Policy and Procedure			
Policy Name:	**Prior Authorizations – California Medi-Cal Programs**	Policy ID:	**CL.002.02**
Approved By:	Dental Director (signature on file)	Effective Date:	1/1/2013
States:	California	Revision Date:	07/01/13
Application:	California Medi-Cal GMC and LAPHP 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 California Medi-Cal GMC and LAPHP Programs.

Review and approval of medically necessary dental covered services is conducted in accordance with the California Denti-Cal Manual of Criteria.

***Premier Access* does not delegate any responsibilities of the Plan related to Prior Authorization.**

Procedure

A. 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.

B. All prior authorization information shall be entered and tracked in ***Premier Access'*** benefits administration system. The Claims Department date stamps, batches, and logs the batch under the control log.

C. The Claims Department enters the Prior Authorization request into the Benefits Administration System (BAS), verifies that the necessary documentation is complete and the requested procedure is a covered benefit under the applicable program.

D. The Claims Department forwards the request to the Dental Director, or designee, to evaluate the request and determine dental necessity/appropriateness.

E. 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.

F. The Dental Provider and the Member receive written notification of approval or disapproval of the Prior Authorization Request.

G. If the procedure is approved, the Provider and Member are notified according to the timeframes described in the Review Timeframes/Communication Policy and Procedure.

   1. The notification shall include the valid period of the prior authorization (90 calendar days).
   2. 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.
   3. The Benefit Administration System (BAS) tracks the approved Prior Authorizations. System generated reminder cards are sent to Members with approved Prior Authorizations when a corresponding encounter for the services has not been received within 45 (forty-five) calendar days of the approval date.

H. If the procedure is denied, the Member and Provider are notified as described in the ***Policy CL.012.01, Denials***.

1. If the Prior Authorization Request is missing required information or not a benefit under the plan, the Prior Authorization request is denied. Notifications with explanation of the additional information needed or benefit limitations are mailed to the Provider and Member within 3 calendar days of the receipt date, in accordance with the ***Policy CL.012.01, Denials*** and ***Policy CL.013.01, EPSDT Supplemental Services***.

2. If the Prior Authorization Request is denied due to clinical review by the Dental Consultant, the Provider and the Member are notified within 24 hours of the decision in accordance with the ***Policy CL.012.01, Denials***. The Claims Department faxes the notification to the PCD's office. Notifications with explanation of the reason for denial are also mailed to the Provider and Member.

3. ***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.

I. Determinations are logged into the Benefits Administration System (BAS) and remain available for claims reference upon submission.

J. Routine authorizations: Within five (5) business days from the receipt of the information that is reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network services not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than ten (10) business days from the receipt of the request. The decision may be deferred and the time limit extended an additional ten (10) business days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

K. Expedited authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than three (3) business days after receipt of the request for services. The Contractor may extend the three (3) business days' time period by up to ten (10) calendar days if the Member requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

L. Written notices of denial, deferral or modification of Prior Authorization requests, including requests for referral for Specialist Dental Care, shall be provided on a standardized form, approved by the Department of Health Care Services (DHCS), informing the Member of the following:

1. The Member's right to, method of obtaining, and time limit for requesting a fair hearing to contest the denial, deferral, or modification action and the decision ***Premier Access*** has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action;

2. The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson;

3. The name and address of ***Premier Access*** and the Department of Social Services (DSS) toll-free telephone number for obtaining information on legal service organizations for representation.

4. Written notices shall be deposited with the United States Postal Service, or similar postal service, in time for pick-up no later than the third (3rd) calendar day after the decision is made, not to exceed fourteen (14) calendar days from the receipt of the original request.

M. If the decision regarding a prior authorization request, including a request for referral for specialist dental care, beyond the defined timeframes, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

Dental Services Requiring Preauthorization

A. Preauthorization (Prior Authorization) is required for designated services performed by primary care dentists (PCDs) that have a supplemental fee for service payment and require preauthorization under the published Denti-Cal Manual of Criteria (for the fee-for-service program).

Example:

Premier Access provides a supplemental fee-for-service payment for cast crowns and requires Providers to obtain prior authorization before performing services.

B. All specialty referrals, including orthodontia, require prior authorization, except emergencies, in accordance with ***Policy CL.003.02, Referrals for Specialty Dental Care – California Medi-Cal Programs***.

C. Prior Authorization criteria is identical to the Denti-Cal Manual of Criteria requirements.

D. Prior Authorization is limited to non-emergency services. Prior Authorization is not required for emergency services. (see ***Policy CL.011.01, Emergency Dental Care***)

E. Services requiring preauthorization are included in **Exhibit A.**

References

California Denti-Cal Manual of Criteria (04/2012)
Quick Reference Guides by Beneficiary Type (Child, Adult FRADS, Pregnant Women)
Frequently Asked Questions

See also related policies:

Policy CL.002.01, Prior Authorizations,
Policy CL.003.02, Referrals for Specialty Dental Care – California Medi-Cal Programs,
Policy CL.010.01, Review Timeframes for Prior Authorizations and Specialist Referrals,
Policy CL.011.01, Emergency Dental Care,
Policy CL.012.01, Denials, Policy CL.013.01, EPSDT Supplemental Services

Revision History

Date:	Description
01/01/2013	Written policy developed.
3/19/2013	DMHC Routine Dental Survey Audit
07/01/13	Additional changes due to Medi-Cal Contract, Exhibit A, Attachment 7

Exhibit A
List of Services Requiring Prior Authorization
California Medi-Cal GMC and LAPHP Programs

List of Procedures that require Prior Authorization when performed by a Primary Care Dentist

A. Beneficiaries Under Age 21
   1. Prior Authorization (Preauthorization) is required with additional documentation for non-emergency services for the following procedures:

      D2740
      D2750
      D2751
      D2752
      D2780
      D2781
      D2782
      D2783
      D2791
      D2790
      D2792
      D3330

B. Beneficiaries Age 21 and Over

   1. Prior Authorization (Preauthorization) is required with additional documentation for non-emergency services for the following procedures:
      D7850
      D7852
      D7854
      D7858
      D7860
      D7865
      D7872
      D7873
      D7874
      D7875
      D7876
      D7877
      D7940
      D7941
      D7943
      D7944
      D7945
      D7950
      D7951
      D7955
      D7991
      D7995