Policy and Procedure			
Policy Name:	**Referrals for Specialty Dental Care - General**	Policy ID:	**CL.003.01**
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 consistent evaluation of referral requests for specialty dental care, when required by the program or plan.

Policy

Prior authorization is not required for Specialist referrals in all programs and/or plans. Program and/or plan requirements are described in the Evidence of Coverage, Certificate of Insurance, and applicable Provider Manual.

For Plans and/or Programs that require prior authorization, all non-emergency Specialist referrals require prior authorization as well as preauthorization of the Specialist's treatment plan. Emergency services do not require prior approval or preauthorization. Second opinions from a Specialist are available to Members upon request.

All Specialist referrals must meet criteria for dental necessity and be a covered benefit under the applicable Program or Plan.

Procedure

1. Specialist referral requirements vary by Program.
2. Prior authorization of Specialist referrals is waived for contracted dental providers that are capitated for both primary care dental services and applicable specialist services. Prior authorization for Specialist referrals is required in the following circumstances and ***Premier Access*** will facilitate the Specialist referral and/or care coordination, in accordance with Specialist referral guidelines, timelines, and policies.

    a. The capitated Specialist Provider does not have qualified Specialist capability within its organization and referral must be made to an outside Specialist; or,

    b. in any instance of hospital-based dentistry treatment need.
3. The Primary Care Dentist ("PCD") submits a Specialist Referral Form request via mail, fax or email. The referral request must include the required supporting documentation demonstrating dental necessity.
4. All referral information shall be entered and tracked in ***Premier Access'*** benefits administration system.
5. The Referral Department reviews the referral and submitted documentation, and requests additional documentation as needed.
6. The Referral Department evaluates the request to verify that the necessary documentation is complete, the established criteria are met and the requested procedure is a covered benefit under the applicable program. (Specialty Referral criteria are defined under *Policy and Procedure "Review Criteria-Specialty Referrals"*.)
7. If the request meets the established criteria, the Referral/Case Management Coordinator refers the request to the Dental Director, or designee for review. All Specialty referrals are reviewed by the Dental Director, or designee.
8. The Dental Director, or designee, evaluates the request to determine dental necessity.
9. If a determination cannot be made due to missing or insufficient information, the provider and member are notified according to the timeframes described in ***Policy CL.010.01, Review Timeframes for Prior Authorizations and Specialist Referrals***.

10. Following approval, a referral notification letter is sent to the Specialist, the Member, and the PCD. The referral notification indicates that the referral has been approved and advises that the PCD needs to be contacted for continuity of care and follow-up treatment.
11. The referral notification letter informs the Specialist that pre-authorization is required for all non emergency, basic and major services.
12. The referral notification letter shall include the valid period of the referral.
13. After completion of treatment, the Specialist submits a claim form to ***Premier Access*** for payment of authorized services.
14. ***Premier Access*** sends a reminder letter to the Member within 45 (forty-five) calendar days after Specialist services have been approved if no claim has been received for the approved services.
15. If the referral is denied, the Member and Provider are notified as described in the *Denials* Policy and Procedure.
16. ***Premier Access'*** claims staff will audit five percent (5%) of Referral Notification for denied letters prior to mailing ensuring the required information is included and communicated appropriately to Plan Members and Providers.
17. ***Premier Access*** determines where the Member is referred for approved specialty services from within the contracted specialty provider network. Referrals to non-contracted dentists are approved, if there is no similar or same contracted Specialist within the network.

References

This policy was previously tracked as *Quality Management Program Policy and Procedure* ***UM-07 – Referrals for Specialty Dental Care.***

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

Exhibits

Exhibit A: Specialist Referral Process Flow Chart

Revision History

Date:	Description
02/17/2012	Conversion to revised policy and procedure format and naming convention.
01/01/2013	Annual review and update to clarify the applicability and scope of specialist approval prior authorization guidelines.
3/19/2013	DMHC Routine Dental Survey Audit

EXHIBIT A
Referrals for Specialty Dental Care
Specialist Referral Process Flow Chart