Dental Health Services

Appeal Process

Initial/Internal Review Process*:*

- You must submit the appeal within one hundred-eighty (180) days from the date of the adverse benefit determination letter.
- You and your dentist will be notified of the appeal decision through US Mail.
- If we continue to deny the payment, coverage, or service requested, you have a right to appeal this through the Second Level Review Process.

Urgent Appeal

You and your dentist can request for an urgent appeal if:

- You are currently receiving or are prescribed treatment or benefits that would end because of the adverse benefit determination; or
- Where your treating provider believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain; or
- When the claim determination is related to an issue of admission, availability of care, continued stay, or emergency health care services when you have not been discharged from the emergency room or transport service.

You and your dentist will be notified of the decision regarding the urgent appeal within seventy-two (72) hours. All notification for urgent appeal decision is by phone and US Mail.

Second Level Review Process

If you disagree with the Initial/Internal process determination.

- You have thirty (30) days from the date of the Initial/Internal process determination letter to request for a Second Level Review of the confirmed adverse benefit determination.
- You may submit this request orally, electronically or by US Mail.
- Dental Health Services' Service Review Committee or the Dental Director will review your appeal. In all cases, the reviewer will be someone other than the person who upheld the Initial/Internal appeal. The reviewer will not give deference to the initial denied claim or the Initial/Internal upheld appeal. If the decision is based on medical judgement, the consulting dentist will be different from the dentist involved in the Initial/Internal Review Process. If the decision does not require medical judgement, the Management Committee excluding the Dental Director will do the Second Level Review.
- The decision at the Second Level Review is binding unless other remedies are available under state or federal law.

Concurrent Expedited Appeal

A concurrent expedited review means initiating both Initial/Internal and Second Level Review simultaneously to:

- Review a decision made under the provisions of this Plan; or

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- Review a course of treatment in a facility, dental professional's office, or any inpatient/outpatient health care setting so the final Adverse Benefit Determination is reached expeditiously.

Continuation of Care
During review of your Appeal, Dental Health Services will continue to provide coverage for the disputed Benefit pending outcome of the review if you are currently receiving services or supplies under the disputed Benefit. If Dental Health Services prevails in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the Second Level Review is binding unless other remedies are available under state or federal law.

Other resources to help you: If you have questions or would like assistance with an appeal or complaint regarding your coverage, insurance company or agent, you have the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available via the following:

Director of the Department of Consumer and Business Services
P O Box 14480, Salem OR 97309-0405
Toll Free 888-877-4894 or 503-947-7984
Email: Cpi.ins@state.or.us
Or online via: http://www.insurance.oregon.gov/consumer/consumer.html

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