

PREDETERMINATIONS

OVERVIEW

Predetermination (also known as prior authorization) is the process of obtaining information about anticipated coverage and payment for a treatment plan before the treatment is started.

Predetermination can be sought for any treatment plan, but providers should predetermine treatment plans for adults particularly when the recommended services are subject to limitations, i.e. dentures. i By predetermining the treatment plan, the provider becomes aware of any frequency or other coverage limitations in advance of the treatment, including any treatment that may be above the adult annual maximum. The provider can educate the patient about any out of pocket costs they may incur as a result of the treatment.

All treatment plans with billed charges of over \$500 will be automatically reviewed at the time of claim submission unless a predetermined voucher is issued. When totaling the \$500 that is required for review, examinations, radiographs, prophylaxis, fluorides, sealants, and adjunctive general services are excluded from the total. If a predetermination is done, no additional review is needed at the time of claim submission unless there is a change to the treatment plan with the exception of a pre-determination or a root canal which require post-operative x-rays of the completed root canal.

If a predetermined voucher is not obtained and a claim is denied, the provider will not receive payment from South Dakota Medicaid. It is best practice to obtain predetermination prior to the service.

The South Dakota Department of Social Services reserves final authority to approve or deny any proposed treatment plans.

PREDETERMINATION PROCESS

1. The request for predetermination is submitted by the treating dentist.
2. The treating dentist completes an ADA claim form with the full proposed treatment plan leaving the Procedure Date field blank. The treating dentist checks the Request for Predetermination/Preauthorization box in Field 1: Type of Transaction.
3. The predetermination request is submitted to the dental vendor in the same way the treating dentist submits claim forms – either electronically through a clearinghouse or on paper.
4. The dental vendor verifies that the recipient is eligible for dental benefits under South Dakota Medicaid. Active eligibility at the time of predetermination does not guarantee eligibility at the time the services are rendered. Providers should verify eligibility on each date of service.
5. A comparison is made between the proposed treatment plan and the South Dakota Medicaid contract to determine if the proposed dental services are covered benefits.
6. The recipient's history is reviewed to determine if he/she is eligible for the proposed benefit or has any frequency limitations.
7. If all information needed for predetermination is not submitted with a request, an inquiry is sent to the provider to supply the required information.
8. The request and all supporting documentation is reviewed clinically.

9. Computations are made to determine Medicaid's payment obligation and the financial responsibility of the recipient, if any.
10. A Predetermination Voucher outlining the estimated coverage is sent to the treating provider.
11. After reviewing the predetermination voucher with the recipient, the dentist may proceed with treatment. A significant departure from the original treatment plan will void the Voucher and the provider must submit a new proposed treatment plan for predetermination.

PREOPERATIVE CLINICAL EVALUATION

In some circumstances, a proposed treatment plan requires a visual examination to determine South Dakota Medicaid's obligation. This in-person examination is known as a preoperative clinical evaluation. The dental vendor contracts with licensed dentists to serve as dental consultants and conduct preoperative clinical reviews.

CLINICAL EVALUATION PROCESS

The following occurs during the preoperative clinical evaluation process:

1. The provider is notified that the patient is being requested for a preoperative clinical evaluation. The provider is asked not to perform any further services until the evaluation is completed;
2. The dental vendor notifies the recipient of the need for an evaluation and works with the recipient to schedule an appointment for the evaluation;
3. The dental consultant conducting the preoperative clinical evaluation is sent information outlining the reason for the examination and any supporting documentation needed for a comprehensive evaluation;
4. The preoperative clinical evaluation is conducted;
5. The consultant summarizes the preoperative clinical evaluation findings for the dental vendor; and
6. The dental vendor reviews the findings and issues a predetermined voucher to the treating provider.

SUBMITTING A PREDETERMINED VOUCHER FOR PAYMENT

When the services listed on the Predetermined Voucher are completed, the treating provider must list the date of service next to each completed service, sign the Voucher, and submit it for payment. Providers should not submit a new, separate claim for predetermined services. If a service listed on the predetermined voucher was not completed, the provider should cross it out on the Voucher. Vouchers may have several pages and all pages must be submitted at the same time.

CANCELING A PREDETERMINED VOUCHER

South Dakota Medicaid recommends cancellation of any Predetermined Voucher that is not going to be performed. To cancel, cross out the services on the Voucher, write "cancel" on the Voucher, and return

it to the Dental vendor. If the recipient wants to begin treatment after the Voucher has been canceled, a new treatment plan must be submitted to the vendor for predetermination.

PREDETERMINED VOUCHER

1. **Patient Name** - the first and last name of the person for whom the treatment is planned.
2. **Date of Birth** - list the month, day, and year of the recipient's birth. This information is provided for identification purposes.
3. **Subscriber Name and Address** - the first and last name of the recipient, along with the address which was submitted on the claim form.
4. **Issue Date** - the date the voucher was produced by the Dental vendor.
5. **Receipt Date** - the date the claim was received at the Dental vendor for predetermination.
6. **SSN No (Recipient ID Number)** - the identification number of the recipient.
7. **Group Number** - the recipient's South Dakota Medicaid group number (1900).
8. **Claim Document Number** - an individual number assigned by the Dental vendor to identify your treatment plan. This number, along with the recipient's ID number is important to South Dakota Medicaid in locating information on cases when there is an inquiry.
9. **NPI Number** – the treating provider's assigned individual NPI number.
10. **Tooth Number or Letter** - use universal tooth code numbers 1 through 32 or letters A through T for tooth reference. Use arch code "U or 01" (upper), "L or 02" (lower). Use quadrant code "UR or 10" (upper right), "UL or 20" (upper left), "LL or 30" (lower left), and "LR or 40" (lower right).
11. **Surface** - use "M" (mesial), "D" (distal), "O" (occlusal), "I" (incisal), "L" (lingual or palatal), "B" (buccal) and "F" (facial).
12. **Date of Service** - the month, day, and year (MM/DD/YY) on which the procedure is completed. To receive payment for predetermined services which have been completed, the provider must complete this column on the voucher, sign it, and submit it to the Dental vendor.

NOTE: Completion dates are defined as follows: for dentures and partials, the delivery date; for crowns and bridgework, the permanent cementation date; and for root canal and periodontal treatment, the date of the completion of the procedure.
13. **Procedure Code** - the most current ADA procedure code number for the proposed procedure in the treatment plan. Providers must use the most current CDT code as published by the ADA.
14. **Submitted Amount** - the fee requested by the dentist for the proposed dental procedure.

15. **Approved Amount** - the amount, per procedure, South Dakota Medicaid approves for South Dakota Medicaid payment.
16. **Code** - the condition coding system is identified on the bottom of the predetermined voucher.
17. **Applied to Deductible** - not used with this program.
18. **Estimated Patient Payment** - the estimated amount the recipient must pay for the proposed procedure.
19. **Estimated South Dakota Medicaid Payment** - the estimated amount the dental vendor will pay for the proposed procedure.
20. **Processing Policies** - policies used by the dental vendor for use in processing treatment plans in accordance with generally accepted dental standards and in compliance with the Medicaid dental program.
21. **Total Submitted** - the total amount submitted by the attending provider for the entire treatment plan.
22. **Total Approved** - the total amount approved by the dental vendor for total Medicaid payment.
23. **Patient Pays** - the total amount the recipient must pay for the dental treatment rendered.
24. **South Dakota Medicaid Pays** - the total amount South Dakota Medicaid will pay for the dental treatment rendered.
25. **Dentist Signature** - necessary when the voucher is submitted for payment after completion of treatment.
26. **Patient Signature** - is not required for payment but provider offices must maintain signature for proposed/rendered treatment.

DEFINITIONS

1. "Predetermination", (also known as prior authorization) is the process of obtaining information about anticipated coverage and payment for a treatment plan before the treatment is started.
2. "Predetermined Voucher", a document issued by the dental vendor when a provider requests review of a treatment plan in advance. The predetermined voucher outlines the anticipated coverage and payment.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

1. What services should a predetermination be submitted for?

A predetermination should be submitted for any treatment plan that amounts to over \$500 in services, including plans that contain extensive restoration services and/or dentures. Providers are encouraged to submit a predetermination for any services they wish to have reviewed prior to completing the service.

2. How long does the predetermination process take?

The dental vendor cannot begin the review process until all supporting documentation is received. If supporting documentation is submitted with the predetermination request, the predetermination process will take no longer than 7 calendar days. Often the process takes fewer days, but requests that require the review of a dental consultant may take longer.

3. What happens if we don't submit a predetermination request and the claim is denied after completion of the service?

The predetermination process is a mechanism to allow providers and patients to make final treatment decisions based on coverage. If a provider completes a service without seeking predetermination, the services may not be covered by South Dakota Medicaid and the patient may be responsible for the cost. For example, if a provider makes a set of dentures for a patient without seeking predetermination, South Dakota Medicaid may deny because the patient had a similar service within the 5-year frequency limit. The patient may become responsible for the cost of the service. Providers should consult the [Billing a Recipient](#) manual for additional requirements regarding billing a recipient.