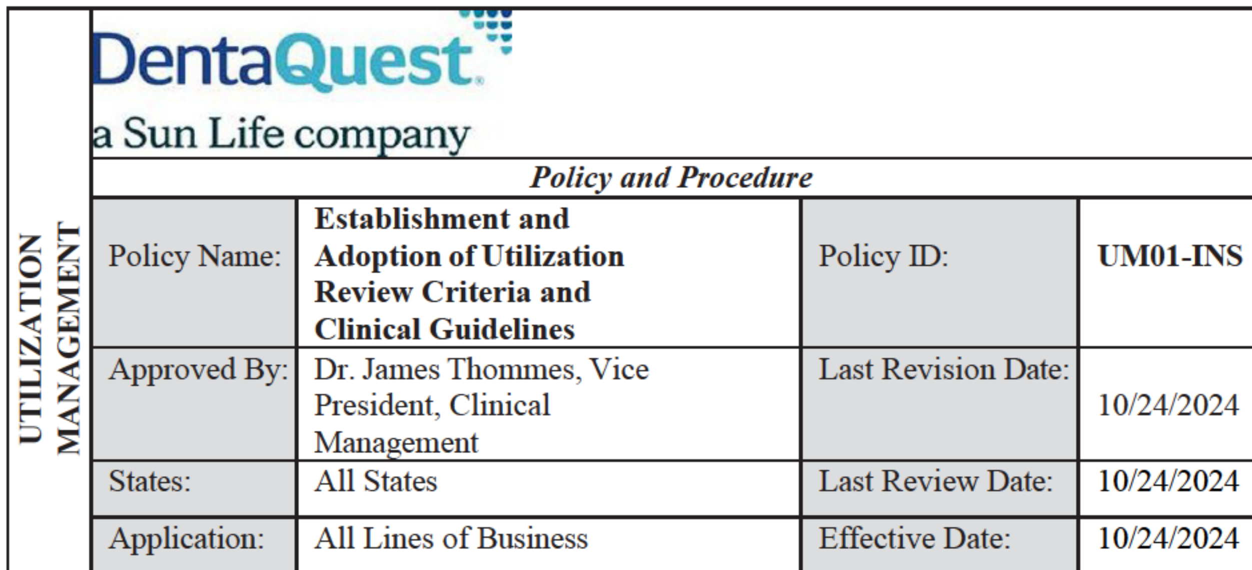

DentaQuest
a Sun Life company

UTILIZATION MANAGEMENT

***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.

**FORMS AND RELATED DOCUMENTS**

- UM01-INS-VIS-SOP – Clinical Algorithms
- UM01-INS-SOP-Clinical Algorithms Development and Implementation

**EXHIBITS**

- **Exhibit C –** Dental Extraction Clinical Criteria
- **Exhibit D –** Crown Criteria
- **Exhibit E –** Fixed Prosthodontic Criteria
- **Exhibit E2-** Fixed Prosthodontic Criteria (Anterior Only)

**Exhibit C –** Dental Extraction Clinical Criteria

**Reference**: American Association of Oral Maxillofacial Surgeons and American Dental Association

Documentation needed for pre-authorization of procedure.

A. Panorex, bitewing radiographs or periapical radiographs showing the entire tooth (teeth) to be extracted as well as opposing teeth

B. Narrative demonstrating medical necessity

   1. A decision regarding benefits is made based on the documentation provided.
   2. Treatment rendered without necessary pre-authorization is subject to retrospective review.

C. Codes: DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.
   1. Gingival Irrigation, collection and application of autologous blood concentrate product, Placement of intra-socket biologic dressing to aid in hemostasis or clot stabilization, Bone grafting and exposure of an adjacent unerupted tooth are included in the extraction benefit and are not separately reimbursable. Alveoloplasty is included in the fee for a surgical extraction or impaction in the same quadrant.
   2. Excision of pericoronal gingiva is included with extraction of same tooth

D. Criteria
   1. The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.
   2. The removal of primary teeth whose exfoliation is imminent is not a covered benefit.
   3. In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.
   4. Alveoloplasty (code D7310) in conjunction with a surgical extraction in the same quadrant is not a covered benefit.
   5. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and is not separately billable.
   6. Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization is considered part of the extraction or surgical fee and is not separately billable.
   7. Bone replacement graft for ridge preservation at the time of an extraction is considered part of the extraction or surgical fee and is not separately billable.
   8. Extractions performed as a part of a course of orthodontics are covered only if the orthodontic case is a covered benefit.
   9. The extraction of primary or permanent teeth does not require authorization unless:
      a. Teeth are impacted wisdom teeth
      b. Residual roots requiring surgical removal
      c. Surgical extraction of erupted teeth.
   10. Removal of primary teeth whose exfoliation is imminent does not meet criteria for extraction.

E. Documentation needed for authorization procedure:
   1. Diagnostic Quality periapical and/or panoramic radiographs,
   2. Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission
   3. Duplicate radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.
   4. Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity.

F. Documentation needed for emergent authorization procedure: In emergency situations when prior authorization is not possible, extractions will require review prior to payment.

G. Documentation requirements for emergent retrospective review will include:
   1. Diagnostic Quality periapical and/or panoramic radiographs.
   2. Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission
   3. Duplicated radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.
   4. Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity.

H. Authorization for extraction of impacted third molars:
   1. Benefit review decisions for authorization of the extraction of impacted third molar teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7220, D7230, D7240, and D7241.
   2. The prophylactic removal of disease-free third molars is not covered.
   3. Impacted third molars that do not show radiographic evidence of complete root formation will not qualify for an authorization for extraction.
   4. Impacted third molars that do not show pathology will not qualify for an authorization for extraction.
   5. Impacted third molars that do not demonstrate radiographic aberrant tooth position beyond normal variations will not qualify for an authorization for extraction.
   6. Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for an authorization for extraction.
   7. Lack of eruptive space will not qualify for an authorization for extraction of impacted third molars.
   8. Lack of root formation is considered pre-eruptive and will not qualify for benefit.
   9. Excision of pericoronal gingiva is included with extraction of same tooth or adjacent tooth

I. Authorization for Surgical Extractions
   1. Benefit review decisions for authorization of the extraction of teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7210, D7250.

2. Surgical extractions of erupted teeth are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and or section of the tooth and closure to remove the tooth. Elevation of mucoperiosteal flap and removal of bone and or sectioning of the tooth for the convenience of the provider is not a surgical extraction.
3. Authorizations for extractions D7210 will not meet criteria if the tooth is single rooted with remaining clinical crown visible in the mouth except in the presence of a root dilaceration, endodontic treatment, or decay exceeding 75% of the crown.
4. Billed and noted in patient record on a tooth-by-tooth basis.
5. Procedures that may meet clinical criteria for approval, may be disallowed due to frequency limitations.
6. Services that fail to meet clinical criteria due prior treatment will be disallowed.

**Exhibit D –** Crown Criteria

**Reference**: American Association of Prosthodontics and American Dental Association

## I. Pre-Authorization Documentation

A. Documentation may be needed for pre-authorization of procedure:
  1. Panorex or, at minimum, 4 bitewing radiographs showing clearly the adjacent and opposing teeth
  2. Treatment rendered without necessary pre-authorization is subject to retrospective review.

## II. Additional Information

A. Crowns are not a covered benefit if:
  1. A lesser means of restoration is possible.
  2. Tooth has subosseous and/or furcation caries
  3. Tooth has advanced periodontal disease
  4. Tooth does not demonstrate 50% bone support
  5. Tooth has furcation involvement
  6. Tooth is a third molar, unless it is an abutment for a partial denture
  7. Tooth is a primary tooth with exfoliation imminent
  8. Tooth has crown less than five years old, which is dislodged, broken, or lost
  9. Crowns are being planned for cosmetics or to alter vertical dimension. If performed, these must be done with agreement of the patient to assume all costs. Such procedures include but are not limited to restorations, procedures or applications done primarily to treat attrition, erosion, abrasion, abfraction, or to realign the dentition, splinting, full-mouth rehabilitation or equilibration, and the treatment of TMD Syndrome.
  10. Splinted Crowns and double abutments are not allowed.
  11. A cast partial denture was denied due to excessive restorative needs or poor bone structure.

## III. Codes

A. DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

B. The crown benefit includes preparation, impression, provisional, as well as custom shade, staining, porcelain butt margin, or characterization of the final restoration. Lab rush fee is not separately reimbursable.

## IV. Criteria

A. In general, crowns are allowed only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.

B. Molars must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and two or more cusps.

C. Bicuspids must have pathologic destruction to the tooth by caries or trauma and must involve three or more surfaces and at least one cusp.

D. Anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.
E. Crown build-up procedures are allowed on teeth that meet crown criteria, where clinical crown breakdown is at a level where the build-up material is necessary for crown retention.
F. Replacement crowns are allowed only on teeth with recurrent decay or missing crowns. Open margins, in the absence of decay, are considered cleansable and do not require replacement.
G. Replacement crowns are not benefited due to chipped or fractured porcelain, without decay
H. Crowns being placed for cosmetic purposed are not a covered benefit
I. A request for a crown following root canal therapy must meet the following criteria:
   1. One month must have passed since the root canal therapy was completed.
   2. Request must include a dated post-endodontic radiograph.
   3. Tooth must be filled within two millimeters of the radiological apex unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
   4. The filling must be properly condensed/obturated.
   5. To be covered, a tooth must oppose a crown or denture in the opposite arch or be an abutment for a partial denture.
   6. The patient must be free from active and advanced periodontal disease.
   7. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated.
   8. Prefabricated or cast post and core procedures are allowed on endodontically treated teeth where clinical crown breakdown is at a level where the post and core is necessary for crown retention.
J. Procedures that may meet clinical criteria for approval, may be disallowed due to frequency limitations.
K. Services that fail to meet clinical criteria due to a more definitive prior treatment will be disallowed.
L. Cast post and core will deny if submitted on same day as a root canal treatment.
M. Cast Crowns will deny if submitted on same day as a root canal treatment.

**Exhibit E –** Fixed Prosthodontic Criteria

**Reference**: American Association of Prosthodontics and American Dental Association

## I. Pre-Authorization Documentation

A. Documentation may be needed for pre-authorization of procedure:
   1. Detailed Treatment plan.
   2. Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapical or panorex.
   3. Treatment rendered without necessary authorization requires appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

## II. Codes

DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

## III. General Criteria

A. The placement of a fixed prosthetic appliance will only be considered for those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis.
B. Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
C. Fixed partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type 1 or 2), and a favorable prognosis where continuous deterioration is not expected.
D. As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

## IV. Criteria: Authorizations for prosthesis do not meet criteria:

A. If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
B. If abutment teeth are less than 50% supported in bone.
C. If there are untreated cavities or active periodontal disease in the abutment teeth.
D. When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date for the denture service to be covered.
E. Double abutments are not authorized for fixed prosthetics.
F. Long-Span Fixed Bridges that violate Antes Law will not meet criteria.

## V. Additional Information

A. Procedures that may meet clinical criteria for approval, may be disallowed due to frequency limitations.
B. Services that fail to meet clinical criteria due to prior treatment will be disallowed.

**Exhibit E1 –** Fixed Prosthodontic Criteria – Anterior Only

Reference: American Association of Prosthodontics and American Dental Association

## I. Pre-Authorization Documentation

A. Documentation may be needed for pre-authorization of procedure:
   1. Detailed Treatment plan.
   2. Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapical or panorex.
   3. Treatment rendered without necessary authorization requires appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

## II. Codes

DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

## III. General Criteria

A. Fixed Partial Dentures are limited to anterior or posterior bridges with 3 or fewer missing teeth in the arch.
B. Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
C. Fixed partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type 1 or 2), and a favorable prognosis where continuous deterioration is not expected.
D. As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

## IV. Criteria: Authorizations for prosthesis do not meet criteria:

A. If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
B. If abutment teeth are less than 50% supported in bone.
C. If there are untreated cavities or active periodontal disease in the abutment teeth.
D. When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date for the denture service to be covered.
E. Double abutments are not authorized for fixed prosthetics.
F. Long-Span Fixed Bridges that violate Antes Law will not meet criteria.
G. Procedures that may meet clinical criteria for approval, may be disallowed due to frequency limitations.
H. Services that fail to meet clinical criteria due to prior treatment will be disallowed.