UTILIZATION MANAGEMENT	EyeQuest A DentaQuest product			
	Policy and Procedure			
	Policy Name:	Authorization Review	Policy ID:	**UM08-INS**
	Approved By:	Angela Metzger, VP, Utilization Management	Origination Date:	7/13/1997
	States:	Kentucky	Last Revision Date:	11/12/2019
	Application:	All lines of business	Effective Date:	1/1/2020

PURPOSE

The basis for granting or denying approval is based on medical necessity according to the definition and Utilization Management standards specified by the Plan, CMS and NCQA accrediting bodies.

POLICY

It is EyeQuest policy that services that require medical necessity review are reviewed by licensed professionals within its Utilization Management Department. Providers may submit requests as a prior authorization or prepayment review where appropriate and as defined within the Office Reference Manual with the exception. As EyeQuest permits all providers to obtain prior authorization, non-emergency treatment started prior the UM Review is at the financial risk of the provider's office and may not be charged to the member unless balance billing is allowed by regulation. Where urgent or emergent services are necessary, defined as those services necessary to treat pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury or what a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate care is required, the EyeQuest encourages the provider to treat the member and submit a completed claim and any necessary documentation marked for "Prepayment Review". The company does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.

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.
- **"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 the clinical criteria established utilizing the current CPT nomenclature and generally accepted practice guidelines. The clinical algorithms are utilized by the Clinical Review Specialists as well as the Clinical Consultant.
- **"Clinical Denial"** is defined as a denial of coverage made when clinical data does not demonstrate the medical necessity of the requested service(s) or when the Provider has failed to provide EyeQuest the 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.
- **"Clinical Review Specialist"** is defined as an individual that is employed by the UM department that determines requests for UM review in accordance with state regulations, contractual agreements, benefit design and medical necessity., Clinical Review Specialists may be licensed vision provider, previous vision assistants or may have graduated with a vision assisting degree or diploma or are otherwise appropriately trained to make such determinations. Clinical Review Specialists can grant approvals based on medical necessity and administrative denials only.

- **"Clinical Consultant"** is defined as a Senior Vision Officer, or other licensed clinician, including a, optometrist, physician or physician assistant, who is employed or contracted by EyeQuest to make determinations for clinical approvals or Clinical Denials.
- **"Vision Consultant"** is defined as a licensed Optometrist or physician, who is employed or contracted by EyeQuest to make determinations for clinical approvals or Clinical Denials.
- **"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.
- "**Prospective Review"** is defined as utilization review that is conducted prior to the provision of health care services. Prospective review also includes any insurer's or agent's requirement that a covered person or provider notify the insurer or agent prior to providing a health care service, including but not limited to prior authorization, preadmission review, prepayment review and pretreatment/pre-service review.
- **"Pretreatment/Preservice Review"** is defined as a review for Medical Necessity that is conducted on a health care service or supply prior to its delivery for the member.
- **"Prepayment Review"** is defined as a request for UM review after the service has been rendered.
- **"Prior Authorization"** is defined as a request for UM review prior to rendering the actual service.
- **"Urgent/Emergent"** is defined as those requests for service to treat situations which involve the pain, swelling, infection, uncontrolled hemorrhage, loss of sight, or traumatic injury or what a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate care is required. In emergent and urgent situations, the provider is encouraged to treat the member and then submit the completed claim and any necessary documentation on a claim form marked "Prepayment Review".

PROCEDURE

A. Prior Authorization Review: The authorization request, along with any additional documentation, is reviewed by a Clinical Consultant, a State licensed Optometrist (OD) in the Utilization Management Department in accordance with the States regulation and Provider Office Reference Manual.

1. *Review Process:* The Clinical Consultant approves the service as a covered benefit if the requested service and submitted documentation is consistent with the Plan benefit design and clinical algorithm.
    - If the requested service requires a denial based on medical necessity or the appropriateness of care, the request is routed to one of EyeQuest's licensed Clinical and/or Vision Consultants within one business day of receipt, for review and determination.
    - All clinical denials must be reviewed and signed off by a Kentucky licensed physician.
    - EyeQuest will provide decision to covered persons, authorized persons & all providers on appeals of Adverse Benefit Determinations and coverage denials.
    - If the procedure has been prior approved, there are no limitation of requiring a prior authorization for materials incidental to the procedure.

2. *Time frames*: unless specified differently by the Plan or regulation, determinations are completed within the following time frames from the receipt of the request:
    - Standard: two (2) business days
    - Emergent/Urgent: 24 hours
3. 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.
4. If the urgent preauthorization request lacks clinical information, EyeQuest will deny the request. EyeQuest will provide written notice to the enrollee and provider of the reason for the denial.
5. If the standard preauthorization request lacks clinical information, EyeQuest may extend the non-

urgent pre-service timeframe up to 14 calendar days. EyeQuest will provide written notice to the enrollee of the reason for the extension as well as the right to file a grievance. An extension may be taken under the following conditions:

6. The Member or the Provider requests an extension; or there is a justified need for additional information and extension is in the Member's interest. In these cases, EyeQuest will notify the Member in writing of the intent to extend the timeframe.
7. The extension period, within which a decision must be made by EyeQuest begins:
   - On the date when receives the member's response (even if not all of the information is provided), or
8. 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.
9. Failure to make the decision and provide written notice within the timeframes in KRS 304.17A-607(1)(i) will be deemed a prior authorization for the vision services or benefits subject to the review.
10. EyeQuest will deny the request if all the necessary information is not received. within the timeframe, and the member may appeal the denial.
    - All Necessary Information is limited to three (3) items listed in KRS 304.17A-607(1)(i):
      - Results of any face-to-face clinical evaluation
      - Any second opinion that may be required &
      - Any other information determined to be necessary to making a utilization review determination.
11. EyeQuest will not deny a claim for failure to obtain preauthorization if the preauthorization requirement was not in effect and posted at the time of the date of service on the claim.

    EyeQuest will partner with the health plan to maintain information on its publicly accessible Web site about the list of services and codes for which preauthorization is required. For each service required to be preauthorized:

    - When preauthorization was required, including the effective date or dates and the termination date or dates, if applicable;
    - The date the requirement was listed on the Web site; and
    - Where applicable, the date that preauthorization was removed

B. Retrospective Review or Post Service: 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. Determinations for retrospective review are made using the same standards, criteria or procedures as used during the preauthorization review process.

1. *Review Process*: The retrospective review claim is reviewed by the Clinical Review Specialist to determine coverage and to certify that the services were medically necessary.
   - The clinical criteria utilized in the retrospective review are the same criteria utilized in the prior authorization process to determine medical necessity and appropriateness of care.
   - A Clinical and/or Vision Consultant reviews all services denied for medical necessity.
2. *Timeframes*: retrospective reviews are determined, and written notification of the decision sent to the Provider within thirty (30) calendar days from the initiation of the UM process unless a more stringent standard applies per Plan or regulation.
3. If the request lacks clinical information, EyeQuest may extend the post-service timeframe for up to 14 calendar days, under the following conditions:
   - The Member or the Provider requests an extension; or
   - There is a justified need for additional information and extension is in the Member's interest. In these cases, EyeQuest will notify the Member in writing of the intent to extend the

timeframe.

4. The extension period, within which a decision must be made by EyeQuest begins:
   - On the date when EyeQuest receives the member's response (even if not all of the information is provided), or
   - 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.

   EyeQuest may deny the request if the information is not received within the timeframe, and the member may appeal the denial.
5. *Extension for other reasons:* In a situation beyond EyeQuest 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 14 calendar days. Within 14 calendar days of a pre-service request or 14 calendar days of a post-service requests, EyeQuest notifies the member (or the member's authorized representative) of the need for an extension, and the expected date of the decision.

6. Authorizations approved by EyeQuest 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.

7. A preauthorized treatment, service or procedure may only be reversed on retrospective review when:
   - The relevant information presented upon retrospective review is materially different from the information presented during the preauthorization review
   - The relevant information presented upon retrospective review existed at the time of the preauthorization review but was withheld or not made available
   - Not aware of the existence of such information at the time of the preauthorization review
   - Had EyeQuest been aware of such information, the treatment, service, or procedure being requested would not have been authorized.

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

The criteria used to determine medical necessity is published in the Provider Office Reference Manual. EyeQuest provides to either the Member or Provider, upon request, a copy of the review criteria utilized in benefit determination.

D. Medically Necessary. Medically necessary criteria are used in making all medical necessity decisions. Medically necessary health care services" means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

a) In accordance with generally accepted standards of medical practice; and
b) Clinically appropriate in terms of type, frequency, extent, & duration.

E. EPSDT: A federal program requiring that comprehensive health care benefits be provided to Medicaid members under the age of 21. The acronym stands for Early and Periodic Screening, Diagnosis and Treatment, which aptly describe the mission of this important effort. The program is designed to improve primary health benefits for children with an emphasis on preventive care.

All authorization requests for EPSDT are based on medical necessity utilizing Eye Quest's clinical criteria regardless of any plan benefit limitation. EPSDT benefits are only considered after the vision benefit plan limitations have been exhausted or if the requested services are considered a non-covered benefit. A Vision Consultant determines all medical necessity authorizations that have been initially reviewed and recommended for denial by a Clinical Review Specialist. A Clinical Review Specialist does not make an adverse clinical determination.

FORMS AND RELATED DOCUMENTS

- **UM04-INS –** Denial and Approval Letters
- **UM07-INS –** Verbal Notification of Authorization Determination
- **UM00-INS –** Preauthorization List