID** or the **NPIN** may help narrow the requests rather than searching by a last name.
- An errant search will trigger you to call Comagine Health for assistance. You may do so or attempt your search again using different parameters.



D. Click **Search**. The search results for the agency will appear on the right.



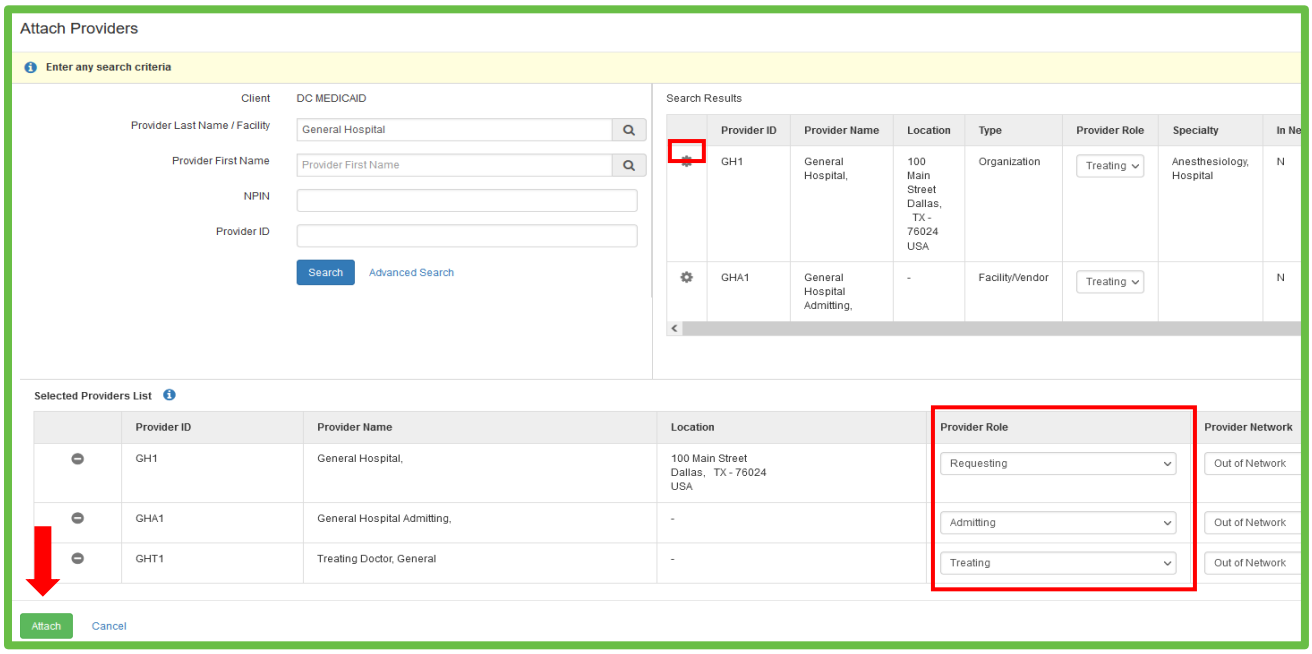
E. Each provider entry must be paired with a specific **provider role** selected from the drop-down contained inside the **Provider Role** column within the search result itself.

- Facility/vendor is always paired with **Admitting**.
- Individual is always paired with **Treating**.
- Organization is always paired with **Requesting**.

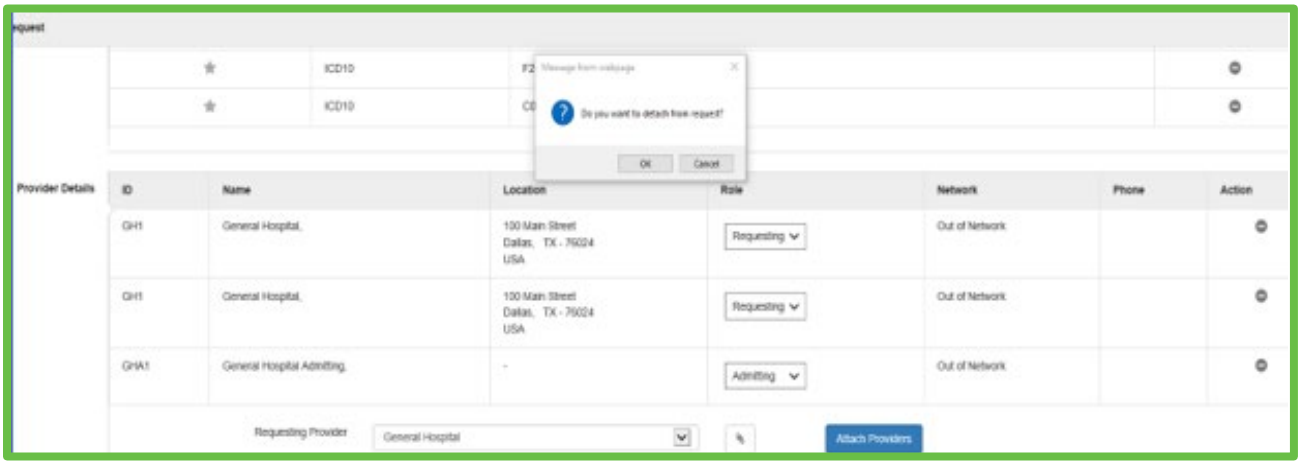
F. Click on the **gear icon** (⚙) under search results and choose **Multiple Attach**.

- The list of the providers will appear under the **Selected Provider's List**.
- The entry will remain there while you complete additional searches to complete your entries.
- When all entries are selected and you are ready to attach, select **Attach** from the bottom left of the screen.
- If you prefer selecting **Single Attach** instead of **Multiple Attach**, this will allow you to attach one provider at a time. You will have to recomplete step C - forward for any additional entries.

G. Once all providers have been selected, click on the green **Attach** button to save all providers.

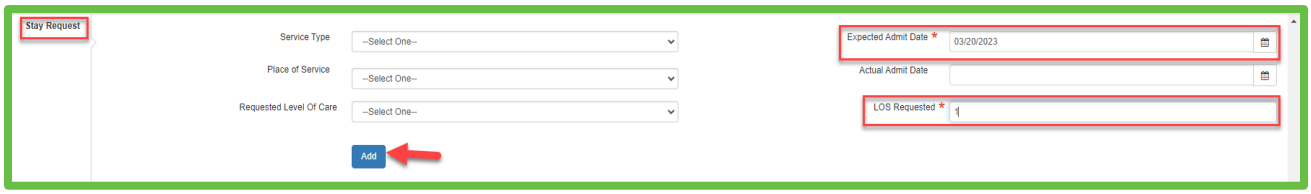


H. If a provider is selected in error, click the icon under **Action** to detach the provider; a pop-up message will ask, "Do you want to detach from request?" Click **OK**.

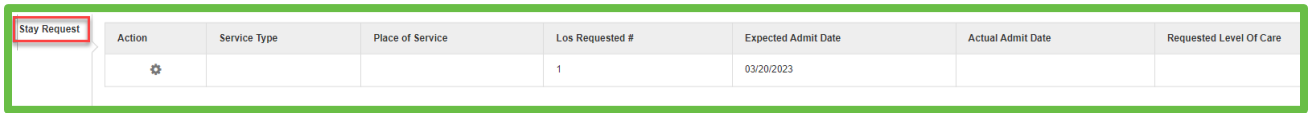


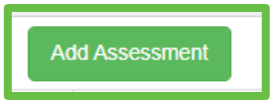
8) **Stay Request** section for Inpatient (IP) admits only:

A. **Service Type**: Leave blank.
B. Place of Service: Leave blank.
C. **Requested Level of Care**: Select Acute Medical/Surgical, Rehab, or N/A.
D. Expected Admit Date*: Enter date.
E. **Actual Admit Date**: Enter Date (if already admitted)
F. **LOS Requested***: Enter number of days requested. For example, 7 days.
G. Click the blue **Add** button.
H. To edit a **Stay Request**, click on the **Gear** under **Action**. A new screen will open for edits.
I. To remove a **Stay Request**, a box will open to confirm you want to remove it, click **OK** to remove.

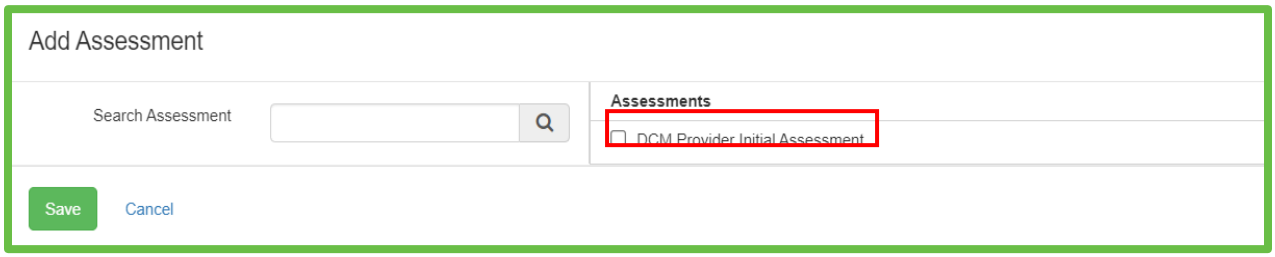


J. At the end you should see the **Stay Request** entered, as below.



9) Add **Assessments**. Click on the **Add Assessment**  tab.

A. Select and complete the DCM Provider Initial Assessment.

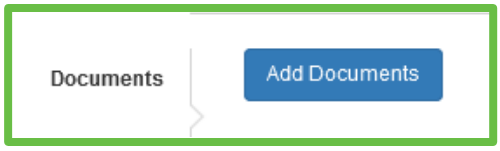


- There are three questions in the **DCM Provider Initial Assessment**.
- Enter Contact Name, Contact Phone Number, and Contact Fax.
- Always select **Complete** when finished with an assessment and not just **Save**.



10) **Add Documents** section:

A. Click on the blue **Add Documents**



button.

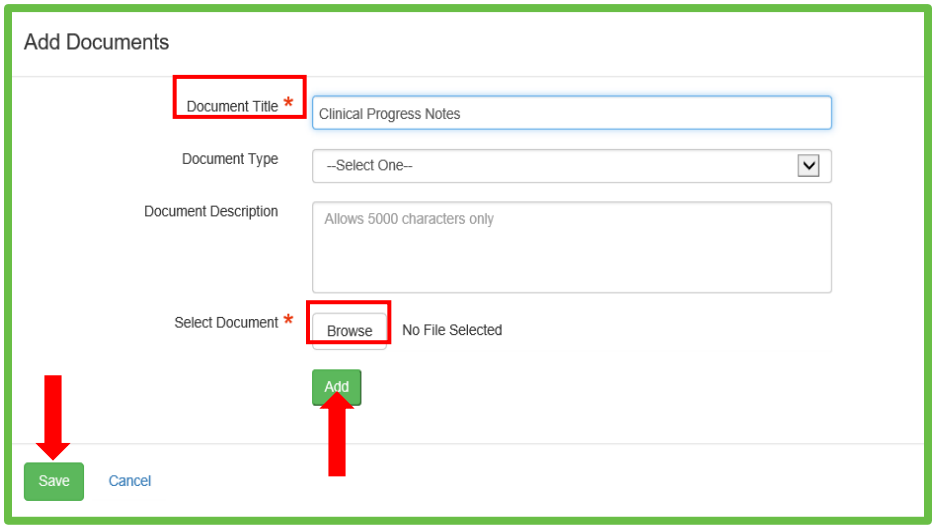
B. **Document Title***: Enter the name of the document being uploaded.

C. **Document Type** and **Description**: Can be left blank.

D. **Select Document***: Choose **Browse** and locate your document to upload.

- Tip: Please only use PDF or DOC files.
- Tip 2: TIFF files will not be accepted and Comagine Health will ask for clinicals to be resubmitted in either PDF or DOC format.

E. Once you have selected the document to be added, click the green **Add** button.

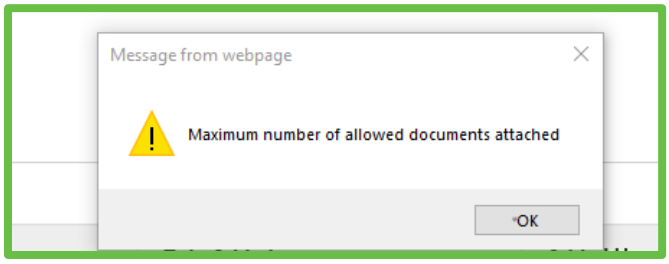


F. If you have multiple documents, please complete step A through E for each document.

G. Once all documents have been uploaded, select **Save**.

H. The maximum number of allowed documents attached is four (4). If the number of uploaded documents exceeds four an error message will appear (see below). Click **OK**. If you need to add more than this, you may either combine documents into one attachment, or attach additional

documents after the request has been submitted. The process for this is outlined below in Step 14.



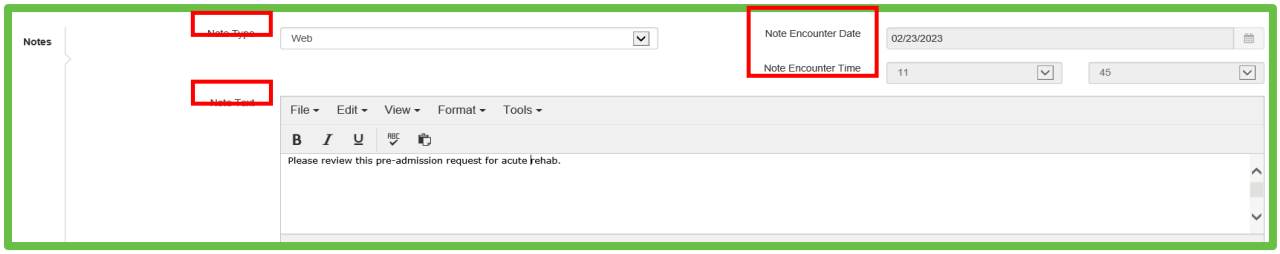
11) **Notes** section:

A. **Note Type**: will auto-populate to Web.

B. **Note Text**: Add notes according to the request (i.e., additional information submitted).

C. **Note Encounter Date** and **Note Encounter Time**: Will auto-populate the date and time.

D. Click **Save**.

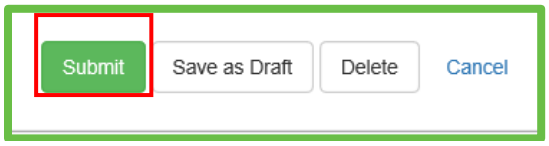


12) **Submit, save, or delete.**

A. **Submit**: Episode will be submitted to Comagine Health. Review to ensure your entered information is correct and click Submit. It will ask you to confirm – click OK.

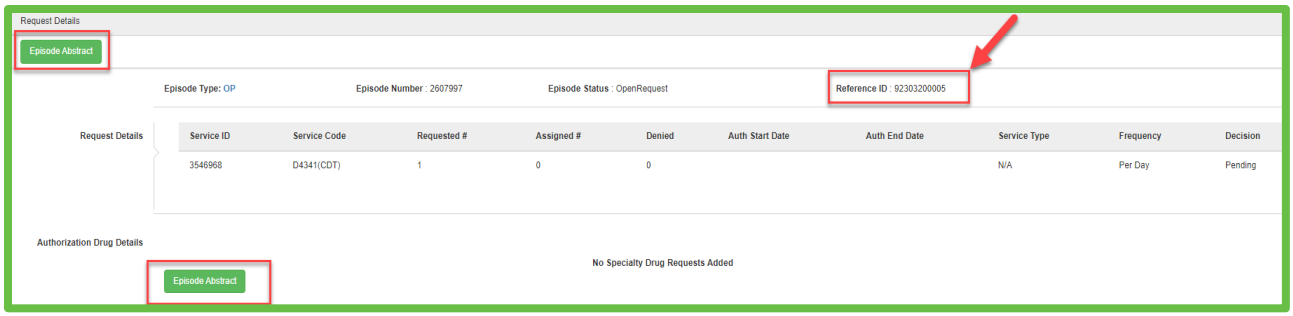
B. **Save as Draft**: Episode will not be submitted to Comagine Health but will be saved as draft for later to edit.

C. **Delete**: The request will be deleted.

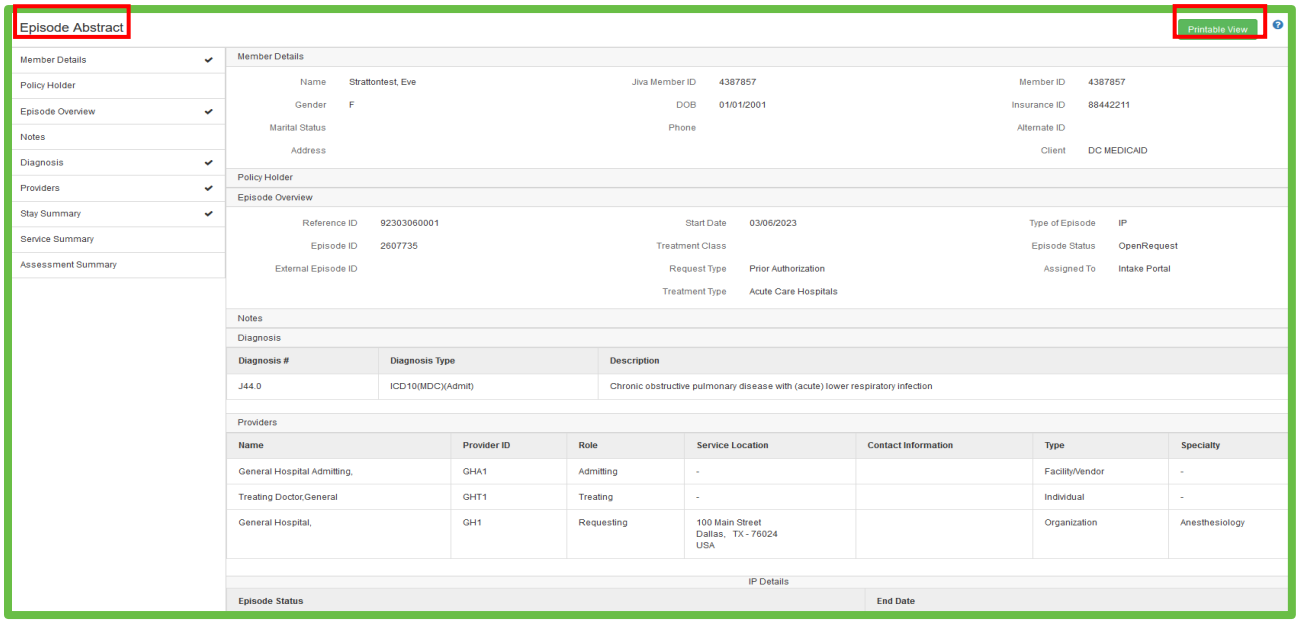


13) Make a note of the CHPP **Reference ID number** for your records to locate the episode faster.

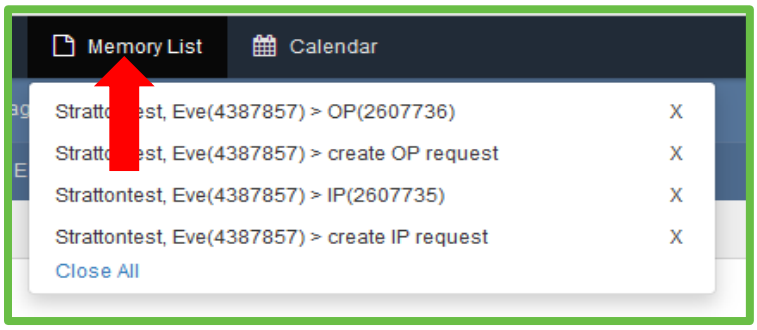
A. Selecting **Episode Abstract** here allows you to review what was submitted; however, you cannot edit from here.



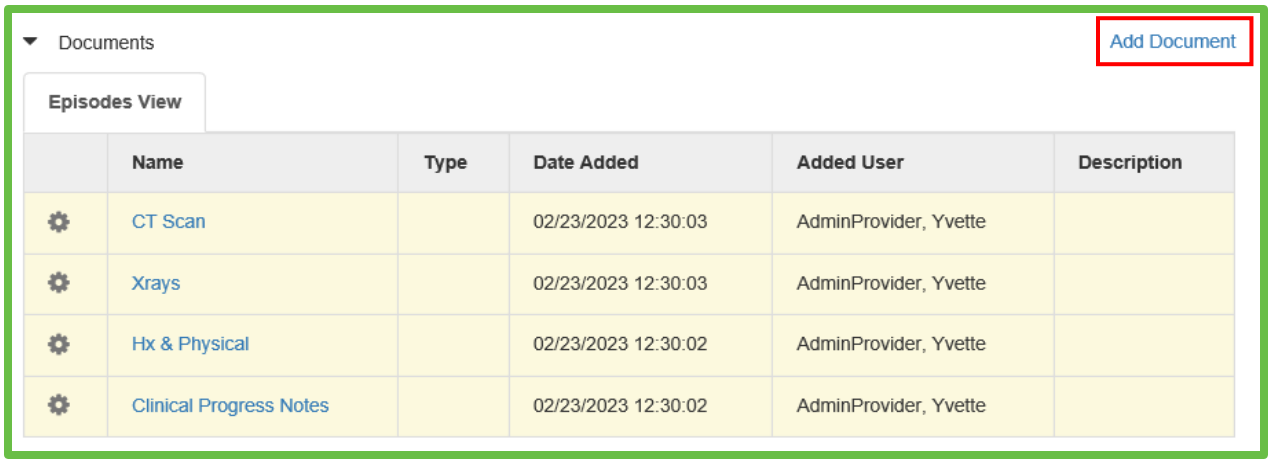
B. You can print by selecting **Printable View** button in the top right corner.



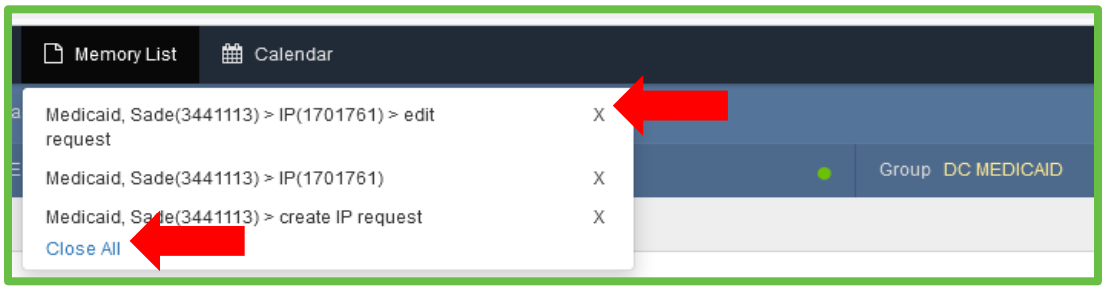
14) If you need to submit additional documents, go to the **Memory List** at the top of the screen. Select the episode you were working on in the **Memory List**.



A. Click on **Add Document** and follow Step 10 above to add additional documents.



15) **Always go to the Memory List and close out of all episodes.** This will ensure Comagine Health has access to review the submission. Click on the **x** next to the episodes or click **Close All** to clear the **Memory List**.



For CHPP TECHNICAL ASSISTANCE: 1-800-251-8890

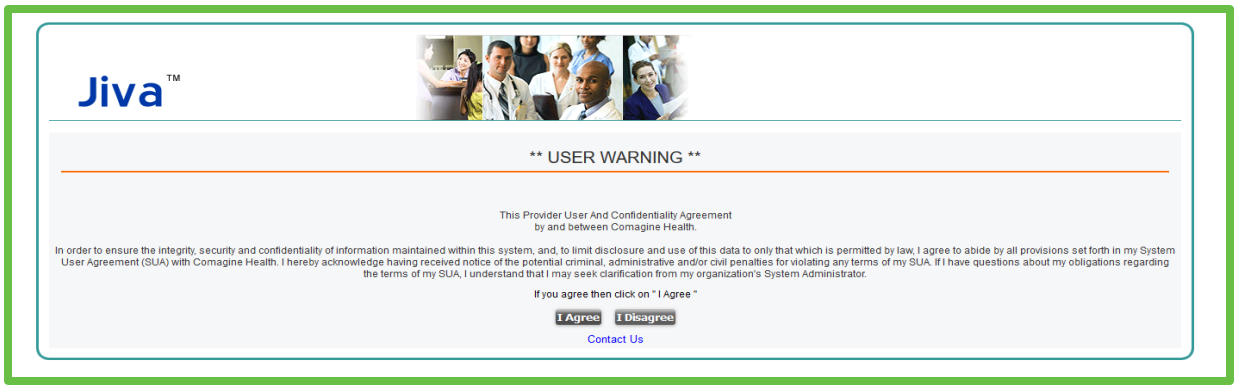
CHPP LOG-ON LINK: https://comaginepp.zeomega.com

I.3 Continued Stay Review

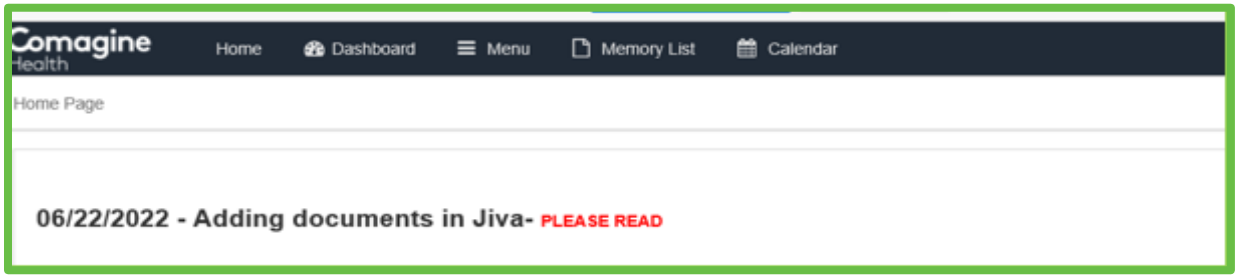
The following are the steps for submitting continued stay review inpatient (IP) extension requests via the CHPP.

Steps

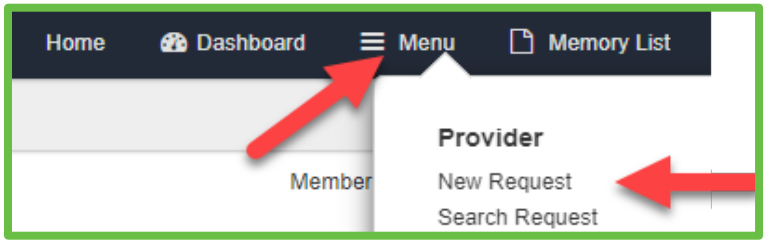
1) Log In:
   A. Enter current **user ID** and **password**.
   B. Compatible with Chrome, Edge, and Firefox. I.E. mode in Edge not required.



2) Main View:
   A. **Home (Splash) Page** – Where Comagine Health posts provider announcements.
   B. **Dashboard** – Where work can be managed individually (through the **To Do** tab) or as a team (through **Team** tab).
   C. Menu – To start a New Request or Search Request.



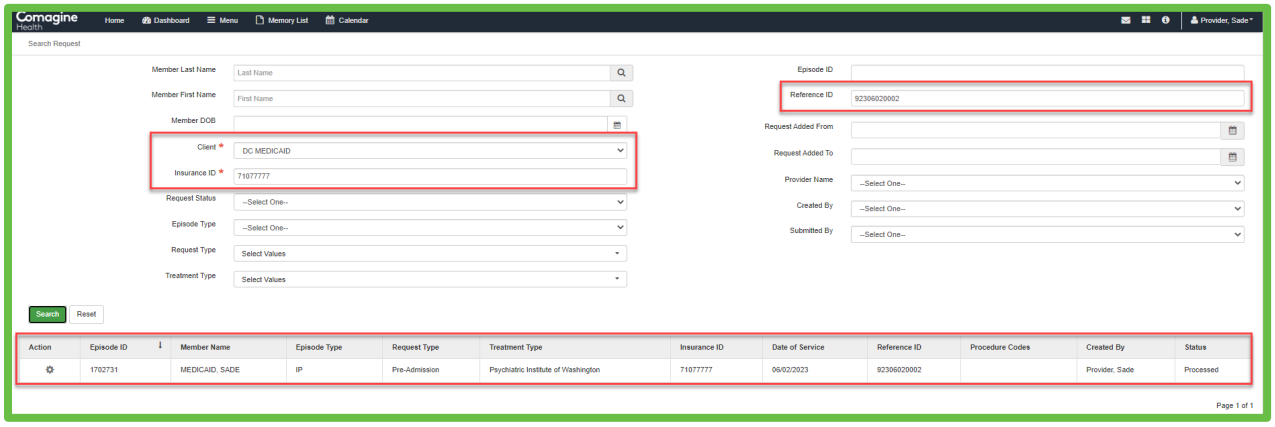
3) To submit a continued stay review extension request:
   A. Click on **Menu** and select **Search Request** from the drop-down.



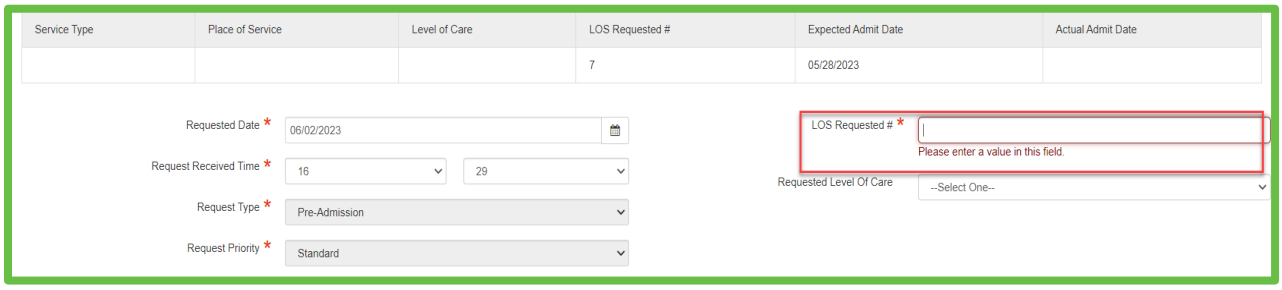
   B. Client: Select DC MEDICAID.
   C. **Insurance ID**: Enter the **Medicaid ID number**, starting with 7.
   D. Enter the **Reference ID** number.
   E. Click on **Search**.

4) Medicaid Recipient **Search**:

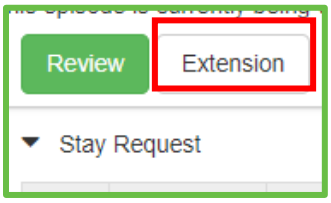
A. Verify correct member name, date of birth, and insurance ID.
B. Click on the **gear icon** next to episode you want to work.
C. Select **Open** from the drop-down menu.



5) Stay Request:
A. Go to the **Stay Request** section and click the box next to the last approved length of stay (LOS) line.



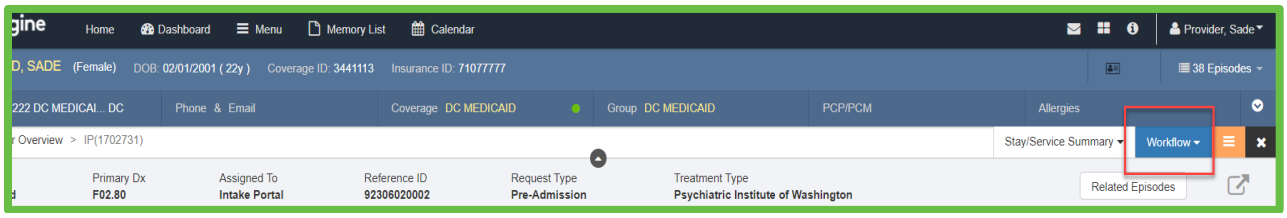
B. Click on the **Extension** button and enter the number of days requested.



C. If the extension request is 24 hours past the last approved date, then you may receive an error message that looks like the following screenshot. This is because currently it is set to error 24 hours from the last approved date or the next review due date. Comagine health is working on extending this 24-hr. timeline, so this error will change.

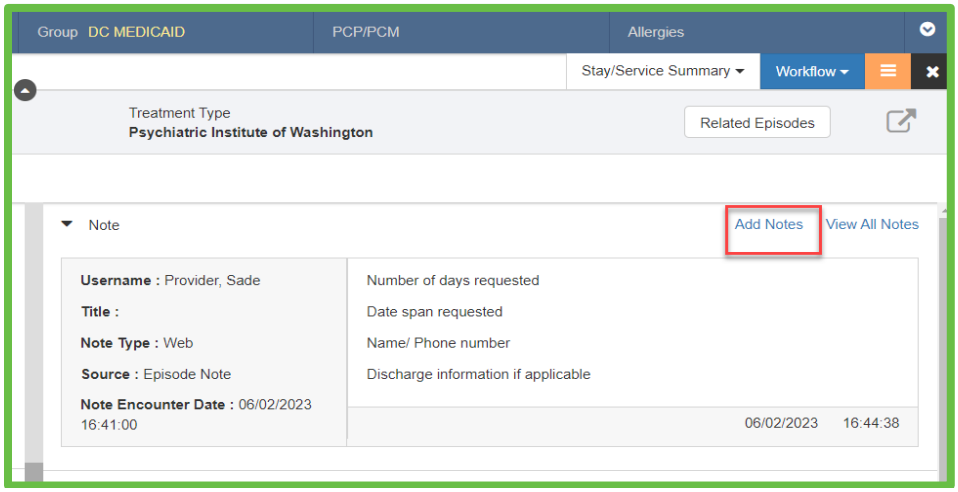


D. Even if you receive the error message and do not have the **Extension** button available to add the number of days requested in the LOS extension request, proceed to the **Workflow** tab to add your assessment.



6) Update the **Notes** section:

A. Click Add Notes.



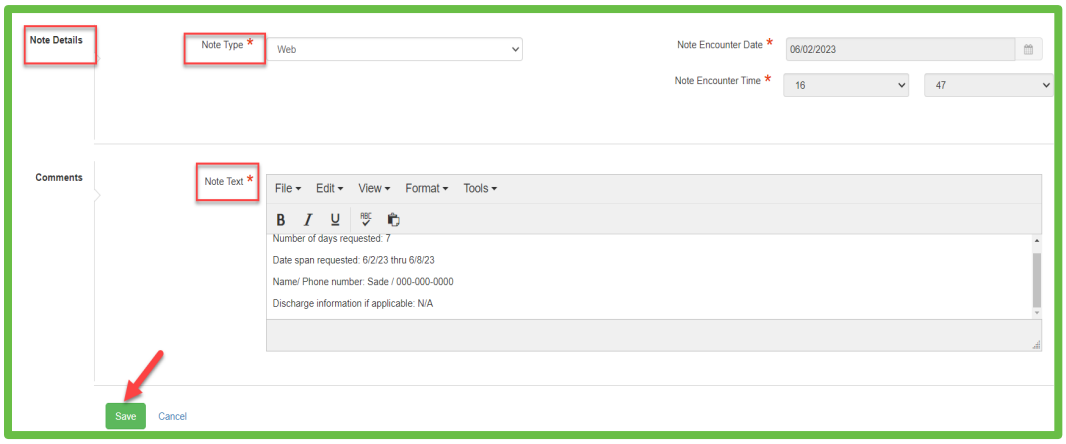
B. Note Type: Select Web.

C. **Note Text**: Add notes according to the request, such as the number of days requested, or your name, phone number, and email address.

D. Add the discharge date, discharge disposition, and follow up appointments, as applicable.

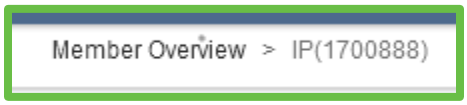
E. **Note Encounter Date** and **Note Encounter Time**: Auto-populates the date and time.

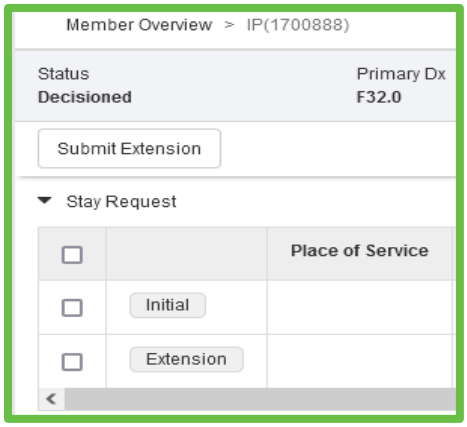
F. Click **Save**.



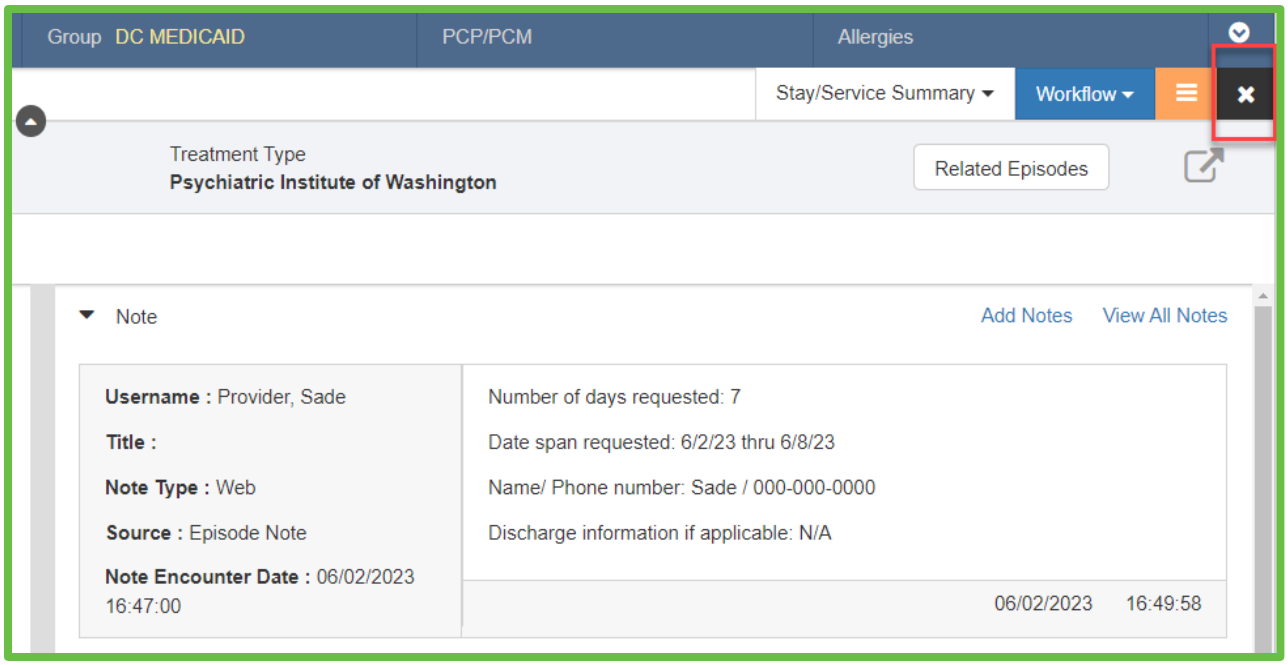
7) Submit the extension:

A. Click on the **Submit Extension** button if you are allowed to complete the LOS extension request, add notes, and complete the assessment. Click on the **IP (episode #)** to navigate in the episode for assessments and notes.

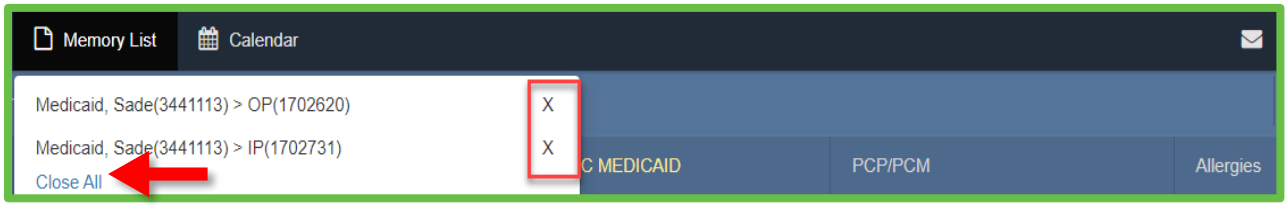




8) Click on the **x** in the right corner to close the episode when you have completed your request.



9) **Always go to Memory List and close out of episodes.** This will ensure Comagine Health will have access to review your submission.
   A. Click on the **x** next to the episode or click **Close All** at the bottom to clear the **Memory List**.



For CHPP Technical Assistance: 1-800-251-8890

CHPP Log-On Link:
https://comaginepp.zeomega.com

I.4 Outpatient Medical Services & Surgical Procedures

The following are the steps for submitting an outpatient (OP) authorization request via the CHPP.

Steps

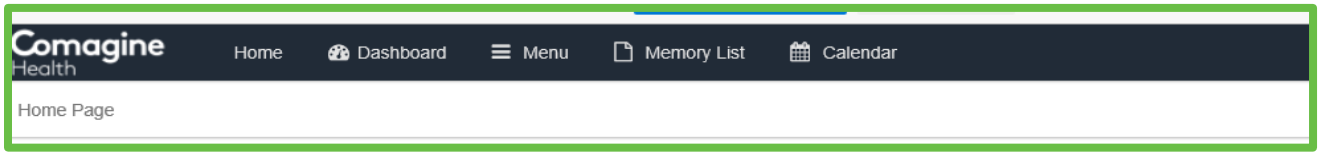
1) Main View:

A. **Home (Splash) Page** – Where Comagine Health posts provider announcements.

   B. **Dashboard Menu** (**New Request** or **Search Request**) – Where work can be managed individually (through the **To Do** tab) or as a team (through **Team** tab).

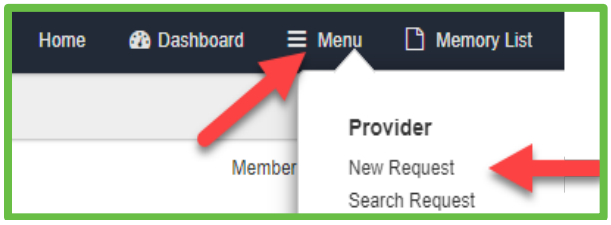
   C. **Menu** – To start a **New Request** or **Search** for a request.

D. **Memory List** – Keeps a running list of the episodes viewed so they can be found easily while in the CHPP. Should be cleared out at the end of each session.



2) Submit a New Request:

A. Click on **Menu** and select **New Request**.



B. Client: Select DC MEDICAID.

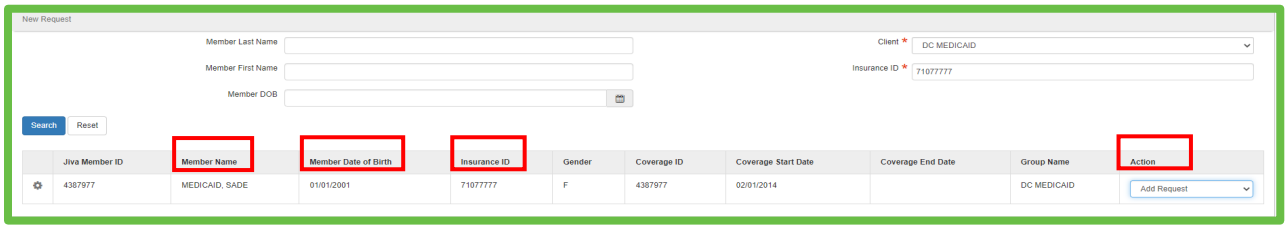
C. **Insurance ID**: Enter **Medicaid ID Number**, which starts with 7.

D. Click on **Search**.

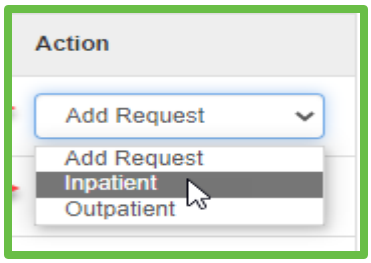


3) Medicaid Recipient **Search**:

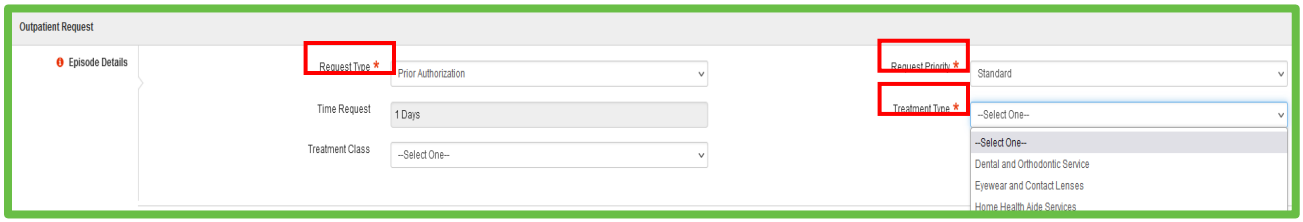
A. Verify correct Member Name, Member Date of Birth, and Insurance ID.



4) Under **Action**, click where it says **Add Request** and select **Inpatient (IP)** from the drop-down menu.



5) Fill out the **Episode Details** with the red asterisks, including the **Treatment Class**. For Outpatient requests complete:
   A. **Request Type***: Enter Prior Authorization or Retrospective.
   B. **Time Request**: Does not need to be filled in.
   C. **Treatment Class**: Select N/A (this field MUST be completed even though an asterisk is not present).
   D. **Request Priority***: Will auto-populate with Non-Urgent.
   E. **Treatment Type***: Select the specific type requested: DME/POS, Dental and Orthodontic Service, Eyewear and Contact Lenses, Home Health Aide Services, Hospice, Nursing Home Add-On, Home Health Occupational Therapy, Home Health Private Duty Nursing, Home Health Physical Therapy, Home Health Skilled Nursing, OP Medical and Surgical DX or Home Health Speech Therapy.

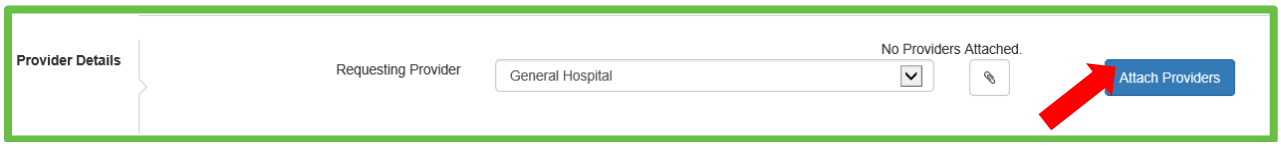


6) Fill out the **Diagnosis** section:
   A. For the **Code Type***: ICD10 will auto-populate.
   B. Under **Diagnosis***: Only enter one diagnosis at a time.
   - The diagnosis codes will appear in a drop-down menu as you start typing and can then be selected.
   - Example: C25.4.0 will appear below and can be selected by clicking on it.
   - If there are multiple diagnoses, the primary diagnosis (**Primary Dx**) can be amended by selecting the **yellow star** on the **Primary Dx** line.

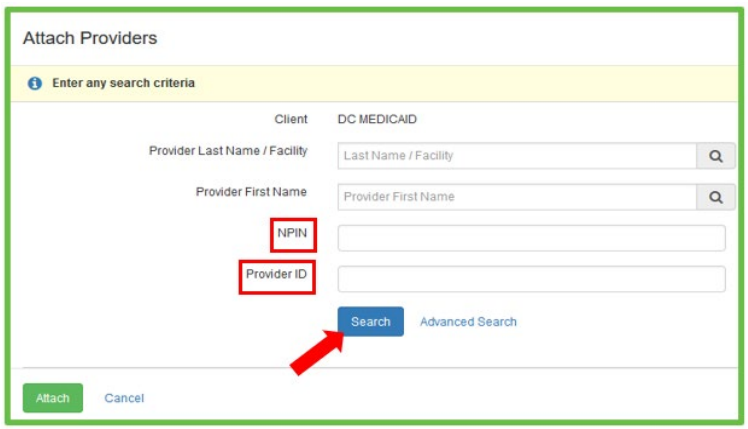


7) Fill out the **Provider Details** section.
   A. To add your organization, click the **paperclip icon** beside the **Requesting Provider** drop-down underneath **Provider Details**.
   - This entry is required for users to access the case via the CHPP and receive update on the status from Comagine Health.

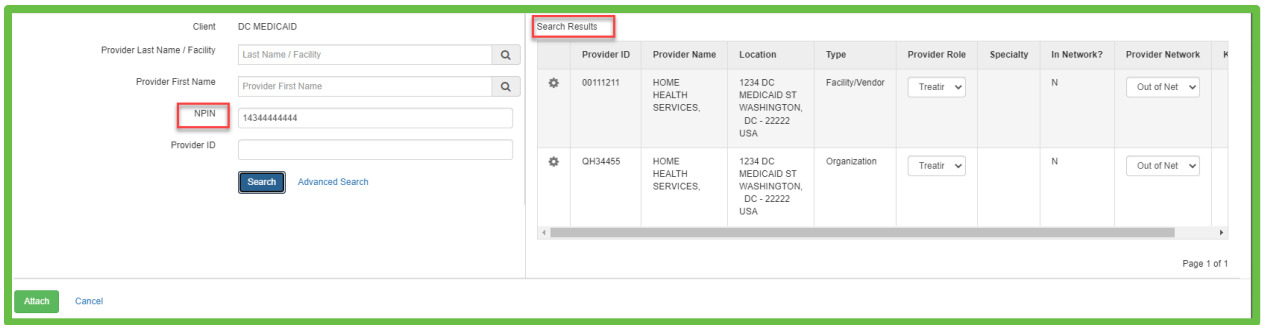
   B. After adding your organization, please select **Attach Providers** by clicking on the blue **Attach Providers** button to the right of the paperclip.



   C. Once selected, you will see the screen below. You can do a basic **Search** or **Advanced Search** for providers. Enter the **DC Medicaid Provider ID** that starts with a zero, or the **National Provider Identification Number (NPIN)**.
   - For facility/vendors and individual selections, searching for the **Medicaid Provider ID** or the NPIN may help narrow the requests rather than searching by a last name.
   - An errant search will trigger you to call Comagine Health for assistance. You may do so or attempt your search again using different parameters.



D. Click **Search**. The search results for the agency will appear on the right.



E. Each provider entry must be paired with a specific provider role selected from the drop-down contained inside the **Provider Role** column within the search result itself. Tip: Disregard the Provider Network drop-down.

- Facility/vendor is always paired with **Admitting**.
- Individual is always paired with **Treating**.
- Organization is always paired with **Requesting**.

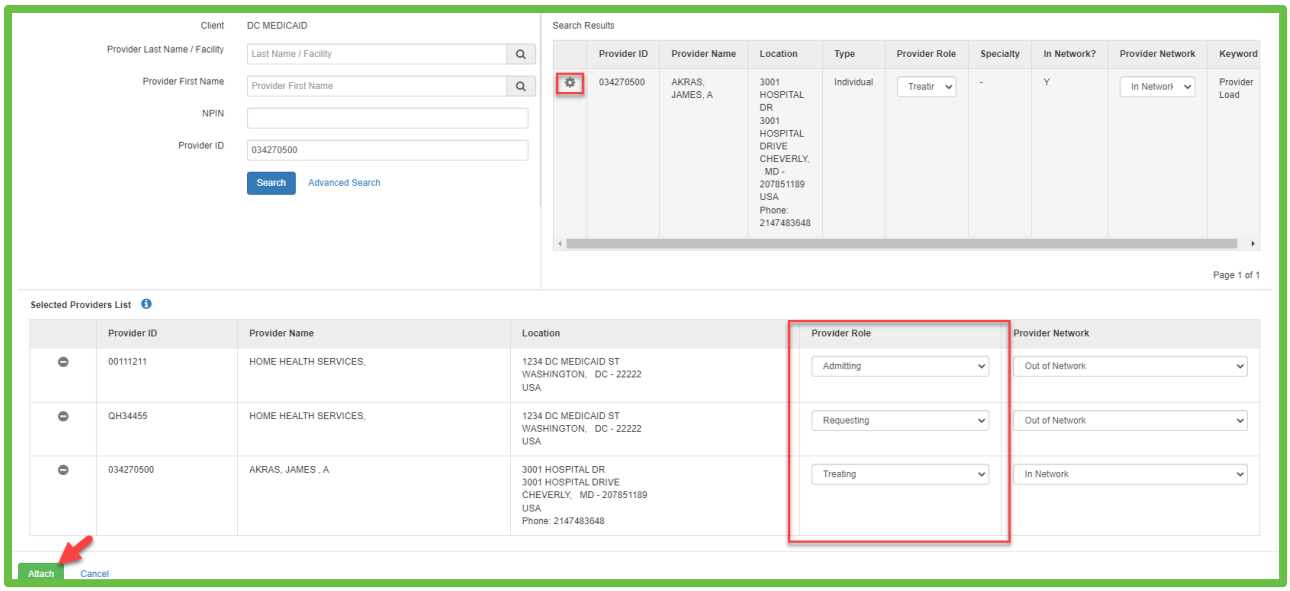
F. Click on the **gear** (⚙) under search results and choose **Multiple Attach**.

- The entry will remain there while you complete additional searches to complete your entries.
- When all entries are selected and you are ready to attach, select **Attach** at bottom left of the screen.
- If you prefer selecting **Single Attach** instead of **Multiple Attach**, this will allow you to attach one provider at a time. You will have to recomplete step C - forward for any additional entries.

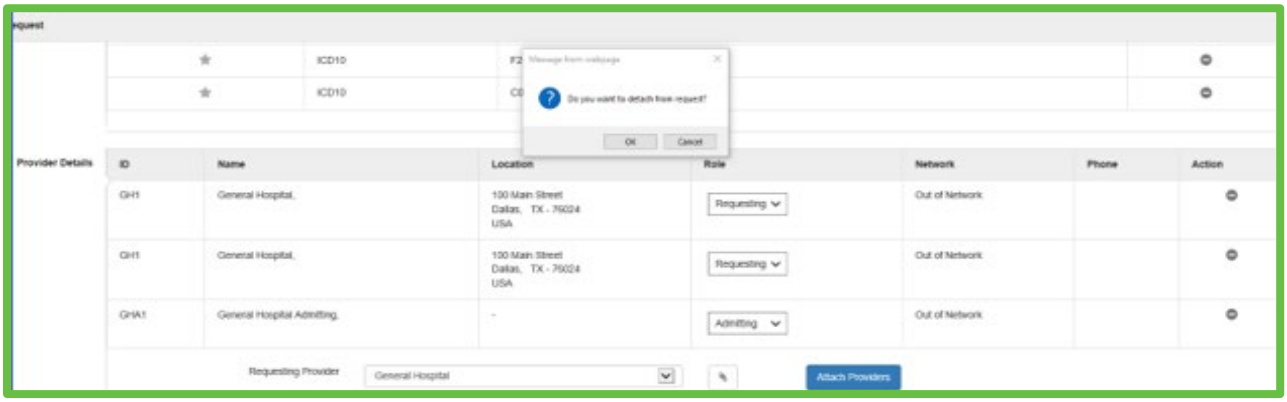
G. Select each **provider role** from the drop-down. They will appear under **Provider Details**.

- **Admitting**: PA is issued to the servicing provider on the 719A.
- **Treating**: The prescribing provider who also signs the 719A.
- **Requesting**: Ensure **CH ID** is selected; this allows access to the episode.

H. Once all providers have been selected then click on the green **Attach** button to save all providers.



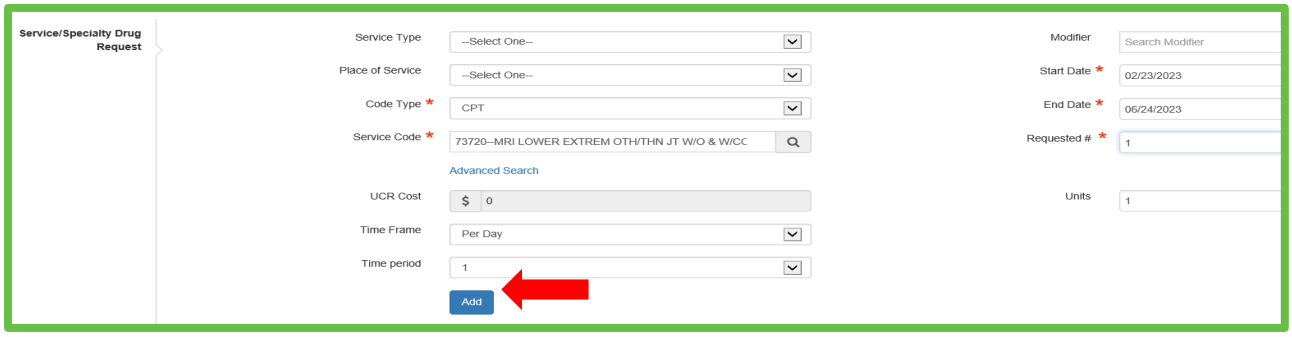
I. If a provider is selected in error, click the icon under **Action** to detach the provider. A pop-up message will ask, “Do you want to detach from request?” Click **OK**.



8) **Service/Specialty Drug Request** (OP only), enter the following information:
   A. **Service Type**: Leave blank.
   B. Place of Service: Leave blank.
   C. **Code Type***: Select appropriate code type (CPT).
   D. **Service Code***: Enter code or search for code; select code by clicking from drop-down box.
   E. **Time Frame**: Auto-populates to per day.
   F. **Time Period**: Leave blank.
   G. **Modifier**: Leave blank.
   H. **Start Date***: Enter MM/DD/YYYY or select from calendar.
   I. **End Date***: Auto-populates and can be modified up to 60 days for home health requests.
   J. **Requested #***: Enter number requested.

K. **Units**: Auto-populates to 1 and can be adjusted; must match requested number.

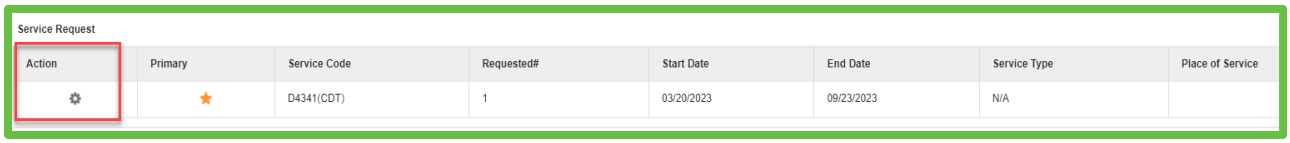
L. Click on the blue **Add** button.

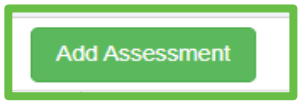


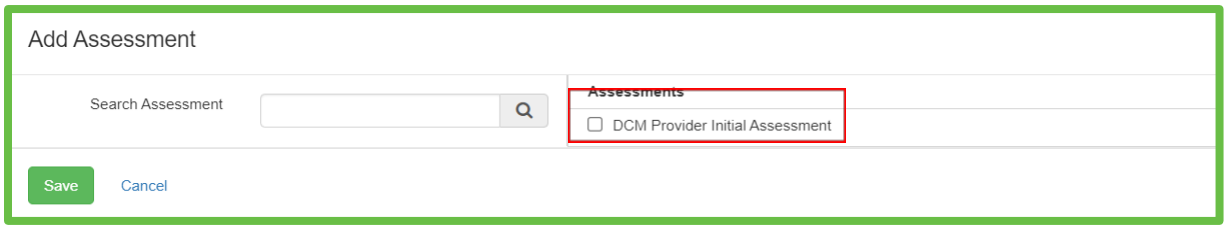
9) **Outpatient** (OP) **Service Request** view:

A. To edit a service request, click on the **gear icon** under **Action**. A new screen will open for edits.

B. To remove a service request, a box will open to confirm removal. Click **OK** to remove.

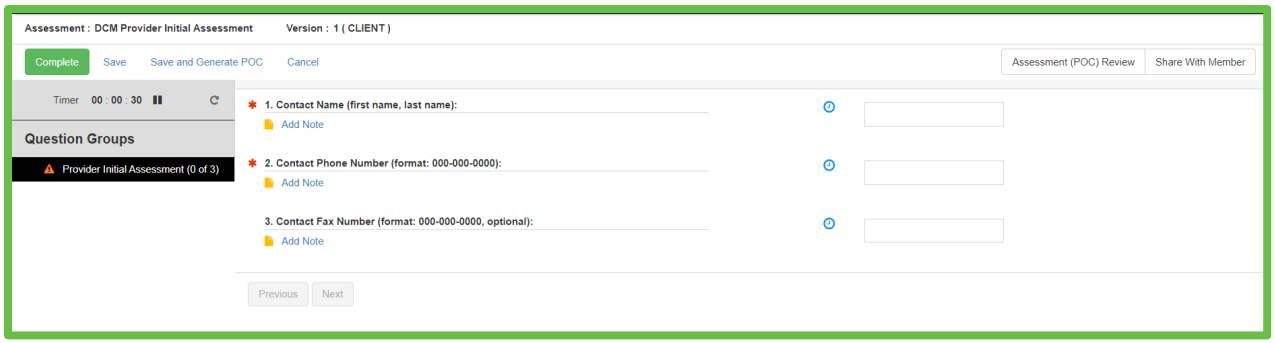


10) Add **Assessments**. Click on  the **Add Assessment** tab.



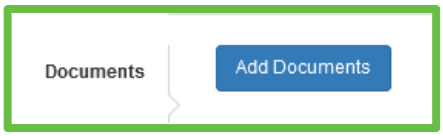
A. Select and complete the DCM Provider Initial Assessment.

- There are three questions in the **DCM Provider Initial Assessment**.
- Enter contact name, contact phone number, and contact fax.
- Always select **Complete** when finished with an assessment and not just **Save**.



11) In the **Documents** section:

A. Click on the blue **Add Documents**



button.

B. **Document Title***: Enter the name of the document being uploaded.

C. **Select Document***: Choose Browse and locate your document to upload.

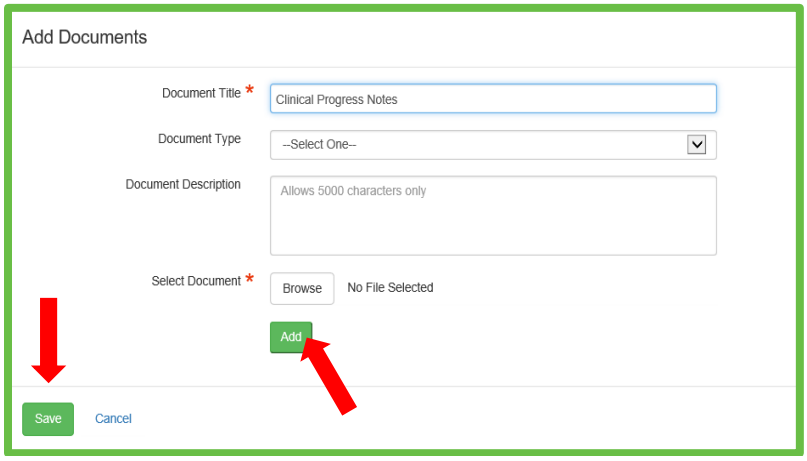
- Tip: Please only use PDF or DOC files.
- Tip 2: TIFF files will not be accepted and Comagine Health will ask for clinicals to be resubmitted in either PDF or DOC format.

D. Document Description: Can be left blank

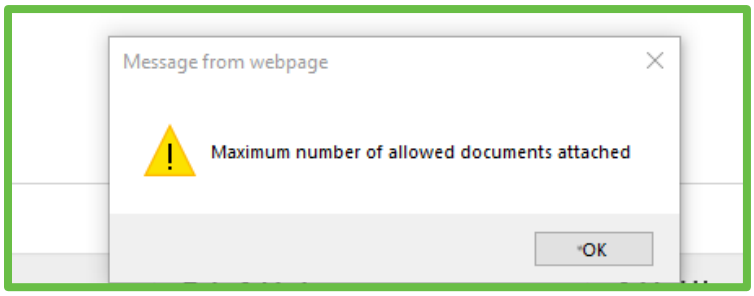
E. Once you have selected the document to be added, click the green **Add** button.

F. If you have multiple documents, please complete Steps A through E for each document.

G. Once all documents have been uploaded, select **Save**. If there are multiple documents, repeat the steps above.

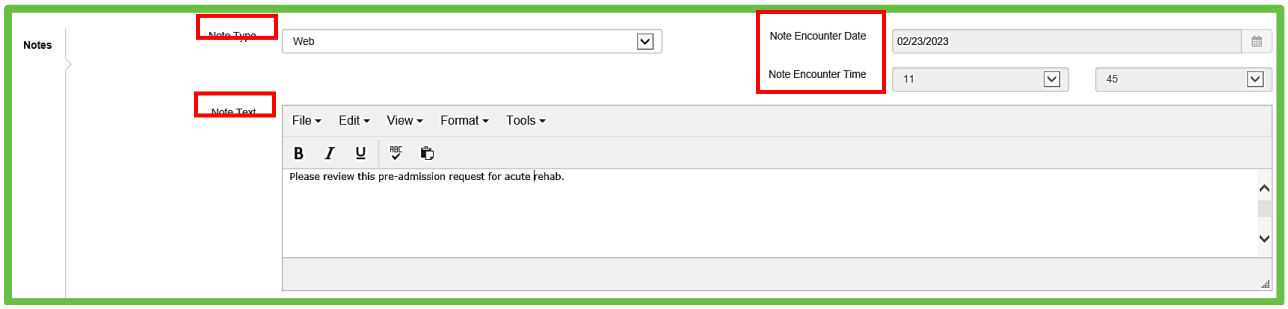


H. The maximum number of allowed documents attached is four (4). If you need to add more than this, you may either combine documents into one attachment, or attach additional documents after the request has been submitted. The process for this is outlined below in Step 14.



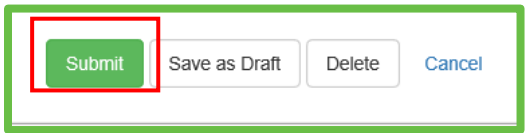
12) Under the **Notes** section, enter the following information:

A. **Note Type**: Auto-populates to **Web**.
B. **Note Text**: Add notes according to the request (i.e., additional information submitted).
C. **Note Encounter Date** and **Note Encounter Time**: Will auto-populate the date and time.
D. Click **Save**.

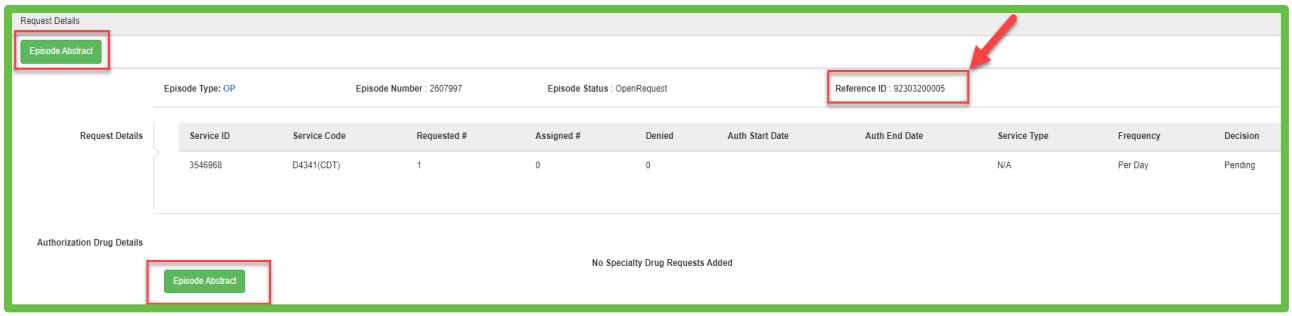


E. **Submit, save, or delete**. Review to ensure your entered information is correct and click **Submit**. It will ask you to confirm – click **OK**.

- **Submit**: Episode will be submitted to Comagine Health.
- **Save as Draft**: Episode will not be submitted to Comagine Health but will be saved as draft for later to edit.
- **Delete**: The request will be deleted.

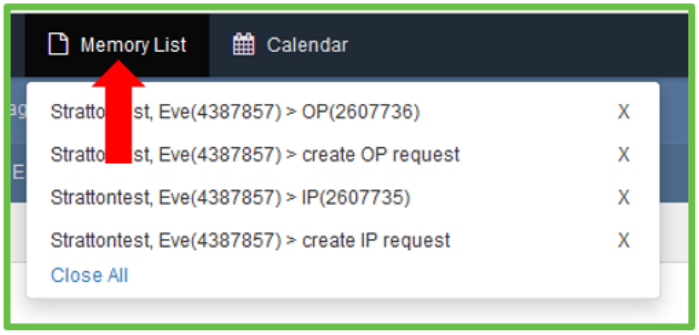


13) Make a note of the CHPP **Reference ID number** for your records to locate the episode faster.

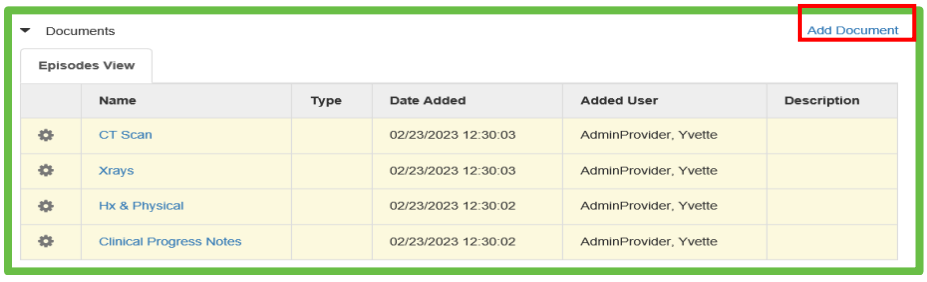


A. Selecting **Episode Abstract** here allows you to review what was submitted; however, you cannot edit from here.
B. You can print by selecting **Printable View** in the upper right corner on this screen.

14) If additional documents need to be submitted, locate the submitted episode by clicking on **Memory List** at the top of the screen, or by completing a search by clicking **Menu** and then **Search Request**.



A. Click on **Add Document** and follow the above step to add additional documents.



15) **Always go to the Memory List and close out all episodes.** This will ensure Comagine Health has access to review the submission. Click on the **x** next to the episodes or click **Close All** to clear the **Memory List**.



For CHPP TECHNICAL ASSISTANCE: 1-800-251-8890

CHPP LOG-ON LINK: https://comaginepp.zeomega.com

I.5 Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DME/POS)

The following are the steps for submitting Durable Medical Equipment (DME) Prior Authorization requests via the CHPP.

Steps

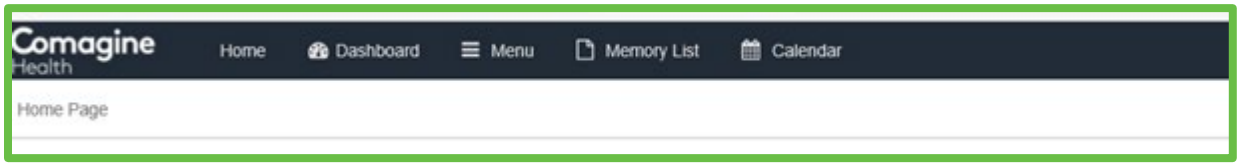
1) Main View:

A. **Home (Splash) Page** – Where Comagine Health posts provider announcements.

B. **Dashboard Menu** (**New Request** or **Search Request**) – Where work can be managed individually (through the **To Do** tab) or as a team (through **Team** tab).

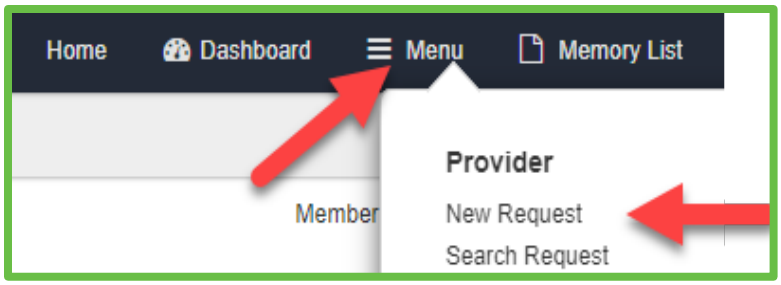
C. **Menu** – To start a New Request or Search for a request.

D. **Memory List** – Keeps a running list of the episodes viewed so they can be found easily while in the CHPP. Should be cleared out at the end of each session.



2) Submit a **New Request**:

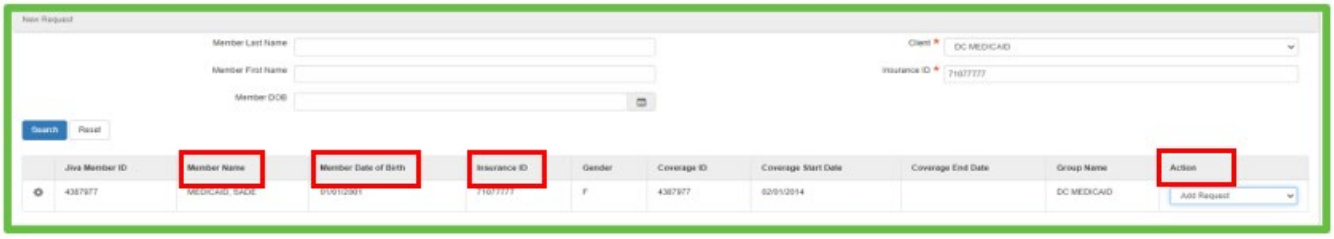
A. Click on **Menu** and select **New Request**.



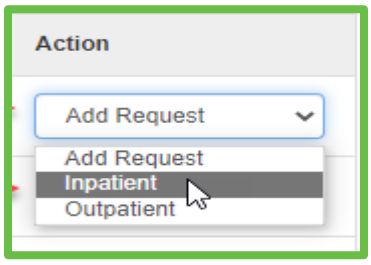
B. Client: Select DC MEDICAID.
C. Insurance ID: Enter Medicaid ID number, starting with 7.
D. Click on **Search**.



3) Medicaid Recipient **Search**:
   A. Verify correct Member Name, Date of Birth, and Medicaid Insurance ID.



4) Under **Action**, click where it says **Add Request** and select **Inpatient (IP)** from the drop-down menu.



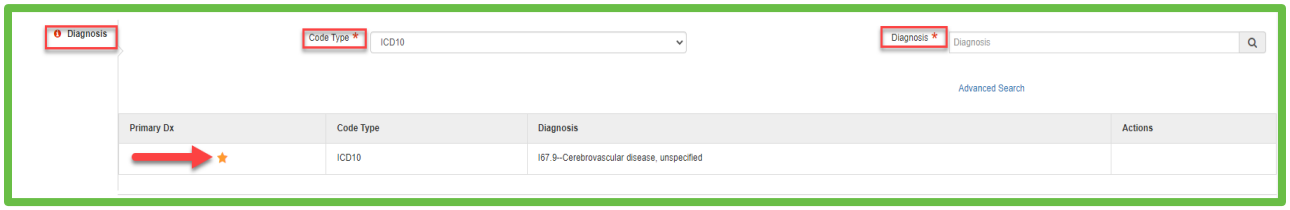
5) Fill out the **Episode Details** with the red asterisks, including the **Treatment Class**. For Outpatient requests complete:
   A. **Request Type***: Enter Prior Authorization.

B. **Time Request**: Does not need to be filled in, automatically populates to 1 day.
C. **Treatment Class**: Select N/A (this field MUST be completed even though an asterisk is not present).
D. **Request Priority***: Will auto-populate with Non-Urgent.
E. Treatment Type*: Select SPECIFIC DME/POS, or DME MADS.



6) Fill out the **Diagnosis** section:
A. For the **Code Type***: ICD10 will auto-populate.
B. Under **Diagnosis***: Only enter one diagnosis at a time.

- The diagnosis codes will appear in a drop-down menu as you start typing and can then be selected.
- Example: I67.9 will appear below and can be selected by clicking on it.
- If there are multiple diagnoses, the primary diagnosis (**Primary Dx**) can be amended by selecting the **yellow star** on the **Primary Dx** line.



7) Fill out the **Provider Details** section.
A. To add your Organization, click the **paperclip** beside the **Requesting Provider** dropdown underneath **Provider Details**.

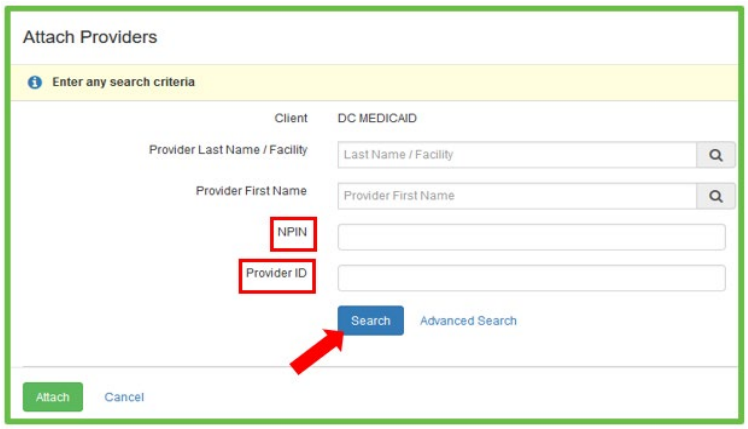
- This entry is required for users to access the case via the Provider Portal and receive updates on status from Comagine Health.

B. After adding your Organization, please select **Attach Providers** by clicking on the blue **Attach Providers** button to the right of the paperclip.

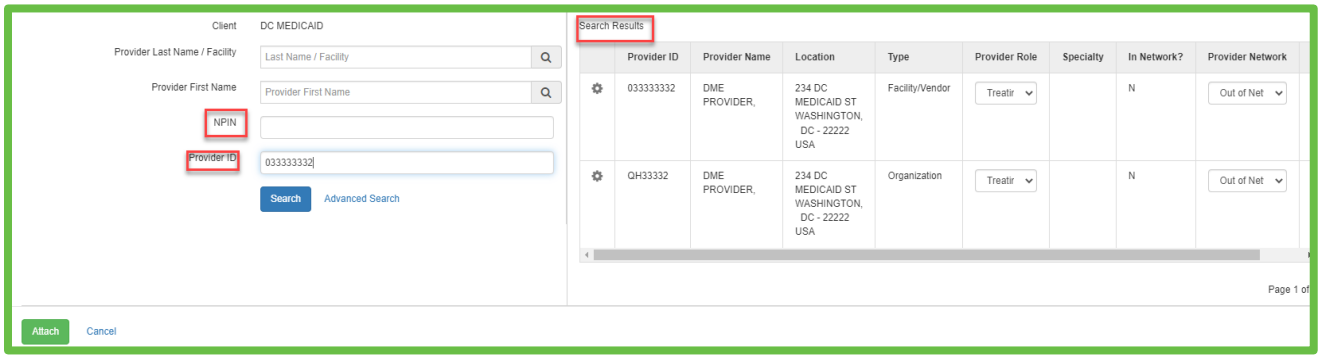


C. Once selected, you will see the screen below. You can do a basic **Search** or **Advanced Search** for Providers. Enter the **DC Medicaid Provider ID** that starts with a zero, or the **National Provider Identification Number (NPIN)**.

- For facility/vendors and Individual selections, searching for the **Medicaid Provider ID** or the **NPIN** may help narrow requests versus searching by last name.
- An errant search will trigger you to call Comagine Health for assistance. You may do so or attempt your search again using different parameters.



D. Click **Search**. The search results for the agency will appear on the right.



E. Each provider entry must be paired with a specific **provider role** selected from the drop-down contained inside the **Provider Role** column within the search result itself.

- Facility/vendor is always paired with **Admitting**.

- Individual is always paired with **Treating**.
- Organization is always paired with **Requesting**.

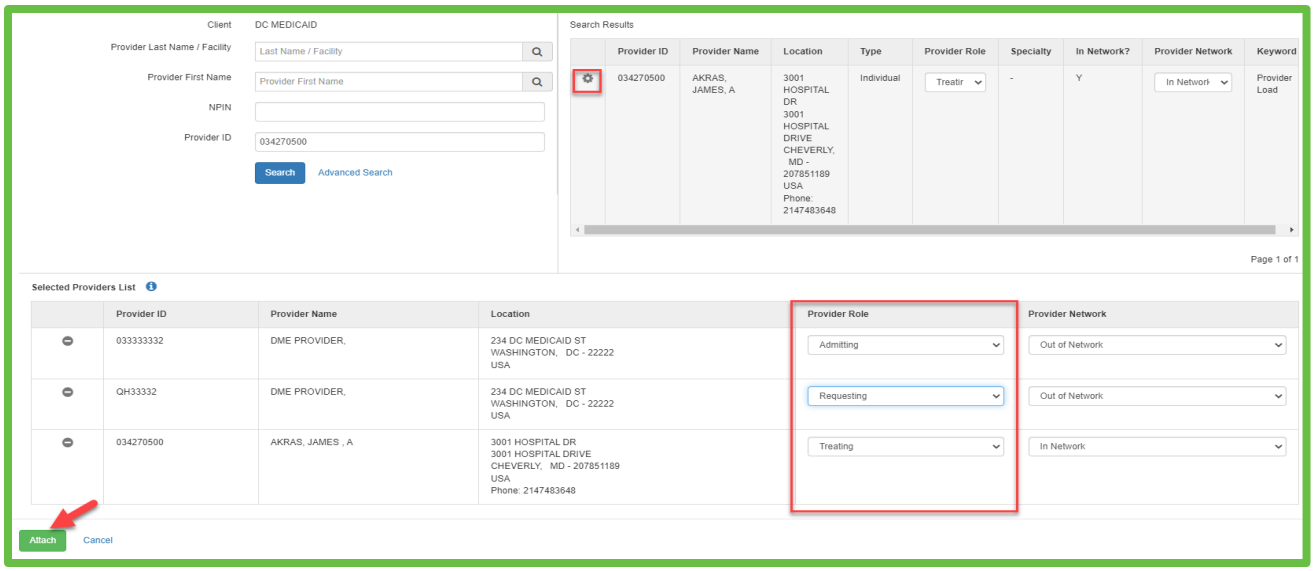
F. Click on the **gear** ( ) under search results and choose **Multiple Attach**.

- The entry will remain there while you complete additional searches to complete your entries.
- When all entries are selected and you are ready to attach, select **Attach** at bottom left of the screen.
- If you prefer selecting **Single Attach** instead of **Multiple Attach**, this will allow you to attach one provider at a time. You will have to recomplete step C - forward for any additional entries.

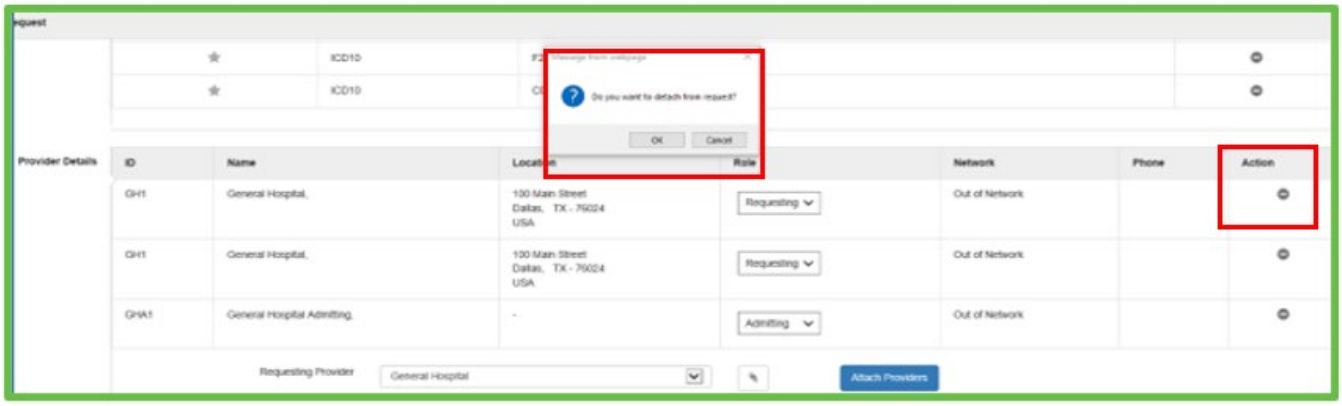
G. Select each provider role from the drop-down.

- **Admitting**: PA is issued to, also the servicing provider on the 719A.
- **Treating**: the prescribing provider who also signs the 719A.
- **Requesting**: Ensure QH ID is selected; this allows access to the episode.

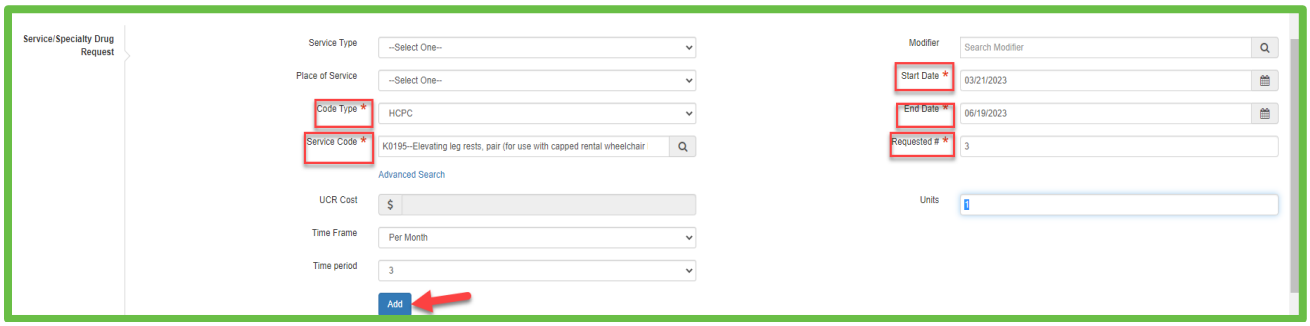
H. Once all providers have been selected, click on the green **Attach** button to save.



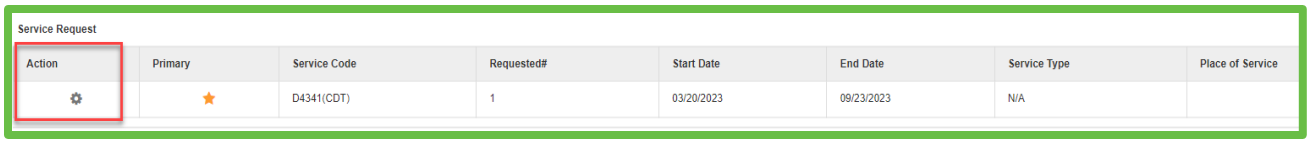
I. If a provider is selected in error, click the icon under **Action** to detach the provider; a pop-up message will ask, “Do you want to detach from request?” Click **OK**.

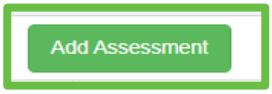


8) **Service/Specialty Drug** Request (OP only):
   A. **Service Type**: Leave blank.
   B. Place of Service: Leave blank.
   C. **Code Type***: Select appropriate code type (CPT).
   D. **Service Code***: Enter code or search for code, select code by clicking from drop-down box.
   E. **Time Frame**: Auto-populates to per day.
   F. **Time Period**: Leave blank.
   G. **Modifier**: Leave blank.
   H. **Start Date***: Enter MM/DD/YYYY or select from calendar.
   I. **End Date***: Auto-populates and can be modified up to 3 months for DME requests.
   J. **Requested #***: Enter number requested.
   K. **Units**: Auto-populates to 1 and can be adjusted, must match requested number.
   L. Click on the blue **Add** button.

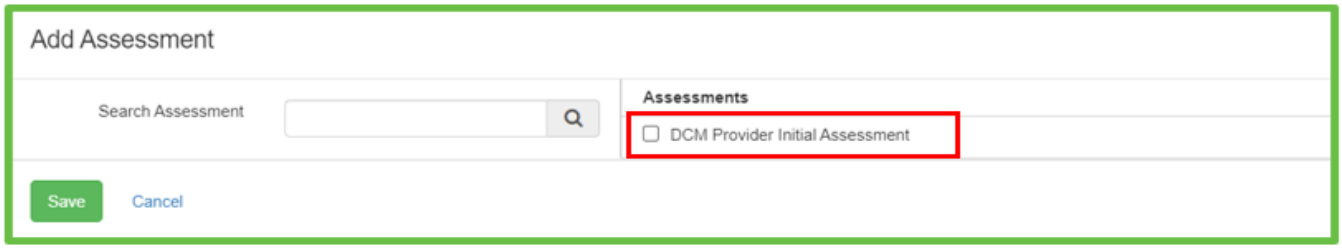


9) **Outpatient** (OP) **Service Request** view:
   A. To edit a service request, click on the **Gear** under **Action**. A new screen will open for edits.
   B. To remove a service request, a box will open to confirm you want to remove, click **OK** to remove.



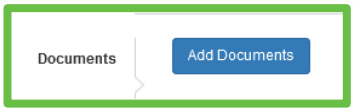
10) Add **Assessments**. Click on the green  **Add Assessment** button.

A. Select and complete the DCM Provider Initial Assessment.

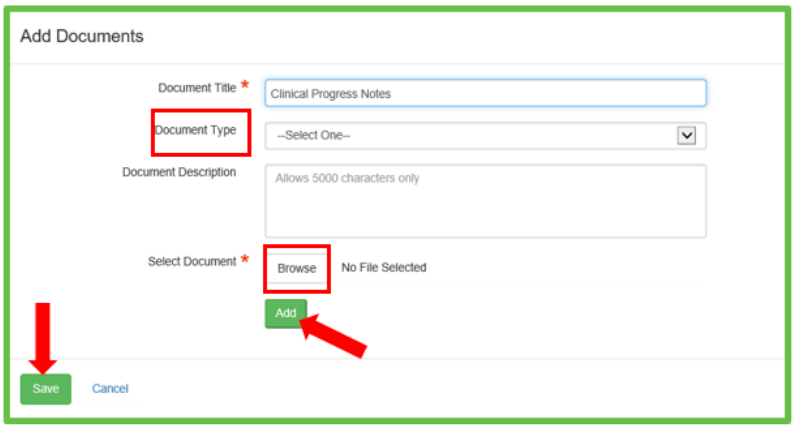


- There are three questions in the **DCM Provider Initial Assessment**.
- Enter Contact Name, Contact Phone Number, and Contact Fax.
- Always select **Complete** when finished with an assessment and not just Save.



11) In the **Documents** section: 

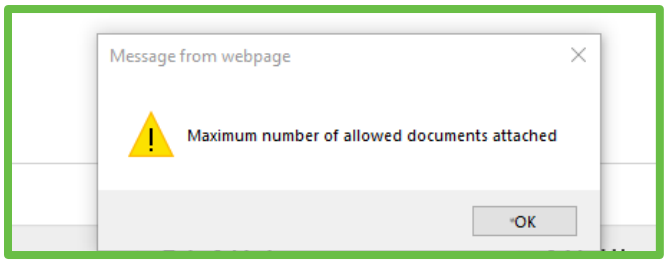
A. Click on the blue **Add Documents** button.
B. **Document Title***: Enter the name of the document being uploaded.
C. **Document Type** and **Description**: Can be left blank.
D. **Select Document***: Choose Browse and locate your document to upload.
   - Tip: Please only use PDF or DOC files.
   - Tip 2: TIFF files will not be accepted and Comagine Health will ask for clinicals to be resubmitted in either PDF or DOC format.
E. Once you have selected the document to be added, click the green **Add** button.



F. If you have multiple documents, please complete step A through E for each document.

G. Once all documents have been uploaded, select **Save**.

H. The maximum number of allowed documents attached is four (4). If the number of uploaded documents exceeds four an error message will appear (see below). Click **OK**. If you need to add more than this, you may either combine documents into one attachment, or attach additional documents after the request has been submitted. The process for this is outlined below in Step 15.



12) Under the **Notes** section, enter the following information:

A. **Note Type**: Auto Populates to Web.

B. **Note Text**: Add notes according to the request (i.e., additional information submitted).

C. **Note Encounter Date** and **Note Encounter Time**: Will auto-populate the date and time.

D. Click **Save**.

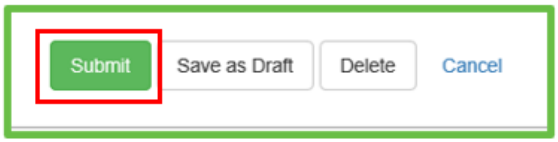


13) **Submit, save, or delete**.

A. **Submit**: Episode will be submitted to Comagine Health. Review to ensure your entered information is correct and click Submit. It will ask you to confirm – click OK.

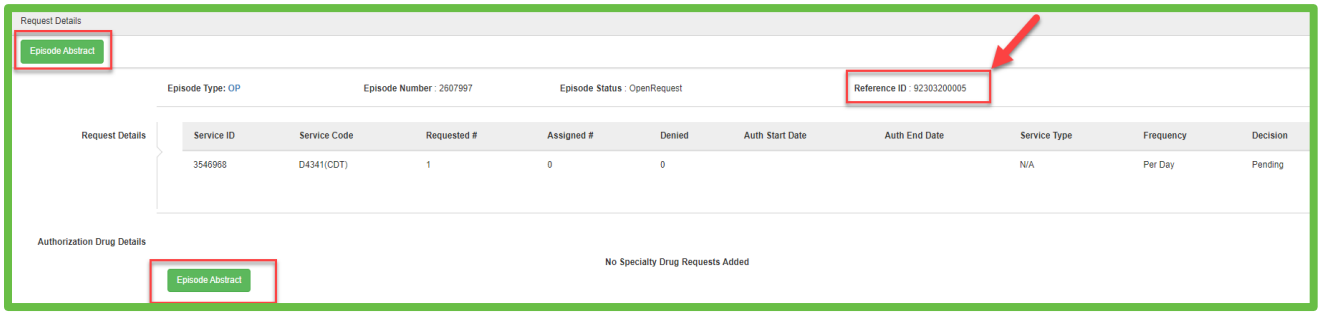
B. **Save as Draft**: Episode will not be submitted to Comagine Health but will be saved as draft for later to edit.

C. **Delete**: The request will be deleted.

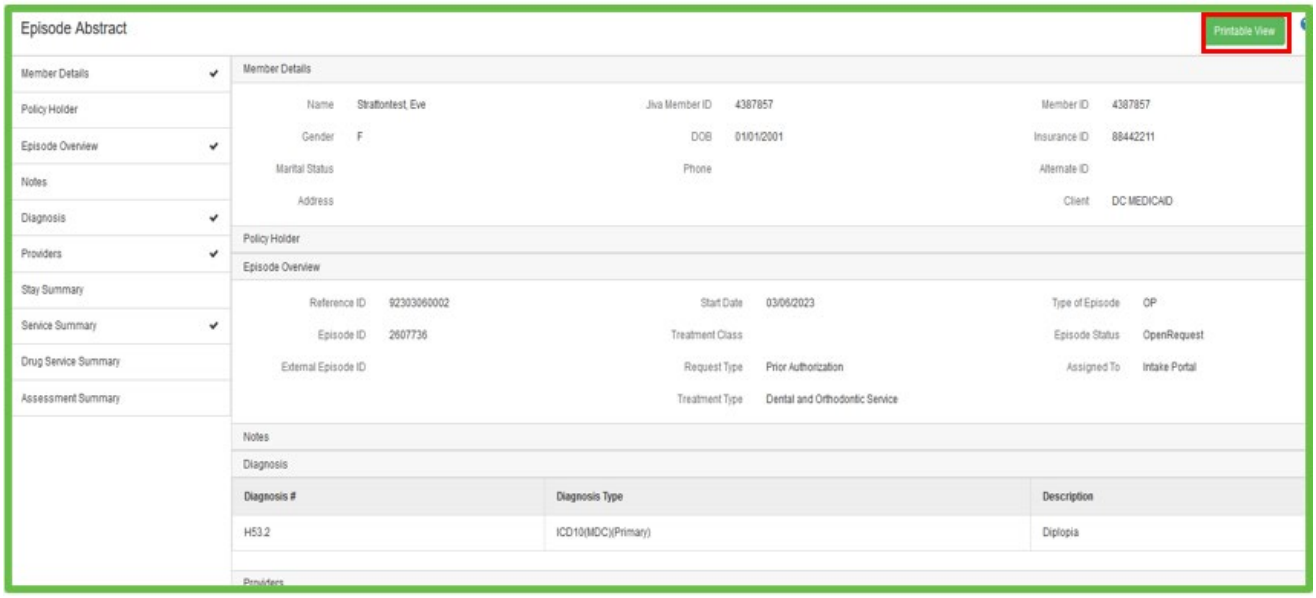


14) Make a note of the CHPP **Reference ID number** for your records to locate the episode faster.

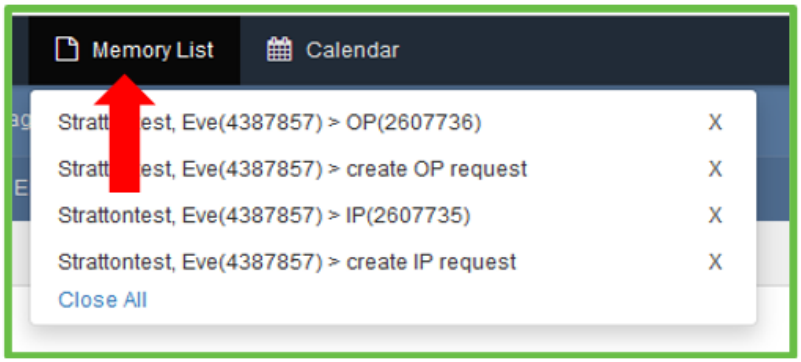
A. Selecting **Episode Abstract** here allows you to review what was submitted; however, you cannot edit from here.



B. You can print by selecting **Printable View** button in the top right corner.

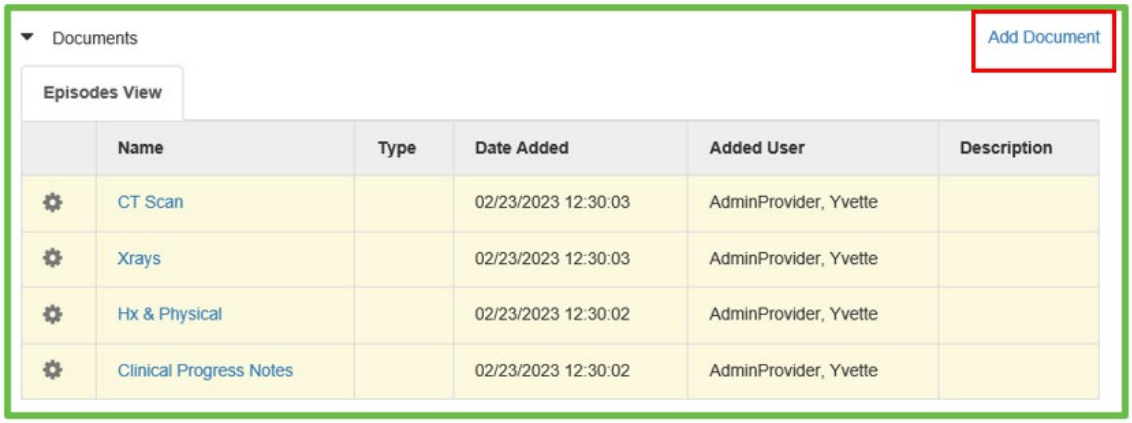


15) If you need to submit additional documents, go to the **Memory List** at the top of the screen.



A. Either select the episode you were working on in the **Memory List** or search for the **Reference ID** in the **Search Request**.

B. Click on **Add Document** and follow Step 11 above to add additional documents.



16) Always go to the **Memory List** and close out all episodes. This will ensure Comagine Health has access to review your submission. Click on the **x** next to the episodes or click **Close All** to clear the **Memory List**.



Required Documents for Home Health

- A DC Medicaid-approved 719A form, completed in its entirety to include frequency, duration, and number of units requested and signed by a physician, nurse practitioner, or physician assistant.
- Any pertinent supporting clinical documentation.
- Supporting clinical documentation: An independent manufacturer's price quote - cannot be the same as the requesting provider, if using a miscellaneous code.

For CHPP TECHNICAL ASSISTANCE: 1-800-251-8890

CHPP LOG-ON LINK: https://comaginepp.zeomega.com

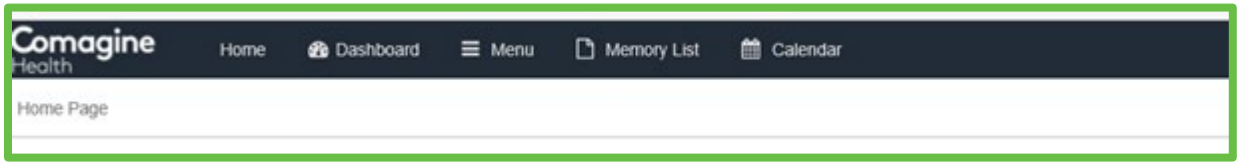
I.6 Dental & Orthodontic Service

The following are the steps for submitting Dental and Orthodontic Prior Authorization requests via the CHPP.

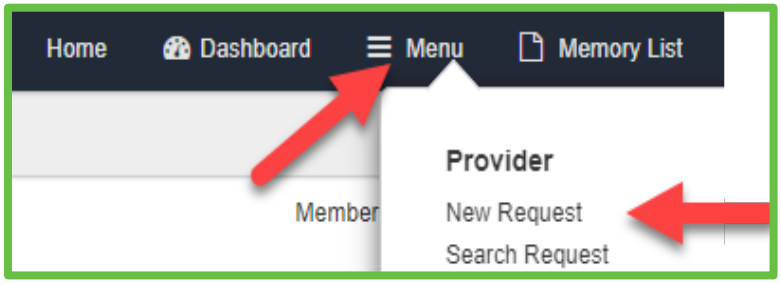
Steps

1) Main View:

A. **Home (Splash) Page** – Where Comagine Health posts provider announcements.
B. **Dashboard Menu** (**New Request** or **Search Request**) – Where work can be managed individually (through the **To Do** tab) or as a team (through **Team** tab).
C. **Menu** – To start a New Request or Search for a request.
D. **Memory List** – Keeps a running list of the episodes viewed so they can be found easily while in the CHPP. Should be cleared out at the end of each session.



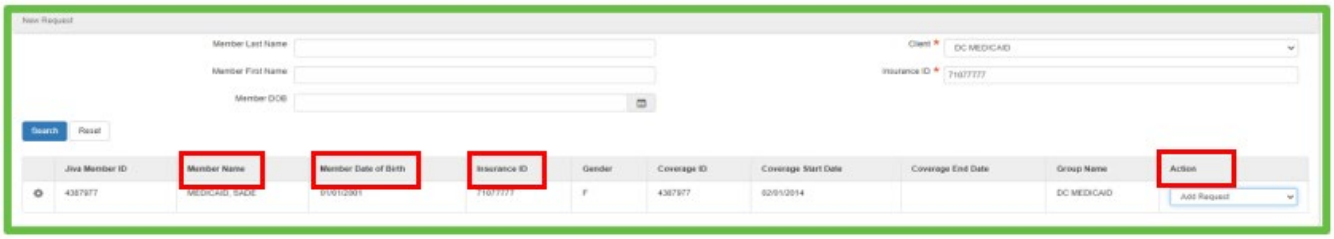
2) Submit a **New Request**:
   A. Click on **Menu** and select **New Request**.



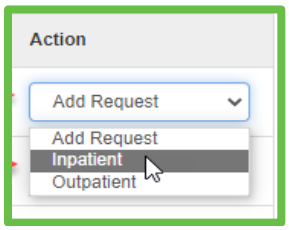
   B. Client: Select DC MEDICAID.
   C. Insurance ID: Enter Medicaid ID number, starting with 7.
   D. Click on **Search**.



3) Medicaid Recipient **Search**:
   A. Verify correct Member Name, Date of Birth, and Medicaid Insurance ID.



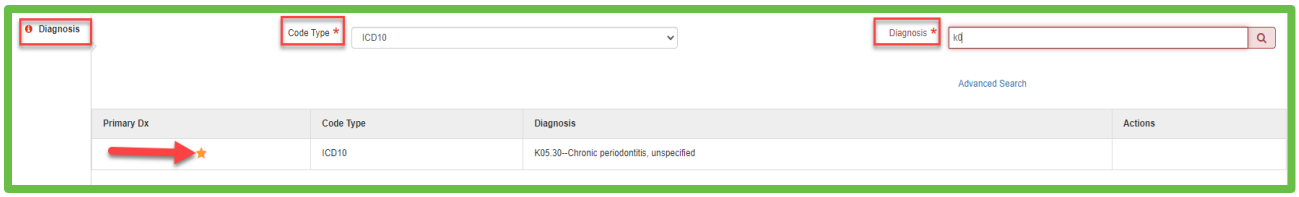
4) Under **Action**, click where it says **Add Request** and select **Outpatient** (OP) from the drop-down menu.



5) Fill out the **Episode Details** with the red asterisks, including the **Treatment Class**. For Outpatient requests complete:
   A. Request Type*: Select Prior Authorization.
   B. **Time Request**: Does not need to be filled in.
   C. **Treatment Class**: Select **N/A** (this field MUST be completed even though an asterisk is not present).
   D. **Request Priority***: Will also auto-populate with Non-Urgent.
   E. Treatment Type*: Select Dental and Orthodontic Service.

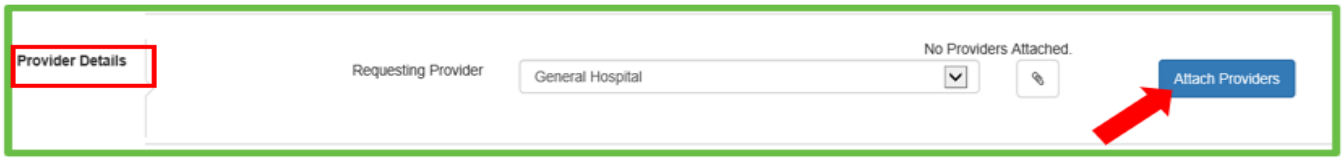


6) Fill out the **Diagnosis** section:
   A. For the **Code Type***: ICD10 will auto-populate.
   B. Under **Diagnosis***: Only enter one diagnosis at a time.
      - The diagnosis codes will appear in a drop-down menu as you start typing and can then be selected.
      - Example: K05.30 will appear below once you select it by clicking on it.
      - If there are multiple diagnoses, the primary diagnosis (**Primary Dx**) can be amended by selecting the **yellow star** on the **Primary Dx** line.

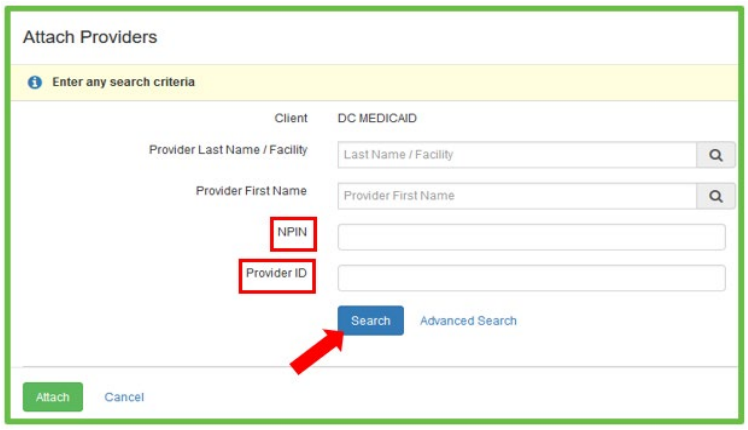


7) Complete the **Provider Details** section.

- To add an organization, click the **paperclip icon** beside the **Requesting Provider** drop-down menu underneath **Provider Details**.
- This entry is required for users to access the case via the CHPP and receive updates on status from Comagine Health.
- After adding the organization, please select **Attach Providers** by clicking on the blue **Attach Providers** button to the right of the paperclip.

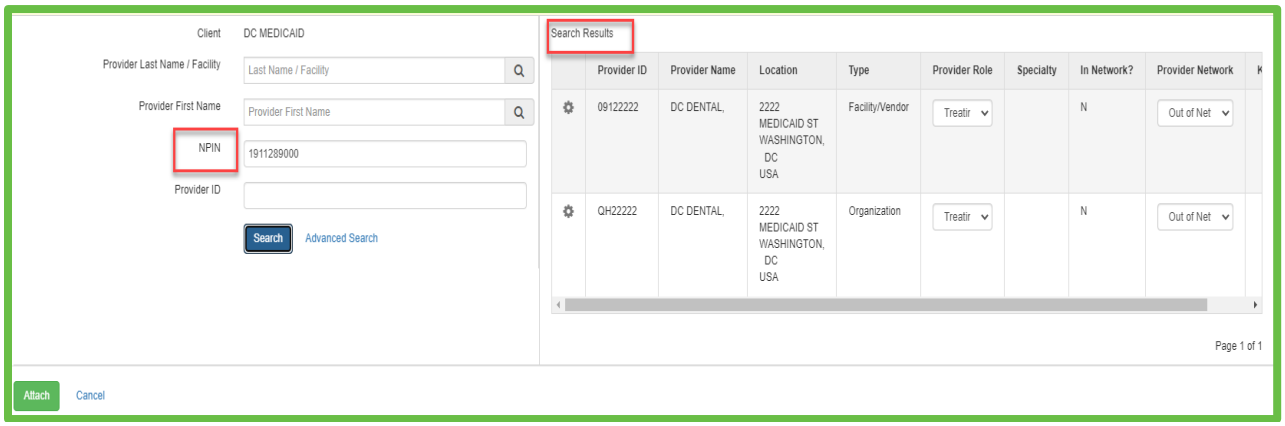


C. Once selected, you will see the screen below. You can do a basic **Search** or **Advanced Search** for Providers. Enter the **DC Medicaid Provider ID** that starts with a zero, or the **National Provider Identification Number (NPIN)**.
   - For facility/vendors and individual selections, searching for the **Medicaid Provider ID** or the **NPIN** may help narrow the requests rather than searching by a last name.



   - An errant search will trigger you to call Comagine Health for assistance. You may do so or attempt your search again using different parameters.

D. Click **Search**. The search results for the agency will appear on the right.

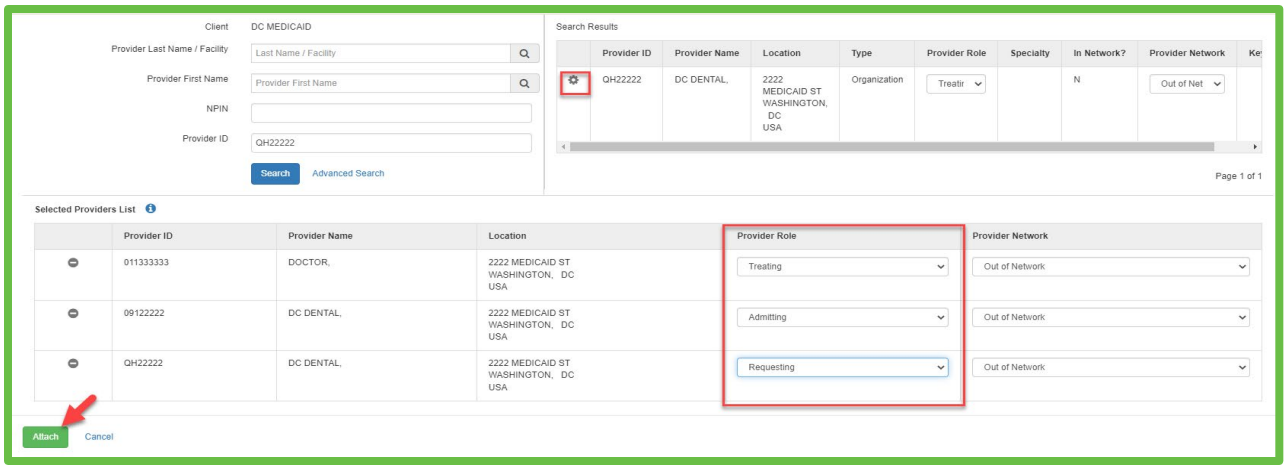


E. Each provider entry must be paired with a specific **provider role** selected from the drop-down menu contained inside the **Provider Role** column within the search result itself. Tip: Disregard the Provider Network drop-down.
   - Facility/vendor is always paired with **Admitting**.
   - Individual is always paired with **Treating**.
   - Organization is always paired with **Requesting**.

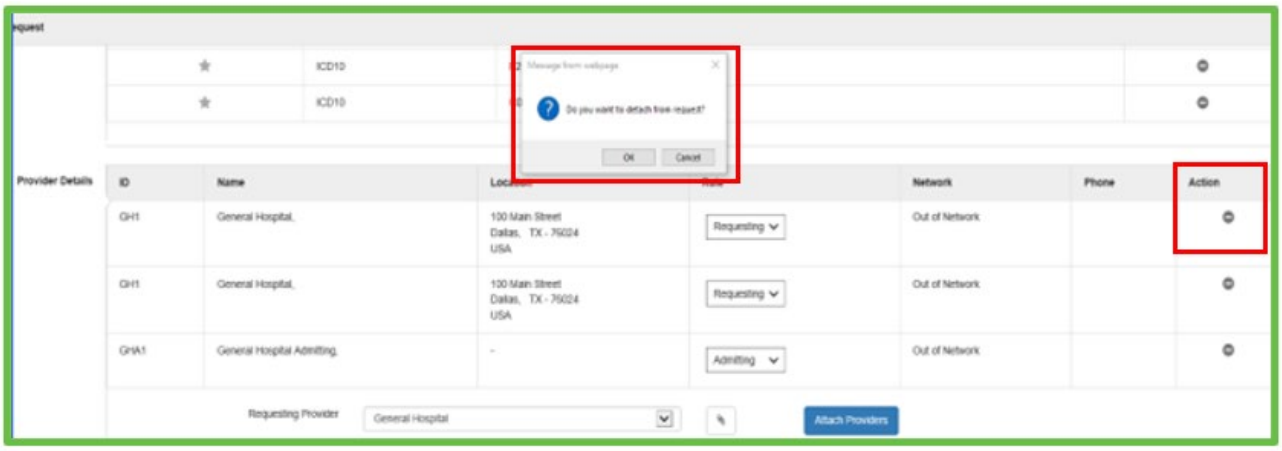
F. Click on the **gear icon** (⚙) under search results and choose **Multiple Attach**.
   - The list of providers will appear under **Selected Provider's List**.
   - The entry will remain there while you complete additional searches to complete your entries.
   - When all entries are selected and you are ready to attach, select **Attach** from the bottom left of the screen.
   - If you prefer selecting **Single Attach** instead of **Multiple Attach**, this will allow you to attach one provider at a time. You will have to recomplete Step C - forward for any additional entries.

G. Select each provider role from the drop-down menu.
   - **Admitting**: PA is issued to, also the servicing provider on the 719A.
   - **Treating**: The prescribing provider who also signs the 719A.
   - **Requesting**: *Ensure **CH ID** is selected; this allows access to the episode*

H. Once all providers have been selected, then click on the green **Attach** button to save all providers.

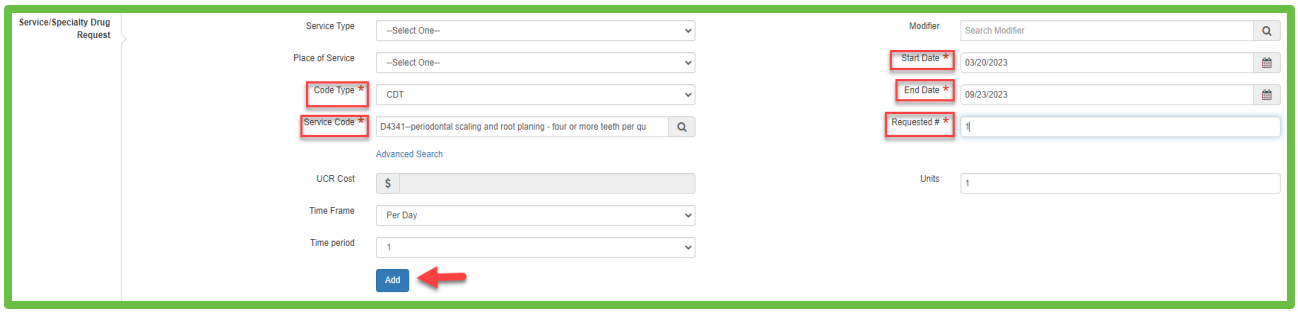


I. If a provider is selected in error, click the icon under **Action** to detach the provider. A pop-up message will ask, "Do you want to detach from request?" Click **OK**.



8) **Service/Specialty Drug Request** (Outpatient only):
   A. **Service Type**: Leave blank.
   B. **Place of Service**: Leave blank.
   C. **Code Type***: Select appropriate code type (CPT).
   D. **Service Code***: Enter code or search for code; select code from drop down box.
   E. **Time Frame**: Auto-populates to per day.
   F. **Time Period**: Leave blank.
   G. **Modifier**: Leave blank.
   H. **Start Date***: Enter MM/DD/YYYY or select from calendar.
   I. **End Date***: Auto-populates and can be modified up to 6 months for dental requests.
   J. **Requested #***: Enter number requested.
   K. **Units**: Auto-populates to 1 and can be adjusted; must match requested number.

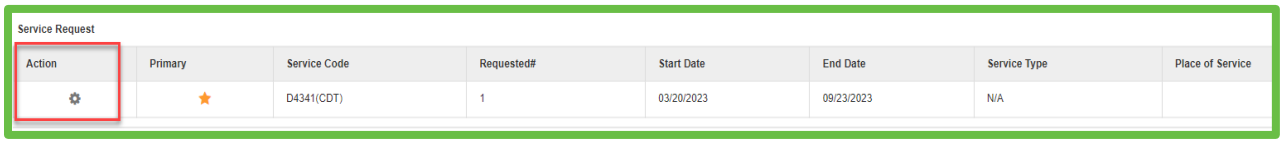
L. Click on the blue **Add** button.

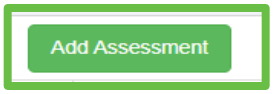


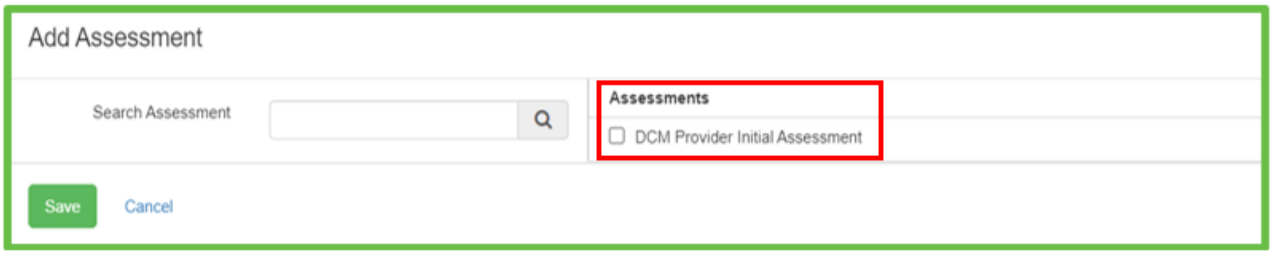
9) **Outpatient** (OP) **Service Request** view:

A. To edit a service request, click on the **gear icon** (⚙) under **Action**. A new screen will open for edits.

B. To remove a service request, a box will open to confirm you want to remove it, click **OK** to remove.



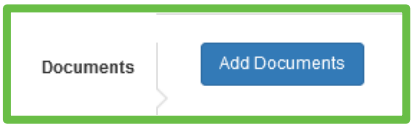
10) Add **Assessments**. Click on the green **Add Assessment**  tab.



A. Select and complete the **DCM Provider Initial Assessment**.

- There are three questions in the **DCM Provider Initial Assessment**.
- Enter **Contact Name**, **Contact Phone Number**, and **Contact Fax**.
- Always select **Complete** when finished with an assessment and not just **Save**.





11) In the **Documents** section:

A. Click on the blue **Add Documents** button.

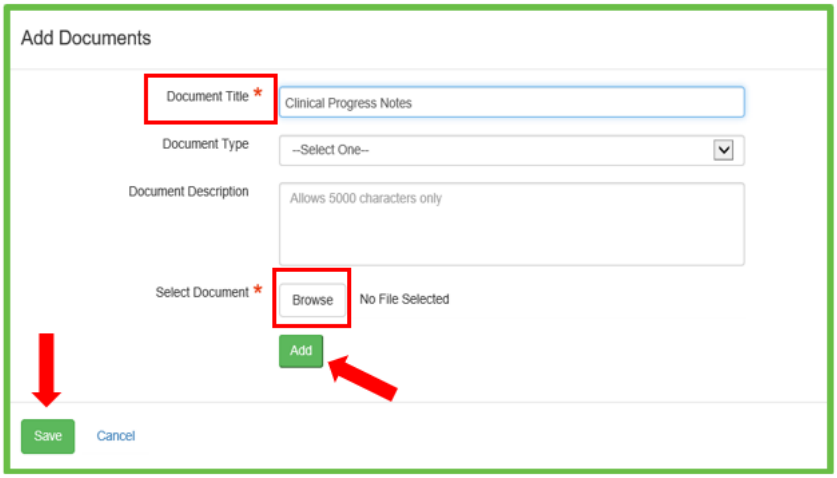
B. **Document Title***: Enter the name of the document being uploaded.

C. **Document Type** and **Description**: Can be left blank.

D. **Select Document***: Choose Browse and locate the document to upload.

- Tip: Please only use PDF or DOC files.
- Tip 2: TIFF files will not be accepted and Comagine Health will ask for clinicals to be resubmitted in either PDF or DOC format.

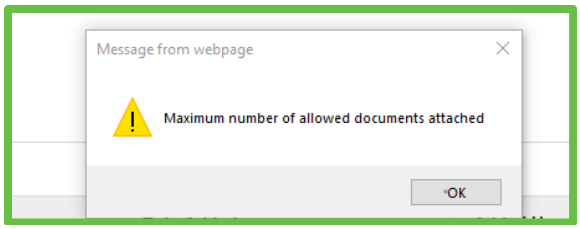
E. Once you have selected the document to be added, click the green **Add** button.



F. If you have multiple documents, please complete step A through E for each document.

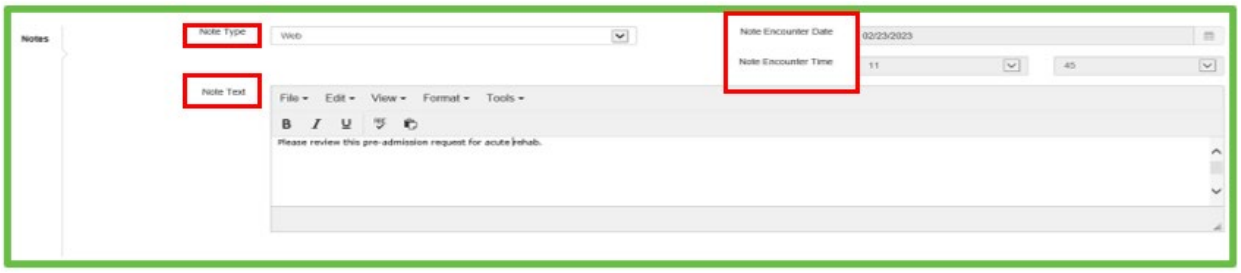
G. Once all documents have been uploaded, select **SAVE**.

H. The maximum number of allowed documents that can be attached is four (4). If the number of uploaded documents exceeds four an error message will appear (see below). Click **OK**. If you need to add more than this, you may either combine documents into one attachment, or attach additional documents after the request has been submitted. The process for this is outlined below in Step 15.



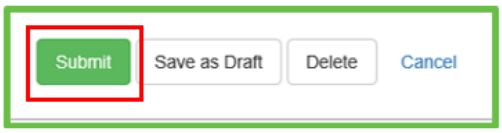
12) Under the **Notes** section, enter the following information:

A. **Note Type**: Will auto-populate to **Web**.
B. **Note Text**: Add notes according to the request (i.e., additional information submitted).
C. **Note Encounter Date** and **Note Encounter Time**: Will auto-populate the date and time.
D. Click **Save**.



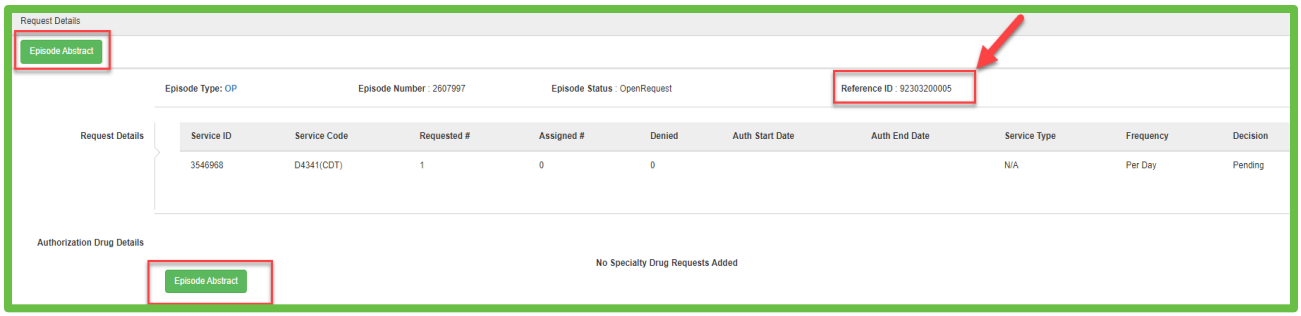
13) **Submit, save, or delete**.

A. **Submit**: Episode will be submitted to Comagine Health. Review to ensure your entered information is correct and click **Submit**. It will ask you to confirm – click **OK**.
B. **Save as Draft**: Episode will not submit to Comagine Health; but will be saved as draft for later to edit.
C. **Delete**: The request will be deleted.

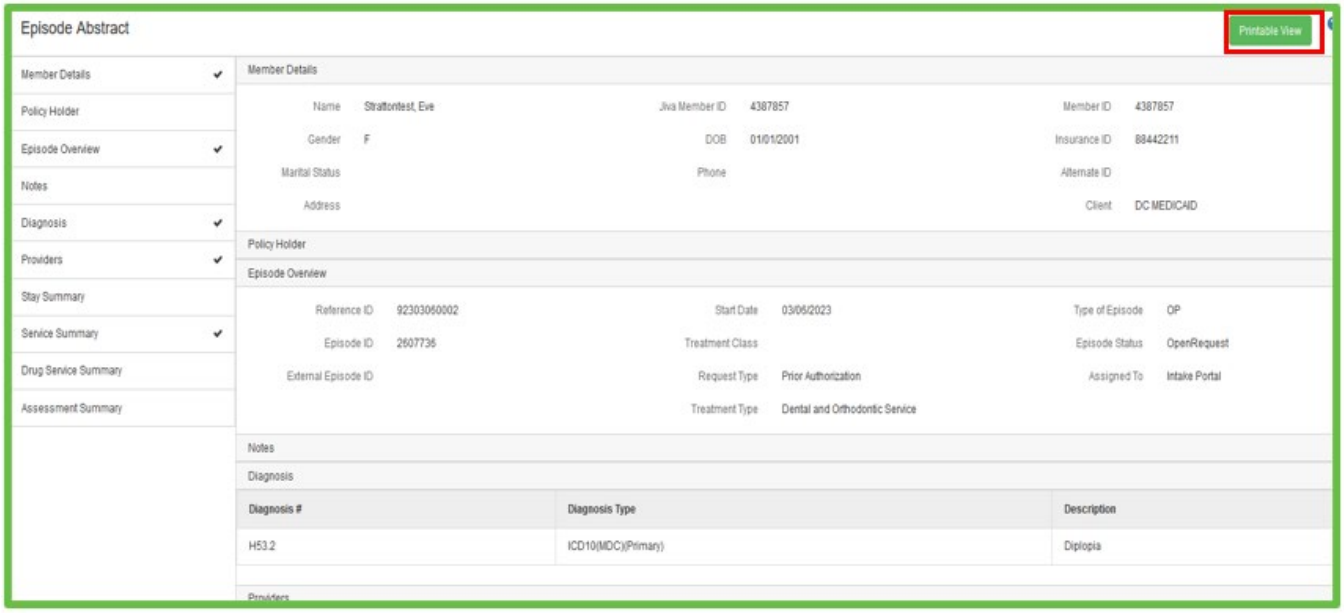


14) Make a note of the CHPP **Reference ID number** for your records to locate the episode faster.

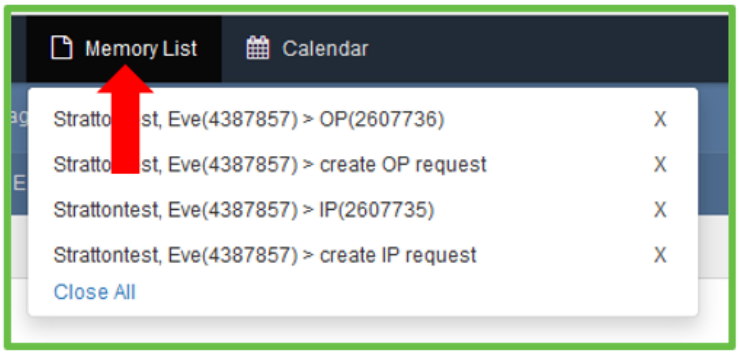
A. Selecting **Episode Abstract** here allows you to review what was submitted; however, you cannot edit from here.



B. You can print by selecting **Printable View** in the upper right corner on this screen.

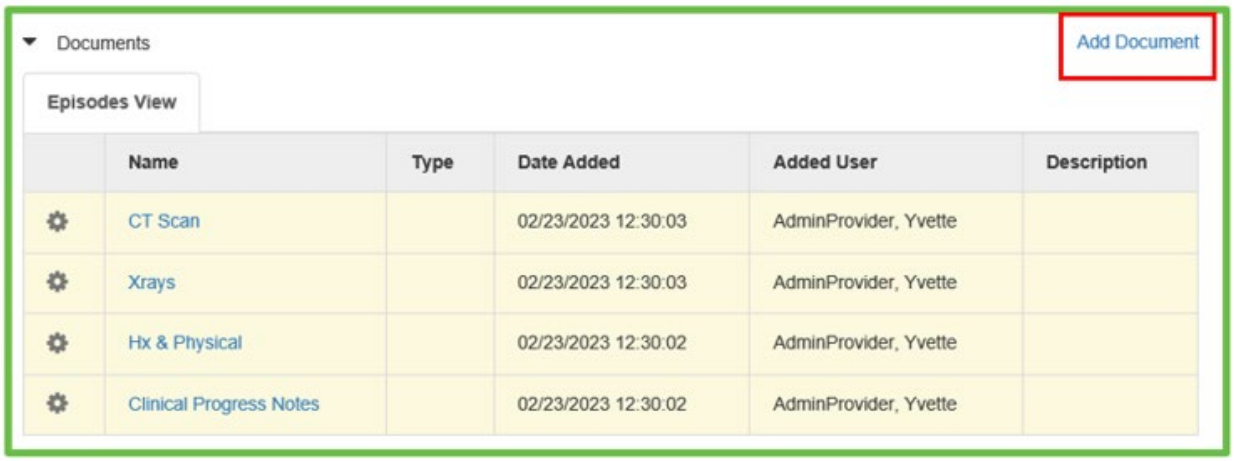


15) If additional documents need to be submitted, locate the submitted episode by clicking on **Memory List** at the top of the screen, or by completing a search by clicking **Menu** and then **Search Request**.



A. Select the episode you were working on in the **Memory List** or search for the **Reference ID** in the **Search Request**.

B. Click on **Add Document** and follow Step 11 above to add additional documents.



16) Always go to the **Memory List** and close out of all episodes. This will ensure Comagine Health has access to review your submission. Click on the **x** next to the episodes or click **Close All** to clear the **Memory List**.



Required Documents for Dental Reviews

- Include a 719A form – the appropriate descriptions of the dental service, summary reason regarding the nature of the question and the dental procedure code on the 719A form used to request prior authorization.
- DC Medicaid-approved 719A form completed in its entirety to include duration and number of units requested for the respective service.
- The 719A form is to include a dental diagnosis (ICD-10 code) related to the need for the dental service.
- A brief summary justification regarding the services requested.
- Letter of necessity for a beneficiary with cognitive, physical, or psychologically impairment.
- Anesthesia request –submit on the 719A form the service codes that are related to the anesthesia request. Include the anesthesia code and anesthesia licensure number on the 719A form.

- X-ray(s), dental CBCT scan if applicable, Panorex, periodontal charting and pictures must include (the date of service, name, and date of birth of the beneficiary).
- Supporting clinical documents/medical history.

For CHPP TECHNICAL ASSISTANCE: 1-800-251-8890
CHPP LOG-ON LINK: https://comaginepp.zeomega.com