Policy and Procedure			
Policy Name:	Denials	Policy ID:	CL.012.01
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 that denials for dental services are appropriate, and a consistent process is followed when dental services are denied.

Policy

Requests for dental services may be denied for any of the following reasons:

- The member is not enrolled in the Plan.
- The procedure is not a benefit.
- There is insufficient documentation to determine dental necessity.
- The services requested do not meet dental necessity/appropriateness criteria.
- The dental services requested are within the scope of the PCD.
- Poor prognosis or longevity questionable.

Only a qualified, licensed dentist, competent to evaluate the specific clinical issues involved, may deny, delay, or modify requests for authorization of dental services for reasons of dental necessity or inappropriate treatment.

California Medi-Cal GMC and LAPHP Programs: For members under 21 years of age, if dental services are denied based on Medi-Cal benefits, the member, member's parent, or member's legal guardian must be contacted to seek assistance through Children's Health and Disability Program (CHDP), California Children's Services (CCS), or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, in accordance with ***Policy CL.013.01, EPSDT Supplemental Services***.

Procedure

1. Prior to, or concurrent with, the provision of dental services, the decision to deny, delay or modify dental services shall not exceed five business days after ***Premier Access*** receives all of the information reasonably necessary and requested to make the determination.
2. Prior to, or concurrent with, the provision of **emergency/urgent** dental services, the decision to deny, delay or modify dental services shall not exceed 72 hours after ***Premier Access*** receives all of the information reasonably necessary and requested to make the determination.
3. The dental provider is notified by fax or telephone within 24 hours and the member and provider are notified in writing within 2 business days of the determination.
4. For review conducted retrospective to the provision of dental services, decisions to deny, delay or modify are communicated to the dental provider and member in writing within 30 days.

5. Written communication includes a clear and concise explanation of the reason(s) for the denial, the criteria or guidelines used to make the determination, and the clinical reasons for the determination, if the denial is based on dental necessity/appropriateness, in language that can be reasonably understood by laypersons.
6. Written communication clearly specifies the provision in the member's evidence of coverage or certificate of insurance that excludes the service when the requested dental service is not a covered benefit.
7. Written communication includes instructions on how to file a grievance so that members who believe that dental services have been improperly denied, modified, or delayed by ***Premier Access*** or a contracting provider have an opportunity to file a grievance.
8. Written communication to the dentist requesting the service includes the name and direct telephone number/extension of the dental professional responsible for the denial, delay, or modification.
9. When dental services are denied because they fall within the scope of the PCD, they are recorded in the referral log. The Referral/Case Management Department:
    - Sends a letter to the member instructing the member to return to his/her PCD for treatment.
    - Sends a reminder letter after 60 days if the member has not followed up with his/her PCD.
10. ***Premier Access*** will notify Provider within 24 hours of a denial based on dental necessity/appropriateness.
11. ***California Medi-Cal GMC and LAPHP Programs:*** 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:

    a. 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;

    b. The member's right to represent himself/herself at the 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 (3rd) business 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 specialist dental care, within 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.

References

This policy was previously tracked as *Quality Management Program Policy and Procedure* ***UM-04 –Denials.***

See also related policies:

Policy CL.002.01, Prior Authorizations
Policy CL.002.02, Prior Authorizations – California Medi-Cal Programs
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, CL.013.01, EPSDT Supplemental Services

Revision History

Date:	Description
01/01/2013	Converted to new template and naming convention. Updated with program-specific language.