Chap 20: Oral Health Services

Introduction

Health Choice Insurance Co. (Health Choice) is confident that Dentists are capable of providing the majority of medically necessary dental services to their patients. However, should the need arise for medically necessary dental specialty services, Health Choice's Chief Clinical Officer, Medical Director(s), Dental Director(s) or their designee, will make dental necessity determinations based upon nationally recognized and evidence-based standards of care.

Accurate and prompt dental necessity determinations depend upon the comprehensive content and the quality of dental documentation that Health Choice (or its delegated entities) receives with each request. Health Choice is committed to making the prior authorization process simple and efficient; however, the requesting provider should make a best effort to submit requests in a manner which will facilitate this review process.

Health Choice utilizes specific dental utilization Clinical Review Criteria (CRC), which has been developed by the Health Choice Dental Director(s) to consistently and accurately conduct prior authorization reviews. Ensuring proper utilization and payment of covered dental services.

The Pediatric Dental Rider serves as a guided reference for dental offices. A complete listing of covered dental services, and those that may require prior authorization, can be located at: http://www.healthchoiceessential.com/docs/members/benefits/PediatricDentalRider2016.pdf.

Prior Authorizations

Dental Prior Authorization Mailing Address:

Health Choice Insurance Co.
Dental Authorization
410 N. 44th St. Ste 520
Phoenix, AZ 85008

Please follow these key steps when requesting a medically necessary prior authorization (PA):

- Providers must legibly complete all necessary fields of the most current ADA claim form leaving the "date of service" blank
- Providers should request specific CDT codes (and HCPCS/J-codes when applicable.)
- Providers should only request PA for services listed in the Evidence of Coverage
- Providers must include ALL necessary documentation to support medical necessity to avoid unnecessary denials or inappropriate delays in the dental review/approval process
- Providers should clearly indicate if the request is "**Standard**" or **"Expedited"** (see below for details). Providers must not abuse expedited service requests. Inappropriate *expedited requests will result in slower*

processing times for truly urgent dental authorizations for all network providers. Inappropriate ***Expedited*** requests will be downgraded to standard by Health Choice, which may take up to 14 calendar days to complete

- The ADA claim form should be mailed to the Health Choice Dental authorization department along with all corresponding information

NOTE: Receipt of an authorization from Health Choice is **not** a guarantee of payment for dental services.

- The claim must be billed correctly and timely
- The service must not be deemed experimental or investigational
- Services rendered must be covered under the Health Choice Insurance Co. program
- The member must be eligible on the date of service

Time Frames for Health Plan Prior Authorization Review

STANDARD: Up to 14 calendar days – Standard means a request for which Health Choice Insurance Co. must provide a decision as expeditiously as the member's health condition requires, but no later than 14 calendar days following receipt of the authorization request. A possible extension of an additional 14 calendar days may be needed if:

1. Member or provider requests an extension
2. If Health Choice determines a request for additional information is in the enrollee's best interest

EXPEDITED: 72 hours from receipt of request – Expedited means a request for which a provider indicates, or Health Choice determines, that using the standard time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain, maximum function. Health Choice must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, no later than 72 hours from receipt of the authorization request. A possible downgrade, from expedited to standard request, may be made if the information received does not meet the aforementioned criteria for an expedited request. If a request is downgraded to a standard request, Health Choice has 14 days to complete the request from the initial date received. A request that is downgraded would not meet the definition of an expedited request.

Prior Authorization Determination: Authorizations which are submitted correctly to Health Choice will be processed and completed in one of the following standard methods:

- Approved: The information received met all Health Choice requirements and an authorization was granted. No further action is required by the office except to notify the member and coordinate care for the approved services, unless additional documentation must be submitted with the dental claim. In some instances, the Health Choice Dental Department will review the requested dental service(s) and approve an "equivalent" service, which does not constitute a formal "reduction" of services (see below). This action is intended to facilitate the authorization process and eliminate barriers to car.

The Health Choice "Referral/Authorization" form that is issued will contain specific information regarding the approved equivalent service.

Exception*. In some instances, the Health Choice Dental Department will review the requested dental service and grant an authorization; however final payment requires documentation to show medical/dental necessity not yet demonstrated at the time the authorization was granted (i.e. radiographs not taken at the time of service due to member special behavioral or medical conditions). This is unique to the provision of dental care, and the capacity of Health Choice to perform a retrospective review of services. Final coverage and payment of the amount, duration, and scope of services is dependent upon final documentation received with retrospective claim.

The Health Choice "Referral/Authorization" form issued will contain specific information instructing the office what required documentation (i.e. dental radiographs or clinical notes) should be submitted with the retrospective review claim.

- **14 day Extension** (see below*): If Health Choice does not receive sufficient information to make a coverage determination within the legally required timeframes; a 14 day extension will be requested. Health Choice will frequently make an initial attempt to call or fax the office in order to obtain the needed information before resorting to a formal 14 day extension
  NOTE: The decision will be issued no later than 28 days from the date Health Choice receives a **Standard** request or 17 days from the date Health Choice receives an **Expedited** request
- Reduction: The information received met all Health Choice medical necessity requirements, and a partial authorization is granted. Requested services may be reduced when the documentation provided does not support the full amount, duration and/or scope of service at the time of the request
- If Health Choice does not respond to the authorization request within the required time frame, the request is considered "denied' as stated above
  14 day Extensions*: In some instances where prior authorization has been requested, the documentation received by Health Choice may suggest that medical/dental necessity exists for the service but the records provided are insufficient to render an authorization.
    - When this occurs, additional information may be requested via fax or direct phone contact. When additional information cannot be obtained for Health Choice to meet the mandated expedited or standard PA time frames, Health Choice will issue a 14 day extension letter to both the member and the requesting Provider. This 14 day extension will afford both Health Choice and the requesting Provider up to 14 additional calendar days to obtain the additional information necessary to render a final determination. If at the end of the 14 day extension Health Choice has not received the necessary additional information, the request will be denied and both the Provider and member will be notified

Supporting Documentation

Documentation of medical/dental necessity must accompany all requests for prior authorization. For most PA requests, supporting documentation should include:

- Current diagnosis and treatment already provided by the PCP/PDP/requesting Provider
- All pertinent medical/dental history and physical (dental/oral) examination findings
- Diagnostic imaging (and laboratory reports, if applicable)
- Indications for the procedure or service
- Alternative treatments, risk, and benefits (including the indication of such discussions with patient)
- For Out-of-Network (OON) providers/facilities/services, and/or Non-Formulary (NF) medication requests, specific information which explains the medical necessity for the OON or NF service is required. A PA is required in order for any service to be covered at OON providers/facilities

Prior Authorization Denials

All members must be notified of a denial of service request within 3 business days for **Expedited** request, and within 14 calendar days for **Standard** request. When a denial is issued, Health Choice Insurance Co. must inform the member of the denial of service and the reason for denial in clearly understood language in the form of a "Notice of Action" (NOA) letter.

Written information which communicates a denial of service will also be sent to the requesting Provider (or their designee). Provider denial letters are sent to the individual who has requested the prior authorization and will contain varying degrees of detail in order to explain the basis for denial.

Special Considerations and Information Regarding Dental Prior Authorizations

- The Primary Dental Provider (PDP) should initiate the referral process (Dental and alternative Oral Specialists should not generally refer directly to other specialists). Although this practice is not expressly prohibited, it may fragment care coordination performed by the PDP and reduce the capacity to provide a Dental Home for your patient
- Health Choice members should be instructed not to self-refer to specialists without the express recommendation of their PDP
- Health Choice will provide notice of approval/denial within the allowable timeframes via fax and/or phone to the requesting provider
- If the service requires prior authorization and an authorization was not approved, or if the member was ineligible at the time of service, the claim will be denied
- The authorization number or denial should be noted in the member medical record
- The PDP (or ordering Provider) is responsible to facilitate coordination of care and assist/alert the member to make the necessary appointments for approved services
- When difficulty arises in coordinating and/or facilitating care, the referring provider should contact Health Choice for additional assistance

- Authorization is **NOT** a guarantee of payment for services
- Authorizations are valid for 180 days
- Contracted health professionals, hospitals, and other providers are required to comply with Health Choice Insurance Co. Prior authorization policies and procedures

Retrospective Prior Authorizations (AKA "Retro")

Health Choice Insurance Co. requires that prior authorization be obtained for some non-emergency/non-urgent services listed in the Member Evidence of Coverage. Health Choice does not generally entertain requests for retro prior authorization as these are, by definition, contradictory. It is the responsibility of the Provider or Facility rendering care to verify insurance eligibility, as well as benefit coverage and/or authorization requirements/status.

In the event that a PA is not obtained, and a non-authorized service is rendered as a direct result of an urgent or emergent medical/dental condition, the dental provider should take the following action:

- The Dental provider should submit the claim for the urgent/emergent, non-authorized service(s) with documentation to:

  Health Choice Insurance Co.
  Dental Claims
  410 N. 44th St. Ste 500
  Phoenix, AZ 85008

  1. Documentation to support the medical/dental necessity of the care rendered
  2. Documentation to support that the care rendered was either:
     - Required on an urgent or emergent basis
     - Required as a result of a necessary or unexpected modification in the dental care plan

The Claim and supporting documentation will be reviewed by the Health Choice Insurance Co. Chief Clinical Officer, Medical Director(s) and/or Dental Director(s), or their designed, for approval or denial. In the event that the dental claim is denied, Providers/Facilities have the right to file a Claims Dispute. See Chapter 15, Claim Disputes and Member Appeals. If a provider submits a claim which is denied for no PA being obtained, the claim can be grieved along with documentation of medical necessity and a basis for why PA was not obtained.

Health Choice uses the following protocol to resolve appeals regarding authorizations:

- The requesting provider may resubmit a new PA request with new/additional information pertinent to the original non-authorized request to the Prior Authorization Department
- Requests should only be resubmitted to the Prior Authorization Department if new/additional pertinent information is being provided with the resubmission
- The original information (denial packet) will be gathered from storage, combined with the current request which contains new/additional information, and the request

will be presented to the Health Choice Dental Director, or their designee for re-review

- If no new and/or additional information is received, the resubmitted request will be "cancelled" and the office notified by telephone or fax. New and/or additional information is needed to constitute a new PA request. If the member wishes to file an appeal on a denied authorization, please refer the member to their Evidence of Coverage or Member Services at 1-855-452-4242