

December 22, 2010

Clarification of “Authorization” reference in December 6th Client letter:

We have received some inquiries from clients and providers asking for authorization to continue coverage for some or all services that will be eliminated January 1, 2011. We wish to clarify this for everyone.

The Department requires prior authorization for some specific procedures or services. For example: some dental services, dentures, and some types of vision aids and hearing aids must be authorized before the service can be rendered. The purpose of this prior authorization process is to determine if the service meets the department’s criteria for medical necessity and approve payment.

This process prevents the client from receiving this non-emergent care while the department makes a determination. We know there are providers who have already submitted or were planning to submit a request for the Department’s authorization, as required by Department rule, to perform a service before the end of the year. We wanted to reassure these providers and clients that these authorization requests will be reviewed and will not be returned or discarded when the benefit ends January 1, 2011.

The Department will not review any requests to authorize services that do not require prior authorization by its rules. We know the elimination of these benefits is a hardship for our clients, and we regret that these cuts are necessary. We apologize for any inconvenience caused by this misunderstanding.