Policy and Procedure			
Policy Name:	**Referrals for Specialty Dental Care – California Medi-Cal Programs**	Policy ID:	**CL.003.02**
Approved By:	Dental Director (signature on file)	Effective Date:	1/1/2013
States:	California	Revision Date:	11/19/2013
Application:	Medi-Cal Programs		

This policy applies to 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 consistent procedures for the processing of Specialty dental care referrals.

Policy

All services provided by Specialty Providers, including pedodontists/pediatric dental specialists that are not the Member's assigned Primary Care Dentist (PCD), require Prior Authorization of the Specialty referral as well as Prior Authorization of the Specialty treatment plan. Emergency services do not require Prior Authorization. Second opinions from a Specialist are available to Members upon request.

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

***Premier Access* does not delegate any responsibilities related to referrals for Specialty dental care.**

Procedure

1. All Specialty referrals require Prior Authorization.
2. Prior Authorization of Specialty referrals is waived for contracted Dental Providers (including "Extended Scope Primary Care Providers (ESPC)" that are contracted for both primary care dental services and applicable Specialty services.
3. The PCD submits a Specialist Referral Form request via mail, fax or email. The referral request must include the required supporting documentation demonstrating dental necessity, including appropriate X-ray films, whenever possible.
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. Missing information is requested for incomplete referral requests.
6. The Referral Department evaluates the request to verify that the necessary documentation is complete, the established criteria is met and the requested procedure is a covered benefit under the applicable program.
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 required timeframes.
10. If the referral is denied, the Member and Provider are notified as described in the *Denials* Policy and Procedure.

    Premier Access' claims staff will audit five percent (5%) of Referral Notifications for denied letters prior to mailing ensuring the required information is included and communicated appropriately to Plan Members and Providers.
11. *Emergency refe*rrals are processed the same day they are received. Referrals marked as "emergency" by the referring dental Provider or referrals indicating "pain" are logged as emergency referrals.

a) If the referral is approved, the Provider, Member and/or their authorized representative, and the Specialty Provider are notified within twenty-four (24) hours of the receipt of the request.

b) If the referral is denied after clinical review by the Dental Director or designee, the Provider and the Member and/or their authorized representative are notified within twenty-four (24) hours of the decision. The Referral Department faxes the notification to the PCD. Notifications are also mailed to the PCD and the Member. The notice includes information on how the PCD can contact the Dental Director, how to file a grievance with ***Premier Access*** and/or the Department of Managed Health Care (DMHC), and information on rights and the process for requesting a State Fair Hearing.

12. *Emergency Referrals* Follow-Up Process: After receiving a Notice of Approval (NOA), ***Premier Access*** and/or Provider call the Member on the same day an NOA is received to schedule a same day appointment.

    a) If the Member is unable to make a same day appointment, or if it determined after speaking with the Member, that a same day appointment is no longer appropriate, ***Premier Access*** and/or Provider document that a same day appointment was offered to the Member **and** document the reason why the Member was not seen. If ***Premier Access*** and/or Provider are unable to contact the Member on the same day an NOA is received, ***Premier Access*** and/or Provider document the time and day of the phone call **and** the unsuccessful attempt to contact the Member.

    b) ***Premier Access*** and/or the Provider make a second attempt to contact the Member within twenty-four (24) hours of receiving an NOA.

    c) If ***Premier Access*** and/or Provider are unable to contact the Member within twenty-four (24) hours of receiving a NOA, ***Premier Access*** and/or Provider documented the day and time of the second phone call and the second unsuccessful attempt to contact the Member.

    d) If ***Premier Access*** and/or Provider are unable to contact the Member within twenty-four (24) hours of receiving a NOA, ***Premier Access*** and/or Provider send the Member a letter (within five (5) days) informing the Member of:

        1) The unsuccessful attempts to make contact; **and**,

        2) To contact ***Premier Access*** and/or Provider to make an appointment.

13. Non-emergency (Routine) referrals are generally processed within three (3) calendar days of receipt and not more than five (5) calendar days after all of the information reasonably necessary to make the determination is received. Referrals marked as “routine” by the referring PCD are processed as non-emergency referrals, except any request marked “routine” that indicates the Member is experiencing pain, is identified and processed as an emergency referral.

    a) If the referral is approved, the PCD, the Member and/or their authorized representative, and the Specialty Provider are generally notified within three (3) calendar days of the receipt of the request and no more than five (5) calendar days from the receipt of all necessary information. The notifications include the valid period of the Specialty Referral Approval (ninety (90) calendar days). The Specialty Provider is notified that Prior Authorization is required for all non-emergency basic and major services to be completed in the treatment plan. The Specialty Provider is notified that necessary follow-up treatment will be performed by the PCD.

    b) If the referral is denied after clinical review by the Dental Consultant, the PCD and the Member and/or their authorized representative are notified within twenty-four (24) hours of the decision. The Referral Department faxes the notification to the PCD’s office. Notifications are also mailed to the Provider and to the Member. The notice includes information on how the PCD can contact the Dental Director, how to appeal the decision, how to file a grievance with ***Premier Access*** or the DMHC, and information on rights and the process for requesting a State Fair Hearing.

14. Non-emergency (Routine) Referrals Follow-Up Process. Within five (5) days of receiving a NOA, ***Premier Access*** and/or Provider call the Member to schedule an appointment. The time and day of the appointment are documented and the appointment is provided within 30 days of the receipt of the NOA.

    a) If ***Premier Access*** and/or the Provider are unable to contact the member within five (5) days, ***Premier Access*** and/or Provider document the day and time of the attempted phone call.

    b) ***Premier Access*** and/or Provider make a second attempt, within thirty (30) days of receiving the NOA, at scheduling an appointment. ***Premier Access*** and/or Provider send a reminder letter to the member (within thirty (30) days after specialty services have been approved if no claim has been received by ***Premier Access***) informing the member that:

        1) ***Premier Access*** and/or Provider attempted to reach the member; **and**,

        2) To contact ***Premier Access*** and/or Provider to make an appointment.

15. Identification of Members with Special Health Care Needs can occur through Member contact with the Customer Service Department or through Dental Provider contact with the Care Coordination or Utilization Management processes. Upon identification, Care Coordinators work with the family to ensure appropriate Specialty referrals. Ongoing treatment needs can be facilitated through standing authorizations to Specialty Providers based on the treatment needs of the Member. Standing authorizations are processed through the Referral/Care Coordination Department.

16. ***After*** completion of treatment, the Specialty Provider submits a claim form to ***Premier Access*** for payment of authorized services.

17. ***Premier Access*** sends a reminder letter to the Member within forty-five (45) days after Specialty services have been approved if no claim has been received for the approved services.

18. ***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. Under no circumstances, will the Member be charged for services provided by Non-Contracted Providers.

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

    a. The Member's right to a State Fair Hearing, method of obtaining a State Fair Hearing, and time limit for requesting a State 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 ***Premier Access*** authorization procedures supporting the action;

    b. The Member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend or other spokesperson;

    c. 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.

    d. 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 (3^{rd}) calendar day after the decision is made, not to exceed fourteen (14) calendar days from the receipt of the original request.

    e. If the decision regarding a prior authorization request, including a request for referral for specialty dental care, within the defined timeframes cannot be processed, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

20. Los Angeles Pre-Paid Health Plan (LAPHP) Transportation Program: LAPHP Members are eligible for free transportation to and from Specialty appointments. Information on obtaining transportation services is described in the NOA.

Revision History

Date:	Description
1/2013	Written policy developed.
3/19/2013	DMHC Routine Dental Survey Audit.
11/19/2013	Written policy revised.

EXHIBIT A
Referrals for Specialty Dental Care – California Medi-Cal Programs
Specialist Referral Process Flow Chart