Name:	**Prior Authorization Policy**
Date of Origin:	**10/23/2002**
Current Effective Date:	**3/24/2025**
Scheduled Review Date:	**3/24/2026**

I. PRIOR AUTHORIZATION POLICY:

Capitol Dental Care (CDC) requires prior authorization (PA) on certain services as required by the Division of Medical Assistance Programs, or as determined by Capitol Dental Care's policies and procedures.

CDC members are provided services that are sufficient in amount, duration, and scope according to their needs. CDC will not deny or reduce the amount, duration, or scope of authorized serviced for any arbitrary reason, according to 42 CFR §438.210. That is to say that the services will be the same for those that are fee-for-service members.

For those services requiring PA the dental office is instructed to submit a request and applicable supporting documentation (i.e. CDT Code, x-rays, complete treatment plan) to our administrative office.

CDC's designated dental consultant reviews PAs. If clinical documentation notes a potential co- morbidity, that is considered in the decision. Approved requests are sent back to the dental office and the dental office then contacts the patient/member to schedule the treatment. Denied PAs are sent back to the dental office. The member is simultaneously sent a formal denial with appeal and administrative hearing rights. Any patient information delivered to and/or between dental offices and/or the patient and CDC is delivered in a manner consistent with HIPAA Privacy and Security Rules.

Special consideration is afforded to LTCSS members as dentally appropriate and necessary under OAR 410-141-3835.

II. PRIOR AUTHORIZATION PROCEDURES:

A. PA requests are received and date and time stamped on the day of receipt, or when the request was actually received via email or otherwise.
   i. PA requests submitted after hours or on weekends will be date and time stamped when the request was actually received via email or otherwise.

B. Member eligibility is verified
   i. Enrollment (currently enrolled)
   ii. Benefit Package (Plus, Limited, Standard)
   iii. Benefit limitations (check claims history for service eligibility)

C. PA is logged "received" (Y) into the claims processing software.

D. PA for members not meeting eligibility verification (B above) are denied and returned to the provider. The member receives a denial letter outlining the members appeal and administrative hearing rights. A copy of the denial is sent to the provider.

E. The PA request is reviewed by administrative staff for accuracy and completeness within one week. Any incomplete PAs are returned to provider for completion. Additional information is requested to be given within one week. Three attempts will be made, using two separate methods to obtain the necessary information during the 14 (fourteen) day period.

- Complete PA requests are reviewed by a designated dentist and a formal decision is made within 14 days or sooner based on the guidelines set forth in the OHP Administrative Rules.
- If an Ortho PA:
  - » Submission via mail of the complete package to Capitol Admin
  - » Complete package includes:
    - Referral form with ICD-10 diagnosis code(s)
    - Health history
    - Progress records noting free and clear of dental disease
    - Models
  - » Once the completed package has been received, they will be reviewed for dental necessity or dental appropriateness.
- Approved PAs are stamped, dated and returned to the provider for patient scheduling.
- Denied PAs are stamped, dated and returned to the appropriate provider office. A denial letter is sent to the member with appeal and administrative hearing rights.
- Clinically A request will be made for additional information from the provider if needed to make a determination. Once the information is, or is not received, a determination will be made within the allowable time frame.
- The PA details are logged into the PA database and theclaims processing software.

F. Approved PAs are not transferable to a new provider and have expiration dates of six months to one year depending upon the requested service.

G. A Provider may not resubmit a Referral or Pre-Authorization during the 60 day Appeal period.

III. STANDARD AND EXPEDITED DECISIONS

A. For standard authorization decisions, CDC's goal is to process all prior authorizations decisions as expeditiously as the member's health condition requires but not to exceed fourteen (14) days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if

i. The member, or the provider requests extension or,

ii. CDC justifies (to OHA upon request) a need for additional information and how the extension is in the member's interest.

iii. If the CCO extends the time frame for standard or expedited authorization decisions, it must:

- Give the member written notice of the reason for the extension (no later than the date the authorization time frame expires).
- Inform the member of the right to file a grievance if he or she disagrees with that decision.
- Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

B. For expedited authorization decisions – In cases in which a provider or CCO indicates, or CDC determines, that following the standard timeframe would jeopardize the member's life or health or ability to attain, maintain or regain maximum function, CDC will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later seventy-two (72) hours after receipt of the request for service.

i. CDC may extend the seventy-two (72) hour time period by up to 14 calendar days if the member requests an extension, or if CDC justifies (to OHA upon request) a need for additional information and how the extension is in the member's interest.

As part of the provider enrollment process, CDC educates panel providers on the option of delivering to CDC an expedited authorization request in cases where delay would jeopardize the member's life, health or ability to attain, maintain or regain maximum function with respect to oral health concerns.

IV. INTERRATER RELIABILITY

It is very important to CDC that the review criteria governing approval/denial of service requests are applied consistently by all those who are involved in the process. Because of this concern, regular auditing of the outcomes will be performed.

Once a month, a clinical reviewer will audit the decisions of the initial clinical reviewer. CDC has referred to this process as "Review the Reviewer." A sample of at least 10 service requests will be reviewed de novo by the second reviewer, who will come to her own, independent decision based on the facts of the request and CDC's review criteria.

A log will be maintained with the results of these audits. If there is disagreement between the reviewers, the Dental Director will have the authority to explain what the appropriate outcome ought to be based on CDC's internal criteria, the facts of the individual case, the rules and regulations, etc.

Annually, the Quality Improvement Committee will review the results of the auditing.

V. PRIOR AUTHORIZATION MONITORING:

CDC will review a record of preauthorization dates (receipt / adjudication /mailing, etc.) consistent with the above required timeframes. 2 times per year at the QI Committee meetings, the committee will review this record to look for instances where timeframe requirements were not met, and implement corrective action as necessary.

VI. REVISION ACTIVITY

Modification Date	Change or Revision and Rationale	**Effective** Date of Policy Change
4/15/2005	Annual Update/Review	4/15/2005
10/1/2006	Bi-annual Update/Review	10/1/2006
6/1/2008	Bi-annual Update/Review	6/1/2008
4/28/2010	Bi-annual Update/Review	04/28/2010
10/24/2012	Bi-annual Update/Review	10/24/2012
12/04/2014	Bi-annual Update/Review	12/04/2014
12/14/2016	Bi-annual Update/Review	12/14/2016
8/29/2018	Update, addition of Interrater Reliability section	8/29/2018
7/20/2019	Update	7/20/2019
11/14/2019	Update	11/14/2019
11/2/2020	Review	11/2/2020
1/5/2021	Review	1/5/2021
06/09/2021	Review	06/09/2021
06/09/2022	Review	06/09/2022
6/21/2023	Annual Revision	6/21/2023
02/17/2024	Revision	02/17/2024
6/19/2024	Revision	6/19/2024
8/21/2024	Revision	8/21/2024
9/23/2024	Revision	9/23/2024
1/17/2025	Revision	1/17/2025
3/10/2025	Revision	3/10/2025

VII. AFFECTED DEPARTMENTS

All CDC Providers

VIII. REFERENCES

CDC Pre-Authorization Form OHP Dental
OHP Administrative Rules