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DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Clinical Standards Office
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Kapolei, Hawaii 96709-0190

July 31, 2009

MEMORANDUM

DENTAL M09-04

TO: All Medicaid Dental Providers

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

SUBJECT: FOREIGN LANGUAGE AND SIGN LANGUAGE INTERPRETER SERVICES

It has been a long-standing policy of the Department of Human Services (DHS) that participants in its programs have equal access to services.

Thus, non-English speaking and deaf/hard of hearing Medicaid clients who have difficulty accessing covered dental services through Medicaid dental providers have the right to receive foreign language interpreter services and sign language interpreter services without charge so they can understand the dental services they receive.

If the Medicaid client has a friend or family member willing to accompany the client to the appointment and provide interpretive assistance, no request for translation/interpretive services is necessary. However, if the dental provider determines that interpreter services from a friend or family member is not available, a request for interpreter services should be made.

To expedite the provision of interpreter services, the dental provider must do the following:

- Request foreign language interpreter service by:
    - Contacting Helping Hands Hawaii (aka Bilingual Access Line) at (808) 526-9724 Option 1. The dental provider's signature (as verification) will be requested on the Helping Hands Encounter form for interpreter sessions exceeding one and one-half hours.

- If you are not able to contact Helping Hands Hawaii directly, you may call Community Case Management Corp. (CCMC) at (808) 792-1070 or toll free 1-888-792-1070 for assistance.

- Request sign language interpreter services by:

  - Completing the Cyrca Dental Authorization form (attached) and fax to the number located on the top right corner of the form which is: 1-877-444-4662. This form functions as the payment authorization for sign language interpreter services. Refer to the "Instructions for Completing the Cyrca Dental Authorization Form for Sign Language Interpreter Services" (attached).

  - Once the sign language interpretive service is authorized, call CCMC at 792-1070 (Oahu) or toll free 1-888-792-1070 to obtain assistance in coordinating sign language interpreter services.

Requests for sign language/foreign language translation interpreters **should not** be made in the following situations:

- The Medicaid client has an interpreter, such as a friend or family member, willing and to accompany the client to the dental visit with no charge; or

- When dental services are provided in the following settings:

  Federally Qualified Health Centers (FQHCs);
  Rural Health Centers (RHCs); and
  Hospitals.

If you need to cancel or postpone an appointment with a Medicaid client who will be using interpreter services, you must inform the client and CCMC or the interpreter at least 24 hours and preferably 72 hours before the scheduled date.

For questions and clarification, please contact DHS Med-QUEST Division, Clinical Standards Office at (808) 692-8124.

Attachments

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:

Instructions for Completing the Cyrca Dental Authorization Form For Sign Language Interpreter Services

1. **Medicaid Identification Number:** Enter patient's Medicaid I.D. number assigned by the State of Hawaii/Department of Human Services.

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 format.

5. **Patient's Mailing Address:** Enter patient's mailing address which may be different from the patient's residence address. If possible, enter patient's home phone number or cell phone number.

6. **Planned date or date range of procedure(s):** Enter the date(s) that you would need interpreter services.

Blocks 7, 8, 9, 10, 15, 16: Do not request dental diagnostic/treatment services on the same form as the request for interpreter services.

11. **Procedure code:** Enter D9999 for sign language interpreter. Do not enter dental diagnostic/treatment services on the same form as the request for interpreter services.

12. **Description:** Enter "sign language."

13. **Justification:** If the patient knows the name of the interpreter he/she wishes to use, enter this name.

14. **Place of treatment:** Check office or other. For interpreter services performed in all hospital settings, make arrangements through the hospital. If "other" is checked, explain this location. (e.g., nursing facility for EPSDT dental exam)

Dental Provider Section

17. **Dentist signature/date:** The dentist requesting the interpreter signs and dates.

18. **NPI number:** The National Provider Identifier (NPI) 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.

20. **Print contact name:** Enter contact name (if other than dentist) who can provide additional information.

21. **Telephone number:** Enter telephone number of dentist or named contact.

22. **Fax number:** Enter fax number of dentist or contact name.

23. **Dentist Mailing Address:** Optional.