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Index

1.1 Introduction

It is Delta Dental of Michigan's policy to maintain a Utilization Management Program that:

- Is clearly defined
- Assigns program responsibilities and activities to appropriate professional and support staff
- Is supervised by a senior-level dentist practitioner
- Has structures and processes that facilitate professional review of dental care services for medical necessity and clinical appropriateness that is accurately carried out in a fair, impartial, consistent and timely manner

All policies and procedures used by Delta Dental for utilization management are reviewed and approved by Delta Dental's Utilization Management Committee.

1.2 Scope of the Utilization Management Program

The scope of Delta Dental's UM Program and this written UM Program description, hereinafter referred to as the UM Plan, is limited to the structures and processes that facilitate and support utilization review of retrospective, preservice prior authorizations, postservice dental claims and appeals of adverse postservice utilization review determinations.[1]

When delegated utilization management responsibilities by a client, Delta Dental maintains and provides the appropriate structures and mechanisms to not only perform the contractually agreed upon services, but to report on the same and supply the required oversight documentation as requested. When delegated responsibility in support of a Medicaid program, Delta Dental will comply with all applicable Medicaid laws, regulations, regulatory guidance and contractual requirements. Delta Dental acknowledges the right of CMS, the state involved, Health and Human Services Inspector General, Comptroller General, or their designees to audit, evaluate and inspect any physical or electronic records that pertain to any aspect of the designated utilization management services and activities. Delta Dental accepts that this right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. The State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time when there is reasonable possibility of fraud or similar risk.

1.3 Purpose of the Utilization Management Program

[1] Delta Dental does not conduct urgent concurrent care review relating to continued or extended health care services (see “Utilization Review for Concurrent Care Claims” in Section 5 below). The extent of Delta Dental's utilization review for benefit coverage is defined by factors including but not limited to the terms of member dental plans, applicable clinical criteria, claim processing policies, patient age and dental condition and the profiles of treating practitioners.

- Ensure that Delta Dental members have access to dental care that is medically necessary, clinically appropriate, of acceptable quality, consistent with the diagnosis and required level of care and performed within generally accepted standards of dental practice.
- Define the responsibilities and authority for conducting utilization review of dental claims and appeals involving medical necessity and clinical appropriateness decision making.
- Ensure that dental utilization review decision making is performed by appropriate professionals, accurately applies the appropriate objective and evidence-based clinical criteria, thoroughly considers the clinical information relevant to a member's dental care and is carried out in a fair, impartial, consistent and timely manner.
- Describe the processes for managing utilization review of dental procedures from claim receipt through appeal handling.
- Ensure that clinical criteria are not applied to dental utilization review determinations without considering the individual needs of Delta Dental members.
- Provide access for members, practitioners and clients to discuss UM issues with utilization management staff, including giving practitioners the opportunity to discuss adverse dental medical necessity or clinical appropriateness determinations with an appropriate dental reviewer.
- Respond in a timely and appropriate manner to inquiries, reconsiderations, appeals, complaints and grievances regarding utilization management activities from members, practitioners and clients.
- Provide members and practitioners with clear information on adverse dental medical necessity or clinical appropriateness determinations and the options for filing appeals.
- Ensure that appeals of adverse dental medical necessity or clinical appropriateness determinations are thoroughly handled in a fair, impartial, consistent and timely manner.
- Facilitate the evaluation of new dental technology.
- Ensure the integrity of claim and appeal data in Delta Dental systems.
- Quantify and qualify the effectiveness of the UM Program through ongoing monitoring of utilization management performance assessment measures such as timeliness of claim processing, appropriate use of clinical criteria and information, communication of utilization review determinations, interrater reliability and appeal handling.
- Ensure that applicable statutes, regulations, policies, guidelines and standards are adhered to.

1.4 Utilization Management Plan

Delta Dental maintains a UM Plan that provides a written description of its UM Program including:

- A description of the UM Program structure
- Involvement of a designated senior-level dental practitioner (i.e., Delta Dental's Dental Director) in UM Program implementation, Supervision, oversight and evaluation
- The scope of the UM Program
- The utilization review processes used to determine benefit coverage dependent on medical necessity and clinical appropriateness decision-making

- Information sources used to make medical necessity and clinical appropriateness decisions

1.5 Utilization Management Program Oversight, Management and Staff

Dental Director: The UM Program is maintained under the management of the Dental Director[2], a senior-level dentist practitioner. The Dental Director is fully involved in the implementation, supervision, oversight and evaluation of the UM Program including but not limited to utilization review activities and the development, adoption, implementation, maintenance, evaluation and revision of the policies and procedures of the UM Program as documented in the UM Plan and associated materials. Utilization Management Department staff, including licensed dentist peer reviewers, report directly or indirectly to the Dental Director.

The Dental Director oversees and is involved in the development, adoption, implementation, maintenance, evaluation and revision of clinical criteria and their application for utilization review determinations. The Dental Director, in conjunction with the Manager of Utilization Review, oversees all Delta Dental licensed dentist peer reviewers (dental consultants), including their orientation, training and performance. The Dental Director also maintains responsibility for ensuring the clinical accuracy of determinations of medical necessity and clinical appropriateness. In conjunction with the Manager of Utilization Review, the Dental Director is involved in reviewing the consistency of the application of clinical criteria by licensed dentist peer reviewers and in implementing corrective actions when needed. When required, the Dental Director can perform utilization review and has the authority to deny coverage based on an adverse medical necessity and clinical appropriateness determination for both claims and appeals. The Dental Director also oversees utilization management quality improvement activities and credentialing of licensed dentist peer reviewers. The Dental Director serves as the chair of the Utilization Management Committee, including participating in the committee's ongoing evaluation of the UM Program's effectiveness. The Dental Director may, as appropriate, delegate specified functions to a designee.

The Dental Director must be a dentist with a current and unrestricted license to practice dentistry in a state, territory or commonwealth of the United States (Puerto Rico) or the District of Columbia and must have had a minimum of 10 years relevant post-graduate direct patient care experience. Dental specialists who take the position of Dental Director must be board certified in the relevant specialty. Appendix A provides more detailed information on the qualifications of Delta Dental's current Dental Director.

Manager of Utilization Review: The requirements of the UM Plan are enforced on a day-to-day basis by the Manager of Utilization Review. The Manager of Utilization Review oversees and manages all aspects of utilization review by Delta Dental's licensed dentist peer reviewers (dental consultants) including the application of clinical criteria by the reviewers. When required, the Manager of Utilization Review can perform utilization review and has the authority to deny coverage based on an adverse medical necessity and clinical appropriateness determination for both claims and appeals. The Manager of Utilization Review participates in the evaluation and any necessary revision of the UM Plan and serves as the vice-chair of the Utilization Management Committee. The Manager of Utilization Review shares with the Dental Director the responsibility of overseeing the Utilization Management Department's compliance with applicable federal and state statutes and regulations, code sets, claim processing

[2] For Delta Dental's dental plans, the "Dental Director" serves the same function relative to the UM Program and UM Plan as the "senior-level physician" does in medical plans, i.e., the Dental Director is the "senior-level dentist".

policies, timely claim adjudication requirements, practitioner agreements, client contracts and accreditation standards.

Manager of NCQA Program Compliance for UM: The Manager of NCQA Program Compliance for UM manages daily, monthly and annual activities of the Dental Consulting and Utilization Management department to ensure compliance with applicable NCQA, URAC and other accreditations, including maintenance of continuous survey readiness, as well as managing the utilization management quality improvement program.

Licensed Dentist Peer Reviewers (Dental Consultants): Licensed dentist peer reviewers who have been trained and authorized by the Dental Director to perform utilization review have the authority to deny coverage based on an adverse medical necessity and clinical appropriateness determination for both claims and appeals. These practitioners have the education, training and professional experience in clinical practice that facilitates thorough utilization review of dental procedures that is accurately carried out in a fair, impartial, consistent and timely manner. For more details regarding the activities and qualifications of licensed dentist peer reviewers, see Sections 4.2 and 4.3 and Appendix B.

Dental Claim Review Staff: Unlicensed dental claim review staff do not have authority to deny coverage based on an adverse medical necessity and clinical appropriateness determination. These staff members can collect and prepare information used by licensed dentist peer reviewers in utilization review, process claims after a licensed dentist peer reviewer has made a determination and, if appropriately trained and supervised, may apply explicit pre-established UM decision criteria that do not require clinical judgment. For more details regarding the activities of dental claim review staff, see Section 4.4 below.

Utilization Management Committee: The Utilization Management Committee oversees the Delta Dental UM Program's clinical activities and operations through continuous, structured monitoring and improvement of the program to ensure appropriate and effective utilization review, establish efficient management of dental plan resources and promote high quality care.

Delta Dental's Utilization Management Committee is a multidisciplinary standing committee chaired by the Dental Director. The composition of the committee is as follows:

- Voting members are the Dental Director, four practicing dentists who are independent contractors free of conflict relative to Delta Dental, the Chief Dental Officer for Government Programs, the Senior Manager of Professional Review, and the Manager of NCQA Program Compliance for UM.
- Non-voting resource personnel to the committee include:
    - Delta Dental staff members from the departments of Dental Consulting and Utilization Management, Focused Review, Population Health Management and Professional Review, and Government Programs
    - Additional clinical and non-clinical experts as required by the committee
- The committee must include in voting member or non-voting resource positions:
    - Practitioners representing the following dental specialties: endodontics, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics and prosthodontics

- A dentist who has had training and experience in the dental care of elderly or disabled individuals

The Utilization Management Committee oversight functions include but are not limited to:

- Review and resolution of unresolved utilization review cases
- Oversight of utilization review activities carried out by licensed dentist peer reviewers
- Credentialing of licensed dentist peer reviewers
- Ongoing evaluation of utilization management performance assessment measures, as well as any internal or external audits of UM quality and/or compliance
- Identification of opportunities for improving UM policies, procedures and activities
- Review of ongoing UM quality improvement plans
- Adoption of clinical criteria
- Review and assessment of new dental technology
- Review and assessment of member, practitioner and client experience with Delta Dental's UM Program
- Facilitation and assessment of the annual UM Program evaluation
- Annual review, revision and approval of Delta Dental's clinical criteria, UM Plan, UM Quality Improvement Plan, UM Communication Plan, UM System Controls Policy and Procedure and Utilization Management Committee Procedure

In carrying out each of these oversight functions, the UM Committee (1) addresses all identified opportunities for UM quality improvement, (2) facilitates appropriate interventions that will likely contribute to measurable UM quality improvement and overcome identified barriers to improvement and (3) documents quality improvement actions taken by the committee. For each intervention, the committee facilitates carrying out and documenting quarterly follow-up evaluations to assess the effectiveness of any committee intervention in achieving the desired quality improvement.

Practitioners and other members serving on the Utilization Management Committee must recuse themselves if the committee reviews a case or other issue in which they have professional, financial or personal involvement. The Dental Director will serve as an objective party to determine whether disclosed personal or financial interests are conflicts of interest and will manage the requirement of recusals due to such conflicts.

For more detailed information about Utilization Management Committee functions, see the Delta Dental of Michigan Utilization Management Committee Procedure.

1.6 UM Program Scope and Processes Used to Determine the Medical Necessity and Clinical Appropriateness of Dental Procedures

Scope: The scope of Delta Dental's determination of benefit coverage based on medical necessity and clinical appropriateness includes utilization review of preservice prior authorization, postservice dental claims, and appeals of adverse postservice utilization review determinations.

Utilization Review: The term utilization review refers to the process of determining if a dental service is medically necessary or clinically appropriate. Utilization review is performed by licensed dentist peer reviewers when required by the terms of a member's dental plan. Utilization review is a necessary component of utilization management and involves assessment of dental services and procedure to determine if they are:

- Medically necessary or clinically appropriate for prevention, evaluation, diagnosis and treatment of a member's dental or maxillofacial disease, condition, illness or injury
- Clinically appropriate and consistent with the applicable evidence-based, generally accepted standards of dental practice
- Not provided primarily for the convenience of the member or dental practitioner

The extent of Delta Dental's utilization review for benefit coverage is defined by factors including but not limited to the terms of member dental plans, applicable clinical criteria, claim processing policies, patient age and dental condition and the profiles of treating practitioners.

Utilization review does not include determinations that a dental service is ineligible for benefit payment due to a contractual exclusion or limitation of a member's dental plan, or because the service exceeds the dental plan's benefit maximum.

Process for Medical Necessity and Clinical Appropriateness Determinations: When utilization review is necessary under a dental plan administered by Delta Dental, the determination of medical necessity or clinical appropriateness is made on a case-by-case basis by appropriate licensed dentist peer reviewers after completion of a thorough review of all relevant information sources. Reviewers take into account the specific clinical criteria applicable to the dental service or procedure provided. For more information on how Delta Dental develops, selects, reviews and revises clinical criteria, see Section 2 below.

When performing utilization review, licensed dentist peer reviewers also give consideration to the particular dental and overall health needs of the member and, if relevant to a utilization review determination, individual circumstances such as age, comorbidities, complications, progress of treatment, psychosocial situation and the particular local dental care delivery system. When necessary and appropriate, utilization review cases may be referred to the Dental Director and/or the Utilization Review Committee for assistance in making a medical necessity or clinical appropriateness determination. Utilization review determinations are documented in Delta Dental's claim processing system so that subsequent reviewers will understand the decision rationale. Members and practitioners are subsequently informed of the decisions by notifications communicated via an online portal or by hardcopy mailing, depending on the recipient's choice.

Denials based on adverse medical necessity or adverse clinical appropriateness UM decisions may only be made by an appropriate licensed dentist peer reviewer who has clinical experience with the dental service or procedure being reviewed. Delta Dental does not offer financial or other forms of compensation to encourage licensed dentist peer reviewers to render adverse medical necessity or clinically appropriateness decisions.

Information Sources Used for Medical Necessity and Clinical Appropriateness Determinations: When conducting review of the medical necessity or clinical appropriateness of a dental service or procedure, Delta Dental's licensed dentist peer reviewers rely on:

- All information contained in member dental records relevant to a member's health condition, treatment plan, treatment provided and prognosis
- Narratives from treating dentists
- Discussions with treating dentists
- Any provisions of the member's dental plan applicable to the review
- The applicable Delta Dental clinical criteria
- Dental evidence-based guidelines and other pronouncements and publications of leading nationally recognized dental public health organizations, health research agencies and professional organizations
- The dental procedure code, nomenclature and descriptor information contained in the current version of the American Association Code on Dental Procedures and Nomenclature
- Any federal and state regulations applicable to the review

If there is an absence of definitive clinical criteria available for a particular utilization review, licensed dentist peer reviewers refer to:

- Credible scientific evidence published in peer-reviewed medical and dental literature, including journals and textbooks generally recognized by the relevant medical and dental communities (focusing on the highest available level of evidence)
- Resources from accredited dental schools
- The regulatory status of relevant dental technologies
- Clinician advisors serving as resource personnel for the Utilization Management Committee
- Appropriate external professional dental expertise and experience.

Delta Dental will not use the policies and procedures in this UM Plan to avoid providing medically necessary or clinically appropriate services or procedures which are benefits within the coverages established under a member's dental plan contract.

1.7 Evaluation, Revision and Approval of the Utilization Management Program

Annual UM Program Evaluation: During the first quarter of each year, the Utilization Management Committee works with the Dental Director, Manager of Utilization Review and Manager of NCQA Program Compliance for UM to evaluate, revise and approve Delta Dental's UM Program based on an annual quality evaluation of program activities during the prior year. The goal of this evaluation is to ensure that the program remains current and appropriate so that members have consistent access to medically necessary care, without unreasonable barriers or interruptions. The Dental Director, Manager of Utilization Review and Manager of NCQA Program Compliance for UM coordinate to collect relevant data for the annual evaluation, develop a detailed assessment of all aspects of the UM Program and prepare

an annual UM program evaluation report, including identification of opportunities to improve UM services, which is forwarded to the Utilization Management Committee.

The Utilization Management Committee reviews the annual UM program evaluation report. If expertise is required for committee deliberations and decision-making outside of committee members and existing committee resource personnel, the committee chair or person designated by the chair arranges for it. When performing their review, the Utilization Management Committee performs an assessment of the following:

- The UM Program scope and structure including the utilization management policies and procedures contained in the UM Plan and its appendices. The Utilization Management Committee's review and approval of the UM Program policies and procedures considers (1) the dental services to which Delta Dental utilization management applies, (2) applicable commercial, Medicare Advantage and Medicaid coverage and decision guidelines, (3) relevant clinical criteria and (4) applicable statutes, regulations and accreditation standards.
- Delta Dental utilization management policies, procedures, guidelines and clinical criteria must (1) be based on current evidence in widely used treatment guidelines or clinical literature, (2) consider the individual needs and dental and medical histories of Delta Dental members, (3) be developed in consultation with appropriate dental practitioners and (4) be periodically reviewed and revised if required.
- Delta Dental's policies, procedures and clinical criteria must ensure that when reviewing the medical necessity and clinical appropriateness of dental services for benefit coverage, licensed dentist peer reviewers consider (1) relevant information sources, (2) the diagnosis, condition and functional status as documented in the dental and medical histories of individual Delta Dental members, (3) recommendations from treating dentists and (4) involvement of the Dental Director if needed.
- UM communication services
- Licensed dentist peer reviewer job description
- Use of board-certified dental specialist consultant.
- Tracking and trending of UM performance assessment measures (quality indicators) including the identification of any performance failures and any barriers to maintenance of desired quality metrics for UM functions including but not limited to:
    - Use of appropriate professionals in UM decision making
    - Timeliness of UM decision making
    - Use of relevant clinical information in UM decision making
    - Appeal record content
- UM Program compliance with applicable statutes, regulations, policies and accreditation standards
- Performance of licensed dentist peer reviewers, including reviewer accuracy and interrater reliability
- Provision of annual notice to members about external appeal rights, as applicable
- Member, practitioner and client experience with UM Program activities
- The level of involvement of the Dental Director in the UM Program

As part of the annual UM Program evaluation, the Utilization Management Committee will also facilitate:

- Revision of Delta Dental clinical criteria for making medical necessity and clinical appropriateness decisions, if required
- Evaluation of new dental technology

When the Utilization Management Committee has completed its assessment of Delta Dental's UM Program, the committee (1) facilitates revision of the UM Program if required, (2) approves the UM Program's policies, procedures, guidelines and clinical criteria as required, (3) determines if any actions need to be taken on identified opportunities for improvement of UM services and (4) facilitates the development of a work plan to implement any UM quality improvements selected for action.

As appropriate, the Utilization Management Committee will remove utilization management and review requirements for dental services that no longer warrant utilization management and review. The Utilization Management Committee will document the rationale for its decisions for the development and revision of utilization management policies and procedures. The process to incorporate any revisions of UM Program organization, areas of responsibility, criteria and/or methodology authorized by the Utilization Management Committee takes place under the direction and supervision of the Dental Director as soon as possible after the revisions are approved by the committee.

1.8 The UM Program's Role in Delta Dental's Quality Improvement Activities

Delta Dental's UM Program is integrated into the company's overall quality improvement activities. As shown in Figure 1.1 and summarized in Section 1.7, the Delta Dental UM Committee is the main forum

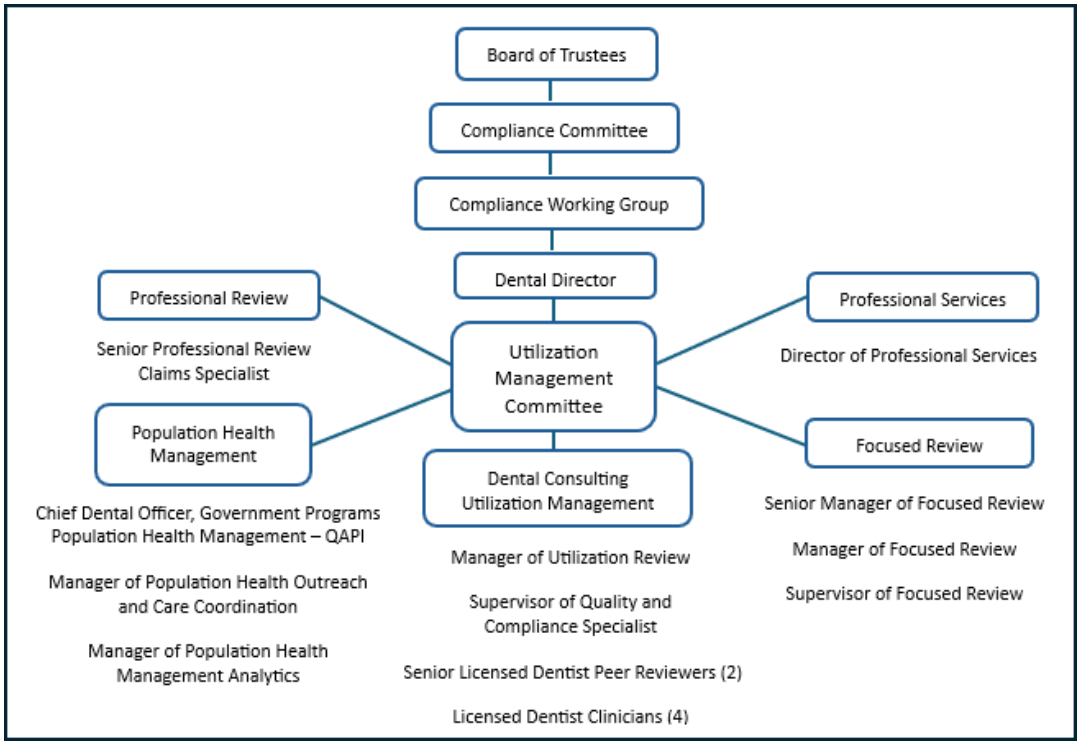

Figure 1.1

for monitoring, assessing and taking actions to maintain and improve the quality of Delta Dental's UM Program. The UM Committee membership includes management staff from departments across the company who have roles in maintaining the quality and compliance of processes directly and indirectly connected with the company's utilization management activities.

As described in Section 1.7, on a regular basis Delta Dental's UM staff compiles information on UM activities for the UM Committee's continuing quality assessment of the UM Program including, but not limited to:

- Utilization management performance assessment measures
- Member, practitioner and client experience information
- Utilization review activities
- Unresolved utilization review cases
- Licensed dentist peer reviewer credentialing information
- Updates on clinical criteria development
- Information on new dental technology
- Ongoing quality improvement plans
- Internal or external audits of UM quality and/or compliance

The committee applies this information in assessing the performance of UM activities, identifying opportunities for UM quality improvement and facilitating appropriate interventions to improve UM policies, procedures and activities.

The UM Committee documents all UM quality oversight activities including quality assessment activities and quality improvement interventions. The UM Committee provides appropriate reporting of potential quality or compliance risks, performance improvement plans and recommendations for corrective actions to the Delta Dental Compliance Working Group through the Dental Director, who is a member of both the committee and the working group. If the Compliance Working Group identifies any quality or compliance risks through information provided by the UM Committee, the working group may provide feedback to the Dental Director and UM Committee on corrective actions or, in the case of a quality or compliance risk of particular concern, may develop and submit recommendations for further review to the Delta Dental Compliance Oversight Committee.

The Delta Dental Compliance Oversight Committee is appointed to assist the Board of Directors of Delta Dental Plan of Michigan, Inc. and is composed of leaders throughout the functional areas of the company including operations, claims, legal, risk management, sales, professional services, appeals and human resources. Among its functions, the committee oversees compliance with all applicable laws, regulations, rules, standards and best practices, as well as reviewing the results of investigations and resulting corrective action plans for operations departments including utilization management. The committee prepares and renders appropriate reports of its meetings, actions and recommendations to the Board of Directors directly or through the Board's Audit, Finance and Risk Management Committee.

2.1 Introduction

It is Delta Dental of Michigan's policy to develop and adopt objective and evidence-based written clinical criteria to be applied as guidelines when the administration of member dental plans requires professional determination of the medical necessity or clinical appropriateness of dental services. On at least an annual basis, clinical criteria must be reviewed and revised as necessary to ensure that they remain consistent with current clinical evidence.

Delta Dental's clinical criteria and the utilization management decisions based on them do not qualify as dental or medical advice. Delta Dental advises members to make all decisions about the necessity or desirability of dental services and procedures with their practitioner.

Depending on the provisions of a member's dental plan, federal or state statutes or regulations, dental plan contractual mandates, local or national claim processing policies or other mandated requirements may take precedence over clinical criteria.

Organization of Clinical Criteria: Delta Dental's clinical criteria are organized by and incorporate CDT® dental procedure codes. CDT® is a registered trademark of the American Dental Association (ADA). The Association is the exclusive copyright owner of CDT, the Code on Dental Procedures and Nomenclature and the ADA Dental Claim Form.

Requirements for Clinical Criteria: The development, adoption, application, review and revision of Delta Dental's clinical criteria must meet the following requirements:

- Clinical criteria are developed, adopted, reviewed and revised through a prescribed process using methodology to produce objective criteria which are consistent with current clinical evidence and are relevant for given dental conditions and procedures.
- Appropriate dental practitioners are involved with the development, adoption, application, review and revision of clinical criteria.
- Clinical criteria must be accurately and consistently applied for professional determinations of the medical necessity or clinical appropriateness of dental services.
- The development, adoption, application, review and revision of clinical criteria takes into consideration (1) individual member needs including, if applicable, age, comorbidities, complications, treatment progress, psychosocial situation and home environment and (2) any limitations in the dental delivery system accessible to a member which could adversely impact meeting the member's dental care needs following application of clinical criteria.
- Multiple reviews of medical necessity or clinical appropriateness during the same course of a member's dental treatment must utilize the same unrevised clinical criteria.
- Clinical criteria must be made available to providers and other appropriate recipients through multiple delivery channels.
- Clinical criteria, and the procedures for applying them, must be annually reviewed and are revised if necessary.

2.2 Clinical Criteria Development and Adoption

Delta Dental's clinical criteria are developed by the Clinical Criteria Review Subcommittee of the Utilization Management Committee. Subcommittee members include the Dental Director and Manager of Utilization Review, as well as licensed independent contractor dental general practitioners and dental specialists selected to provide a broad range of clinical expertise within the subcommittee. If necessary, the subcommittee solicits the input of additional relevant internal or external professional experts who have specific expertise with clinical issues in question. In such a case, the Dental Director will determine which specific experts have the knowledge and experience needed to give a reliable professional opinion (e.g., periodontal specialists for the evaluation of periodontal issues). The Dental Director will then determine the availability of appropriate experts, either internal (e.g., independent contractor licensed dentist peer reviewers) or external (e.g., community practitioners or dental school academicians) and will facilitate contact to request their input. Staff will prepare and send any materials needed by the experts and schedule meetings or other further communication as required.

Clinical criteria are developed in alignment with (1) evidence-based clinical recommendations, guidelines and parameters of care of leading nationally recognized dental public health organizations, dental health research agencies and professional dental organizations, (2) other sources of generally accepted standards of dental practice, (3) credible scientific evidence published in peer-reviewed medical and dental literature, (4) resources from accredited dental schools, (5) dental technology assessments, (6) the rules and requirements of the Centers for Medicare and Medicaid Services and applicable state programs, (7) Delta Dental national processing policies, (8) input from practicing network dentists and (9) applicable client requirements.

Nationally recognized dental standards referenced by Delta Dental for the development of clinical criteria include but are not limited to (1) clinical guidelines published by the American Academy of Pediatric Dentistry, (2) clinical guidelines, parameters, positions and statements published by the American Academy of Periodontology, (3) clinical guidelines and positions published by the American Association of Endodontists, (4) parameters of care published by the American Association of Oral and Maxillofacial Surgeons, (5) dental practice parameters and clinical practice guidelines published by the American Dental Association, (6) the Cochrane database of systematic reviews and (7) relevant guidelines published in the National Guideline Clearinghouse of the U.S. Agency for Healthcare Research and Quality. Delta Dental also relies on the dental procedure code, nomenclature and descriptor information contained in the current version of the Code on Dental Procedures and Nomenclature published by the American Dental Association. Scientific evidence published in peer-reviewed medical and dental literature is accessed through resources including but not limited to the American Dental Association database of systematic reviews, the Cochrane Collaboration database of systematic reviews and the PubMed database.

References relied upon to develop and revise Delta Dental’s clinical criteria are cited in each clinical criteria document.

New and revised clinical criteria must be collaboratively reviewed and adopted by the Utilization Management Committee, the Manager of Utilization Review and the Dental Director prior to release for use by Delta Dental licensed dentist peer reviewers. In the case where a Delta Dental client has imposed specific requirements, external client contacts may be included in the review and adoption process.

2.3 Availability of Clinical Criteria

Clinical criteria are made available to practitioners through an open-access Delta Dental (or affiliated dental benefit organizations who delegate utilization management responsibilities to Delta Dental) web site. Practitioners without internet access may request mailing of clinical criteria from UM staff through Delta Dental's utilization management communication services. Practitioners may also use Delta Dental's UM communication services to communicate questions or concerns regarding clinical criteria. Practitioner contacts regarding clinical criteria will be documented in a UM issues communication log.

On at least an annual basis, Delta Dental will communicate with practitioners to inform them on how to access Delta Dental's clinical criteria. Communication channels for this activity may include practitioner manuals, practitioner newsletters, statements on the Dental Office Toolkit portal and the practitioner resource pages of the Delta Dental web site.

2.4 Application of Clinical Criteria

Delta Dental utilizes clinical criteria as a reference when the provisions of a member's dental plan requires a professional determination of the medical necessity or clinical appropriateness of a dental service.

When reviewing a dental service for medical necessity or clinical appropriateness, Delta Dental's licensed dentist peer reviewers apply clinical criteria in conjunction with review of the available information provided by the practitioner and/or member, such as:

- The individual needs of the member including, if applicable, age, comorbidities, complications, treatment progress, psychosocial situation and home environment
- The member's dental and medical history
- The treating practitioner's diagnosis, treatment plan and profile
- The provisions of the members' dental plan
- Limitations in the local dental delivery system accessible to a member which could adversely impact meeting the member's dental care needs when clinical criteria are applied. This involves assessment of the availability of inpatient and outpatient facilities for emergency, preventive, basic restorative, basic periodontal, basic surgical and basic/complex rehabilitative oral health services. Depending on a member's dental health needs, consideration may need to be given to the availability of the services of dental specialists in the community, in local hospitals or in area dental schools.

The application of clinical criteria by Delta Dental's licensed dentist peer reviewers is carried out to ensure that the evaluation, diagnosis and treatment rendered by providers to Delta Dental members and dependents is sufficient, safe and effective for any given oral or maxillofacial injury, illness, conditions or disease. Determinations of medical necessity or clinical appropriateness by Delta Dental's licensed dentist peer reviewers are not made to accommodate or otherwise provide an advantage to patients, patient families, patient caregivers or providers unrelated to the services required to appropriately address the clinical needs of a patient.

Written notification involving the appropriate application of clinical criteria is communicated to members and providers through processing policies using easy-to-understand verbiage citing denial

reasons, a reference to the criterion, and where to obtain the protocol used. As required by state, federal, and/or client contractual guidelines, such information will be shared at specified reading levels and in the recipient's preferred language.

Consistency in Applying Clinical Criteria: On a quarterly basis, Delta Dental evaluates the consistency with which its licensed dentist peer reviewers apply clinical criteria when making determinations of the medical necessity or clinical appropriateness of dental services. Two assessment processes are utilized:

- A random sample of dental claims requiring a UM determination is assessed to establish the percentage of claims where licensed dentist peer reviewers applied the appropriate clinical criteria when making the determination.
- Licensed dentist peer reviewers are presented with hypothetical test cases requiring a UM determination and the percentage of agreement among professional peer reviewers on the test cases is assessed.

In both cases, the resulting performance assessment measurement is reviewed against a performance target set by the Dental Director. If the performance assessment measurement fails to meet the performance target, the Dental Director will implement a corrective action plan to address the root cause(s) of the failure.

Formal ongoing education also takes place that includes, but is not limited to, updating Delta Dental's licensed dentist peer reviewers on new standards, policies, procedures and technologies, reviewing changes in clinical criteria and maintaining interrater calibration to ensure consistent application of clinical criteria in UM decision making.

2.5 Annual Review and Revision of Clinical Criteria

Delta Dental reviews clinical criteria against current dental evidence on at least an annual basis to ensure that the criteria remain consistent with current clinical evidence and generally accepted standards of dental practice. The purpose of the review is to identify changes in scientific knowledge or dental health care technology that could have a material impact on dental utilization review.

The clinical criteria are reviewed at least annually by the Clinical Criteria Review Subcommittee of the Utilization Management Committee. The subcommittee facilitates a search for relevant changes since the prior clinical criteria review in (1) evidence-based clinical recommendations, guidelines and parameters of care of leading nationally recognized dental public health organizations, health research agencies and professional organizations, (2) credible scientific evidence published in peer-reviewed medical and dental literature and (3) information from dental technology assessments.

A report on the subcommittee's findings is prepared that documents scientific or clinical changes that the subcommittee believes should be considered in dental utilization review decisions. The report identifies new treatments, applications and technologies that have been adopted as generally accepted standards of dental practice, and which in the opinion of the subcommittee members warrant revising the clinical review criteria. The report is distributed to the Utilization Management Committee as part of the overall annual UM Program Evaluation Report. The committee reviews the report and adopts appropriate revisions to the clinical criteria if any are required, with any action being documented in the committee minutes. The process to incorporate changes in the clinical criteria after Utilization Management Committee approval takes place under the supervision of the Dental Director and the Manager of Utilization Review.

3.1 Introduction

It is Delta Dental's policy to provide access to utilization management staff for members and practitioners seeking information about the UM process or to discuss UM issues.

3.2 Access to Utilization Management Staff

Delta Dental customer service representatives (CSRs) are available for inbound toll-free calls from members and practitioners regarding UM issues during normal business hours Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time (EST) for commercial plans and 8:00 a.m. to 8:00 p.m. EST for government programs plans. CSRs perform triage on incoming calls through utilization of a supplied script to determine if a caller is contacting Delta Dental regarding a UM issue.

When an incoming call is identified by a CSR as a UM inquiry, the CSR accesses Delta Dental's claim system records to verify that a medical necessity or clinical appropriateness decision was applied to the claim in question. Calls related to a validated UM decision have a case created in the claim system and are labeled with the "UM Determination" workgroup. Calls that are determined not to be a UM-related inquiry are appropriately resolved or routed by the CSR, such as calls related to an adverse benefit determination issued on a claim based on solely on a contractual exclusion, limitation or benefit maximum.

When the "UM Determination" workgroup receives a validated UM inquiry case, detailed information is collected and documented, including the caller's identity and contact information, claim number, processing policies applied, conversation content with the caller's concerns and a timestamped indicator of when the call was taken. The "UM Determination" workgroup is monitored daily, and cases are addressed by senior licensed dental consultants, or by the Manager of Utilization Review to facilitate same day contact (if during normal business hours) with the caller to discuss the issue of concern.

After-Hours Calls: After normal business hours and on holidays, inbound calls regarding UM issues will be answered by Delta Dental's automated telephone answering system. Callers are provided with an option to connect with Delta Dental's dedicated UM communication call center if they are calling about a UM issue. Call center staff will verify if the caller's concerns relate to a UM decision. If not, the caller is directed to the appropriate voice mail option based on the nature of the non-UM inquiry. If the call is verified as a UM inquiry, a case is created in the claim system and labeled with the "UM Determination" workgroup. Detailed information is collected and documented, including the caller's identity and contact information, claim number, processing policies applied, conversation content with the caller's concerns and a timestamped indicator of when the call was taken. The "UM Determination" workgroup is monitored to facilitate returning calls on the next business day or the same business day for calls received after midnight on Monday through Friday.

3.3 Identification of Utilization Management Staff

When initiating or returning calls to members and practitioners regarding UM issues, Delta Dental utilization management staff are trained to identify themselves to incoming and outgoing telephone contacts by name, job or clinical title and organization name, so that callers may identify who they have spoken to and that person's organizational role.

3.4 Additional UM Communication Services

TDD/TTY services are available for members who need them. When required, Delta Dental provides for free of charge contracted translation services through a bilingual translator during normal business hours and a separate phone number for receiving TDD (1-800-537-7697) and TTY (711) messages.

For more information, see the Delta Dental of Michigan Utilization Management Communication Services Policy and Procedure.

4.1 Introduction

It is Delta Dental of Michigan's policy that utilization management decision making regarding the medical necessity or clinical appropriateness of dental services is supervised by appropriately licensed dental professionals and that benefit disapprovals based on determining that dental procedures are not medically necessary or not clinically appropriate are made only by qualified licensed dentist peer reviewers.

Supervision of Utilization Management Activities: Delta Dental's utilization management activities including decision making for medical necessity and clinical appropriateness are collaboratively supervised by the Dental Director and the Manager of Utilization Review, both of whom are licensed dentists with experience in applying utilization management processes in dental benefits administration. The supervisory activities of the directors include:

- Day-to-day supervision of the activities of Delta Dental's licensed dentist peer reviewers (dental consultants), including reviewer activities related to UM decision making for medical necessity and clinical appropriateness
- Maintaining availability in person or by telephone to licensed dentist peer reviewers and non-licensed staff to address issues and answer questions related to utilization management
- Monitoring licensed dentist peer reviewers for thoroughness, decision accuracy, documentation adequacy and consistency in UM decision making
- Participation in orientation and training for new and existing licensed dentist peer reviewers
- Participation in continuing education sessions to maintain interrater calibration among licensed dentist peer reviewers
- Monitoring the involvement of non-professional staff in utilization management activities
- Overseeing the development, adoption, application, review and revision of clinical criteria
- Acting as chair and vice-chair of the Utilization Management Committee

4.2 Professional Review of Dental Healthcare Denials

Delta Dental restricts medical necessity and clinical appropriateness decision making requiring clinical judgment, including benefit disapprovals based on decisions that dental procedures are not medically necessary or clinically appropriate, to qualified licensed dental health professionals. Delta Dental maintains independent contractor consultant relationships with general dentists and dental specialists who serve as licensed dentist peer reviewers. Dental specialists represent the specialties of endodontics, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics and prosthodontics.

When making benefit payment determinations, licensed dentist peer reviewers are not engaged in the practice of dentistry and do not perform any manner of examination, evaluation, diagnosis, treatment planning or treatment of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or adjacent and associated structures.

4.3 Maintaining Qualified Dental Health Professionals for UM Decision Making

Delta Dental licensed dentist peer reviewers are required to have the education, training and professional experience in clinical practice that facilitates thorough, accurate and consistent review of dental services or procedures for medical necessity or clinical appropriateness.
Licensed dentist peer reviewers must meet the following qualifications to be eligible to oversee or participate in reviewing dental procedures for medical necessity and clinical appropriateness:

- Graduation from a dental school accredited by the American Dental Association Commission on Dental Accreditation with full operational status without reporting requirements
- Appropriate unrestricted certification and/or licensure in the United States to practice as a general dentist or specialist dentist
- Residency in the United States
- A minimum of 10 years of clinical practice in general dentistry (if a general dentist licensed peer reviewer) or in a dental specialty (if a dental specialist peer reviewer) unless otherwise approved by the Dental Director
- Agreement to cooperate with Delta Dental's consultant credentialing and recredentialing procedures.
- Agreement in writing to abide by the privacy and confidentiality standards established by Delta Dental
- Agreement to abide by the policies and procedures established by Delta Dental as contained in this UM Plan
- Agreement to maintain a level of knowledge of Delta Dental clinical criteria commensurate with their utilization review responsibilities
- Agreement to process claims requiring a UM decision in a thorough, accurate and timely manner
- Agreement to participate in the monitoring and evaluation of Delta Dental's dental utilization review activities and the implementation of action plans to address opportunities for improvement
- Agreement to participate in all periodic training required by Delta Dental
- Agreement to refrain from the review of dental services or procedures in which they have been professionally involved.

For additional information, see the written Delta Dental licensed dentist peer reviewer job description in Appendix B.

Use of Dental Specialists: Delta Dental's panel of licensed dentist peer reviewers includes dental specialists who perform utilization review in their specialty areas and may be consulted by other licensed dentist peer reviewers and non-licensed staff when additional expertise within their specialty scope of practice is needed. While dental specialists do not have to be board certified to practice or serve as licensed dental specialist peer reviewers, Delta Dental maintains within its group of licensed dentist peer reviewers one or more board-certified endodontists, board-certified oral and maxillofacial surgeons, board-certified orthodontists board-certified pediatric dentists, board-certified periodontists and board-certified prosthodontists. These individuals are routinely utilized for utilization review of claims from both general dentists and dental specialists, as well as providing consultation services as

required in their areas of specialization to the Dental Director, Manager of Utilization Review, licensed dentist peer reviewers and non-professional staff. Delta Dental maintains a list of board-certified and non-board-certified dental specialist peer reviewers, with information for Dental Consulting and Utilization Management department staff needing to contact the specialists.

Prohibitions in the Use of Licensed Dental Peer Reviewers: Licensed dentist peer reviewers are prohibited from performing dental utilization review on claims for dental services or procedures performed on a patient if they (1) participated in diagnosing or treating the patient's disease or condition, (2) participated in developing or executing the patient's treatment plan, (3) have a close familial relationship with the patient[3] or (4) serve as a governing body member, officer, partner, owner, or managing employee in a health care facility where dental services or procedures under review were furnished to the patient. Licensed dentist peer reviewers are also prohibited from reviewing the appeal of an initial adverse UM decision that they previously made.

Incentives: Delta Dental prohibits the provision of monetary or non-monetary incentives of any kind to motivate licensed dentist peer reviewers to disapprove, limit or discontinue medically necessary or clinically appropriate dental services or procedures which are benefits under the benefit coverage established under a dental plan contract.

Offshore Entities: Delta Dental does not contract with or involve offshore entities in (1) the performance of any utilization management activities, (2) the development, implementation or revision of utilization management policies, procedures or clinical criteria or (3) the revision of this UM Plan or any other document related to Delta Dental's UM Program.

To validate appropriate professionals are making utilization review determinations, in support of the professional peer reviewer credentials applied during the adjudication process, as a cross reference, Delta Dental maintains a list of all professional peer reviewer qualifications outlined in a continually updated attestation form highlighting their education, training, and professional experience. The content will be made available for review upon request to contractually affiliated agencies.

4.4 Use of Staff Who are Not Licensed Dental Health Professionals

If appropriately trained and working under the general supervision of the Dental Director, the Manager of Utilization Review or licensed dentist peer reviewers, Delta Dental may allow non-licensed dental claim review staff to approve dental services and procedures when using explicit pre-established UM decision criteria that do not require clinical judgment. Non-licensed staff members are not allowed to make claim review determinations which require the application of clinical judgment in order to determine if a dental service or procedure was medically necessary or clinically appropriate, including decisions to disapprove benefits based on a decision that a dental procedure is not medically necessary or clinically appropriate. Non-licensed staff may prepare information for utilization review by licensed dentist peer reviewers and complete the processing of claims when a UM decision has been made and documented by a licensed dentist peer reviewer. Any incoming communications received from members, practitioners or clients that involve a UM issue are referred by non-licensed staff to the Dental Director, the Manager of Utilization Review or an appropriate licensed dentist peer reviewer.

[3] A close relative of a patient is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent or grandparent.

4.5 Credentialing of Licensed Dentist Peer Reviewers

Before a practitioner begins functioning as a licensed dentist peer reviewer on behalf of Delta Dental, the practitioner must complete the licensed dentist peer reviewer credentialing process. Appendix C contains a copy of Delta Dental's Licensed Dentist Peer Reviewer Credentialing Form that prospective licensed dentist peer reviewers must complete and submit.

Delta Dental carries out the following information collection for prospective licensed dentist peer reviewers.

- Primary verification of state dental licensure from the state board
- Primary verification of specialty license or certification, if applicable
- Exclusion list screenings of:
  - Office of Inspector General List of Excluded Individuals and Entities
  - General Services Administration System for Award Management
  - Any applicable state agency
- Focused Review report
- Collection of information from the National Practitioner Databank.

The Dental Director reviews initial prospective licensed dentist peer reviewer credentialing documentation and makes the determination if a practitioner meets the qualifications to be contracted as a Delta Dental licensed dentist peer reviewer. Practitioners who have licensure restrictions of any kind, or who are on an exclusion list, are not eligible to be a Delta Dental licensed dentist peer reviewer.

Practitioners functioning as licensed dentist peer reviewers on behalf of Delta Dental must immediately notify the Dental Director of any adverse change in their licensure or certification status. If adverse changes are identified, the Dental Director will take the appropriate action.

On an annual basis, Delta Dental collects the following information for each practitioner functioning as a licensed dentist peer reviewer on behalf of Delta Dental.

- Primary verification of state dental licensure from the state board
- Primary verification of specialty license or certification, if applicable
- Exclusion list screenings of:
  - Office of Inspector General List of Excluded Individuals and Entities
  - General Services Administration System for Award Management
  - Any applicable state agency
- Focused Review report
- Collection of information from the National Practitioner Databank

If adverse changes in a dentist's profile are identified, the Dental Director will take the appropriate action. Every three years, Delta Dental recredentials licensed dentist peer reviewers through the procedure used with prospective reviewers. If adverse changes in a practitioner's profile are identified during the reaccreditation process, the Dental Director will take the appropriate action.

4.6 Training of Licensed Dentist Peer Reviewers

Delta Dental provides orientation and initial training to newly recruited licensed dentist peer reviewers to ensure that they are prepared for their role of providing dental utilization review services. Continued periodic training takes place to (1) update licensed dentist peer reviewers on new standards, policies, procedures and technologies, (2) review changes in clinical criteria, (3) maintain interrater calibration to ensure consistent application of criteria in UM decision making, (4) discuss any identified questions or problem areas and (5) maintain knowledge of Delta Dental's UM Program and UM Plan.

Prior to engaging in utilization review activities, newly recruited licensed dentist peer reviewers are provided with didactic orientation and training on utilization management and dental utilization review, including but not limited to the following information:

- Overview of Delta Dental
- Provisions of Delta Dental client contracts
- Laws and regulation for claim payment and prompt payment
- Principles of professional dental peer review
    - Requirements for licensed dentist peer reviewers, including compliance with required Delta Dental training (e.g., training on information privacy and security issues)
    - Licensed dentist peer reviewer qualifications
    - Reviewer clinical expertise and body of knowledge
    - Professional dental peer review standards and guidelines
    - Evidence-based dentistry
    - Conflicts of interest
- Terminology related to professional claims review
- Billing and coding dental procedures
    - Structure and use of the Code on Dental Procedures and Nomenclature
    - Purpose of the current dental terminology (CDT) manual
    - Major sections found in the CDT manual
    - Individual procedure codes
    - Sample claim forms and attachments
- Protected health information
    - Privacy and security
- Professional dental peer review process
    - Organizing and recording the documents that are provided
    - Determining whether the documents are adequate for the purpose of peer review
    - Requesting additional information when necessary
    - Verification of the client or sub-client benefit contract agreement
    - Reviewing claims made for benefit payment
    - Review of claim attachments (radiographs, treatment records, photographs, periodontal charting, study models, lab reports, and letters from dentists)
    - Reviewing patient claim history

- Matching the treatment record to the claim
- Selecting applicable clinical criteria for professional UM review of medical necessity and/or clinical appropriateness
- Integrating clinical criteria, patient characteristics, local delivery system availability and professional knowledge to create an appropriate professional UM determination and rationale-based evaluation of the claim and attached information
- Documenting UM determinations

- Communication with practitioners
  - Communication for different types of peer review (e.g., medical necessity, clinical appropriateness, quality issues)
  - Basing communication on established guidelines; directing practitioners to pertinent resources
- Claim disputes
  - Resolution of claim disputes submitted by treating practitioners
  - Resolution of claim disputes submitted by members
- Health care insurance fraud and abuse
  - Defining fraud and abuse
  - Practitioner fraud and abuse
  - Consumer fraud and abuse
  - Focused review
  - Sentinel effect
  - Identification/statistical analysis/case analysis
  - Intervention/review/practitioner education
  - Audits

5.1 Introduction

It is Delta Dental of Michigan's policy to ensure that utilization management decision making is overseen and performed as appropriate by qualified dental health professionals, is based on objective and evidence-based clinical criteria, uses relevant clinical information and is completed in a fair, impartial, consistent and timely manner.

Delta Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex or gender identification. Delta Dental continually strives to ensure that members receive all necessary services at the appropriate time and in the appropriate setting. Upon verification of coverage, Utilization Management (UM) activities include utilization review determinations of medical necessity and appropriateness of care.

All Delta Dental utilization management decisions must be documented and include the identity of the licensed dentist peer reviewer making the determination. Delta Dental does not offer financial or other forms of compensation to encourage peer reviewers to render adverse medical necessity or clinically appropriateness decisions.

In the context of utilization management, an adverse benefit determination may include the dental or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness of care, or effectiveness of a covered benefit. Additionally, as related to Medicaid programs:

- An adverse benefit determination may also result in the reduction, suspension, or termination of a previously authorized service(s).
- A denial, whole or in part, of a payment for a service solely because the claims does not meet the definition of a “clean claim” is not considered an adverse benefit determination, where a clean claim is defined as being submitted within the required timeframe, includes accurate patient/provider data, as having no technical defects, errors or omissions, that doesn’t require additional investigation or information before adjudication, contains accurate dental service coding and all necessary and/or required clinical documentation for a medical necessity and/or appropriateness of care determination. A claim is not considered “clean” if it contains errors or lacks necessary documentation.
- Failure to provide services in a timely manner may result in an adverse benefit determination.

5.2 Delta Dental Utilization Review Process

When required by the provisions of a client's dental plan, Delta Dental's licensed dentist peer reviewers perform utilization review to determine if dental services and procedures are medically necessary and clinically appropriate. In the context of this UM Plan, utilization review means a review by a licensed dentist peer reviewer performed to assess the medical necessity or clinical appropriateness of a dental service or procedure for the purpose of making a utilization management decision to determine benefit coverage.

In conducting utilization management activities, Delta Dental abides by all state and federal laws regarding information confidentiality and the privacy of individually identifiable health information. In support or reporting requirements, information shared by Delta Dental is made available only to the

extent necessary to assist in the valid administrative needs of the program, including those UM functions related to the services provided to eligible beneficiaries. Comprehensive privacy and confidentiality policies and procedures are available upon request.

As required by client dental plan provisions, Delta Dental's licensed dentist peer reviewers perform utilization review at the pre and post dental service request and the appeal levels.

The scope of Delta Dental's utilization review at the claim level includes preservice prior authorization and the review of postservice dental claims.

5.2.1 Utilization Review for Postservice Claim

The following process applies to postservice utilization review performed by Delta Dental licensed dentist peer reviewers.

When a postservice claim requiring utilization review is received, it is entered into the Delta Dental claims processing system. Depending on the claim condition, the claim is routed to non-licensed administrative staff or directly to licensed dentist peer reviewers.

When postservice claims are routed to non-licensed administrative staff, they review the claims, all attached claim information and any relevant dental plan documents to determine whether a claim may be subject to a maximum benefit amount or other dental plan exclusions or limitations that preclude utilization review. As appropriate, administrative staff route claims to licensed dentist peer reviewers, and may complete the processing of claims after the peer reviewers have rendered a UM decision. In limited cases, and under the supervision of the Dental Director and Manager of Utilization Review, appropriately trained administrative staff may approve dental services or procedures utilizing explicit UM criteria where no clinical judgment is required.

When postservice claims are routed to licensed dentist peer reviewers, they perform utilization review on the claims taking into consideration:

- The review time frame.
- All clinical information relevant to the patient.
- The applicable clinical criteria.
- Any applicable provisions of the members' dental plan, e.g., cosmetic exclusions.
- Individual patient dental and general health characteristics, including patient compliance with oral health maintenance and disease prevention routines, maintenance of follow-up appointments and the presence of general health factors or medical conditions that may affect the outcome of treatment.
- Specific clinical and technical issues that may compromise the results or affect the intended outcome of treatment.
- Clinical variables including periodontal condition, clinical condition of teeth to be restored with direct/indirect restorations (e.g., crown-root ratio, endodontic condition, structural condition, length of span of bridge replacement teeth), ridge support (e.g., soft tissue characteristics, resorption level), existing fixed/removable partial dentures or other prostheses, condition of adjacent and opposing teeth and teeth to be extracted.

- Information sent by the practitioner as to the conditions that may have required the practitioner to deviate from normal dental protocols (e.g., with a medically compromised or special needs patient).
- Any issues related to the patient's local dental care delivery system.
- Any other relevant factors.

After a full and fair review of the submitted information, licensed dentist peer reviewers approve or disapprove the claim based on review of medical necessity or clinical appropriateness. When performing utilization review, licensed dentist peer reviewers must link their UM decisions to the appropriate element(s) contained in the relevant clinical and contractual criteria.

If a postservice claim requires utilization review for different dental procedures, the UM decision to approve or disapprove is made separately for each procedure. UM decisions are documented in Delta Dental's claim processing system with the applicable determination reason codes to disapproved claims and, if appropriate, with additional information in the claim notepad.

If a postservice claim is submitted without the clinical information required to render a UM decision, and as appropriate to the adjudication process, the claim is either disapproved for missing information, or the missing information will be requested within 30 calendar days. If an information request is sent, the member or member's authorized representative has 45 calendar days to respond with the information. When the information is received or at the end of the 45-day period without a response, whichever comes first, Delta Dental processes the postservice claim within the original 30-day time frame.

If Delta Dental faces a situation outside its control requiring an extension beyond the 30-day postservice time frame, within 30 calendar days of claim receipt the member or member's authorized representative will be notified about the need for up to a 15-calendar daytime frame extension and the expected date of the UM decision. Extensions are not requested for postservice Medicare claims.

When a postservice claim requiring a UM decision has been completely adjudicated, the member and practitioner are notified of the decision and the reasons for any claim disapproval. For postservice claims, this notification occurs within 30 calendar days of claim receipt by Delta Dental. The details of Delta Dental's notification processes are described in Sections 8 and 9.

5.2.2 Utilization Review for Concurrent Care Claims

Dental treatment is comprised of distinct preventive, restorative and surgical services and procedures that are approved and performed as a single continuous course of treatment that commonly spans as little as a single date of service.

Due to this temporally bounded nature of dental services and procedures, there is no cause for requesting extended coverage while the member is in the process of receiving a single course of dental treatment. The only exception may be orthodontic treatment where a request might be made to extend a previously approved course of orthodontic tooth realignment to cover additional orthodontic treatment visits to achieve the desired tooth positions and occlusion. However, such treatment does not meet the definition of urgent. Therefore, no client dental plans require Delta Dental to perform utilization review of urgent dental concurrent care claims. In the unlikely event that Delta Dental was ever faced with a unique and heretofore unencountered dental condition where urgent dental concurrent care review was required, the following process would apply.

The utilization review process for determining medical necessity or clinical appropriateness for urgent concurrent care claims would generally follow the same utilization review process and application of clinical criteria as described for the review of postservice claims, with the following differences:

- Urgent concurrent care claims would be processed with notification to members and practitioners within 24 hours of claim receipt for commercial and Exchange claims and within 72 hours for Medicare and Medicaid claims but would take the urgency of the clinical situation into consideration.
- If an urgent concurrent care claim (1) was submitted less than 24 hours prior to the expiration of a previously approved number of treatments, (2) was asking for coverage of additional treatments but (3) failed to submit the clinical information required to render a UM decision, Delta Dental would make an attempt to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional treatments. Delta Dental would then have a one-time option to extend the time frame to process the urgent concurrent care claim up to 72 hours.
- Time extensions for situations outside Delta Dental's control would not be requested for urgent concurrent care claims.
- All utilization review for urgent concurrent care claims would be performed by Delta Dental licensed dentist peer reviewers.

5.2.3 Utilization Review for Prior Authorization Requests

Delta Dental performs utilization review for prior authorizations of dental preservice, which is defined in the process below.

A UM prior authorization decision issued on a preservice claim would be effective for subsequent postservice claims for 180 days from the effective date of the decision unless:

- Benefit limitations are reached.
- The postservice claim documentation fails to support the original approval.
- The patient's condition has changed such that the preservice claim approval is no longer appropriate.
- Another organization is responsible for paying the postservice claim.
- The practitioner has already been paid for the service(s).
- The submitted preservice and/or postservice claims are fraudulent.
- The preservice claim decision was based on erroneous information provided to Delta Dental.
- The member or procedure is no longer eligible for coverage.

Expired prior authorization approvals preservice requests would need to be resubmitted with current supporting documentation for de novo utilization review.

- *Utilization Review for Prior Authorization of Urgent (Expedited)Preservice Requests*

  The utilization review process for determining medical necessity or clinical appropriateness for prior authorization of urgent dental services would generally follow the same utilization review process and application of clinical criteria as described for the review of postservice claims, with the following differences:

- All utilization review for prior authorization of urgent preservice requests would be performed by Delta Dental licensed dentist peer reviewers.
- Expedited preservice requests of dental services may include those indicated by a provider as needed to avoid seriously jeopardizing the member's life, health, or the ability to attain, maintain, or regain maximum function.
- Urgent preservice requests would be processed with notification to both members (or their legal representatives) and practitioners within 72 hours of request receipt but would take the urgency of the clinical situation into consideration.
    - For Medicaid clients, if an urgent preservice request was submitted without the clinical information required to render an appropriate UM decision, the missing information would be requested within 24 hours of receipt of the request through outreach to the involved provider (and member or member's legal representative). The provider, member, or their legal representative would have 48 hours to respond with the information to ensure the urgent request decision is made no later than 72 hours after receipt of the initial request. Delta Dental or the involved MCO may extend the 72-hour time period by up to 14 calendar days if the member or their legal representative requests an extension, or Delta Dental or the involved MCO can justify (to the involved state agency upon request) the need for additional information and how the extension is in the members' best interest. Delta Dental will document at least one attempt to obtain the necessary information (e.g. outreach attempt or information request).
    - For commercial and Exchange clients, if an urgent preservice request was submitted without the clinical information required to render an appropriate UM decision, the claim would either be disapproved for missing information or a request for the missing information sent to the member and provider within 72 hours of the service request receipt. If an information request was sent, the member or member's authorized representative would have 48 hours to respond with the information. When the information was received or at the end of the 48-hour period without a response, whichever comes first, Delta Dental would have a one-time option to extend the time frame to process the urgent preservice request up to 48 hours.
    - For Medicare clients, Delta Dental may extend the time frame once, by up to 14 calendar days if:
        - The member requests an extension, or;
        - Delta Dental needs additional information, and documents that it made at least one attempt to obtain the information and notifies the member or their authorized representative of the delay.
- Time extensions for situations outside Delta Dental's control would not be requested for urgent preservice claims.

- *Utilization Review for Prior Authorization of Nonurgent Preservice Requests*

  The utilization review process for determining medical necessity or clinical appropriateness for prior authorization of nonurgent preservice requests will generally follow the same utilization review process and application of clinical criteria as described for the review of postservice claims with the following differences:

- For nonurgent commercial and exchange preservice requests, Delta Dental notifies providers and members (or their legal representative) of the determination within 15 calendar days of request receipt.
    - For commercial and exchange clients, if a nonurgent preservice request was submitted without the clinical information required to render a UM decision, and as appropriate to the adjudication process, the service would either be disapproved for missing information within 15 calendar days or Delta Dental may extend the nonurgent preservice time frame for up to an additional 15 calendar days if Delta Dental asks the provider, or member (or member's legal representative) for the additional information and gives them 45 days to provide the same. Delta Dental may make a negative UM determination if it does not receive the requested information within this timeframe, and the member (or member's legal representative) may appeal the decision.
- For nonurgent Medicare preservice requests, Delta Dental notifies providers and members (or their legal representative) of the determination within 14 calendar days of request receipt.
    - For Medicare, Delta Dental may extend the nonurgent determination time frame once by up to 14 calendar days if the member (or their legal representative) requests an extension or if Delta Dental needs additional information to appropriately adjudicate the request and documents that it made at least one attempt to obtain the necessary information and notifies the member (or their legal representative) of the delay.
- For nonurgent Medicaid preservice requests, Delta Dental notifies providers and members (or their legal representative) of the determination within 7 calendar days of request receipt.
    - For Medicaid clients, nonurgent preservice requests may have an extension of up to 14 additional calendar days if the member (or their legal representative) requests an extension or if Delta Dental (or the involved MCO) needs additional information to appropriately adjudicate the request and can justify the reason(s) to the involved State agency. Delta Dental will document that at least one attempt was made to obtain the missing information and will notify the provider and member (or their legal representative) of its determination as expeditiously as the member's condition requires, but no later than the expiration of the extension.
- If Delta Dental faced a situation outside its control (e.g., waiting for an evaluation by a specialist) requiring an extension beyond the 14-day nonurgent preservice time frame for Medicaid claims, or the 15-day nonurgent preservice time frame for commercial and Exchange groups, within 14 or 15 calendar days of receipt, the member or member's authorized representative would be notified about the need for up to a 15 calendar day time frame extension and the expected date of the UM decision. Extensions would not be requested for Medicare submissions.

5.2.4 Urgent/Emergency and Post-Stabilization Care Services

Delta Dental does not require preservice authorization for urgently needed dental services received in the emergency department or other outpatient settings and is financially responsible for the same whether they are provided by in or out of network providers without regard to official preservice authorization or timely notification of the same within ten (10) calendar days of the eligible members presentation for the emergency dental services. After the services are rendered for those dental conditions requiring urgent intervention, Delta Dental is financially responsible for post-stabilization dental services provided by a contracted or non-contracted provider that were either deemed to be

medically necessary and clinically appropriate through the pre-service adjudication process or for those dental services that were not pre-approved until:

- A Delta Dental participating dentist at the treating hospital assumes responsibility for the member's treatment, or;
- A Delta Dental participating dentist assumes the responsibility for the member's care through transfer, or;
- The member, the member's representative and the treating dentist reach an agreement concerning the member's care, or;
- The member is discharged.

Within one (1) hour of a request, Delta Dental must cover the post-stabilization dental services associated with the emergency treatment whether the services are/were provided by contracted or non-contracted dentists and whether or not they were pre-approved to maintain the member's stabilized dental condition.

5.2.5 Utilization Review for Appeals

Delta Dental licensed dentist peer reviewers may perform utilization review at the appeal level when an adverse utilization management decision made on a previously reviewed claim is appealed. Appeal utilization review follows the time frames and other provisions described in Section 11, Utilization Management Appeals.

For State Specific guidelines regarding Section 5, please see Appendix D.

6.1 Introduction

It is Delta Dental of Michigan's policy to obtain and use the clinical information relevant to a member's care when making coverage decisions based on an evaluation of the medical necessity or clinical appropriateness of a dental service or procedure.

6.2 Collection and Usage of Relevant Clinical Information

Delta Dental collects and archives in the claim record the clinical information on individual members required for accurate and complete processing of prior authorizations and postservice claims for dental benefit coverage including, as appropriate to claims for various dental procedures:

- Dental claim forms
- Dental radiographs and other diagnostic images
- Periodontal charts
- Maxillofacial photographs
- Dental casts
- Results from orofacial diagnostic tests and examinations
- Dental treatment plans
- Dental treatment records
- Dental practitioner notes and narratives
- Information from other health care practitioner

If enough clinical information is not provided for Delta Dental to determine the medical necessity or clinical appropriateness of a dental service or procedure, the notification informing the member and practitioner of the deficiency is recorded in the claim record in Delta Dental's Roosevelt claim processing system's database.

As appropriate to an individual member, Delta Dental's licensed dentist peer reviewers consider the following information when reviewing dental claims to determine the medical necessity or clinical appropriateness of a dental service or procedure:

- Dental and medical history.
- Current health condition and presenting problems.
- Examination and test findings.
- Pathology reports.
- Treatment documentation including operative reports.
- Progress reports.
- Reports from dental specialists and other health practitioners.
- Information from caregivers and other responsible persons.
- Contract provisions and policies of the member's dental plan.
- Clinical criteria relevant to the procedure(s) for which benefit payment is requested.

Delta Dental claim disapprovals due to a dental procedure not being medically necessary or clinically appropriate are based on findings that the clinical information provided does not support the procedure subject to the specific provisions of the relevant clinical criteria.

6.3 General Requirements for Dental Clinical Information

When a dental practitioner provides dental radiographs and other diagnostic images to support a claim for dental benefit payment, the practitioner must provide credible evidence of benefit eligibility through pre-operative images of diagnostic quality that fully show the areas of the maxillofacial area(s) involved with the procedure(s) to be reviewed. Images must be labeled with the identity of the member and practitioner and the date the image was taken, and must have acceptable brightness, contrast and clarity as appropriate to the image type. The maxillofacial areas of interest must not be obscured by artifacts or defects in image exposure or processing.

Periodontal charts submitted by dental practitioners must at a minimum document 6-point probing depths, bleeding upon probing, missing teeth, furcation exposures, clinical attachment loss and the mobility for each tooth. Charts and other clinical records must be legible with dated entries and any abbreviations used must be common to dental records or defined if proprietary to a practitioner.

If a dental practitioner submits additional information that is separate from a member's dental treatment record, e.g., a claim attachment from a practitioner providing clinical rationale for a dental procedure, that additional information must coincide with the documentation in the dental treatment record or it cannot be relied upon in performing utilization review. For example, if a member's dental treatment record documents a crown preparation with no diagnosis or rationale for treatment, but the practitioner provides a claim attachment note stating that the member had "cracked tooth syndrome", unless there is some confirming documentation in the treatment record, the unsupported note is inadequate information to support a determination of medical necessity for the crown procedure.

6.4 Clinical Information for Specific Dental Procedures

The specific amount of clinical information required to process individual dental claims can vary depending on a member's condition, treatment history, dental plan provisions, the dental procedure(s) in question, the treating practitioner's profile and other information relevant to a claim. The following list provides examples of dental clinical information that are commonly needed to make medical necessity or clinical appropriateness determinations for specific dental procedures. An adequately documented dental treatment record, including treatment rationale and reasonably detailed documentation of specific treatment episodes, is required for making medical necessity or clinical appropriateness decisions for any procedure, so that requirement is not included in the list.

Direct Restorations
– Current preoperative bitewing radiograph(s) of the involved tooth/teeth.

Onlays and Crowns
– Current preoperative periapical radiograph(s) of the involved tooth/teeth. – Current preoperative photograph(s) of the involved tooth/teeth (may be optional or requested).

Cracked Tooth Syndrome
– Treatment record indicating (1) history of cracked tooth syndrome, (2) conservative treatment(s) have been attempted to make the tooth asymptomatic and (3) at least two bite tests separated by time with repetition of painful symptoms upon pressure release. – Current preoperative periapical and/or bitewing radiograph of the involved tooth. – Current preoperative photograph of the involved tooth (if the crack is apparent on the image).

Laminate Veneer
– Current preoperative periapical radiograph(s) of the involved tooth/teeth. – Current preoperative photograph(s) of the involved tooth/teeth. – Treatment record indicating preoperative reason for performing the veneer.

Cores/Substructures
– Current preoperative periapical radiograph(s) of the involved tooth/teeth. – Treatment record indicating the preoperative reason for performing substructure

Endodontic Treatment
– Current preoperative and postoperative periapical radiograph(s) of the involved tooth/teeth. – Treatment record indicating preoperative reason for performing the endodontic treatment.

Periodontal Soft Tissue Grafts
– Current preoperative full mouth periodontal chart. – Current preoperative photograph(s) of the surgical area(s). – Narrative description of the gingival condition specifying the amount of attached gingiva. – Narrative of the need if more than 2 quadrants are treated on the same day.

Other Periodontal Surgery
– Current preoperative periapical radiograph(s) of the surgical area(s). – Current preoperative photograph(s) of the surgical area(s). – Current preoperative full mouth periodontal chart. – Narrative of the need if more than 2 quadrants are treated on the same day.

Periodontal Scaling and Root Planing
– Current preoperative periapical or bitewing radiograph(s)s of the area(s) to be scaled. – Current preoperative full mouth periodontal chart. – Periodontal diagnosis. – Narrative of the need if more than 2 quadrants are treated on the same day.

Complete and Partial Dentures
– Current pretreatment radiographs of the requested arch. – Date of prior insertion of existing full or partial dentures and the reason for replacement. – Dates of extractions of teeth being replaced.

Implants
– Current preoperative periapical radiograph(s) of the involved tooth position(s) and postoperative radiograph(s) of the osseointegrated fixture(s). – Dates of prior insertion of any prior bridges or partial dentures and the reason for replacement. – Dates of extractions of teeth being replaced.

Fixed Partial Dentures
– Current preoperative periapical radiographs of the involved tooth positions. – Dates of prior insertion of any existing bridges or partial dentures and the reason for replacement. – Dates of extractions of teeth being replaced.

Extractions
– Diagnostic preoperative periapical or panoramic radiographs that show the entire periapical area of the tooth/teeth and any associated vital structures. – Report of symptoms, locally deleterious conditions and/or pathology requiring extraction of the tooth/teeth.

Temporomandibular Joint Treatment
– A definitive and substantiated TMD diagnosis (narrative for occlusal guards or orthotics, and a narrative and radiographs for TMD surgery and extensive TMD procedures other than occlusal guards or orthotics).

It is Delta Dental of Michigan's policy to provide a treating practitioner with the opportunity to have a peer-to-peer discussion with a licensed dentist peer reviewer about a claim submitted by the practitioner that was disapproved by Delta Dental based on an adverse medical necessity or adverse clinical appropriateness decision.

Delta Dental notifies practitioners about the opportunity for a peer-to-peer discussion with a licensed dentist peer reviewer in the explanation of benefits denial notifications of dental claims where adverse medical necessity or adverse clinical appropriateness decisions have been made. Peer-to-peer discussions are not available for claim denials based on client contract exclusions, limitations, benefit exhaustion and other reasons not involving an adverse medical necessity or adverse clinical appropriateness determination.

A peer-to-peer discussion allows a treating practitioner who disagrees with a claim disapproval based on an adverse medical necessity or adverse clinical appropriateness determination to have a discussion with a licensed dentist peer reviewer familiar with the case. The goal of peer-to-peer discussions is to provide the treating practitioner with a better understanding of the specific clinical basis for an adverse decision, to facilitate presentation of new or additional information and, if possible, to resolve the disagreement before pursuing other available avenues for resolution of the dispute. A peer-to-peer discussion is not considered part of the appeal process.

Unless otherwise required by a client or other external entity, Delta Dental's process for facilitating peer-to-peer discussions follows these steps:

- A practitioner may schedule a peer-to-peer discussion with a Delta Dental licensed dentist peer reviewer by going to www.deltadentalmi.com/ptp and following the instructions to submit a peer-to-peer request form.[4] The instructions guide the practitioner to provide all the information needed for a productive discussion. Practitioners may also submit a request to Delta Dental for a peer-to-peer discussion via fax, e-mail or general mail, but the request must be in writing and must be signed by the treating practitioner requesting the discussion. Practitioners using these alternate methods to communicate with Delta Dental may be required to provide additional information about the case in question prior to the scheduling of a peer-to-peer discussion.

- Once a request for a peer-to-peer discussion has been made, and all the information required for the discussion has been received, Delta Dental staff schedule a telephone conversation within a reasonable time period between the practitioner and a Delta Dental licensed dentist peer reviewer. Peer-to-peer discussions will be limited to a duration of thirty minutes unless approved in advance by the Dental Director due to an atypical clinical situation.

[4] As of the latest review of this document, Delta Dental of Michigan does not process claims for dental benefits involving urgent concurrent care claim requests. If and when such requests must be processed by Delta Dental, the procedure for peer-to-peer discussion requests and scheduling will be immediately revised to ensure that peer-to-peer discussions involving urgent care cases are handled in timely manner according to applicable statutory, regulatory, policy and accreditation requirements.

- A practitioner may receive one peer-to-peer discussion per episode of treatment unless the practitioner has new, pertinent information that is applicable to a second conversation. Otherwise, the practitioner who requests a second conversation is informed that no further peer-to-peer discussions will be available for that episode of care.

- Peer-to-peer discussions are digitally recorded. All recordings are made with prior notification of the involved practitioner. Delta Dental staff involved in a peer-to-peer discussion document the outcome of the discussion in the associated claim notepad or other appropriate database.

Section 8 | Notification of Appeal Rights and Process | INDEX

Delta Dental provides notification of favorable and adverse utilization management decisions to members and practitioners through electronic or hard copy explanation of benefits statements in compliance with federal and state requirements, client requirements and applicable accreditation standards.

It is Delta Dental's policy to include in explanation of benefits notifications a description for members and practitioners of appeal rights, the appeal process and, if applicable, a description of the expedited appeal process and concurrent external review.

For all adverse UM decisions where Delta Dental disapproves benefit payment for a dental service or procedure based on a professional determination that a dental procedure is not medically necessary or is clinically inappropriate, explanation of benefit notifications must describe appeal rights and the appeal process including:

- The right of members to be represented by anyone they choose, including an attorney.
- The procedures for filing the appeal including where to direct the appeal and the specific information to include in the appeal.
- The right to submit information relevant to the appeal.
- The time frame for filing the appeal and deciding the appeal.
- If applicable, the contact information for a state office of health insurance consumer assistance or ombudsperson.

Currently, no client dental plans require Delta Dental to perform utilization review of either urgent preservice or urgent concurrent care claims which would require an expediated appeal process for denials. If a client were to require utilization review of either urgent preservice or urgent concurrent care claims in the future, explanation of benefits denial notifications would provide a description of an expedited appeals process for denials including:

- The time frame for filing an expedited appeal.
- The procedures for filing an expedited appeal, including where to direct the appeal and the specific information to include in the appeal.
- The time frame for Delta Dental to decide an expedited appeal.
- If applicable, notification that expedited external review can occur concurrently with the internal appeals process for urgent care.

9.1 Introduction

It is Delta Dental's policy to maintain a full, fair and impartial process for thorough, appropriate and timely resolution of member appeals.

The right to appeal an adverse benefit determination by Delta Dental is available to any member, or to an authorized representative of a member with a valid authorization form. Depending on the dental plan involved, a non-contracted practitioner with a valid waiver of liability statement may also be eligible to file an appeal. If applicable, Delta Dental will treat such an appeal in the same manner as an appeal from a member or authorized member representative.

Federal laws/regulations, state laws/regulations and contractual requirements regarding appeals are followed in all instances and will prevail if there is a conflict with Delta Dental appeal policies and procedures. In the case where a Delta Dental client manages their own appeal process, Delta Dental appeal staff follows the specific client rules identified in the appeal case management system to determine proper handling of the appeal.

9.2 Appeal Filing

Delta Dental does not charge a fee to a member or authorized member representative for filing an appeal of an adverse benefit determination by Delta Dental.

From the date that a written notification of an adverse benefit determination is sent to a member and practitioner, Delta Dental allows the member at least 180 calendar days to file an appeal if the member has a commercial or Exchange dental plan, or at least 60 calendar days if the member has a Medicare or Medicaid dental plan. Appeals generally must be received in writing but may be submitted orally depending on a member's dental plan.

Members and authorized member representatives have the opportunity to provide additional written comments, documents or other information relevant to an appeal during the course of the appeal review. If a member or authorized member representative requests a copy of the appeal case file, including any criteria relied upon to make the adverse benefit determination that is being appealed, this documentation will be provided free of charge.

Depending on the rules of a member's dental plan, if a member’s dental services are reduced or stopped and an appeal is filed, the member may be eligible to continue receiving the same level of services while the appeal is pending.

9.3 Appeal Processing

9.3.1 Appeal Documentation and Investigation

The appeal receipt date is recorded as the earliest date that an appeal was received in any department at Delta Dental. If required, a written notice will be sent to a member that their appeal was received and is being reviewed.

Delta Dental appeal staff thoroughly document the substance and handling of an appeal into the appeals case database including:

- The reason that the member filed the appeal
- All documents relevant to the appeal
- The history of relevant claim and appeal activities conducted before the appeal
- Clinical information relevant to the appeal
- Actions taken to respond to and process the appeal

Appeal staff fully investigates each appeal including a review of:

- Unique state specific, program specific or client specific appeal processing requirements
- The documents submitted with the appeal
- Member dental plan benefit and contract information
- The adjudication of the claim(s) involved and any follow-up activities prior to the appeal
- The aspects of any clinical care involved

Staff does not give difference to the adverse benefit determination that is being appealed.

9.3.2 Appeal Decision Making

If an adverse benefit determination being appealed is based on an exclusion, limitation or other client contract provision and does not require utilization review, appeal staff who were not involved in the initial determination, and who are not subordinate to any person involved in the initial determination, will review and decide the appeal.

If an adverse benefit determination being appealed requires utilization review, appeal staff refer the appeal for review by a licensed dentist peer reviewer who (1) was not involved in the initial determination, (2) who is not subordinate to any person involved in the initial determination and (3) who has the training and experience that aligns with the dental condition in question and facilitates a clinically authoritative utilization management decision. The peer reviewer documents the determination on the appeal decision, the reason for the determination and the clinical criteria upon which the determination was based. The peer reviewer's documented determination is applied to the appeal decision and notification.

9.4 Appeal Decision Time Frame

Delta Dental's appeal process occurs within the following time frames:

- Appeals of adverse benefit determinations on postservice claims are processed within 60 days if the member has a commercial or Exchange dental plan, within 48 days if the member has a Medicare dental plan and within 30 days if the member has a Medicaid dental plan.
- Expedited urgent appeals of adverse benefit determinations on preservice claims would be processed within 72 hours of appeal receipt. Preservice appeals would be eligible for expedited processing if a member's life, health or ability to regain maximum function could be seriously jeopardized by the standard preservice appeal processing time frame. Standard nonurgent preservice claim appeals would be processed within 30 days. Within both time periods, Delta Dental would process appeals as expeditiously as the member's health requires.

Any appeal time frame extensions will comply with federal and state laws, program requirements and any client-specific requirements, and will be administered as expeditiously as the member's health requires.

9.5 Appeal Decision Notification

Members and authorized member representatives are notified of Delta Dental's appeal decisions in accordance with the applicable time frame and in language that a layperson can understand. Appeal decision notification includes:

- The specific reason(s) for the appeal decision, including the reason(s) for upholding a denial in terms specific to a member's condition
- A reference to the benefit provision, guideline, protocol or criterion on which an appeal decision is based
- A list of titles and qualifications, including specialties, of individuals participating in an appeal review
- Information that a member has the right to reasonable access to and copies of all documents relevant to an appeal, free of charge upon request
- Information on member appeal rights explaining the next level of internal or external independent appeal, depending on the member's dental plan.
- Cultural, linguistic and literacy appropriate content

9.6 Independent Review Organization (IRO) External Review

As appropriate to Delta Dental's lines of business and member dental plans, notices of appeal denials will include information about member rights and eligibility for external review. If applicable, members will be informed that they are not required to bear the costs of an IRO review, including any filing fees. If upon external review an IRO overturns an appeal denied by Delta Dental, the IRO's decision will be implemented in all such cases.

As appropriate to lines of business and member dental plans, Delta Dental will annually notify members on the availability of independent, external review of final appeal decisions.

9.7 Reference

Delta Dental maintains the following procedures to support appeal handling:

- Appeal Work Instructions – Commercial Business
- Appeal Work Instructions – HKD
- Appeal Work Instructions – Healthy Michigan Plan and Pregnant Women Dental
- Appeal Work Instructions – Medicare Advantage
- Appeal Work Instructions – MI Health Link
- Appeal Work Instructions – Medicare Advantage IRE Procedure
- External Review Procedure
- Grievance and Appeal Assistance Work Instructions – Medicare

Section 10 | Evaluation of New Technology | INDEX

It is Delta Dental of Michigan's policy to maintain a formal process to evaluate new dental technology as applied to dental procedures, dental devices and dental materials, including the new application of existing dental technologies to procedures, devices and materials utilized for dental care. The purpose of this process is to assess the circumstances under which new dental technologies may more effectively meet the clinical needs of dental patients and be considered for benefit coverage. The intent of this policy is to help ensure that members have access to appropriate dental care conducted according to the relevant standards of dental practice currently in effect at the time care is rendered.

Delta Dental maintains a written Policy and Procedure for Evaluation of New Technology document describing the formal, systematic and evidence-based determination process to evaluate new dental technology that is within the scope of practice of dentistry and is not currently covered or defined as an exclusion across client dental plans. On at least an annual basis document is reviewed and revised if necessary.

Delta Dental's new technology policy and procedure document includes a description of:

- How requests to evaluate new dental technology from members, practitioners, clients or other internal or external sources are received and handled.
- The process for the assessment of new dental technology.
- The decision variables used in the assessment of new dental technology.
- The sources of information used in the assessment of new dental technology.
- The process of recommending new dental technology for coverage review and determination.

On at least an annual basis, Delta Dental will:

- Document new technology evaluation requests for the previous year in the Utilization Management Program Evaluation Report.
- Assess the evidence supporting new dental technology that became available in the previous year for potential coverage in dental benefit plans. Any content changes in the clinical criteria are developed by appropriate dental professionals using the best available clinical evidence and are approved by the Utilization Management Committee.

For more detailed information about Delta Dental's evaluation of new dental technology, see the Delta Dental of Michigan Policy and Procedure for Evaluation of New Technology.

Section 11 | Utilization Management System Controls | INDEX

It is Delta Dental of Michigan's policy to have internal system controls in place to protect utilization management data, including recorded UM claim and UM appeal receipt, closeout, and decision notification dates, by maintaining physical, administrative and technical controls to secure access to the operating environment that houses UM data, including computer servers, hardware and physical records and files. These UM system controls are designed to prevent unauthorized access and changes to system data, capture pertinent information relating to any date changes made and ensure that accurate notification of UM decisions and other UM-related information is sent to members and practitioners within the appropriate turn-around timeframe, consistent with the applicable NCQA standards.

Delta Dental maintains a written UM System Controls Policy and Procedure document describing internal system controls specific to protecting the integrity and accuracy of UM claim and UM appeal receipt, closeout, and decision notification dates. The document describes the system controls that have been established, monitoring of the system controls and corrective actions to be taken if an alteration is made in UM claim or UM appeal date data that violates the controls. The document is reviewed and, if necessary, is revised on at least an annual basis.

Delta Dental's system controls policy and procedure includes a description of:

- The definitions for UM claim and UM appeal receipt, closeout, and decision notification dates.
- The process for recording dates in Delta Dental's claim and appeal systems.
- The staff who are authorized to modify dates in claim and appeal systems once initially recorded, and the circumstances when modification is appropriate.
- How date change actions and the reasons for the actions are tracked in claim and appeal systems.
- The security controls applied to claim and appeal systems for protection of data from unauthorized modification.
- How Delta Dental monitors and manages workforce compliance with system controls policies and procedures.

On at least a quarterly basis, Delta Dental carries out oversight monitoring to identify any UM claim or UM appeal receipt, closeout or decision notification date modifications that did not meet Delta Dental's authorized protocols for such modifications. This oversight monitoring will include a quantitative and qualitative analysis of unauthorized date modifications to determine the cause of the violation of system controls and identify the solution(s) to prevent further violations. If corrective action must be taken, Delta Dental will implement a quarterly monitoring process that will continue until it can be identified that the cause of the violation has been mitigated. The results of the annual oversight monitoring and any corrective actions will be reviewed at least annually by the Delta Dental Utilization Management Committee.

For more detailed information about Delta Dental's system controls, see the Delta Dental of Michigan Utilization Management System Controls Policy and Procedure.

12.1 Introduction

It is Delta Dental of Michigan's policy to maintain a program of quality improvement structures and processes required for objective and systematic performance measurement and analysis that drives continuous quality improvement of Delta Dental's utilization management operations and activities across all lines of business. Under the leadership of the Dental Director and the Director of Professional Service, the departments of Dental Consulting and Utilization Management department and the Professional Services are responsible for Delta Dental's utilization management quality improvement activities. Department staff are committed to incorporating quality improvement awareness into daily utilization management activities, focusing on those areas that are most important to achieving the department's goals and objectives.

The scope of the Delta Dental of Michigan's Program for Utilization Management Quality Improvement is limited to the operations and activities that facilitate and support utilization review of retrospective, preservice prior authorizations, postservice dental claims and appeals of adverse utilization review determinations.[5]

- In accordance with §438.242 regarding "Health Information Systems," it is our policy to maintain a system capable of collecting, analyzing, and integrating utilization management data (as described in Section 12.2) into its overall quality assessment and performance improvement (QAPI) activities. This data is used to assure Delta Dental members have access to dental care that is medically necessary, clinically appropriate, of acceptable quality, consistent with the diagnosis and required level of care and performed within the generally accepted standards of care. Member and provider details for dental services rendered and subsequently evaluated are maintained within our dental benefits administration platform in compliance with NCQA system integrity standards and is available for reporting in compliance with § 438.818 accuracy and completeness criteria. Internally vetted reports provided to engaged stakeholders will comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards and be made available for review and validation upon request by the involved agencies in line with § 431.300 requirements.

The purpose of the Delta Dental Program for Utilization Management Quality Improvement is to:

- Provide high quality utilization management services to internal and external customers.
- Improve Delta Dental utilization management operations and activities through continuous quality improvement activities based on defining quality goals and the collection and analysis of verifiable performance assessment measures (quality indicators).
- Provide a process for identification and prioritization of opportunities to improve utilization management services based on the analysis of performance assessment measures.

[5] Delta Dental does not conduct urgent concurrent care review relating to continued or extended health care services (see "Utilization Review for Concurrent Care Claims" under section 5). The extent of Delta Dental's utilization review is defined by factors including but not limited to the terms of member dental plans, applicable clinical criteria, claim processing policies, patient age and dental condition and the profiles of treating practitioners.

- Measure the effectiveness of interventions implemented to improve utilization management performance.
- Incorporate the best utilization management practices applicable to Delta Dental's business and structure.
- Maintain a utilization management staff who are trained in evaluating and improving quality and are empowered to contribute to quality improvement decisions.
- Facilitate the annual UM Program evaluation.
- Provide essential information to management for decision making.

12.2 Goals and Objectives of the Delta Dental Program for Utilization Management Quality Improvement

The Delta Dental Program for Utilization Management Quality Improvement establishes a framework of goals and objectives that directly relate to the quality of Delta Dental's UM services realized by internal and external customers. UM performance assessment measures are selected to monitor the effectiveness of key processes that facilitate achievement of the goals and objectives.

The description for each performance assessment measure includes the goal and objective associated with the measure, a definition of the measure, the data source for the measure, the numerator and denominator for the measure's calculation, the measurement period and the performance target for the measure.

Delta Dental sets UM performance assessment measures in the operational areas of:

- Timeliness of utilization management decision making.
- Interrater reliability among licensed dentist peer reviewers (dental consultants).
- Application of clinical criteria in utilization management decision making.
- Use of appropriate professionals for utilization management decisions.
- Use of relevant clinical information for utilization management decisions.
- Appropriate handling of appeals.
- Implementation of external review decisions.
- Monitoring of the UM system controls process.

12.3 Assessment and Improvement of Utilization Management Functions and Services

Assessment of the outcomes and success of Delta Dental's UM functions and services, and the identification of opportunities for improvement, is formulated on ongoing analysis and trending of quantifiable performance assessment measures.

UM quality assessment and improvement activities performed and documented by Delta Dental staff and the Utilization Management Committee include but are not limited to:

- Reporting and tracking of UM performance assessment measures and other quality indicators.

- Monitoring compliance with UM policies and procedures.
- Identification and implementation of opportunities to improve UM policies, procedures, functions and services.
- Evaluation of the effectiveness of UM functions and services.
- Review of clinical criteria and new technology.
- Review and revision of:
    - The Delta Dental Utilization Management Plan.
    - The Delta Dental Utilization Management Committee Procedure.
    - The Delta Dental Utilization Management System Controls Policy.
    - This Delta Dental Program for Utilization Management Quality Improvement document.

For more detailed information see Delta Dental of Michigan's Program for Utilization Management Quality Improvement.

13.1 Introduction

It is Delta Dental of Michigan's policy to maintain privacy and security standards for the Delta Dental workforce and contracted practitioners to ensure that the confidentiality of member information and records is properly managed and protected.

13.2 Delta Dental Workforce

Every member of the Delta Dental workforce is responsible for being aware of and complying with Delta Dental's policies and procedures to maintain the privacy and security of member information and records.

Delta Dental workforce members have provided an attestation that they will maintain the confidentiality of all member information and records, including when they are engaged in activities covered and authorized under this Utilization Management Plan. Protected health information will only be shared with persons authorized to receive it. Workforce members have agreed to protect the confidentiality of member information by collecting and using only the minimum necessary protected health information (PHI) that is required to conduct business operations. See the Delta Dental System Controls Policy and Procedure for additional details on the system controls that Delta Dental maintains to protect the integrity of claim and appeal data.

As an additional measure to ensure that member PHI is securely maintained and protected pursuant to 45 C.F.R. § 164.530(b)(1), all workforce members are required to participate in ongoing periodic training on the Health Insurance Portability and Accountability Act (HIPAA) and Delta Dental's privacy and security policies. Privacy and security training includes instruction on:

- The nature and requirements of the Health Insurance Portability and Accountability Act.
- Changes in applicable federal and state privacy and security statutes and regulations.
- Delta Dental privacy and security administrative structure and policies.
- Administrative, technical and physical safeguards that must be employed to secure protected health information.
- Access by individuals to protected health information.
- Authorization required for uses and disclosures of protected health information.
- Minimum necessary request, use or disclosure of protected health information.
- Amendment of protected health information.
- Restrictions on use or disclosure of protected health information.
- Accounting of disclosures of protected health information.
- Privacy incident reporting.

13.3 Delta Dental Contracted Practitioners

In addition to complying will all applicable federal and state laws regarding confidentiality and disclosure of member records, practitioners who maintain a network participation agreement with Delta Dental are contractually required to take the following actions outlined in the agreement to maintain the confidentiality of member records and information:

- Safeguard the privacy and confidentiality of all information that identifies a particular member.
- Ensure that member medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.
- Maintain member records and information in an accurate and timely manner.
- Ensure that members have timely access to their records and information.
- Maintain procedures that specify for what purposes a member's information may be used within the practitioner's organization and to whom and for what purposes such information may be disclosed outside the practitioner's organization.

Erik J. Stier, D.D.S. is Delta Dental's current Dental Director.

Qualifications

Past Positions

1995 – 1996
Oral and Maxillofacial Resident, MetroHealth Medical Center, Cleveland Ohio

1996 - 2008
Private Practice, Owner/Operator, New London Dental Associates, New London, Ohio

2004 - 2008
Private Practice, Owner/Operator, Monroeville Dental Associates, Monroeville, Ohio

2008 - 2018
Dental Consultant/Professional Peer Review and Research, Delta Dental of Michigan, Ohio and Indiana

2018 - 2022
Director of Quality Improvement and Performance Improvement (QAPI), Delta Dental of Michigan, Ohio and Indiana

2018 - 2022
Director of Population Health, Delta Dental of Michigan, Ohio and Indiana

2018 - 2022
Director of Utilization Management, Delta Dental of Michigan, Ohio and Indiana

Current Positions

May 2022 – Present
Dental Director, Delta Dental of Michigan, Ohio, Indiana, and North Carolina

Education

1983 - 1988
Pre-Medical Studies, Oakland University, Rochester Michigan

1991 – 1995
D.D.S., University of Michigan School of Dentistry, Ann Arbor, Michigan

1995 - 1996
Oral and Maxillofacial Residency, MetroHealth Medical Center, Cleveland, Ohio

Certification and Licensure

1995
National Board, Joint Commission of National Dental Examiners, Certified
North East Regional Board, Certified
Central Region Dental Testing (CRDTS), Certified

1995 – 2008
Unrestricted License to Practice Dentistry – State of Ohio

2008 – Present
Unrestricted License to Practice Dentistry – State of Michigan

Dental Academic and Healthcare Honors

Omicron Kappa Upsilon Honor Society

Alpha Omega Scholarship Award

Comprehensive Care Award

American Association of Oral and Maxillofacial Surgeons Award

University of Michigan School of Dentistry Senior Scholarship Merit Award

Class Salutatorian

2021 Greater Detroit Area Health Council (GDAHC) "Breakthrough Award" honoring the dedication, extraordinary efforts, leadership, innovation and progress individuals and organizations have made in advancing healthcare in Southeast Michigan

Dental Benefits Administration Experience: General

Claims adjudication, reconsiderations, appeals, grievances and interrater reliability

Essential Health Care Benefits (EHB) and Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

CDT code business rule development, implementation and application

Focused Review, program integrity and network access activities

Operations policies and procedures

Clinical practice guidelines

Continuing education content developer and presenter

Dental Benefits Administration Experience: Internal Committee and Project Participation

QAPI Committee Director

Utilization Management Committee Director

Quality Assurance Committee Director

Credentialing/Re-Credentialing Committee Director

Research Committee

DDPA and BRIDE (Business) Rules Committees

CMS/Government Programs Business Planning

CMS Compliance Working Group

NCQA Credentialing/Re-Credentialing and Utilization Management Accreditation Projects

Practitioner and Member Manuals

Dental Benefits Administration Experience: Affiliations and Activities

Michigan, Macomb County (MI) and Wayne County (MI) Oral Health Coalitions

McLaren Health Plan Quality Improvement Committee

Dental Quality Committees for:

- Health Alliance Plan (HAP)
- Priority Health
- McLaren Health Plan

Appendix B	Licensed Dentist Peer Reviewer Job Description	INDEX

SUMMARY:

Reviews and analyzes claims and inquiries that require the expertise of a licensed dental general practitioner or dental specialist to ensure that accurate benefit determinations are made and that dental policies, procedures and guidelines are consistently applied.

RESPONSIBILITIES:

1. Reviews, analyzes and makes determinations on claims and inquiries that require the expertise of a general dental practitioner or dental specialist, e.g., determination of the medical necessity or clinical appropriateness of dental services.
2. Reviews, analyzes and makes determinations on Focused Review claims.
3. Provides benefit determination information to dentists and various corporate personnel.
4. Refers possible abuse and/or fraud claims to the Manager of Utilization Review.
5. As requested by the Dental Director or Manager of Utilization Review, assists with personnel training on the claims processing system, the application of dental policies, procedures and guidelines to claims adjudication, and clinical/non-clinical issues related to the practice of dentistry.
6. As requested by the Dental Director or Manager of Utilization Review, and in compliance with State and professional continuing education requirements, attends specific continuing education programs, reads specific professional dental journals or performs specific research associated with individual claims, general claims adjudication processes, or clinical/non-clinical issues related to the practice of dentistry.
7. Participates with quality assurance processes and initiatives within the Dental Consulting and Utilization Management department, including standards conformance audits (related to claims processing) and calibration activities.
8. Supports and promotes the corporate and department mission, vision, and core values.

REQUIREMENTS:

Skills and Knowledge

1. Knowledge of dental terminology.
2. Knowledge of dental procedures.
3. Ability to read and interpret radiographs.
4. Ability to analyze and make determinations on dental claims and inquiries that require the expertise of a general dental practitioner or dental specialist.
5. Knowledge of changes occurring in clinical dentistry/dental science.

6. Knowledge of changes occurring in the dental benefits marketplace and the body of knowledge for dental claims adjudication consulting.
7. Knowledge of the claims processing system.
8. Knowledge of claims data warehouses (e.g., MIS) and the ability to run and evaluate reports as appropriate.
9. Knowledge of departmental policies, procedures and guidelines.
10. Communication skills.
11. Problem solving skills.

Education/Experience

- Graduation from a dental school accredited by the American Dental Association Commission on Dental Accreditation.
- If applicable, graduation from a dental specialty program accredited by the American Dental Association Commission on Dental Accreditation (i.e., a dental specialty program in endodontics, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics or prosthodontics).
- Appropriate unrestricted certification and/or licensure in the United States to practice as a general dentist or specialist dentist.
- Residency in the United States.
- Knowledge equivalent to that which normally would be acquired by completing a four-year professional dental degree program (D.D.S. or D.M.D.).
- If applicable, knowledge equivalent to that which normally would be acquired by completing a dental specialty program (i.e., a dental specialty program in endodontics, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics or prosthodontics).
- As required by the work to be performed by the licensed dentist peer reviewer, a minimum of ten years' experience performing general dentistry, a minimum of ten years' experience performing specialty dentistry or a different level of experience at the discretion of the Dental Director.
- At least three years prior experience working in dental claims adjudication within a dental benefits organization is preferred.
- Membership in organized dentistry is preferred (e.g., the American Dental Association tri-partite structure, Academy of General Dentistry, appropriate dental specialty organizations).

Licensed Dentist Peer Reviewer Credentialing Form (Page 1)

DELTA DENTAL

Licensed Professional Peer Reviewer Credentialing/Recredentialing Profile

Please type or print all of the information requested on this form. If not applicable please indicate N/A. Incomplete forms cannot be accepted and will be returned for completion. Faxed or photocopies of this form are acceptable.

Personal Information		
Name:	Individual SSN:	
Address/City/State/Zip: ☐ Home ☐ Office		
Fax Number:	E-mail Address:	
Contact Phone Number:	Date Of Birth:	Gender:

Licenses			
State	License Number	Expiration Date	Specialty Information
			GP Or Specialist? If specialist, list specialty(ies)
			Board Certified? ☐ Yes ☐ No If yes, list certified specialty(ies)

Education/Certification		
Dental School Attended	Degree	Graduation Date

Work History	
Primary Practice Setting:	Number of hours per week in clinical practice:
Has your practice address changed in the last 5 years? ☐ Yes ☐ No	If yes, please fill out the information below
Previous Office Name/Address:	Month/Year:
Previous Office Name/Address:	Month/Year:

Hospital Privileges
Do you have hospital privileges? ☐ Yes ☐ No
Name/Address Of Primary Hospital:

Academic Appointment (Faculty Member Of A Dental School Or Teaching Facility)
Current Or Previous Academic Appointments (include dates):

Languages
Languages spoken (other than English):

Please Turn Form Over And Fill Out Information On Back

Licensed Professional Peer Reviewer Credentialing/Recredentialing Profile-Professional Services 10/2012

Licensed Dentist Peer Reviewer Credentialing Form (Page 2)

Are you willing to discuss cases with treating dentists? ☐ Yes ☐ No	Are you willing to participate in clinical review criteria development? ☐ Yes ☐ No	Are you willing to participate in quality review activities? ☐ Yes ☐ No

Professional Information

Please provide an explanation on the lines below for all yes answers for the following questions:

(**Recredentialing**: Please check all boxes and add any actions that have occurred in the last four years.)

Have you ever been involved in a malpractice suit or claim? (include dates, nature of suit, amount of the settlement)	☐ Yes	☐ No
Have any claims or suits been brought against you outside of the professional liability arena?	☐ Yes	☐ No
Has your license to practice dentistry in any state ever been revoked, suspended, placed on probation or voluntarily relinquished?	☐ Yes	☐ No
Has disciplinary action of any sort ever been taken against you by an ethics committee, licensing board or professional association?	☐ Yes	☐ No
Has your Drug Enforcement Agency (DEA) license ever been revoked, suspended or placed on probation?	☐ Yes	☐ No
Have you ever been denied participation or subject to sanctions by Medicare, Medicaid or any other state or federal program?	☐ Yes	☐ No
Have you ever been reported to the National Practitioner Data Bank?	☐ Yes	☐ No
Have your hospital staffing privileges (if applicable) ever been revoked or suspended or have you ever been refused membership on a hospital staff?	☐ Yes	☐ No
Have you ever been convicted of a criminal offense?	☐ Yes	☐ No
Do you have a condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a licensed professional peer reviewer in your area of practice?	☐ Yes	☐ No
Within the past five years, have you ever had any substance abuse problems that would impair your ability to practice dentistry?	☐ Yes	☐ No

_____

_____

_____

I authorize the State Board (or other dental licensing agencies in any state in which I am licensed to practice dentistry) and any health care facility, health maintenance organization or professional organization with whom I have had employment, practice, association or privileges, to release information to Delta Dental regarding my professional skills, any pending or final disciplinary action or malpractice action, and any other information relevant to my character or professional competence. I authorize and request my professional liability (malpractice) insurance carrier to release information to Delta Dental regarding any claims or actions for damages pending or closed during the previous ten years, whether or not there has been a final disposition. I release from liability: a) any person or entity who, in good faith and without malice, provides information to Delta Dental for the purpose of evaluating my application, credentials and qualifications; and b) Delta Dental for their acts performed in good faith and without malice, in connection with the evaluation of my application, credentials and qualifications.

I certify that all of the information herein is accurate and true to the best of my knowledge and agree to notify Delta Dental, in writing, of any changes in this document within 10 days of their occurrence. I understand that information which is found to be false could result in denial/termination of licensed professional peer reviewer status with Delta Dental.

A photocopy or fax of this permission will be as valid as the original.

_____
Dentist's Name (Please Print)

_____ _____
Dentist's Signature Date

Return this form to:
ATTN: Dental Director
Delta Dental of Michigan, Ohio, Indiana
P.O. Box 30416
Lansing, MI 48909-7916
Fax Number: 517-381-5527

For Dental Director Only:
☐ Approve ☐ Reject
Date _____ Initials _____

Licensed Professional Peer Reviewer Credentialing/Recredentialing Profile-Professional Services 10/2012

Appendix D	State-Specific Statutes, Regulations and Procedures	INDEX

If the requirements of a particular state applicable to Delta Dental, as expressed in statute, regulation, rule or order, contradicts the policies or procedures described in this Plan, the state requirements will have precedence and will be complied with.

Left-click on state name to go to state-specific information:

Indiana	Michigan	New York	North Carolina	Ohio

Note: The information contained in this section is taken from a variety of sources deemed to be reliable. However, if applied to a question of compliance requirements, the information should be reviewed for statutory and/or regulatory accuracy as of the date the information is accessed.

State-Specific Statutes, Regulations and Procedures: Indiana

State	Indiana		[State Index]
Appeals (Internal) Indiana Code Annotated §27-8-28-17	**Emergency (Urgent) Appeal Timeline**	No state action	
	Prospective Review Request Timeline	No state action	
	Retrospective Review Request Timeline	- 5 business days after the appeal is filed must provide written or oral acknowledgement of the appeal - Decision within 45 days after the appeal is filed - Written notification within 5 days of completing an investigation	
	Other	If case of an appeal of a determination that a service or proposed service is not appropriate or medically necessary; or is experimental or investigational - must appoint a panel	
External Review Indiana Code §27-13-10.1-1 to 27-13-10.1-12	**Mandates External Review?**	Yes	
	Applies To	HMOs in the individual and group markets	
	Type of Grievance	Denials of service based on medical necessity, experimental or investigational status of the treatment or any denial of a covered service	
	Filing Time Limit/Fee	Within 45 days of final notice of denial by the plan/Fee not specified	
	Who Pays for Review	Permits enrollees to be required to pay up to $25, but requires HMOs to pay the remainder of the cost	
Utilization Review	**UR License Required?**	Yes	
	Applies To	N/A	
	Other	No license needed if consulting on insurance claims, as per the Professional Licensing Agency.	
Prompt Pay Indiana Insurance Code 27-8-5.7-1 to 27-8-5.7-11	**Payment Due for Clean Claim**	**Electronic**	30 calendar days from receipt
		Paper	45 calendar days from receipt

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State-Specific Statutes, Regulations and Procedures: Indiana, continued

Prompt Pay Indiana Insurance Code 27-8-5.7-1 to 27-8-5.7-11 Continued	**Payment for Disputed Claim**	Must give written notice of disputed claim within time frame due dates for clean claim and describe any remedy necessary to establish a clean claim. Failure of an insurer to notify a provider as required establishes the submitted claim as a clean claim.
	Interest Penalty	Rate as provided in IC 12-15-21-3(7)(A)(7) which states: paying interest to providers at a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state money for the state's previous year.
Dental Act	No state action relative to dentists reviewing claims for dental benefits.	

State-Specific Statutes, Regulations and Procedures: Michigan

State	Michigan		[State Index]
Appeals (Internal) Michigan Compiled Laws Annotated §500.2213	**Emergency (Urgent) Appeal Timeline**	Determination due 72 hours after receipt of expedited grievance	
	Prospective Review Request Timeline	No information	
	Retrospective Review Request Timeline	35 calendar days after grievance submitted in writing; may be extended 10 business days if requested information is not received timely from provider	
	Other	N/A	
External Review Michigan Compiled Laws §550.1903; 550.1911; 550.1913; and 550.1919	**Mandates External Review?**	Yes	
	Applies To	Health carriers, in the group and individual markets, that perform utilization review. Does not apply to a policy or certificate that provides coverage only for dental.	
	Type of Grievance	Any "adverse determination ", defined as "an admission, availability of care, continued stay, or other health care service that had been reviewed by a URO and been denied, reduced or terminated."	
	Filing Time Limit/Fee	Within 60 days of receipt of notice of the final denial by the health carrier/Fee not specified	
	Who Pays for Review	The state	
Utilization Review	**UR License Required?**	No	
	Applies To	N/A	
	Other	N/A	
Prompt Pay Michigan Insurance Code 500.2006	**Payment Due for Clean Claim**	**Electronic**	45 calendar days from receipt
		Paper	45 calendar days from receipt
	Payment for Disputed Claim	Must notify within 30 days of reasons to prevent claim from being a clean claim	
	Interest Penalty	12% per annum; violation could result in $1,000 fine for each claim	
Dental Act	No state action relative to dentists reviewing claims for dental benefits.		

State-Specific Statutes, Regulations and Procedures: New York

State	New York	State Index
Appeals (Internal)	**Expedited Appeal Timeline**	Determine within 2 business days (§4904(b))
	Prospective Review Request Timeline	30 business days
	Retrospective Review Request Timeline	Make determination and notify within the earlier of: 30 days of receiving necessary information, or 60 days of receiving the appeal.
	Other	An Adverse Utilization Review Determination Appeal must be received, in writing or by telephone, within 180 calendar days of the date the complainant receives notice of an adverse utilization review determination (§4904(c)). Within fifteen (15) business days of receiving the appeal, the utilization review agent shall provide written acknowledgment of the appeal (§4904(c)). Notification of Receipt of an Adverse Utilization Review Determination Appeal New York Insurance Code 4904(c); 11 NYCRR 410.9(b); 29 CFR 2560.503-1(i)(2)(iii) Because Delta Dental only performs Adverse Utilization Review Determinations based on retrospective, post-service review, expedited appeals are not applicable to the clinical review Delta Dental performs. Within 15 business days of an Adverse Utilization Review Determination Appeal being submitted, a written acknowledgement that the appeal has been received by RLHICA/RLHNY or Delta Dental will be sent to the Member and the Member's dental provider. If additional information is necessary to conduct the appeal, RLHICA/RLHNY or Delta Dental shall notify the Member and the Member's provider, in writing, within 15 days of receiving the appeal, to identify and request the necessary information. If only a portion of the necessary information is received, RLHICA/RLHNY or Delta Dental shall request the

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State-Specific Statutes, Regulations and Procedures: New York, continued

Appeals (Internal) Continued	**Other** Continued	missing information, in writing, within five (5) business days of receiving the partial information. A determination will be made with regard to the appeal within the earlier of 30 days of receiving necessary information, or 60 days of receiving the appeal. Delta Dental shall notify the member or provider within 2 business days of the adverse utilization review appeal determination, but no later than 60 days of receipt of the appeal. <u>Content of an Adverse Utilization Review Determination Appeal Decision Notice New York Insurance Code 4904(c}); 11 NYCRR 410.9(e)</u> For the State of New York, the content of an adverse utilization review determination appeal decision notice will include the following (§4902(a); 11 NYCRR 410.9(e)): • The reasons for the determination, including the clinical rationale; if any; • A notice of the Member's right to an external appeal together with a description, jointly promulgated by the Commissioner and the Superintendent of Insurance as required pursuant to the external appeals process established by the State of New York, and the timeframes for such external appeals; • A clear statement that the notice constitutes the final adverse determination; • The health care plan's contact person and his or her telephone number; • The insured's coverage type; • The name and full address of the health care plan's utilization review agent; • The utilization review agent's contact person and his or her telephone number; • A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and

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State-Specific Statutes, Regulations and Procedures: New York, continued

Appeals (Internal) Continued	**Other** Continued	• the developer/manufacturer of the health care service; • Notice of the availability, upon request of the Member or the provider, of the clinical review criteria relied upon to make such determination; • Notice of the establishment of a toll-free telephone to discuss patient care with the appropriate clinical review personnel not less than 40 hours a week during normal business hours; • A description of any additional information necessary for the Member or provider to perfect the claim or an explanation of why such information is necessary. ○ Utilization Review Determination Appeal decisions shall be made by a dental consultant other than the dental consultant who rendered the Adverse Determination.
External Review New York Insurance Law §4910 through 4916 and New York Compiled Codes R. & Regulations title §410.1 to 410.13 and §98-2.5	**Mandates External Review?**	Yes
	Applies To	"Health care plans ", including all health carriers that conduct utilization review, in the group and individual markets.
	Type of Determination	Disputes over a plan's final adverse determination made on grounds that the service is not medically necessary or is experimental or investigational (§410.1; §410.3(a)(1)). Also allows out-of-network denials to be appealed (§4904(a-1)).
	Filing Time Limit/Fee	Four (4) months for the Insured to initiate external appeal); 60 days for the Insured's provider to initiate external appeal (§4914(b)(1). Permits health care plans to charge individuals a filing fee of up to $25 (with an annual limit on filing fees for an insured not to exceed $75 within a single plan year), which is refunded if the IRO overturns the plan's final adverse determination and is waived for Medicaid recipients and others for whom an affected entity determines

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State-Specific Statutes, Regulations and Procedures: New York, continued

External Review New York Insurance Law §4910 through 4916 and New York Compiled Codes R. & Regulations title §410.1 to 410.13 and §98-2.5 Continued	**Filing Time Limit/Fee** Continued	the fee would create a financial hardship (§4910(c)). The health care plan may charge the insured's health care provider a fee of up to $50 per external appeal (other than for an external appeal of a concurrent adverse determination) which is refunded if the final adverse determination is overturned (§4910(c)).	
	Who Pays for Review	Health plan (§4914(d))	
Utilization Review	**UR License Required?**	No	
	Applies To	RLHICA	
	Other	Department of Insurance requires insurers to file their UR plans biennially (§4901(a)). Otherwise, no requirements for license or certification in New York.	
Prompt Pay New York (NY) Office of General Counsel Opinion No. 2002-197; NY Ins Law §3224-a; NY Ins Law §3234 & 3235	**Payment Due for Clean Claim**	**Electronic**	45 calendar days from receipt
		Paper	45 calendar days from receipt
	Payment for Disputed Claim	If an insurer's obligation to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim	
	Interest Penalty	12 % per annum	
Dental Act	No state action relative to dentists reviewing claims for dental benefits.		

State-Specific Statutes, Regulations and Procedures: North Carolina

State	North Carolina	[State Index]
Appeals (Internal) North Carolina General Law 58-50-61	**Emergency (Urgent) Appeal Timeline**	No state action
	Prospective Review Request Timeline	No state action
	Retrospective Review Request Timeline	No state action
	Other	Does not apply to dental only insurers
External Review North Carolina General Statutes §58-50-61; §§58-50-75 to 58-50-95 and §58-50-61(a)(13)	**Mandates External Review?**	Yes
	Applies To	Insurers offering health benefit plan and that provide or perform utilization review, the State Health Plan for Teachers, and State Employees, and the NC Health Insurance Risk Pool, and the CHIP. Applies to entities in the group and individual markets.
	Type of Grievance	Utilization review determinations involving a "noncertification decision ", defined as determinations by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care services is denied, reduced, or terminated because it fails to meet the insurer's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness
	Filing Time Limit/Fee	Within 60 days after the date of receipt of a notice of noncertification/Fee not specified
	Who Pays for Review	Insurer
Utilization Review	**UR License Required?**	No
	Applies To	RLHICA-DDMI
	Other	North Carolina specifically exempts dental from its definition of "health benefit plan ", which means that RLHICA would not be considered an "insurer" under state law (since NC law says that insurers write health benefit plans). DDMI, however, would not be exempt,

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State-Specific Statutes, Regulations and Procedures: North Carolina, continued

Utilization Review Continued	**Other**	as they'd be doing UR for another entity's plans under a managed care plan. They would be considered a "Utilization Review Organization." The state requires that insurers doing UR for their own health benefit plans must comply with UR regulations. There is no separate license or certification requirement.	
Prompt Pay North Carolina (NC) Insurance Code 58-3-100; 58-3-225; 58-3-172; 11 NC Administrative Code 12.1404 and 12.1804	**Payment Due for Clean Claim**	**Electronic**	30 calendar days from receipt
		Paper	30 calendar days from receipt
	Payment for Disputed Claim	If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under the utilization review statutes, then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days	

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State-Specific Statutes, Regulations and Procedures: North Carolina, continued

Prompt Pay North Carolina (NC) Insurance Code 58-3-100; 58-3-225; 58-3-172; 11 NC Administrative Code 12.1404 and 12.1804	**Payment for Disputed Claim, continued**	after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.
	Interest Penalty	18% per annum
Dental Act	**Dental Code:** "§90-29. Necessity for license; dentistry defined; exemptions…(b) A person shall be deemed to be practicing dentistry in this State who does, undertakes or attempts to do, or claims the ability to do any one or more of the following acts or things which, for the purposes of this Article, constitute the practice of dentistry…(9) Uses a Roentgen or X-ray machine or device for dental treatment or diagnostic purposes, or gives interpretations or readings of dental Roentgenograms or X rays…"	

State-Specific Statutes, Regulations and Procedures: Ohio

State	Ohio	State Index
Appeals (Internal) Ohio Revised Code Annotated §1751.83/ 1751.19	**Emergency (Urgent) Appeal Timeline**	7 calendar days
	Prospective Review Request Timeline	60 calendar days
	Retrospective Review Request Timeline	60 calendar days
	Other	Must keep copies of complaints and responses for 3 years upon inspection by the commissioner
	Other	Content of a Notice of an Adverse Utilization Review Determination Appeal Decision as Required by the State of Ohio (Ohio Administrative Code 3901-8-11 (H)(5)) For the State of Ohio, the content of an adverse utilization review determination appeal decision notice will include the following: • "If your claim has been denied on the basis that the service is not medically necessary, or you have been diagnosed with a terminal condition and the service has been denied on the basis that it is experimental or investigational, you may have a right to request an independent review by an outside medical practitioner. Submit your request in writing to Dental Director, Delta Dental, P.O. Box 738, Greenwood, IN 46142. If your claim has been denied on the basis that it is not a covered service you have the right to file a complaint with the 'Ohio Department of Insurance, Consumer Services Division, 50 West Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (614)-644-2673, toll free in Ohio 1-800-686-1526.' Complaints may also be filed via the internet at http://insurance.ohio.gov."

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State-Specific Statutes, Regulations and Procedures: Ohio, continued

External Review Ohio Revised Code Annotated §17.1751.84 and 17.3901.81	**Mandates External Review?**	Yes	
	Applies To	Health insuring corporations (HICs) defined as health care entities that assume risk. Applies to entities in the group and individual markets.	
	Type of Grievance	Adverse determinations based on "medical necessity."	
	Filing Time Limit/Fee	Within 60 days of notice by the insured/Fee not specified	
	Who Pays for Review	Health insuring corporations	
Utilization Review	**UR License Required?**	No	
	Applies To	DDOH-DDMI	
	Other	Ohio UR laws apply to health insuring corporations that offer policies covering basic health care services, or to any designee of the health insuring corporation or a UR organization that performs UR for the health insuring corporation's basic health care services. DDOH is considered a health insuring corporation, while RLHICA would be considered an insurer. If DDMI is reviewing claims for DDOH, then they would be considered a UR organization performing UR for a health insuring corporation. Dental care services are considered supplemental health care services, and are not basic health care services. OH requires a yearly filing of a certification of compliance for its UR programs, but it is specifically for health insuring corporations (which would be exempt) and not insurers.	
Prompt Pay Ohio Insurance Code 3901.381 - 3901.389	**Payment Due for Clean Claim**	**Electronic**	30 calendar days from receipt
		Paper	30 calendar days from receipt
	Payment for Disputed Claim	When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than 15 days after receipt of the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Pay or deny within 45 days.	

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State-Specific Statutes, Regulations and Procedures: Ohio, continued

Prompt Pay Ohio Insurance Code 3901.381 - 3901.389 Continued	**Interest Penalty**	18% per annum
Dental Act	No state action relative to dentists reviewing claims for dental benefits.	

Term	Description
administrative controls	Actions, policies and procedures to manage the implementation and maintenance of security measures to protect Delta Dental's information and to manage the conduct of Delta Dental staff in relation to the protection of that information. Includes separation of duties, minimum necessary access controls, password policies, log-in monitoring, security training and awareness, risk assessment and auditing.
adverse benefit determination (commercial plans)	A decision made by Delta Dental to deny, reduce or terminate a benefit or fail to provide or make payment for a benefit (in whole or in part). This includes any such decisions based on: (a) an item or service determined to be not medically necessary or to be clinically inappropriate (including care setting, level of care or effectiveness), (b) an item or service determined to be experimental or investigational, (c) the application of utilization review or (d) a determination that an individual is ineligible to participate in a dental plan. The failure by Delta Dental to respond in a timely manner to a request for a determination is also considered to be an adverse determination.
adverse benefit determination (Medicaid plans)	An act by Delta Dental that adversely impacts a Medicaid enrollee's claim for services due to any of the following: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. • The reduction, suspension or termination of a previously authorized service. • The failure to provide services in a timely manner as defined by a Medicaid plan. • The failure to act within the time frames provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. • The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities.
after normal business hours	Any time other than the time described as normal business hours.
appeal	A request to change an adverse benefit determination issued by Delta Dental on an adjudicated claim. A member or authorized member representative may file an appeal if they do not agree with a coverage or payment decision made by Delta Dental. In some cases, a practitioner may be eligible to file an appeal. Also see *postservice claim appeal* and *preservice claim appeal*.

appeal decision	A decision made by Delta Dental whether to overturn or uphold an adverse benefit determination that is the subject of an appeal filed by a member or authorized member representative. An appeal decision may be favorable in overturning an adverse benefit determination or adverse in upholding an adverse benefit determination.
appeal decision notification	An electronic or written notice of an appeal decision sent to members and authorized member representatives. An appeal decision notification informs recipients of a favorable appeal decision overturning an adverse benefit determination or an adverse appeal decision upholding an adverse benefit determination.
approve	A decision made by Delta Dental to provide benefit coverage for a dental service or procedure for which an individual submitted a claim.
authorized representative	An individual who acts on behalf of another individual through consent or under applicable law.
benefit coverage	The provision of dental benefits to members and their covered dependents as described in the contract between a dental plan sponsor and a dental plan administrator.
benefit decision	A decision made by Delta Dental whether to provide benefit coverage for a dental service or procedure for which an individual submitted a claim. Benefit decisions result from a review of the terms of the contract between a dental plan sponsor and a dental plan administrator and do not involve utilization review. A benefit decision may be favorable in providing benefit coverage to a member or adverse in not providing benefit coverage.
benefit decision notification	An electronic or written notice of a benefit decision sent to members and practitioners in the form of an explanation of benefits statement. A benefit decision notification informs recipients of a favorable or adverse benefit decision. May also be referred to as a *denial notice* or *denial notification*.
benefit maximum	The total amount of money the Delta Dental will pay towards the cost of a member's dental care within a specific time period.
board certified	A practitioner has satisfied the requirements/standards of a nationally recognized specialty board and received the board's specialist certification.
claim	A request for payment for a covered dental service or procedure. Claims are not conditioned upon preservice approval, certification or authorization to receive payment for a covered dental service or procedure.
claim adjudication	The process to bring a claim to final disposition.
client	An employer, organization, group or association that sponsors a dental plan.
clinical appropriateness	Based on judgment of a health care practitioner, applicability of a requested service to a member's case in terms of type, frequency, extent, site and duration.

clinical criteria	Objective and quantifiable guidelines used to assess the clinical appropriateness of specific dental health care decisions, services and procedures.
concurrent care claim	A claim to extend benefit coverage of health care services or procedures that a member is in the process of receiving, even if the benefits administrator did not previously approve the services or procedures in progress. May also be referred to as a concurrent request.
convenience	The degree to which a dental service or procedure is designed or recommended for the personal comfort or ease of a member, caregiver, or provider. Alleviation of pain is not considered under this Plan to be a matter of convenience.
covered services and procedures	The unique dental services and procedures selected for coverage as described in the contract between a dental plan sponsor and a dental plan administrator.
Delta Dental	Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. May also be referred to as Delta Dental of Michigan.
denial	An adverse benefit decision or adverse UM decision made by Delta Dental not to provide benefit coverage for a dental service or procedure for which an individual submitted a claim.
denial notice or notification	See *benefit decision notification*, *UM decision notification*, and *explanation of benefit statement*.
dental benefits	Payment for the covered services and procedures that have been selected under a contract between a dental plan sponsor and a dental plan administrator.
Dental Director	A licensed practitioner who is an employee of Delta Dental. The Dental Director oversees Delta Dental's Utilization Management Program.
dentist	See *practitioner*.
diagnosis	A process carried out by a practitioner to identify a patient's dysfunction (e.g., disease, disorder, condition) toward which the diagnosing provider, or another provider, directs treatment. The patient's dysfunction is identified based on information obtained from the patient's history, observed signs and symptoms, examination of the patient and relevant tests. Identification of a patient's dysfunction for the purpose of allowing treatment decisions to be made is the expected outcome of the diagnostic process.
disapprove	See denial.
effective	Describes the provision of a dental service or procedure that produces the intended beneficial outcome, and where the health benefit(s) of the service or procedure outweighs any potential risks. To qualify as being safe and effective, the type, scope, frequency, intensity and duration of a dental service or procedure must be consistent with the symptoms or confirmed diagnosis of a patient’s dental condition.
enrollee	See *member.*

evidence based	The ordered and explicit use of the best scientific evidence available within the dental evidence base when making health care decisions.
Exchange	A government-regulated marketplace of insurance plans with different tiers or levels of coverage.
experimental	A dental service or procedure is considered experimental if the weight of dental evidence does not support the safety and efficacy of the item or service in question for the purpose for which it is being used or applied in patient treatment. May also be referred to as *investigational*.
external review	A review of an organization's adverse benefit determination or adverse appeal decision by a third-party, independent review organization.
explanation of benefits (EOB)	A notice sent to the member detailing benefit coverage provided by their dental plan for dental services and procedures rendered. An EOB communicating an adverse benefit determination may be referred to as a denial notice or notification.
generally accepted standards of dental practice	Rules or requirements for clinical dental practice commonly accepted as correct. Based on credible scientific evidence published in peer-reviewed medical literature, professional organization recommendations, expert opinions, and other relevant factors.
goal	A desired level of achievement measured by specific objectives and targets. Expressed as minimum performance levels, benchmarks or permitted variance from the standard.
interrater reliability	The level of agreement between conclusions, observations, assessments, etc., drawn by different persons on the same data or information.
IRO	Independent review organization. A third-party entity external to Delta Dental that provides unbiased, objective opinions based on clinical evidence as to whether dental services or procedures are medically necessary, clinically appropriate or investigational/experimental.
IVR	Interactive voice response
licensed dentist peer reviewer	A licensed general dentist or dental specialist who meets the qualifications described in Section 4 and Appendix B of this Plan and who is authorized to perform utilization review and make UM decisions on behalf of Delta Dental. May be referred to as a dental consultant.
medical necessity	Accepted dental care services and procedures provided by dental practitioners that are appropriate to the evaluation, prevention or treatment of an oral or maxillofacial injury, illness, condition or disease and are consistent with applicable generally accepted standards of dental practice.
member	A person insured or otherwise provided benefit coverage through a dental plan administered by Delta Dental. May be referred to as an enrollee or subscriber.
monitor	A periodic or ongoing activity to determine opportunities for improvement or effectiveness of interventions.
nonurgent preservice claim	A preservice claim where the application of the standard time periods for making a nonurgent benefit decision or nonurgent UM decision would not

	seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or subject the member to severe pain.
normal business hours	Regular business hours means the hours between 8 a.m. and 8 p.m., during a weekday Monday through Friday, excluding Federal holidays. Business hours are determined based on the time zone of the individual communicating with DDMI.
objective	A measurable target or result that a program aims to achieve within a time frame, based on verifiable evidence.
oversight	Monitoring and directing a set of activities, resulting in a desired outcome.
patients	Individuals to whom dental services and procedures are rendered.
peer review	Evaluation or review of colleague performance by professionals with similar types and degrees of expertise.
performance assessment measure	A quantifiable element of performance that can be compared to the same element of other performances, such as a dimension of a function, process, or outcome. Measures can be activities, events, occurrences, or outcomes for which data can be collected to allow comparison with a threshold, a benchmark, or prior performance.
physical controls	Physical measures, policies and procedures to protect Delta Dental's electronic information systems, and related buildings and equipment, from unauthorized intrusion. Includes locked doors, security surveillance cameras, security guards, identification badges, key card access, visitor logs, workstation security and device and media controls.
policies and procedures (operational)	A formal documented process adopted by the organization that describes the course of actions the organization will follow and the methods that will be carried out to achieve the policy objectives.
postservice claim	A claim for benefits under a dental plan where the terms of the plan do not condition receipt of the benefits, in whole or in part, upon preservice approval, certification or authorization. Postservice claims arise when a member receives a dental service or procedure before filing the claim. Postservice claims may require a benefit decision (postservice benefit claim) or a UM decision (postservice UM claim). May also be referred to as a *postservice request*.
postservice claim appeal	An appeal of an adverse benefit determination that was issued on a postservice claim.
Post-stabilization	Post-stabilization care services are covered services related to an emergency dental condition that are provided after a member is stabilized to maintain the stabilized condition or, under certain circumstances, to improve or resolve the member's condition.
practitioner	An individual licensed to practice dentistry in the state or jurisdiction in which dental services are rendered. May be referred to as a provider or dentist. Includes general dental practitioners and dental specialists.
preservice claim	A claim for benefits under a dental plan where the terms of the plan condition postservice receipt of the benefits, in whole or in part, on preservice prior authorization approval of a dental service or procedure before treatment is initiated. Preservice claims may require a benefit

	decision (preservice benefit claim) or a UM decision (preservice UM claim) and be urgent or nonurgent. May also be referred to as a *preservice request*. Also see *nonurgent preservice claim* and *urgent preservice claim*.
preservice claim appeal	An appeal of an adverse benefit determination that was issued on a preservice claim.
prior authorization	An assessment of a preservice claim to determine whether a proposed dental service or procedure is medically necessary or clinically appropriate for a particular patient. When prior authorization is required by a member's dental plan, postservice benefit payment is conditioned on preservice prior authorization approval and coverage by the member's dental plan. May be referred to as prior approval or prior certification.
procedure (clinical)	A planned process rendered by a practitioner, or an individual working under the supervision of a practitioner, that has the objective of contributing to a desired health effect through evaluation, prevention or treatment of an oral or maxillofacial injury, illness, condition or disease.
protected health information (PHI)	Individually identifiable health information that is transmitted or maintained in any form or medium (electronic, oral, or paper) by a covered entity or its business associates, excluding certain educational and employment records.
provider	See practitioner.
service (clinical)	Any activity provided by a practitioner, or an individual working under the supervision of a practitioner, that relates to the evaluation, prevention or treatment of an oral or maxillofacial injury, illness, condition or disease.
specialist	Refers to practitioners who limit their practice to specific services, including endodontics, pediatric dentistry, periodontics, prosthodontics and oral surgery.
technical controls	The technology and the policy and procedures for its use that protect Delta Dental's electronic information, and that control access to that information. Includes firewalls, intrusion detection systems, encryption, network authentication, access control lists, antivirus software, software ownership, remote access control and data integrity mechanisms.
urgent preservice claim	A preservice claim where the application of the standard time periods for making a nonurgent benefit decision or nonurgent UM decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, and/or subject the member to severe pain.
utilization management (UM)	A system of policies and procedures for evaluating and determining medical necessity, clinical appropriateness and coverage for dental care services and procedures, as well as providing needed assistance to practitioners or members, in cooperation with other parties, to ensure the appropriate and efficient allocation of dental health care resources.
Manager of Utilization Review	A licensed practitioner who is an employee of Delta Dental. The requirements of the UM Plan are enforced on a day-to-day basis by the Manager of Utilization Review.

Utilization Management Committee	A Delta Dental standing committee comprised of licensed practitioners and Delta Dental staff which is chaired by the Dental Director. Oversees the Delta Dental Utilization Management Plan through continuous, structured monitoring and improvement of the UM program.
Utilization Management Program	A Delta Dental program that encompasses the activities of developing, adopting, implementing, maintaining, evaluating and revising the policies, procedures and processes governing dental utilization review to ensure appropriate and effective review, establish efficient management of dental plan resources and promote high quality care.
utilization management (UM) decision	A decision made by Delta Dental whether to provide benefit coverage for a dental service or procedure submitted on a claim. UM decisions result from utilization review of the medical necessity or clinical appropriateness of a dental service or procedure. A UM decision may be favorable in providing benefit coverage to a member or adverse in not providing benefit coverage. May also be referred to as a *UM determination*, *medical necessity determination* or *clinical appropriateness determination*.
utilization management (UM) decision notification	An electronic or written notice of a UM decision sent to Delta Dental members and practitioners in the form of an explanation of benefits statement. A UM decision notification informs recipients of a favorable UM decision or an adverse UM decision. An adverse UM decision notification may be referred to as a *denial notice* or *denial notification*.
utilization management program	A documented framework of policies and procedures describing a systematic approach and activities for utilization review of the medical necessity and clinical appropriateness of dental procedures submitted on claims for benefit payment. The framework includes the process for retrospective review, the application of clinical criteria for utilization review by appropriate professionals, UM communication services, review time frames, denial notifications, appeal handling, UM system controls, delegation of UM and quality improvement of UM services.
utilization review	Review by a licensed dentist peer reviewer performed to assess the medical necessity or clinical appropriateness of a dental service or procedure for the purpose of making a utilization management decision to determine benefit coverage.

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