


PLAN PROCESSING DEPARTMENT	 From DentaQuest		
	<i>Policy and Procedure</i>		
	Policy Name:	Pre-Authorization	Policy ID: PLANCG-44
	Approved By:	Quality Assurance and Performance Improvement Committee	Last Revision Date: 04/27/2026
	States:	Oregon	Last Review Date: 04/28/2026
Application:	Medicaid	Effective Date: 04/29/2026	

PURPOSE

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

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 Dental Services Rulebook.

The Dental Subcontractor requires pre-authorization for certain covered services, provided that such pre-authorization does not violate any applicable law, and that the services supporting enrollees identified to have ongoing or chronic conditions, or those who require Long Term Services and Supports are authorized in a manner that reflects enrollee’s ongoing needs for such services and the services furnished are sufficient in amount, duration or scope to reasonably achieve the purpose for which the services are furnished. Review criteria for service authorizations and prior authorizations are developed with consideration to applicable clinical practice guidelines.

1. When to Submit a Pre-Authorization: A Provider should submit a pre-authorization for a requested service when: (1) the service is a non-covered 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 pre-authorized before being performed by the Primary Care Dentist (PCD) or specialist, as applicable:

*Services requiring pre-authorization by specialists

	ADA Codes Affected	Attachments Required with Pre-Authorization Request
Crowns	D2390; D2710; D2712; D2740; D2751; D2752;	Radiographs, Date of Initial Placement, & Chart Notes with Clinical Findings
Root Canals	D3330	Recent Radiographs (PA not older than 60 days), Chart Notes with Clinical Findings, & Plan for Restoration.

Decoronation or submergence of an erupted tooth	D3921	Radiographs & Chart Notes with Clinical Findings
Partials	D5211; D5212; D5221; D5222	Radiographs, Date of Initial Placement, History of Previous Partials/Flippers, & Chart Notes Showing Teeth to be Replaced and Clasped;
Rebases	D5710; D5711; D5720; D5721;	Date of Denture Placement & Date of last Rebase
Implant Services	D6010-D6199	Radiographs & Chart Notes with Clinical Findings
Removal of temporary anchorage device	D7298; D7299; D7300	Radiographs & Chart Notes with Clinical Findings
Removal of Torus	D7472; D7473	Radiographs & Chart Notes with Clinical Findings
Frenulectomy/ Frenuloplasty	D7961; D7962; D7963	Radiographs & Chart Notes with Clinical Findings
Orthodontic Treatment*	D8070; D8080; D8090; D8091; D8220; D8680; D8695	Radiographs, Chart Notes with Clinical Findings including certification the member is free and clear of dental decay and periodontal disease, Handicapping Malocclusion Scoresheet (for treatment requests only, not necessary for evaluation referrals); digital photographs of articulated study models
Hospital Dentistry* (must be pre-authorized by the provider who is doing the hospital dentistry)	D9410; D9420	Full Treatment Plan, Chart Notes Showing in Office Sedation Attempts, Hospital Referral Form, & Radiographs (if available)
General Anesthesia and Sedation	D9222; D9223; D9224; D9225; D9239; D9243; D9246; D9247	Full 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.
Any medically necessary covered or non-covered services for review under EPSDT guidelines or for enrolled YSHCN members		Radiographs and Chart Notes with Clinical Findings

2. How to Submit a Pre-Authorization:

- a. All providers will submit pre-authorizations using the Provider Portal system. The Provider Portal system tracks the date and time the pre-authorization was submitted by the provider. Providers must include all requested information on the Provider Portal 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 Provider Portal pre-authorization, referral, case review manuals. Providers will submit pre-authorizations with one of the following Levels of Urgency:
 - i. Standard
 - ii. Expedited
- b. Review of Pre-authorization: The completed pre-authorization will be evaluated through the Dental Subcontractor’s pre-authorization system which includes a review of the pre-authorization request by the Dental Subcontractor’s Plan Processing staff. The Vice President of Dental Services or their designee(s), Dental Reviewers, who are licensed dentists, and Plan Processing staff process the pre-authorization based on the rules and guidelines per the Dental Services Rulebook and general rules for OHP covered services to ensure consistent application of the review criteria. Dental Reviewers are licensed Oregon dentists who have expertise and experience to evaluate the specific clinical issues involved in the health care services requested by the provider. Any decision to deny a pre-authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a licensed Oregon Dentist who has appropriate expertise in addressing the enrollee’s medical, behavioral health or long-term services and supports needs. The Dental Subcontractor will consult with the requesting provider as appropriate and respond to and issue a decision within the timelines defined below based on the level of urgency:

- i. Standard pre-authorizations will be responded to and a decision made within 7 calendar days of Dental Subcontractor's receipt of the pre-authorization request. If additional information is needed, the Dental Subcontractor will follow up with the requesting provider within three days. The Dental Subcontractor will make three reasonable attempts using two methods to obtain the information needed within the timeframe. The time frame for making standard authorization decisions may be extended by up to 14 additional calendar days if: the enrollee, the enrollee's representative or the provider requests an extension, or the Dental Subcontractor justifies to the CCO a need for additional information and how the extension is in the enrollee's interest. If the Dental Subcontractor extends the time frame for standard authorization decisions, it will: give the enrollee written notice of the reason for the extension (no later than the date the authorization time frame expires); inform the enrollee of the right to file a grievance if he or she disagrees with that decision; issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
- ii. Expedited pre-authorizations will be responded to and a decision made within 72 hours of Dental Subcontractor's receipt of the pre-authorization request. If additional information is needed, the Dental Subcontractor will follow up with the requesting provider within one day. The Dental Subcontractor will make three reasonable attempts using two methods to obtain the information needed within the timeframe. The time frame for making expedited authorization decisions may be extended to 14 calendar days if: the enrollee, the enrollee's representative, or the provider requests an extension, or the Dental Subcontractor justifies to the CCO a need for additional information and how the extension is in the enrollee's interest. If the Dental Subcontractor extends the time frame for expedited authorization decisions, it will: give the enrollee written notice of the reason for the extension (no later than the date the authorization time frame expires); inform the enrollee of the right to file a grievance if he or she disagrees with that decision; issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

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

- a. If the pre-authorization is approved, the Dental Subcontractor shall notify the provider and the enrollee. The provider will be notified electronically and is responsible for notifying the enrollee.
- b. If the pre-authorization is denied, the Dental Subcontractor shall notify the provider electronically and send the enrollee a Notice of Action/Adverse Benefit Determination (NOABD) stating that the requested service is denied and include a notice of the enrollee's appeal rights.
 - i. The Dental Subcontractor will not allow for new information or a new pre-authorization to be submitted if it is within the 60-day appeal window of a denial for the same service. If additional information is received for a service that was denied within 60 days of the adverse benefit determination, it is not considered a new pre-authorization, as it is not a new service requested but a request for

reconsideration of the denied service. If new information or a new pre-authorization is submitted within 60 days of the same denied service, it will be cancelled and sent back to the PCD without being reprocessed.

4. After Hours Provision of Services that Require Pre-Authorization

- a. To ensure compliance with all regulatory response timeframes, the Dental Subcontractor has an afterhours system in place for processing of all pre-authorization requests. The Dental Subcontractor's Plan Processing Department has an on-call staff member on weekends and holidays. The staff will ensure that the request is responded to, and escalated to a clinical reviewer as needed, within the allowed timeframes.

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

- a. 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 Dental Subcontractor and the Dental Subcontractor shall send a NOABD to the enrollee as provided in the Notice of Action/Adverse Benefit Determination Policy and Procedure.

6. 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.

7. Availability of UM Decision Criteria

- a. The Dental Subcontractor makes the UM Decision Criteria available to all providers upon request.
- b. To request a copy of the Dental Subcontractor's UM Decision Criteria, providers shall contact the Dental Subcontractor Provider Relations Department.

8. Processing Authorization Requests

- a. Prior authorization requests are received in the Provider Portal and automatically "date and time stamped" electronically upon submission.
- b. Within 3 days the Dental Subcontractor will determine whether a prior authorization request is valid or non-valid.
- c. The Dental Subcontractor shall allow 2 days to follow-up on pended prior authorization requests to obtain additional information.
- d. Following receipt of the additional information, an approval or denial shall be issued within 7 days.

9. Delegation of Authorization Request Processing

- a. In cases where the Dental Subcontractor delegates authorization request processing to a subcontractor or vendor, the subcontractor or vendor will follow the same process and standards outlined in this policy, and be subject to regular audits and monitoring.

REFERENCES

42.CFR 438.100

42 CFR 438.210

OAR 410-141-3835 MCE Service Authorization

Revision History

Date:	Description
08/28/2013	Approval and adoption.
08/28/2014	Updates based on annual review.
03/02/2015	Updates based on annual review.
02/23/2016	Updates based on annual review.
07/11/2016	Updates based on CCO partner audit findings.
02/24/2017	Updates based on annual review.
07/12/2017	Updates based on CCO partner audit findings.
03/12/2018	Updates based on annual review.
05/09/2018	Updates based on internal process review.
05/20/2019	Updates based on annual review.
12/09/2019	Conversion to revised policy and procedure format and naming convention.
03/12/2020	Updates to align with contract changes.
05/19/2020	Updates based on CCO partner audit findings.
6/16/2021	Updates based on CCO partner audit findings.
01/13/2022	Updates based on annual review.
12/31/2022	Updates based on annual review.
11/13/2023	Updates based on annual review.
04/26/2024	Updates based on annual review.
07/22/2024	Updates based on CCO partner audit findings.
08/16/2024	Updates based on CCO partner audit findings.
01/09/2025	Updates based on annual review.
06/03/2025	Updates based on CCO partner audit findings.
12/16/2025	Policy updates based on upcoming authorization timeframe changes for 2026.

02/03/2026	Updates based on annual review.
04/27/2026	Aligning urgency levels with OAR terminology