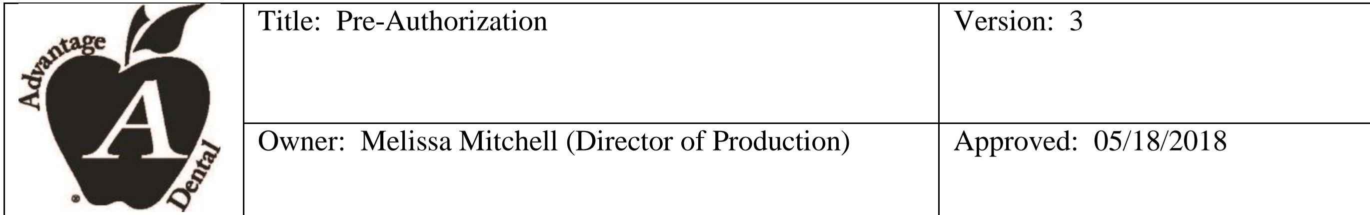

	Title: Pre-Authorization	Version: 3
	Owner: Melissa Mitchell (Director of Production)	Approved: 05/18/2018

Purpose: To establish the policy for submitting and processing pre-authorizations for services.

Responsibility: Quality Improvement (QI)/Utilization Review (UR) Committee

Scope: Advantage Dental Services, LLC

Definitions: n/a

Forms: n/a

References: 42.CFR 438.100; 42 CFR 438.210; OAR 410-141-3225; OAR 410-141-3240

Policy:

The Oregon Health Plan (OHP) only covers certain procedures to be performed on enrollees. There are rigid requirements as to what services/procedures are covered under the capitated fees. These requirements are set forth in the Summary of Benefits section in the Dental Services Rulebook.

1. When to Submit a Pre-Authorization: A Provider should submit a preauthorization for a requested service when: (1) the Provider denies the enrollee a requested service or (2) the Provider or enrollee is unsure whether the requested service is covered under the enrollee's benefit plan under the Oregon Health Plan.

The following services are required to be preauthorized before being performed by the Primary Care Dentist (PCD):

	ADA Codes Effected	**Attachments Required**
Crowns	D2390; D2710; D2712; D2751; D2752	Radiographs, Date of Initial Placement, Chart Notes with Clinical Findings, & Preventative Treatment Plan
Removal of Torus	D7472; D7473	Radiographs & Chart Notes with Clinical Findings
Partials	D5211; D5212	Radiographs, Date of Initial Placement, History of Previous Partials/Flippers, Chart Notes Showing Teeth to be Replaced and Clasped, & Preventative Treatment Plan
Root Canals	D3330	Recent Radiographs (PA not older than 60 days), Chart Notes with Clinical Findings, Plan for Restoration, & Preventative Treatment Plan
Rebases	D5710; D5711; D5720; D5721;	Date of Denture Placement & Date of last Rebase

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Hospital Dentistry (must be preauthorized by the provider who is doing the hospital dentistry)	D9410; D9420	Full Treatment Plan, Preventative Treatment Plan, Chart Notes Showing in Office Sedation Attempts, Hospital Referral Form, & Radiographs (if available)
General Anesthesia/ IV Conscious Sedation	D9223; D9243	Full Treatment Plan, Preventative Treatment Plan, Chart Notes with Clinical Findings, & Radiographs (if available)
Additional Services Beyond Allowed Frequencies		Radiographs and Chart Notes with Clinical Findings
ALL Non-Covered Services Requested by the enrollee		Radiographs, Date of Initial Placement, Chart Notes with Clinical Findings, & Preventative Treatment Plan

2. How to Submit a Pre-Authorization:

A. All PCDs will submit pre-authorizations using the ADIN system (for details on how to submit a preauthorization please refer to the preauthorization, referral, and case review manuals). The ADIN system tracks the date the pre-authorization was submitted by the PCD. PCDs must include all requested information on the ADIN pre-authorization form including a description of the procedures being pre-authorized, procedure codes, chart notes, radiographs, etc. For detailed instructions on how to submit pre-authorizations refer to the ADIN pre-authorization, referral, case review manuals.

Providers will submit pre-authorizations with one of the following Levels of Urgency

- Normal
- Low
- High (urgent and expedited requests)

B. Review of Preauthorization: The completed preauthorization will be evaluated through the Dental Care Organization's (DCO's) preauthorization system which includes a review of the preauthorization request by the DCO's Case Management staff and\or President/CEO or their designee(s), who are licensed dentists depending on the services requested in the preauthorization. The Vice President of Dental Services or their designee(s), who are licensed dentists and Case Management staff process the preauthorization based on the rules and guidelines per the Dental Services Rulebook and general rules for OHP covered services to assure consistent application of the review criteria. The DCO will respond to and issue a decision within the timelines defined below based on the level of urgency:

i. Normal and Low level preauthorizations will be responded to and a decision made within 14 calendar days
ii. High level (urgent and expedited requests) preauthorizations will be responded to and a decision made by the next working day or within 72 hours.

3. What happens if a Pre-Authorization is Approved or Denied?

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A. Pre-authorization is Approved. If the preauthorization is approved, the DCO shall notify the Provider and the enrollee of the DCO's decision by electronically notifying the Provider of the approval of the treatment of requested service(s).

B. Pre-authorization is Denied: If the preauthorization is denied, the DCO shall notify the Provider and send the enrollee a Notice of Action-Adverse Benefit Determination (NOABD) stating that the requested service is denied and a notice of the enrollee's appeal rights.

1) NOABD: Upon the denial of a pre-authorization of a requested service or the reduction, suspension or termination of a previously authorized service, the DCO will mail to the enrollee a NOABD letter. The NOABD letter will include those requirements stated in the Notice of Action-Adverse Benefit Determination Policy and Procedure.

2) Filing an Appeal: An enrollee can dispute the NOABD by filing an appeal with the DCO within 60 days of the date on the NOABD pursuant to the Enrollee Grievance and Appeal Policy and by requesting a Medical Assistance Program (MAP) Administrative Hearing pursuant to the Enrollee Grievance and Appeals policy and procedure. All Administrative Hearings and Appeals are reviewed by the DCO's Vice President of Dental Services or their designee(s), who are licensed dentists who may uphold the decision or overturn it based on additional information or circumstances.

4. The Reduction, Suspension or Termination of a Previously Authorized Service:

A. Previously Authorized Service: If a previously authorized service is reduced in the type or level of service from that previously authorized, suspended or terminated, the Provider shall notify the DCO and the DCO shall send a NOABD to the enrollee as provided in the Notice of Action-Adverse Benefit Determination Policy and Procedure.

5. No Incentive to Deny, Limit, or Discontinue

A. Individuals or entities that conduct utilization management activities are not compensated in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Approvals:

Date: 05/18/2018

Approved by:
Melissa Mitchell (Director of Production), Director of Production, Production

Reviewed and Revised

08/28/2013					
08/28/2014	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Laura Donadio	
03/02/2015	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Jeff Dover	Laura Donadio
02/23/2016	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Jeff Dover	
07/11/2016	Jeanne Dysert	Missy Mitchell			

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11/10/2016	Jeanne Dysert	Missy Mitchell			
02/14/2017	Jeanne Dysert	Tamara Kessler	Missy Mitchell		
07/12/2017	Jeanne Dysert	Tamara Kessler	Missy Mitchell		
07/27/2017	QI/UR Committee				
03/12/2018	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Rose Novak	
05/09/2018	Gary Allen, DMD	Missy Mitchell			

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