UTILIZATION MANAGEMENT	DentaQuest a Sun Life company			
	Policy and Procedure			
	Policy Name:	**Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines**	Policy ID:	**UM01-INS**
	Approved By:	Dr. James Thommes, Vice President, Clinical Management	Last Revision Date:	10/24/2024
	States:	All States	Last Review Date:	10/24/2024
	Application:	All Lines of Business	Effective Date:	10/24/2024

PURPOSE

To ensure that written clinical criteria for the delivery of covered services are the primary components of the medical management and utilization review process and that they provide consistent clinical guidelines for making determinations for coverage. The determination of medical necessity is often necessary for prior authorization or retrospective review for claims processing. This policy creates a consistent process for establishing and maintaining guidelines and criteria for the Utilization Management Program.

POLICY

To ensure consistent and equitable determination of coverage for certain covered services, the Company has implemented a process for establishing clinical criteria for many services, where applicable and reasonable. The specifics of criteria applicable are outlined or referenced within the Provider Office Reference Manual. Affected parties may request a copy of all applied criteria.

PROCEDURE

A. Formulation/Establishment

Written criteria and clinical guidelines utilized in the process of benefit determination are developed based on: Medicare and State Medicaid guidelines, *National Correct Coding Initiatives*, professional educational materials (e.g. Best Practice Guidelines of AOA, AAO), specific health plan developed guidelines, accepted industry standards of care, State and Health Plan specific requirements, current evidence in widely used treatment guidelines or clinical literature when criteria are not fully established, as well as the information contained in the current CDT© and CPT© Manual published by the American Medical Association. Specialty organizations include:

- The American Academy of Pediatric Dentistry
- The Academy of General Dentistry
- The American Endodontic Society
- The American Orthodontic Society
- The American Association of Oral and Maxillofacial Surgery

- The American Academy of Ophthalmology
- The American Optometric Association

Medical necessity and benefit guidelines may be further defined by CMS, the State, the Plan, or through the adoption of other outside source written criterion or guidelines. Reference to the source of such guideline and criterion may be found in the Provider Office Reference Manual. All clinically based guidelines and criterion implemented and utilized for making medical necessity determinations shall meet the following overriding goals; in that they must:

1. Provide for consistency.
2. Allow for individualized application.
3. Be consistent with generally accepted professional medical standards.
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.
5. Ensure the ability to achieve age-appropriate growth and development and the ability to attain, maintain, or regain functional capacity.
6. Be necessary to prevent, diagnosis, and treat a member's disease, condition, and/or disorder that results in health impairments and/or disability.
7. Be formulated in a manner not primarily intended for the convenience of the Member, the Member's caretaker, or the Provider; e.g. The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or a service does not, in itself, make such care, goods or services medically necessary or a medical necessity.
8. Not be established based in any way on the goal of limiting services, access, or financial incentive.
9. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
10. May 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.
11. Practice guidelines are consistent with other areas to which the guidelines apply.

B. Adoption

Utilization Review Criteria and Guidelines are adopted after the DentaQuest Peer Review Committee, through collaboration, reviews, refines, and then approves the final version of a Policy. Coverage criteria decisions are documented in the UM Committee meeting minutes.

Where and when required because of specific client contractual obligations, the Company has established a policy whereby any Company-developed clinical guidelines will be submitted to any such client (Plan) for documentation purposes, when and if requested. Such clinical guideline(s) shall be adopted for UM program use upon formal approval of the DentaQuest Peer Review Committee in the usual way. A client (Plan) has the right to submit recommendations for edits which will be reviewed by the DentaQuest Peer Review Committee.

C. New and Emerging Technology

New and emerging diagnostic and treatment technologies continue to be developed. DentaQuest must address the inclusion of these services to respond to Plans' (Clients) and Members' clinical needs and to maintain access to the most current standards of care. As

such, the company has a formalized process to assess coverage on an ongoing basis, for determination of medical necessity or evolving standards of care.

DentaQuest utilizes the expertise of the DentaQuest Peer Review Committee members and when indicated, invited subject matter expects, to evaluate whether new technologies, and new applications of existing technologies, shall be provided as covered services or included in a Plan benefit package; and for development of appropriate clinical guidelines that might apply. A formal evaluation shall be initiated when the Clinical Director, a Provider, or client Health Plan (Medical Director) requests an opinion or petitions DentaQuest for such assessment. The Peer Review Committee is responsible for conducting the review and submitting an opinion to the full Quality Oversight Committee for discussion and final determination. The Peer Review Committee shall consider the following sources and documents:

1. A statement of whether the American Academy of Ophthalmology or American Dental Association has endorsed the new technology as a standard of care or clinically appropriate diagnostic or management option.
2. A statement of whether the new technology or new application of an existing technology has met with approval of the FDA, where applicable.
3. When DentaQuest is delegated this function, and the request is initiated by a Plan, a written opinion statement from the Plan (Client) involved, as to whether they feel the service should be considered for coverage under the overall benefit package or for an individual case.
4. If the involved Plan includes Medicaid or Medicare Members and DentaQuest is delegated this function, current coverage status of the investigated service by the state and/or CMS.
5. If initiated by a Provider, a written request from the Provider offering evidence of clinical justification and supporting documentation.
6. Written opinion statement from a relevant specialist and/or professional who has expertise in the technology.

The Committee Chairperson shall be responsible for coordinating the initial research and receipt and distribution of the indicated materials. The Committee shall provide a written opinion for the request within 45 days of receipt. Upon acceptance of any emerging technology as a covered service in any market, the clinical guidelines will be formulated in the usual way, subject to robust scrutiny for coverage delineation, and possible Plan approval of the appropriateness of any new guidelines.

D. Ongoing and Annual Assessment

The development and implementation processes and all current criteria will be assessed on an ongoing basis and modified, when indicated, based on updated professional literature, emerging technology, and evolving standards of care. Established Clinical Guidelines are reviewed for acceptance by the Peer Review Committee on a yearly basis. The Clinical Director shall be responsible for distributing the current guidelines to Committee members during the first quarter each calendar year. Committee minutes shall reflect Committee assessment, documentation of recommended revisions, and approval of final versions. Final Annual Approval shall be completed not later than May 31st of the subsequent year.

To evaluate the consistent application of standardized criteria, DentaQuest performs an inter-rater reliability audit for those making approval and denial decisions.

Any changes to criteria are communicated to the internal Intent of Deal (IOD) email. Those on the distribution list consist of Operations, Client Engagement and Provider Engagement. Client Engagement ensures any Office Reference Manual changes are made and Provider and Member communication is disseminated, as appropriate.

Exhibit DD – Ohio Medicaid Criteria
This section is in addition to Section A of the general policy. All other components will apply as above.

Reference*:* Appendix A OAC 5160-5-1, Ohio Medicaid MCO Dental Program Office Reference Manuals, UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines

A. Formulation/Establishment
Written criteria and clinical guidelines utilized in the process of benefit determination are developed based on Ohio Department of Medicaid guidelines, Appendix A to OAC 5160-5-1, as well as other applicable administrative codes, *National Correct Coding Initiatives*, professional educational materials (e.g. Best Practice Guidelines of AOA, AAO), specific health plan developed guidelines, accepted industry standards of care, State and Health Plan specific requirements, as well as the information contained in the current CDT© and CPT© Manual published by the American Medical Association.

B. Criteria
- Criteria is outlined in individual separate exhibits, by category.