Policy and Procedure			
Policy Name:	**Prior Authorizations –General**	Policy ID:	**CL.002.01**
Approved By:	Dental Director (signature on file)	Effective Date:	02/17/2012
States:	All States	Revision Date:	03/19/2013
Application:	All programs		

This Policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".

Purpose

To provide a standard process for reviewing prior authorization requests based on covered benefits and dental necessity and appropriateness.

Policy

Certain procedures (excluding emergency) require prior authorization from ***Premier Access***. To be approved, dental services must meet criteria for dental necessity/appropriateness and be a covered benefit under the applicable program or plan.

Procedure

1. The conditions or circumstances under which prior authorization is required vary by program.
2. A Provider may submit a prior authorization request via mail, fax, e-mail or Electronic Data Interchange (EDI) submission. The prior authorization request must include the required supporting documentation based on the procedure being requested.
3. All prior authorization information shall be entered and tracked in ***Premier Access'*** benefits administration system.
4. The Claims Department verifies that the necessary documentation is complete and the requested procedure is a covered benefit under the applicable program.
5. The Claims Department forwards the request to the Dental Director, or designee, to evaluate the request and determine dental necessity/appropriateness.
6. If a determination cannot be made due to missing or insufficient information, the Provider and Member are notified according to the timeframes described in the Review Timeframes/Communication Policy and Procedure.
7. If the procedure is approved, the Provider and Member are notified according to the timeframes described in the Review Timeframes/Communication Policy and Procedure.
    - The notification shall include the valid period of the prior authorization.
    - If a Specialist is performing the procedure, the Member is advised that, when appropriate, follow-up treatment needs to be performed by the Primary Care Dentist.
    - For managed care programs, ***Premier Access*** sends a reminder letter to the member within 45 (forty-five) calendar days after the procedure has been approved if no claim has been received for the approved services.
8. If the procedure is denied, the Member and Provider are notified as described in the Denials Policy and Procedure.
9. ***Premier Access'*** claims staff will audit five percent (5%) of Notice of Authorization for denied letters prior to mailing ensuring the required information is included, and communicated appropriately to Plan members and providers.

References

This policy was previously tracked as *Quality Management Program, Policy and Procedure* ***UM-09 – Prior Authorization.***

See also related policies:

Policy CL.010.01, Review Timeframes for Prior Authorizations and Specialist Referrals, Policy CL.011.01, Emergency Dental Care, Policy CL.012.01, Denials, QM.009.01, Performance Measures

Revision History

Date:	Description
02/17/2012	Conversion to revised policy and procedure format and naming convention.
01/01/2013	Annual review. Revisions required to process description.
03/19/2013	DMHC Routine Dental Survey Audit