| Policy and Procedure | | | |
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| Policy Name: | Review Timeframes for Prior Authorization and Specialist Referrals | Policy ID: | CL.010.01 |
| Approved By: | Dental Director (signature on file) | Effective Date: | 1/1/2013 |
| States: | All states | Revision Date: | N/A |
| 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 ensure decisions to approve, modify, delay, or deny dental services are made in a timely manner.

## *Policy*

***Premier Access*** processes all requests for Prior Authorization and review, including preauthorization of Primary Care Dental Services and referrals for specialist dental care, within timeframes appropriate to the dental/medical condition of the patient, and in accordance with applicable regulatory and/or program requirements. Decisions and appeals are made in a timely manner and are not unduly delayed for dental conditions requiring time sensitive services.

## *Procedures*

1. Determinations to approve, modify, delay, or deny requests by providers for dental services shall comply with the following:

2. For routine dental services, notifications of determinations made prior to, or concurrent with, the provision of dental care services shall not exceed five (5) business days from receipt of the information requested by ***Premier* Access** as reasonably necessary to make the determination.

    a. Any extension or decision deferral may only occur where the member or provider has requested an extension or when **Premier Access** can provide justification and it is in the interest of the member.

    b. Any decision delayed beyond such time limits is considered a denial and must be immediately processed in accordance with ***Policy CL.012.01, Denials***.

3. For emergency/urgent dental services, notifications of determinations shall not exceed 72 hours after receipt of the information requested by ***Premier Access*** as reasonably necessary to make the determination.

    a. Emergency/urgent dental services include any instance in which a provider indicates, or ***Premier Access*** determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

    b. Decision and notice will be provided as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for services.

    c. Any extension or decision deferral may only occur where the member or provider has requested an extension or when ***P*remier Access** can provide justification and it is in the interest of the member.

    d. Any decision delayed beyond such time limits is considered a denial and must be immediately processed in accordance with ***Policy CL.012.01, Denials***.

4. In cases where the review is retrospective, the determination shall be communicated to the member and requesting provider within thirty (30) days of the receipt of the information that is reasonably necessary to make the determination.

5. Determinations made prior to, or concurrent with, the provision of dental care services shall be communicated to the requesting provider within 24 hours of the determination.

6. Except for concurrent review decisions pertaining to dental care that is underway, which shall be communicated to the member's treating provider within 24 hours, determinations shall be communicated to the member in writing within two (2) business days of the determination being made.

7. In the case of concurrent review, dental care shall not be discontinued until the member's treating provider has been notified of ***Premier Access***' determination, and the treating provider has agreed with an appropriate care plan.

8. Communication regarding approval of requested dental services specifies the specific dental care service approved.

9. In the event that ***Premier Access*** cannot make a determination within the timeframes specified above because:

    a. ***Premier Access*** has not received all the needed information;

    b. Consultation by an expert reviewer is needed; or

    c. ***Premier Access*** determines that an additional examination or test, that is reasonable and consistent with good health care practice, be performed;

    d. ***Premier Access*** shall notify the provider and the member in writing that a determination cannot be made within the specified timeframe.

    e. The provider and the member are notified in writing immediately upon the expiration of the specified timeframe or as soon as ***Premier Access*** becomes aware that it will not meet the specified timeframe, whichever occurs first.

    f. The written notification shall specify the:

        1) Information requested but not received;

        2) Expert reviewer to be consulted; or

        3) Additional examinations or tests required.

        4) The written notification shall specify the anticipated date on which a decision may be rendered.

        5) Upon receipt of all reasonably requested information, a determination and notification to the member and provider shall be made within the required timeframes.

## *References*

This policy was previously tracked as Quality Management Program Policy and Procedure **UM-13 – Review Timeframes.**

**22 CCR Sections 51014.1, 51014.2, 53894, and California Health and Safety Code, Section 1367.01**

See also related policy:

***Policy CL.012.01, Denials***

## *Revision History*

| Date: | Description |
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| 01/01/2013 | Conversion to revised policy and procedure format and naming convention.<br>Updates to procedure description. |