[Contractor Name]

Plan name: Louisiana Medicaid
Pre-Authorization#: 123456789123
Subscriber ID: 987654321987

Pre-authorization Partial Dental Notice

09-14-19

Member name
Address
City, State Zip Code

Dear **[Member Name]**:

We are writing to tell you about your request for prior authorization of dental service(s) that was received on [Date request received] is a partial denial.

Approved Services

[Contractor Name] will pay for the following care:

Tooth/Area/Surface	Procedure/Description:
19 O,B	Tooth colored filling – two surfaces, back tooth
3 O, L	Tooth colored filling – two surfaces, back tooth
J	Simple removal of tooth
A	Partial removal of the pulp – baby tooth

Denied Services

[Contractor Name] will not pay for the following care:

Tooth/Area/Surface	Procedure/Description:	Denial Code
	Treatment in the hospital	Medically Necessity

To find out why we won't pay, please keep reading. If you think we made a mistake, you may ask for an appeal.

If you have questions, call **[Contractor Name]** at 1-XXX-XXX-XXXX. TTY users call 1-XXX-XXX-XXXX. This call is free. Your dentist also got a copy of this letter, so you should also talk to your dentist.

Why won't [Contractor Name] pay for service?

Denial Code	Denial Reason
Medical Necessity	**[Contractor Name]** reviewed the request and determined that your condition does not meet the criteria as stated in **[Contractor Name]**'s Utilization Review and Criteria Guidelines. ***[When applicable, include link to the criteria/regulation/policy/Rule used for the decision – per ACT 330]***. The information we received does not show that you met one or more of these criteria: • Your dentist has already tried to take care of your problem in the office. • You need more than one procedure. • You need equipment that is only at the hospital. • You have physical or mental special needs. • You have behavior that is out of control. • You have had problems with past surgery. • The procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of member's needs. **[Contractor Name]** determined that: • *[Denial reason and service being denied]* • *[Correlate the specific reasons for denial to each justification for the request as denoted in the documentation submitted. Explain in detail why **[Contractor Name]** determined that the documentation submitted is insufficient to meet the criteria denoted above. Sufficiently describe the considerations that played a role in the denial decision. The denial reason/explanation should assist the member in preparing a meaningful defense in the event that he/she wishes to appeal. Add as many bullet points as needed to ensure the information is easily understood, clear and concise. Use plain language.]* Because of all these reasons stated, **[Contractor Name]** does not think the care is medically necessary. According to LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) ***[When applicable, include link to the criteria/regulation/policy/Rule used for the decision – per ACT 330]***, for a service to be considered medically necessary, it must show that the services are: 1) Deemed reasonably necessary to diagnose, correct, cure, alleviate, or prevent the worsening of a condition or conditions that endanger life, causing suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) those for which no equally effective,

	and more conservative course of treatment is available or suitable for the member.

Your dentist can call **[Contractor Name]** to get a full copy of the **[Contractor Name]** guidelines for the requested services that were denied. You or your dentist can ask for a written copy of the criteria used to make this decision by calling **1-XXX-XXX-XXXX.**

Do you have questions?
Call us at **1-XXX-XXX-XXXX. TTY users call 1-XXX-XXX-XXXX. This call is free.** Your dentist got a copy of this letter. You may also want to talk to your dentist.

Does your dentist want to talk to someone about this decision?
Your dentist can call **[Contractor Name]** if he/she has questions at **1-XXX-XXX-XXXX.** Your dentist can speak with the Clinical Reviewer Monday – Friday, 7a.m. to 7p.m. to discuss the information used to make this decision.

What can you do if you think [Contractor Name] made a mistake?
If you think we made a mistake, you may ask for a reconsideration or an appeal. If you want to request an informal reconsideration or an appeal, you must do so within 60 calendar days from date of this notice.

How do you ask for an informal reconsideration?
You, your dentist, or someone you pick may ask for an informal reconsideration with **[Contractor Name]** if they have your permission in writing. We will send you a form that you can sign and return to us. You can also get this form from your dentist or from our website at [website address/link]. This form tells us that you give permission to the person you name to represent you during the informal reconsideration process. You can ask for an informal reconsideration by calling our Member Hotline toll-free at **1-XXX-XXX-XXXX**. You can also send a letter to:

[Contractor Name]
Appeals Department Name
Address
City, State Zip Code

We will take no more than 1 business day from the date we receive your request for an informal reconsideration to make a decision about it.

You will receive a written response with our informal reconsideration decision. If you disagree with our decision, you can also ask for an appeal. Your request for an informal reconsideration does not extend the time you have to ask for an appeal.

How do you ask for an appeal?

You, your dentist, or someone you pick may ask for an appeal. If you want someone to file an appeal for you, you must tell us in writing first. We must receive your written request before we can process the appeal. You can ask for an appeal by phone, in person, or send in writing by mail or fax to:

[Contractor Name]
Appeals Department Name
Address
City, State Zip Code
Phone: 1-XXX-XXX-XXXX
Fax: 1-XXX-XXX-XXXX
TDD/TTY: 1-XXX-XXX-XXXX
Email:

If you ask for an appeal by phone, you must also send the request in writing. This is not required if you need a fast decision.

You or your dentist can send us more information to show us why you do not agree with our decision. To learn more about your appeal rights, see your Member Handbook or call our Member Services Department.

If you are going to reduce, or stop a service we had approved you to receive in the past, you have the right to request to keep getting the service until **[Contractor Name]** makes our decision.

To keep getting the service, you must ask to continue the service on or before 10 calendar days form the date of this notice or the effective date of the action. Please call **[Contractor Name]**'s Member Hotline toll-free at **1-XXX-XXX-XXXX** if you need to continue a service. If you appeal the action and keep getting the service you may have to pay for the service if the appeal decision does not go your way.

What if you need a fast decision on the appeal?
If your condition is considered urgent, we may be able to make a decision about your appeal much sooner. You may need a fast decision if, by not getting the requested services, one of the following is likely to happen:

- You will be at risk of serious health problems, or you may die;
- You will have serious problems with your heart, lungs, or other body parts; or
- You will need to go into a hospital.
- Your dentist must agree that you have an urgent need.

If you ask for an expedited appeal, we will call you and your dentist with our decision within 72 hours from when we get your appeal. If **[Contractor Name]** determines that your request does not qualify for a fast decision, it will be resolved within 30 calendar days.

The appeal can be made either verbally or in writing. Please call **[Contractor Name]**'s Member Hot line toll-free at **1-XXX-XXX-XXXX** and tell us that you want a fast decision on your appeal. A Member Advocate will help you file an appeal where you will get a fast answer.

How do you ask for a State Fair Hearing?
After you get our decision to your appeal and still don't agree, you have the right to ask for a state fair hearing. A state fair hearing is when you ask that our decision be looked at again by a judge. Instructions on how to request a state fair hearing will be included in your appeal decision letter. Before you ask for a state fair hearing, you must complete **[Contractor Name]**'s appeal process.

Do you need help with this letter?
Call **[Contractor Name]** at **1-XXX-XXX-XXXX**, 7 a.m. to 7 p.m., Monday – Friday.

If you need help in another language, call **1-XXX-XXX-XXXX** (toll-free).

Sincerely,

[Contractor Name]'s Utilization Management Department

Cc: [Dentist]