Eligibility Expedited Prior Authorization (EPA) Criteria

The Agency requires providers to use Expedited Prior Authorization (EPA) numbers at the **header** level of the claim to certify to the Agency one of the following:

- That the client meets the criteria to receive care under the comprehensive dental benefit or
- That the client's clinical situation meets the criteria to receive care under the emergency oral health benefit.

Failure to bill with an EPA number will result in claim denial.

Use the first eligibility expedited authorization number that your client qualifies for on the list below.

The use of these EPA numbers does not override the need for site-of-service authorization or procedure prior authorization. Providers must put eligibility authorization number in box #6 of the General Information Form (HCA form 13-835) when requesting procedure authorization.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to the Department on request. If the Department determines the documentation does not support the criteria being met, the claim will be denied or recouped.

ELIGIBILITY EXPEDITED PRIOR AUTHORIZATION NUMBERS		
EPA	**Criteria**	**Procedure Codes**
870000033	**Pregnant DD–** Services provided to a client that: 1. Is on CNP, 2. Is pregnant or within 2 months** post delivery; and 3. Has a letter from their primary care provider or from their OB/GYN stating that the client is pregnant and the due date. *The letter can be signed by the nurse on behalf of the OB/GYN OR 4. Has Public Health documentation for pregnancy verification that states a positive pregnancy test and due date signed by a Public Health Nurse. OR 5. Has a "***Waiver/RCL Verification"* form** **Effective for dates of service October 1, 2011 and after.**	See "Pregnant/ADSA Adults" column of coverage table.
870000018	**Pregnant –** Services provided to a client that: 1) Is on CNP, ERSO, GA/ADATSA or LCP/MNP; and 2) Is pregnant or within 2 months**post delivery; and 3) Has a letter from their primary care provider or from their OB/GYN stating that the client is pregnant and the due date. *The letter can be signed by the nurse on behalf of the OB/GYN	See "Pregnant/ADSA Adults" column of coverage table.

	OR 4) Has Public Health documentation for pregnancy verification that states a positive pregnancy test and due date signed by a Public Health Nurse. **Effective for dates of service July 1, 2011 and after.**	
870000022	**Institutional/DD client-** Service provided to a client that: 1) Has an active DDD segment in provider One. 2) Is on CNP, GA/ADATSA or LCP/MNP; AND 3) Has ACES coverage group of F01, G01, G02, L01, L02, L95, L99 or R01; and 4) Resides in a nursing home, state veteran's home, veteran's wing of a nursing home, Residential Habilitation Center (RHC) or privately-operated ICF/ID; 5) Presents with an "Institutional Residence Verification" form: **Effective for dates of service Oct 1, 2011 and after.**	See "Pregnant/ADSA Adults" column of coverage table.
870000020	**Institutional-** Service provided to a client that: 1) Is on CNP, ERSO, GA/ADATSA or LCP/MNP; AND 2) Has ACES coverage group of F01, G01, G02, K01, K95, K99,L01, L02, L04, L95, L99 or R01; and 3) Resides in a nursing home or state veteran's home, or veteran's wing of a nursing home; and 4) Presents with an "Institutional Residence Verification" form. **Effective for dates of service July 1, 2011 and after.**	See "Pregnant/ADSA Adults" column of coverage table.
870000021	**Waiver/DD** Services provided to a client that: 1) Is on CNP; 2) Has ACES coverage group L21 or L22 and is not on the hospice program OR **3)** Is a hospice client and has ACES coverage group L21, L22, F01,G02, R01 or S08; and has "***Waiver/RCL Verification* form** Or **4)** Has ACES coverage group F01, G02, R01, or S08 and has a "Waiver/RCL verification form.	

	Effective for dates of service Oct 1, 2011 and after.	
870000019	**Waiver-** Services provided to a client that: 1) Is on CNP, ERSO or GA/ADATSA; AND 2) Has ACES coverage group L21 or L22 and a) Is not on the hospice program or b) Is a hospice client and PAN contains the words "COPES", "New Freedom", or "RCL" or **3)** Has ACES coverage group F01,G02, R01 or S08; and PAN contains the words "COPES", "New Freedom", or "RCL". **Effective for dates of service April 1, 2012 and after.**	See "Pregnant/ADSA Adults" column of coverage table.
870000005	**Extractions** that: 1) are performed on or after January 1, 2011 2) did not require authorization in 2010; 3) were allowed in the 2010 dental benefit; 4) were necessary in order to place **dentures** that: a) has an authorization request that was received by the department on or before December 31, 2010 and; b) were authorized by the department.	D7111, D7140, D7210, D7220, D7230, D7240 and D7250
870000002	Services rendered for pain, infection, or trauma. **Effective for dates of service January 1, 2011 and after.**	Any procedure allowed under the Emergency Oral Healthcare Benefit
870000003	Services rendered as part of a cancer treatment regimen*** or part of a pre-transplant/medical protocol* **Effective for dates of service January 1, 2011 and after.**	Any procedure allowed under the Emergency Oral Healthcare Benefit**

Note: Failure to bill with the appropriate EPA number at the header level will result in claim denial.

*If a client requires emergency oral health care services as a pre requisite to surgeries involving implants you will need to send in an authorization request and put the name of the primary service in the "description of service requested" box of the authorization form. ie: "Pre-op for Knee Replacement"

****2 months post delivery** = comprehensive dental coverage for women who qualify because they are pregnant, allows continued dental coverage through the end of the month in which the 60th day following the end of the pregnancy falls (e.g., pregnancy ends June 10, medical benefits continue through August 31). This is applicable regardless of how the pregnancy ends.

*** For those clients who require services as part of a cancer treatment regimen, if the client has lost their teeth as a result of radiation/chemo therapy the agency will consider requests for dentures. The provider will need to submit a request for prior authorization with the qualifying EPA for eligibility to the authorization department with all document required for dentures listed in the Billing guide.