UTILIZATION MANAGEMENT	DentaQuest			
	Policy and Procedure			
	Policy Name:	Authorization Review	Policy ID:	**UM08-INS-VIS**
	Approved By:	John R. Davis, O.D. Clinical Vision Director	Last Revision Date:	9/12/2022
	States:	All States (with noted exception)	Last Review Date:	12/14/2022
	Application:	All lines of business	Effective Date:	12/15/2022

PURPOSE

To ensure that the basis for granting or denying approval is consistent with the Utilization Management standards regarding Medical Necessity that are specified by the Plan, State, CMS and NCQA, as applicable.

POLICY

It is the policy of DentaQuest Vision (DentaQuest) to assess the coverage of a vision benefit and the medical necessity of specific services provided or procedures proposed for covered members. A formal review process is employed to make an initial determination for approval or denial of the requested service or procedure. A basic premise of the Authorization Review process is an understanding that the coverage of a service as a Plan benefit does not, in and of itself, make the service medically necessary in every case, and as such not always payable.

An initial clinical determination is made after assessment of the clinical information submitted and using other relevant variables. This Authorization Review process will take into consideration established guidelines, benefit coverage and limitations, patient and locality specific variables, and community standards for medical care, where applicable and available. DentaQuest does not deny or reduce the amount, duration, or scope of a required service solely based on diagnosis, type of illness, or condition of the enrollee.

The establishment, implementation, documentation and modification of this policy and process shall be based primarily on the utilization management standards pertinent to this subject as established by the NCQA, with CMS, State or Plan specific edits as indicated. Using these standards as the overall frame of reference, the policy and process shall also consider the following factors:

Verification that Medically Necessary services are those which:

- Are essential for the diagnostic evaluation or treatment of the presenting condition or illness;
- Are safe and effective according to nationally accepted standards of medical practice;
- Can be reasonably expected to improve an individual's condition or level of functioning;
- Are delivered at an appropriate and cost-effective level of care.

Providers and or Members will be notified of any Initial determination in a timely manner taking into consideration:

- The patient's medical condition;

- Minimum decision and notification turn-around-time as defined and mandated by specific CMS, State, NCQA or Plan requirements.

It is DentaQuest's policy that services requiring Authorization Review are evaluated by licensed professionals or other appropriately trained staff within its Utilization Management (UM) Department. The DentaQuest Clinical Vision Director oversees this process as it applies to the delivery of vision and eye care services, and the policies associated with effectuation and implementation of the Authorization Review process.

DEFINITIONS

- **"Administrative Denial"** is defined as a denial of coverage made based on benefit exclusion, delay in service, contractual requirements or non-compliance with administrative policy.
- **"Administrative Algorithm"** is defined as a series of non-clinical yes/no questions that will prompt an approval or pend to a Clinical Consultant depending on how the question is answered. The algorithms are developed based on benefit exclusions, contractual requirements, or non-compliance with an administrative policy.
- **"Clinical Algorithm"** is defined as a series of yes/no clinical questions that will prompt an approval or denial of a service depending on how the question is answered. The Clinical Algorithms are developed using clinical criteria and or Clinical Guidelines that are established by or adopted from CMS, MAC Payers, and generally accepted practice guidelines, or by utilizing various vision industry specialty organizations, Managed Care Organizations, Plan benefit description documents, as well as the information contained in the compendium for *Current Procedural Terminology* (CPT) published by the American Medical Association.
- **"Clinical Guideline"** is defined as a comprehensive, peer reviewed outline of criterion and coverage guidelines for specific medical services. Clinical Guidelines are established based on or adopted from CMS, MAC Payers, or by utilizing criterion recognized by various vision industry organizations, Managed Care Organizations, the Plan benefit description documents, as well as the information contained in the Current Procedural Terminology published by The American Medical Association, and from generally accepted practice standards of care.
- **"Clinical Denial"** is defined as a denial of coverage made when submitted clinical data does not demonstrate the medical necessity of the requested service(s) or when the Provider has failed to provide DentaQuest the supportive information required to fully evaluate the medical necessity of the requested service(s). All clinical denials are reviewed and determined by a licensed Clinical Consultant.
- **"Vision UM Specialist"** is defined as UM staff members who are specifically trained to provide primary and secondary supportive assistance of the UM functions. Decision making duties are limited to affirmative determinations only as they relate to benefits and covered services.
- **"Clinical Consultant"** is defined as a licensed clinician, including a board certified ophthalmologist, optometric physician, physician assistant, or other physician types, as applicable, who is employed or contracted by DentaQuest to make UM determinations for coverage of a service.
- **"Early Periodic, Screening, Diagnostic Test (EPSDT)"** is defined as a federal program requiring that comprehensive health care benefits be provided to Medicaid members under the age of 21

- **"Exception to Rule (ETR)"** is a request by a Member or a requesting provider for the Member to receive a non-covered health care service.
- **"Limitation Extension (LE)"** is a request by a Member or the Member's provider to exceed the scope, amount, duration, and frequency of a covered health care service.

- **"Prepayment Review"** is defined as a request for UM review after the service has been rendered, but prior to claim adjudication.
- **"Prior Authorization Review"** is defined as a request for formal UM review prior to rendering a service. Prior Authorization Reviews are Classified as either Standard or Expedited. Concurrent Review is not applicable to reviewable vision services.
- **"Urgent/Emergent Review"** is defined as those requests for authorization to evaluate and treat a patient and where in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. Urgent/Emergent Reviews are classified as Expedited. In emergent and urgent situations, Prior Authorization Review is not required. In these instances, the provider is encouraged to treat the member and then submit claims for Prepayment Review.

PROCEDURE

A. Prior (prospective) Authorization Review: The authorization request, together with any additional supporting documentation, is initially reviewed by a Vision UM Specialist in accordance with the applicable Algorithm.

1. *Review Process:* The UM Specialist approves the service as a covered benefit if the requested service and submitted documentation are consistent with the Plan benefits design and applicable Administrative or Clinical Algorithm.
    a. If the requested service does not meet the requirement for approval based on the Algorithm, the request is routed to a Clinical Consultant for medical review and determination.
    b. All clinical denials must be reviewed, and formal determination made by a Clinical Consultant.
2. *Time frames*: unless specified differently by the Plan or other regulation, determinations are completed, and notice provided within the following time frames from the receipt of the request:
    a. Standard: fourteen (14) calendar days.
    b. Expedited: seventy-two (72) hours.

- The decision-making timeframes must accommodate the urgency of the situation and must not result in the delay of the provision of covered services to Members beyond the required specified timeframes or where medically contraindicated.
- If the request lacks clinical information, DentaQuest may extend the non-urgent pre-service timeframe for up to fourteen (14) additional calendar days. DentaQuest will provide written notice to the enrollee of the reason for the extension as well as the enrollee's right to file a grievance. An extension may be taken under the following conditions:
    i. The Member or the Provider requests an extension; or
    ii. There is a justified need for additional information and an extension is in the Member's interest. In these cases, DentaQuest will notify the Member in writing of

the intent to extend the timeframe.

- The period, within which a decision must be made by DentaQuest begins:
    i. On the date when DentaQuest receives the member's response (even if not all information is provided), or
    ii. At the end of the time period given to the member to supply the information, if noresponse is received from the member or the member's authorized representative.
    iii. DentaQuest may deny the request if the information is not received within the mandated timeframe,and the member may appeal the denial.
- DentaQuest may extend the expedited pre-service timeframe due to a lack of information, once, for forty-eight (48) hours, under the following conditions:
    i. Within twenty-four (24) hours of receipt of the expedited pre-service request, DentaQuest asks the provider, member or the member's representative for the specific information necessary to the make the decision.
    ii. DentaQuest gives the provider, member or member's authorized Representative at least forty-eight (48) hours to provide the information.
- In providing for emergent/urgent services and care as a covered service, DentaQuest does not:
    i. Require prior authorization for emergent/urgent service and care.
    ii. Deny payment based on the member's failure to notify DentaQuest in advance or within a certain period after the care is provided.
- Emergent/Urgent services are covered in the following situations:
    i. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably; would have believed that an emergency medical condition existed; or
    ii. If an authorized representative acting for the organization, authorized the provision of emergency services
- Although DentaQuest does not require an authorization for emergency services, in the instance where a provider insists on the submission of a request for authorization, an authorization to render "emergency services," as defined in this policy, are provided within seventy-two (72) hours of request. Upon receipt of the claim for payment, records may be requested and reviewed, and the claim paid in accordance with the guidelines for the emergency services provided, as defined in this policy.
- DentaQuest will not downgrade the status of Expedited authorization requests received from a treating provider and will be processed as requested.
- Expedited Authorization Request – Process and Procedure
    i. An emergent/urgent authorization request for Utilization Management review is received by DentaQuest's Office Services area, via fax, through the DentaQuest portal, or by other electronic means. The request is scanned, imported, or keyed into the DentaQuest system which then creates a permanent file which contains all pertinent Member and Provider information.
    ii. All Member plan benefits are linked to each individual Member; assuring that only covered benefits are authorized.
    iii. The requested service(s) and relevant clinical information is entered into the system, flagged as an Expedited case, and added to the correct case queue for Expedited review.

B. Retrospective Authorization Review: All retrospective reviews are determined in compliance with UM standards established by NCQA and URAC. The strictest timeliness standard is applied for all review decisions.

1. *Retrospective Review Process*: The claim is initially reviewed by the Vision Specialist to determine *coverage* of the services provided and to approve or, if determined to not be covered, pend to a Clinical Consultant, as applicable.
    a. The clinical criteria utilized in the retrospective review are the same criteria utilized in the prospective authorization process to determine coverage and medical necessity and appropriateness of care.
    b. A Clinical Consultant reviews all services designated as not covered upon initial review. The Clinical Consultant will make the final determination for approval or denial of the billed service, based on available guidelines and medical necessity.
2. *Timeframes*: Retrospective reviews are conducted, and written notification of the decision sent to the Provider, and where mandated, the member, within thirty (30) calendar days from the initiation of the UM process unless a more stringent standard applies per Plan, CMS or NCQA regulation.

- If the request lacks required clinical information, DentaQuest may extend the post-service timeframe for up to fourteen (14) additional calendar days, under the following conditions:
    i. The Member or the Provider requests an extension; or
    ii. There is a justified need for additional information and extension is in the Member's interest. In these cases, DentaQuest will notify the Member in writing of the intent to extend the timeframe.
- The extension period, within which a decision must be made by DentaQuest begins:
    i. On the date when DentaQuest receives the member's response for a request for extension (even if not all of the information is provided), or
    ii. At the end of the time period given to the member to supply the information, if no response is received from the member or the member's authorized representative.

DentaQuest may deny the request if the information is not received within the timeframe,and the member may appeal the denial.

3. *Extension for other reasons:* In a situation beyond DentaQuest's control (e.g., waiting for an evaluation by a specialist), the non-urgent pre-service and post-service timeframes may be extended once, for up to fifteen (15) calendar days. Within fifteen (15) calendar days of a pre- service request or thirty (30) calendar days of a post-service requests, DentaQuest notifies the member (or the member's authorized representative) of the need for an extension, and the expected date of the decision. **This provision is not applicable to Medicaid and Medicare lines of business.**

    Authorizations approved by DentaQuest cannot be retrospectively denied except for fraud or abuse, or misinformation and/or incomplete information from the Provider, subject to the eligibility and coverage provisions of the contract.

- A preauthorized treatment, service or procedure may only be reversed on retrospective review when:
    i. The relevant information presented upon retrospective review is materially

different from the information presented during the preauthorization review;

ii. The relevant information presented upon retrospective review existed at the time ofthe preauthorization review but was withheld or not made available.

iii. Not aware of the existence of such information at the time of the preauthorization review.

iv. Had DentaQuest been aware of such information, the treatment, service, or procedure being requested would not have been authorized.

v. The planned course of treatment for the member that had been approved was not substantially followed by the provider.

Determinations for retrospective review are made using the same standards, criteria and procedures used during the preauthorization review process.

i. If treatment has been approved for a member, criteria used in the initial utilization review decision will not be revised or modified to then make an adverse determination regarding the services delivered to the member.

C. Notification: The Utilization Management Department delivers written notification to the Member and Provider as applicable to the mail room within one business day following the determination ensuring notification timeframe requirements outlined in the contract or regulation are met.

DentaQuest provides to either the Member, Member's Representative, or Provider, upon request, a copy of the review criteria utilized in any benefit determination.

D. EPSDT: All authorization requests for EPSDT are based on medical necessity utilizing DentaQuest's clinical criteria or guideline regardless of any plan benefit limitation. EPSDT benefits are only considered after the benefit plan limitations have been exhausted or if the requested services are considered a non-covered benefit. A Clinical Consultant determines all authorizations subject to EPSDT provisions for medical necessity.

E. ETR – LE: DentaQuest ensures that providers have an opportunity to request ETR and LE and that DentaQuest will review for medical necessity, as appropriate, and will send to Clinical Consultants for approval and denials.

F. Use of External Board-Certified Consultants: Contracted Clinical Consultants may be utilized to assist in making fair and prudent determinations of coverage for specific services. In these instances, a DentaQuest Clinical Consultant will consult with licensed, board-certified specialists from appropriate clinical areas, as necessary and as needed. Evidence of such collaboration is detailed in the case file.

FORMS AND RELATED DOCUMENTS

- **UM04-INS –** Denial and Approval Letters
- **UM07-INS –** Verbal Notification of Authorization Determination

EXHIBITS

- **Exhibit A –** TennCare
- **Exhibit B –** Michigan
- **Exhibit C –** Kentucky
- **Exhibit D** – Washington Medicaid
- **Exhibit E** – Nevada
- **Exhibit F** - Maryland

Exhibit C – Kentucky

An Emergent or Urgent request is defined as:

- Treatments to ameliorate pain, infection, swelling uncontrolled hemorrhage and traumatic injury that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment to the dentition or would place the person's health in serious jeopardy; or
- In the opinion of a physician with knowledge of the covered person's condition, a delay in treatment would subject the covered person to severe pain, loss of sight, or permanent damage to the eye that cannot be adequately managed without the care or treatment that is being requested.

- Urgent requests are processed as Expedited.
- Clinical Consultants are licensed optometrists or ophthalmologists and make the final medical necessity decision when the decision is adverse.
- Clinical Consultants are available to the review specialist staff during the review process to answer questions relating to the request and documentation received and to the clinical criteria.
- Notification Process:
  - For all decisions DentaQuest sends written notification to the Member and/or provider within two (2) business days of determination.
  - DentaQuest will provide this notification in an electronic format, including email or fax, when a member, authorization representative or provide have agreed in advance in writing to receive the notice electronically.
- Timeframes for Prior Authorizations:
  - All standard determinations are completed within two (2) business days of receipt.
  - All urgent/expedited requests are completed within twenty-four (24) hours of receipt of the request.
    - If additional information is needed, the member and/or provider are notified within twenty-four (24) hours of receipt that more information is needed. The notification includes a reference to the specific information that is needed to make a decision.
    - The member and/or provider have forty-eight (48) hours to submit the required information.
    - Failure to make a determination and provide written notice within the required time frames will result in the approval of the prior authorization request. This does not apply where the failure to make the determination or provide the written notice results from circumstances which are documented to be beyond DentaQuest's control.
- Timeframes for Retrospective Review:
  - DentaQuest is allowed a one-time extension of up to fifteen (15) days for circumstances that are out of our control to meet the thirty (30) day timeframe.
  - If additional information is needed, DentaQuest will notify the member and/or provider within the original thirty (30)-day timeframe. The member and/or provider are allowed forty-five (45) days from the date of receipt of the notification to provide the information specified in the notice.
- Procedure for Concurrent review
  - Concurrent Review is not applicable for dental or vision services.
  - This statement includes reviews relating to requests for continued hospital stays.

Changes to UM Policies

- DentaQuest will submit any changes to the UM policies and procedures to the Kentucky Department of Insurance. DentaQuest understands that the changes in the policy and procedure are not effective until after the filing is completed and approval is received from the Commissioner.
- The filing will be accompanied by a $50 filing fee, made payable to the Kentucky State Treasurer.
- DentaQuest will maintain a current address and contact person with the Commissioner, DentaQuest will file any changes to this information to the Kentucky Department of Insurance within 30 days of the change.

- Annual UM Reporting
  - DentaQuest will submit the Annual Utilization Review Report (HIPMC-UR-2(07/08)) as required.
  - The report will be submitted prior to March 31st each year for the volumes from the preceding year.
- UM Review
  - DentaQuest will provide the Kentucky Department of Insurance with a listing of clients for which UM review activity is done in the state of Kentucky.
  - DentaQuest will notify the Kentucky Department of Insurance of any changes to the listing of client within thirty (30) days of the change.
  - If the decision is made to cease operations and UM review activity in the state of Kentucky, DentaQuest will submit a written notice to the Department of Insurance. The notice will be submitted thirty (30) days prior to the planned date, or as soon as possible. The notice will include the following information:
    - Date of the proposed cessation
    - Number of pending UM review with corresponding assignment dates
    - A written action plan for ceasing operations
  - DentaQuest understands that the Department of Insurance must approve the plan to cease operations prior to implementation. DentaQuest will comply with the required annual reporting requirements and will submit the reports within thirty (30) days of ceasing operations.