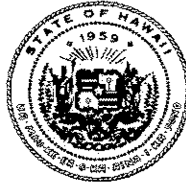
LINDA LINGLE
GOVERNOR



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August 9, 2007

MEMORANDUM ACS M07-14

TO: Dental Providers and Federally Qualified Health Centers (FQHC)

FROM: Lois Lee, Acting Med-QUEST Division Administrator

SUBJECT: IMPORTANT INFORMATION REGARDING THE TRANSITION OF DENTAL CLAIMS PROCESSING

This memo notifies dental providers of the transition of dental claims processing effective September 1, 2007.

As noted in the previous memorandum (ACS Memorandum ACS M07-08 dated May 23, 2007), dental Third Party Administrator (TPA), Cyrca Dental has been selected to administer the dental program for the Med-QUEST Division (MQD). Dental claims will be received and adjudicated by Cyrca Dental according to the benefits and reimbursement rates approved by MQD. Claims for services provided through August 31, 2007 are the responsibility of ACS.

Claims can be submitted to Cyrca Dental beginning September 1, 2007 and must have dates of service on or after September 1, 2007. For an initial transition period only, ACS and Cyrca Dental will exchange claims to route claims to the appropriate fiscal agent for processing.

Adult (21 years or older) dental benefits are limited. Refer to ACS M06-20 for a more in-depth explanation of the benefits implemented effective December 1, 2006. Preventive and restorative adult dental benefits are limited to $500 per benefit year and the denture benefits are limited to $1,000 per benefit year (a benefit year is July 1 through June 30). Dental benefits for individuals less than 21 years old are afforded a wider array of preventive and restorative services.

Prior to performing any preventive, restorative or denture work on an adult, dentists may contact Cyrca Dental to determine the benefit amount a recipient has available to use. Please contact Cyrca Dental at:

1-800-460-3443

For HIPAA privacy purposes, please be prepared to verify your information and the recipient information. You will need to be ready to provide the recipient's name (First and Last), date of birth, or the recipient's Medicaid ID number.

Prior Authorization Information
A new Prior Authorization Form specific to dental procedures is being implemented (see attached). Information can be mailed or providers can download this information from the Cyrca website:

https://cyrcadental.com

More detailed claims filing information to follow shortly in the mail.

Dental providers may also call Cyrca Dental beginning August 22, 2007 at the following numbers:

Contact Numbers
Cyrca Dental
1440 Kapiolani Boulevard, Suite 1503
Honolulu, Hawaii 96814
Office Hours: 7:45 a.m. – 5:00 p.m.
Monday through Friday, except State Holidays

Recipient verification:
 	
With the exception of Cyrca Dental, the identified systems only verify Medicaid/QUEST eligibility. You must contact Cyrca Dental to determine whether an adult recipient has reached the benefit limits or has any benefits remaining.
	• **Automated Voice Response System (AVRS) at 1-800-882-4608**
	• **Medicaid On-line: https://hiweb.statemedicaid.us**
	• **Med-QUEST Division Customer Service Section:**
	  • **Oahu: 524-3370**
	  • **Neighbor Island: 1-800-316-8005**
	• **Cyrca Dental: 1-800-460-3443**

Claims filing questions:	Cyrca Dental: 1-800-460-3443 https://cyrcadental.com
Available balance of ADULT dental benefits:	Cyrca Dental: 1-800-460-3443 https://cyrcadental.com
Prior Authorization:	Cyrca Dental: 1-800-460-3443 Fax: 1-877-444-4662 (without X-Rays)
Claim questions/information:	Cyrca Dental: 1-800-460-3443 https://cyrcadental.com
Case management/coordination:	CCMC: Oahu - 792-1070 Neighbor Islands - 1-888-792-1062
Translation/Transportation/Meals/Lodging:	CCMC: Oahu - 792-1070 Neighbor Islands - 1-888-792-1062
Electronic Claims Filing	Cyrca Dental: 1-800-460-3443
Payment Status, lost checks, reissuance, ACH	Cyrca Dental: 1-800-460-3443

Attachment

Cyrca Dental
1440 Kapiolani Blvd., Suite 1503
Honolulu, Hawaii 96804-2561

Fax: 1-877-444-4662
Phone: 1-800-460-3443

REQUEST FOR DENTAL AUTHORIZATION

CYRCA USE ONLY
PA No.:

☐ New Request ☐ Extension Request

Check only ONE – Other Services Must Be Requested on an 1144 Form.

☐ DE – Dental ☐ OP –Dental services performed in the hospital

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

PLEASE PRINT INFORMATION CLEARLY

1. Medicaid Identification Number:	2. Patient Name (Last, First, M.I.):	3. Gender [ ] M [ ] F	4. Date of Birth ____/____/____
5. Patient Mailing Address (St., Apt. No., City, Zip Code)			

Dental Service Section

	6. Planned Date or Date range for procedure(s)	7. Area of Oral Cavity	8. Tooth System	9. Tooth No(s). or Letters	10. Tooth Surfaces	11. Procedure Code	12. Description
1							
2							
3							
4							
5							

13. Justification:

14. Place of Treatment: [ ] Office [ ] Hospital [ ] Other	15.Attachment: [ ] Yes [ ] No	16. If attachments: Note # of: Radiograph s: Oral Images: Model(s):

Dental Provider Section

17. Dentist Signature/Date:	18. NPI :	19. Medicaid Provider Number
20. Print Contact Name: (if different from Dentist)	21. Telephone Number:	22. Fax Number:
23. Dentist Mailing Address (St., Suite No., City, Zip Code)		

To be completed by Medicaid (A= Approved P= Pended D= Denied R= Revoked)

			Approved Period		
	Procedure Code	**Auth Code**	**From**	**To**	**Consultant Comments:**
1					
2					
3					
4					
5					

Dental Consultant Signature/Date:

Cyrca Dental

Prior Authorization Form Instructions

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

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

Dental Provider Section

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

Cyrca Dental

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

To be Completed by Medicaid

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