UTILIZATION MANAGEMENT	DentaQuest a Sun Life company			
	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:	04/05/2024
	States:	All States (with noted exception)	Last Review Date:	04/09/2024
	Application:	All lines of business	Effective Date:	04/09/2024

PURPOSE

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

POLICY

It is the policy of DentaQuest Vision (also referred to as EyeQuest) 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 a DentaQuest Vision 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, and along with other affiliated Clinical Consultants, supervises 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, provider participation status, 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. Administrative Algorithms are developed based on non-clinical coverage rules, e.g.- 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 the resultant outcome. The Clinical Algorithms are developed using clinical criteria and or Clinical Guidelines that are established by or adopted from various, reputable industry sources, and generally accepted ophthalmologic standards of practice. Plan benefit description documents, as well as the information contained in the compendium for *Current Procedural Terminology* (CPT) published by the American Medical Association and current ICD-10 tables.
- **"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 ICD-10 tables and the Current Procedural Terminology published by The American Medical Association, and from generally accepted standards of eye 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 Vision sufficient 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 a UM staff member who is 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. This process is applicable only for urgent cases or when mandated by fraud prevention recovery action.
- **"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. 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.
    c. UM Specialist have access to a licensed Clinical Consultant at all times, by telephone, messaging, or email as they perform tasks.
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 Vision may extend the non-urgent pre-service timeframe for up to fourteen (14) additional calendar days. DentaQuest Vision will

provide written notice to the Member and submitting provider 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 Vision 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 Vision receives the member's response (even if not all information is provided), or
  ii. DentaQuest Vision may deny the request if the information is not received within the mandated time frame. In this case the member may appeal the denial.
- DentaQuest Vision 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 Vision contacts the submitting provider, member or the member's representative for the specific information necessary to the make the decision.
  ii. DentaQuest Vision 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 Vision does not:
  i. Require prior authorization for emergent/urgent service and care; or
  ii. Deny payment based on the member's failure to notify DentaQuest Vision 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 Vision 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.
- DentaQuest will not downgrade the status of Expedited authorization requests received from a treating provider and will be processed as requested.
  - A preauthorized treatment, service, or procedure may only be reversed on retrospective review when:
    i. The velevant 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 of the 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.

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B. Retrospective Authorization Review: All retrospective reviews are determined in compliance with UM standards established by respective state regulations, CMS, 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 Vision may extend the post-servicetimeframe 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 Vision will notify the Member and submitting provider in writing of the intent to extend the timeframe.
- The extension period, within which a decision must be made by DentaQuest Vision begins:
  i. On the date when DentaQuest Vision 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 Vision may deny the request if the information is not received within the timeframe,and the member may appeal the denial.

Authorizations approved by DentaQuest Vision 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.

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

i. If a service 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 Vision provides to either the Member, Member's Representative, or Provider, upon request, a copy of the review criteria or other source of guideline utilized in any benefit determination.

D. EPSDT: All authorization requests for EPSDT are based on medical necessity utilizing appropiate clinical criteria or other applicable 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 Vision ensures that providers have an opportunity to request ETR and LE and that DentaQuest Vision will review for medical necessity, as appropriate. Such determinations will be made by appropriately trained Clinical Consultants. ETR and LE is not applicable to EPSDT cases.

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 Vision 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.

G. Oversight and Monitoring of the Process: Effective UM Authorization Review requires al high level of consistency in the application of clinical criteria and guidelines, and adherence to timeliness standards (TAT). The Clinical Vision Director monitors the TAT and Interrater Reliability testing (IRR) results on a regular basis; intervening when results do not meet the mandated standards.

FORMS AND RELATED DOCUMENTS

- **UM04-INS –** Notice of Action Letters
- **UM07-INS –** Verbal Notification of Authorization Determination

EXHIBITS

- **Exhibit A –** TennCare
- **Exhibit B – Anthem** Kentucky Medicaid
- **Exhibit C** – Washington Medicaid
- **Exhibit D** – Anthem Nevada Medicaid
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Exhibit A – TennCare

- DentaQuest Vision has mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.

- Prior approval fro covered vision care services will not be required for direct referrals from a Public Health Screening Program, Primary Care Physicians, and for preventive services.

- The claim and submitted documentation is reviewed by the UM Review Specialist in using the approved criteria. If the claim is missing documentation, every effort is made to contact the submitting Provider (orally or electronically) to submit the required documentation.

- DentaQuest allows fourteen (14) calendar days from the received date for the Providers to submit additional information. If the additional information requested from the Provider is not received within the fourteen (14) calendar day timeframe, the services will be denied citing prong (b) of medical necessity for the missing information if it's not received timely. Members retain appeal rights in these cases.

- All authorization decisions are based on TennCare's Medical Necessity definition and rules. These decisions are based upon written Clinical Guidelines, where available and criteria referenced in the EyeQuest Office Reference Manual and available to review upon request by a member or submitting provider. Clinical criteria are derived from:
  - TennCare's general medical necessity criteria
  - Clinical protocols approved by TennCare, and the EyeQuest Peer Review Committee
  - Nationally recognized guidelines and standards,
  - Interqual, McKesson, American Academy of Ophthalmology, American Optometric Association.

- Denials made due to lack of medical necessity may be made only by the Clinical Vision Director, or an appropriately trained and licensed Clinical Consultant.

- Any additions to or revisions of clinical criteria are available to Providers, at their request. Changes are completed no less than sixty (60) days prior to the change.

- The Clinical Vision Director or Clinical Consultant(s) are the only individuals with the authority to render adverse determinations based upon medical necessity and/or appropriateness of service or level of care. All Clinical Consultants hold an active and continuously unrestricted license to practice in their respective health care field.

- DentaQuest Vision provides to either the Member or Provider, upon request by telephone or letter, a copy of the review criteria utilized in an adverse benefit determination.

- The retrospective review of a claim is initially reviewed by the Review Specialist to determine coverage and to verify 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 Consultant reviews all services identified for denial based on no medical necessity.

Exhibit B – Kentucky Medicaid – Anthem Health Plan

An Emergent or Urgent request is defined as:

- A request for coverage of a service or 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.

- EyeQuest does not require prior authorization for urgent requests. But if requested urgent request are processed as according to Expedited case protocols.
- Vision Clinical Consultants are licensed optometrists or ophthalmologists and make the final medical necessity decision when the decision is adverse.
- Vision 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 utilized.
- Notification Process:
  - For all decisions DentaQuest sends written notification to the Member and/or provider within two (2) business days of determination.
  - DentaQuest Vision can provide this notification in an electronic format, including email or fax, when a member, authorized representative or provider request 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.
    - If and when requested, 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:
  - All retrospective determinations are completed within fourteen (14) days of receipt.
  - DentaQuest Vision is allowed a one-time extension of up to fifteen (15) days for circumstances that are out of our control to meet the fourteen (14) day timeframe.
  - If additional information is needed, DentaQuest will notify the member and/or provider within the original fourteen (14) 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 covered vision services.
  - This statement includes reviews relating to requests for continued hospital stays.

Exhibit C – Washington Medicaid

- Standard Authorizations
  - Authorization decisions are to be made and notices are to be provided as expeditiously as the Enrollee's health condition requires, not to exceed five (5) calendar days for requests received nonelectronically and not to exceed three (3) calendar days following the receipt of the request for services electronically. DentaQuest Vision will make the decision on expedited request within forty- eight (48) hours if the information provided is sufficient. DentaQuest may request additional information within twenty-four (24) hours, if the information provided is not sufficient to approve or deny the request. DentaQuest must give the provider forty-eight(48) hours to submit the requested information and then approve or deny the request within forty-eight (48) hours of the receipt of the additional information (WAC 284-43- 2000). Washington Apple Health – Fully Integrated Managed Care Contract, Effective 1/1/18, Pages 187-189.
- Expedited Authorizations
  - For cases in which a provider indicates, or DentaQuest determines, that following the timeframe for standard authorization decisions could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, DentaQuest shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires. If the lack of treatment may result in an emergency visit or emergency admission, the decision must be made no later than twenty-four (24) hours after receipt of the request for service. For all other urgent requests for service, the decision must be made within forty-eight (48) hours*.
  - *Electronic urgent prior authorization: For an expedited authorization request that is submitted through an electronic prior authorization process, Delegate must make a decision and notify the health care provider or health care facility within one (1) calendar day of submission of a prior authorization request.

The following should be read in addition to Paragraph A ("Prior Authorization Review") of the general policy. All other components apply as above.

PROCEDURE

A. Prior Authorization Review:

16. DentaQuest Vision considers the following in evaluating a request for a limitation extension:
    a. The level of improvement the client has shown to date related to the requested health care service and the reasonably calculated probability of continued improvement if the requested health care service is extended; and
    b. The reasonably calculated probability the client's condition will worsen if the requested health care service is not extended.

Exhibit D – Anthem Nevada - Medicaid

It is DentaQuest Vision'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. The Clinical Vision Director is licensed to practice optometry and is board certified in that profession.

The following replaces Section A, paragraph 2 in the general policy. All other provisions apply as above.

2. *Time frames for authorization determinations*:
    a. Standard: The Delegate must provide standard authorization decisions as expeditiously as the member's health requires, but not exceed 14 calendar days following receipt of the request.
    b. Expedited: The Delegate must make an expedited authorization decision and provide a Notice of Action as expeditiously as the enrollee's health condition warrants and no later than 72 hours after receipt of the request.
    c. Extension: The Delegate may extend the timeframe if requested by the member or provider, or if the Delegate can justify the need to obtain additional information is in the member's best interest. Untimely decisions are deemed denied.