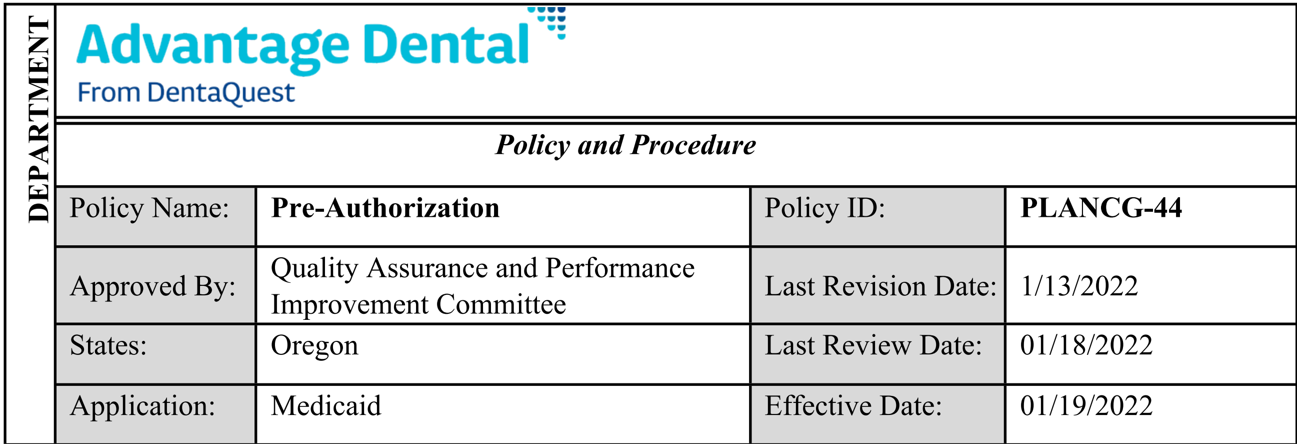

DEPARTMENT

Advantage Dental
From DentaQuest

Policy and Procedure

Policy Name:	**Pre-Authorization**	Policy ID:	**PLANCG-44**
Approved By:	Quality Assurance and Performance Improvement Committee	Last Revision Date:	1/13/2022
States:	Oregon	Last Review Date:	01/18/2022
Application:	Medicaid	Effective Date:	01/19/2022

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 Care Organization (DCO) 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.

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):

	ADA Codes Affected	Attachments Required with Pre-Authorization Request
Crowns	D2390; D2710; D2712; D2751; D2752; D2740	Radiographs, Date of Initial Placement, Chart Notes with Clinical Findings, & Preventative Treatment Plan
Decoronation or submergence of an erupted tooth	D3921	Radiographs & Chart Notes with Clinical Findings

Removal of Torus	D7472; D7473	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, & Preventative Treatment Plan
Removal of temporary anchorage device	D7298; D7299; D7300	Radiographs & Chart Notes with Clinical Findings
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
Soft liner for complete or partial removable denture	D5765	Chart Notes with Clinical Findings including Date of Denture Placement
Hospital Dentistry (must be pre-authorized 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 providers will submit pre-authorizations using the ADIN system. The ADIN system tracks the date and time the pre-authorization was submitted by the provider. Providers 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:

      i. Normal
      ii. Low
      iii. High (expedited requests)

   b. Review of Pre-authorization: The completed pre-authorization will be evaluated through the Dental Care Organization's (DCO's) pre-authorization system which includes a review of the pre-authorization request by the DCO's Utilization Management staff. The Vice President of Dental Services or their designee(s), who are licensed dentists, and Utilization Management 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. 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 an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health or long-term services and supports needs. The DCO 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. Normal and Low level pre-authorizations will be responded to and a decision made within 14 calendar days of DCO's receipt of the pre-authorization request. If additional information is needed, the DCO will follow up with the requesting provider within five days. The DCO will make three reasonable attempts using two methods to obtain the information needed within the timeframe. Following receipt of additional information, the DCO will issue an approval or denial within 4 days from the original date of receipt of the pre-authorization request. If additional information is necessary and not received the DCO will deny the request and a notice will be sent to the provider and the enrollee within 14 calendar days.

ii. High level (expedited requests) pre-authorizations will be responded to and a decision made within 72 hours of DCO's receipt of the pre-authorization request. If additional information is needed, the DCO will follow up with the requesting provider within one day. The DCO will make three reasonable attempts using two methods to obtain the information needed within the timeframe. Following receipt of additional information, the DCO will issue an approval or denial within 72 hours from the original date of receipt. If additional information is necessary and not received the DCO will deny the request and a notice will be sent to the provider and the enrollee within 72 hours.

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

   a. If the pre-authorization is approved, the DCO shall notify the provider and the enrollee. The provider will be notified electronically and the enrollee will be notified in writing within 14 calendar days.

   b. If the pre-authorization is denied, the DCO shall notify the provider electronically and send the enrollee a Notice of Action Benefit Denial (NOABD) stating that the requested service is denied and include a notice of the enrollee's appeal rights.

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

   a. To ensure compliance with all regulatory response timeframes, the DCO has an afterhours system in place for processing of all pre-authorization requests. The DCO's Utilization Management 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 DCO and the DCO shall send a NOABD to the enrollee as provided in the Notice of Action Benefit Denial 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 DCO makes the UM Decision Criteria available to all providers upon request.
   b. To request a copy of the DCO's UM Decision Criteria, providers shall contact the DCO Provider Relations Department.

REFERENCES

42.CFR 438.100; 42 CFR 438.210; OAR 410-141-3835; OAR 410-141-3885

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.