BlueCross BlueShield of Montana

2023 Blue Cross and Blue Shield of Montana (BCBSMT) Utilization Management (UM) Program Description

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Accreditation/ Regulatory References
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State and Federal Laws and Regulations

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2023 BCBSMT UM Program Description

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I. Overview

The Utilization (UM) Management Program description defines the structure of the UM programs for the BCBSMT Retail On-Exchange Marketplace and Off-Exchange products, and Fully Insured Commercial groups.

This document provides a clear definition of authority and accountability within the organization, articulates the scope and content of the Program, identifies the roles and responsibilities of individuals involved and outlines the program evaluation.

In the case where utilization management is delegated, oversight is conducted to assure delegated programs meet requirements, including annual review and approval of the delegate's Utilization Management program description.

II. UM Program Structure

The UM Program is structured to maximize the effectiveness of care and services by ensuring appropriate access to quality and cost-effective care for members.

Medical Management UM is integrated with the BCBSMT Quality Improvement Committee and Behavioral Health UM is integrated with the Behavioral Health Quality Improvement Committee to promote objective and systematic monitoring and evaluation of processes and services within the Care Management program.

Medical Management seamlessly interfaces with their behavioral health colleagues using face to face, telephonic and electronic mechanisms based on the plan's geographic location.
UM activities are conducted in compliance with applicable legal, regulatory, and accreditation standards and are developed with input from corporate committees with subject matter expertise, along with corporate legal and regulatory input.

III. Program Objectives

The UM processes support members in accessing services available to them through their benefit plans. The main objective is to identify and avoid unnecessary services before services are rendered and identify alternatives, thus fostering appropriate health care practice patterns, improved quality of care and cost containment.

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The UM Program is driven to facilitate:

a. Equitable Member access to appropriate, quality, affordable care/program/service delivery.
b. Evidence based and timely utilization decisions that accommodate the clinical urgency of the situation.
c. Individual consideration of criteria for members with special circumstances or complex conditions with use of the American Society of Addiction Medicine (ASAM), MCG Care Guidelines (MCG), and BCBSMT Medical Policies (MP).
d. Special circumstances include, but are not limited to, availability of specified level of care, member unique cultural preferences, and individual needs of the specific case.
e. Benefit determinations that are fair, impartial, consistent and easily interpreted by members and providers.

IV. Program Scope

A. Definitions

Utilization Review

"Utilization review" means a set of formal techniques designed to monitor the use of or to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinions, certification, concurrent review, case management, discharge planning, or retrospective review.

Prior Authorization/Recommended Clinical Review (Predetermination)

There are two types of preservice review to assess benefits and medical necessity: prior authorization and recommended clinical review (predetermination). Similarities predominate over differences between these two types of preservice review. The primary difference is that prior authorization is required for certain services whereas recommended clinical review (predetermination) is voluntary for services subject to medical necessity review, that do not require prior authorization. Once requested, prior authorizations and recommended clinical reviews (predeterminations) are processed in the same manner including, but not limited to, reviewer qualifications to approve and deny and notification of determinations. Because they condition receipt of benefits upon a review before a service is rendered, prior authorization reviews include appeal rights.

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Furthermore, neither prior authorization nor recommended clinical review (predetermination) guarantee benefits or payments. The member's eligibility at the time of service, changes in the member’s condition between the prior authorization or recommended clinical review (predetermination) and the actual rendering of services and the rendering of services different than those that were the subject of the prior authorization/recommended clinical review (predetermination) request, and terms of the member’s plan control the available benefits.

Medical Necessity

"Medical necessity" means health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of practice;
- clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and
- not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.

Authorized Representative

With respect to a benefit, claim or an appeal of an adverse benefit determination, “Authorized Representative” means a person to whom a covered person has given express written consent to represent the covered person; a person authorized by law to provide substituted consent for a covered person; a family member of the covered person; or the covered person's treating health care provider only if the covered person is unable to provide consent.

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B. UM Program Staffing

Non-Clinical Staff

Non-clinical staff with training in care management may process all incoming calls, provide member eligibility and benefit information, and facilitate member access to appropriate providers/facilities. Non-clinical staff members do not conduct utilization review.

Utilization Management Clinical Staff (Preservice, Concurrent, Post Service/Retrospective)

Medical Management Utilization Management Coordinators (UMCs): Licensed Registered Nurses (RNs) or Licensed Practical Nurses (LPNs)/Licensed Vocational Nurses (LVNs) utilize their medical knowledge and expertise to review requests for admissions/level of care, procedures, and services according to established Standard Operating Procedures.

Behavioral Health Clinical Reviewer: Licensed Clinical Practitioners (Registered Nurse (RN) or master's level Behavioral Health Professional) assess treatment progress, authorize benefits for treatment services utilizing clinical criteria, offers care collaboration during the active treatment and review appeals.

Pharmacy Reviewer: Licensed, registered Pharmacists conduct preservice review of outpatient provider administered drug therapies, cellular immunotherapy, gene therapy and other medical benefit drug therapies.

Physician Reviewer (Preservice, Concurrent, Post-Service/Retrospective)

Physician Reviewer Medical Management: Licensed, board certified Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, or Doctor of Dental Medicine. Physician Reviewers evaluate cases for medical necessity determinations based on medical knowledge, experience and current standards of practice. In addition, Physician Reviewers conduct peer to peer reviews with providers, if requested. Physician Reviewers are available during standard business hours for consultation with providers and UM staff. The review for an appeal of a clinical based denial is conducted by an appropriate Physician Reviewer who was not involved in or a subordinate of anyone involved in any previous non-authorization (denial/adverse) determination pertaining to the same episode of care and is located in a state or territory of the United States when conducting an appeals review. The Physician Reviewer will be in the same profession and in a similar specialty as typically manages the medical, behavioral health, or dental conditions, procedures, and/or treatments under review, as mutually deemed appropriate.

Behavioral Health Physician Reviewer: Licensed, board certified psychiatrists or board certified in a specialty other than psychiatry with additional background and training in substance abuse/addiction treatment. Physician Reviewers perform the physician review role. This includes peer initial or second level medical necessity reviews as well as appeal reviews. Additionally, Behavioral Health (BH) Physician Reviewers are available for case consultation with providers to assist in finding the most appropriate level and type of care for each member.

Psychologist Reviewer (Peer Clinical Reviewer): Possesses a Doctorate degree in psychology, with a current, valid license to practice psychology. Psychologists are responsible for review of psychological testing requests and determine medical necessity of testing requested, clinical appropriateness of tests and hours requested for testing being authorized. Conduct and document peer consultations in regard to psychological testing requests and review of outpatient therapy cases using a focused outpatient care management model. The Behavior Health Psychologist can also be a Board-Certified Behavior Analyst-Doctoral level certified by the Behavior Analyst Certification Board to independently practice Applied Behavior Analysis (ABA) and is responsible for review of ABA requests and determine medical necessity of ABA therapy requested, clinical appropriateness of hours requested for ABA therapy authorized. Conduct and document peer consultations in regard to ABA requests and review ABA treatment documentation

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using a prior authorization model. The Behavior Health Psychologist may serve as a Peer Clinical Reviewer in making initial adverse determinations for outpatient requests when they are in the same licensure category as the ordering provider. All appeal determinations will be made by a Behavioral Health Physician Reviewer.

C. Clinical Review Criteria

Utilization Management Clinicians utilize ASAM, MCG care guidelines and BCBSMT Medical Policy to determine the following:

- Medical necessity of the requested care;
- Appropriateness of the location and level of care;
- Appropriateness of the length of stay (including diagnosis related group [DRG] criteria); and
- Assignment of the next anticipated review point.

Requests that do not meet ASAM, MCG care guidelines, BCBSMT Medical Policy, and/or potential contract exclusions are referred to Physician Reviewers/Peer Clinical Reviewers for determination.

1. The American Society of Addiction Medicine Criteria

The ASAM Criteria: *Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* is utilized as the behavioral health clinical screening criteria for patients with addiction disorders for all levels of care.

The ASAM criteria are designed to support multi-dimensional assessments and treatments, attending to the multiple needs of each person and not just their alcohol or drug use. There is also a greater emphasis on the need for integrated care, addressing both the mental and physical health disorders present in patients with addictions.

The ASAM criteria are evaluated at least annually or earlier if new data regarding indications or technologies becomes available. The criteria are presented annually to the Behavioral Health Quality Improvement Committee (BHQIC).

2. MCG Care Guidelines

MCG care guidelines are nationally recognized clinical criteria utilized to screen and evaluate for medical necessity and appropriateness of services, in accordance with the

terms of the member's health benefit plan. MCG care guidelines are explicitly written, created by practicing clinicians and based on current clinical principles and processes and are evidence-based.

MCG care guidelines are evaluated annually or earlier if new data regarding indications or technologies become available and approved by our Chief Medical Officer or delegate. BCBSMT Quality Improvement Committee and Behavioral Health Quality Improvement Committee are informed of the MCG Criteria Version updates annually.

Clinical review staff use MCG care guidelines to review requests for medical/surgical/behavioral health procedures/services and/or inpatient admissions (preservice and concurrent), not completed through the automated web platform.

3. Medical Policy (MP)/ Technology Assessment

BCBSMT Medical Policies (MPs) are based on current clinical principles and processes and provide a link between the philosophy of BCBSMT, its contracts and the reality of making informed decisions about quality medical care within the benefit structure of BCBSMT's coverage plans. Medical policies are evaluated at least annually or earlier if new data regarding indications or technologies becomes available.

MP development is initiated in response to new technologies or new applications of existing technologies, including behavioral healthcare procedures, medical procedures, pharmaceuticals, and devices. Data sources utilized for assessing new technologies or new uses for existing technologies include Blue Cross Blue Shield Association Medical Policy Reference Manual; independent review of peer reviewed scientific literature from a variety of sources; and review of government sponsored agencies or research bodies, such as, the Agency for Health Care Policy and Research (AHCPR), and the Food and Drug Administration (FDA).

Final approval of MPs by the Medical Policy Committee Medical Directors is required. Current and/or revised BCBSMT MPs are located on the BCBSMT Internet website for on-line access.

Clinical review staff use current, explicit and written BCBSMT MPs as guides to assist with benefit determinations regarding new technology, medical procedures, behavioral healthcare procedures, pharmaceuticals, and devices.

D. Utilization Management Process

1. Process Overview

Medical Management Preservice, Concurrent, Post Service/Retrospective Services: Utilization Management (UM) personnel are accessible to the member and provider community during business hours of 8:00 A.M to 5:00 P.M. Mountain Standard Time, Monday through Friday, except legal holidays. A confidential voicemail is available for after-hours messages. UM personnel reply to after-hours messages within one business day. Requests for health care services are reviewed and a determination made regarding the authorization or denial of those services within the timeframes based on the urgency of the member's condition as required by applicable law/regulation.

Requests not completed via the automated web platform for elective or emergent inpatient admissions, select outpatient services, coordinated home care/home infusion therapy (CHC/HIT) services and transplants are reviewed through the utilization review process. Emergency care services for screening and stabilization do not require prior authorization. Non-clinical UM intake staff may complete requests that meet the automated web platform approval guidelines for diagnoses and procedures that do not require clinician review. This is a clerical function to facilitate claims payment and is not based on medical necessity or use/consideration of clinical information.

Behavioral Health Care Management (BHCM) Services: The Program's Care Management (UM) services are accessible 24 hours a day, 7 days a week, and 365 days/year for all time zones for prior authorization requests by telephone. Members, professional providers and facilities may access the Behavioral Health Unit using a toll-free telephone number. Normal service hours are 7 am to 5 pm Mountain Standard Time, Monday through Friday.

After hours, clinicians and psychiatrists are available to provide emergency inpatient prior authorization. Members indicating that they require immediate medical assistance are referred to network providers (if network providers are not available, members will be referred to an appropriate out-of-network provider). BHCM does not perform clinical triage and referral of members. Members who are in crisis outside of normal service hours are immediately connected with a licensed Care Coordinator who will assist the member in directing them to the nearest emergency room or, when necessary, reaching out to emergency medical personnel (911) as appropriate.

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Policies and Procedures

All aspects of UM activities and operations are governed by written policies and procedures, which are maintained in the Plan UM Department. Program policies and procedures are formally reviewed and approved annually and as indicated when revised. Initial policy approval is issued by the Plan Policy and Procedure Committee, with final approval issued by the BCBSMT Quality Improvement Committee
(QIC) or the Behavioral Health Quality Improvement Committee (QIC), as applicable. Policies are developed to support ongoing compliance with all state/federal agency laws and accreditation organization standards.

The application of the ASAM, MCG care guidelines and BCBSMT Medical Policy by Utilization Management Coordinators (UMCs), Licensed Pharmacists, Behavioral Health Clinical Reviewers, Psychologists, and Physician Reviewers facilitate collection of the pertinent information required to review the request and determine the following:

- Medical necessity of the requested procedure/service;
- Appropriateness of the treatment setting and level of care;
- Appropriateness of the length of stay (including diagnosis related group [DRG] criteria);
- Appropriateness of the duration of service; and
- Assignment of the next anticipated review point.

Utilization Management Clinicians document and accept clinical information from multiple reliable sources for assistance in making coverage determinations. Sources include but are not limited to verbal information from physician, medical office and facility personnel as well as provider office and facility medical record information. This information is used to determine whether established clinical criteria is met for the requested service. The UMC/Clinical Reviewers may approve requests that meet established ASAM, MCG care guidelines and/or BCBSMT Medical Policy. A UMC or pharmacist may administratively deny requests if no medical records/clinical information has been received.

Requests that do not meet ASAM, MCG care guidelines, BCBSMT Medical Policy, and/or that are potential contract exclusions are referred to Physician Reviewers/

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Behavioral Health Physician Reviewers (or a Behavioral Health Psychologist when applicable) for determination unless the request is an absolute contract exclusion. A Physician Reviewer is available to UMCs, and Behavioral Health Physician Reviewers or Behavioral Health Psychologists discuss determinations based on medical appropriateness. All adverse determinations are communicated in writing to the member or authorized individual acting on behalf of the member and the member's provider of record, including the health care provider who requested the service. If members and/or providers are not satisfied with the outcome of the decision, they have the right to an appeal. Adverse determinations may only be determined by a physician or other health care provider with appropriate credentials to determine medical necessity or appropriateness, or the experimental or investigational nature of health care services.

Discharge Planning

Discharge planning is an ongoing essential part of utilization management processes. Discharge planning is the process of assessing a member's needs for appropriate and timely discharge. This process involves evaluation of the member's benefits, member and the member's family support of the discharge from the inpatient setting to home or to a less acute setting as well as the provider's assessment of the member's health care needs following discharge.

2. Referral Management

Utilization Management Coordinators (UMCs), Behavioral Health Clinical Reviewers, Psychologists, and Physician Reviewers/ Behavioral Health Physician Reviewers evaluate Out of Network (OON) referral requests for appropriateness. Requests for coverage of OON provider services at in network benefits may be evaluated when a member has a special circumstance in which the current health care treatment plan cannot be interrupted without disrupting the continuity of care and/or decreasing the quality of the outcome of that care or when circumstances under which the most appropriate treatment for the member's condition is not available In Network.

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3. Automated Web Platform Prior Authorization/Recommended Clinical Review (Predetermination) Notification Program

The automated web platform is utilized for submission and notification of referrals, and select inpatient admissions and outpatient services, twenty-four (24) hours a day, seven (7) days a week for network providers/facilities. Physicians and/or facility personnel may input data (such as diagnosis and procedure codes) and submit medical records to request a review for referrals and prior authorization/recommended clinical reviews (predeterminations). Customization of the automated web platform system allows vectoring of OON referrals, select inpatient prior authorizations and outpatient service requests which require further review, to the appropriate UM personnel.

4. Retrospective (Post Service) Review

A retrospective (post-service) utilization management review occurs after the service is rendered. During a post-service utilization management review, UM Clinicians review clinical documentation/information to determine whether a service, drug, procedure, treatment or test was medically necessary, was not experimental or investigational, and was covered under the member's benefit plan.

4. Appeals

Appeals are formal written or verbal requests for a review of an adverse determination, which includes denials, reduction of benefits, or termination of, or a failure to provide or make a payment (in whole or in part) for a service. Adverse determinations may be based on the lack of medical necessity for a service for a specific member, the experimental or investigational nature of a service, instances where a service is not a covered benefit (contract exclusion), or due to network exclusions or other limitations on otherwise covered benefits.

Appeal rights are provided at the time of the adverse determination notification and are available upon request to any member, or authorized representative of the member, which may include the provider or facility rendering service.

Requests for appeal may be initiated by telephone, fax or in writing. Appeals are accepted from the member, or authorized representative of the member which may include the provider or facility rendering service.

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E. Conflict of Interest

Policies and procedures have been established to ensure no conflict of interest occurs during case review. Plan physicians or non-physician reviewers may not review a case in which there may be a conflict of interest. Conflicts of interest may be either personal or financial in nature**.** Employees must review and sign the Conflict-of-Interest policy upon hire and annually thereafter.

F. Delegation of Review

Plans may elect to have prior authorization, concurrent review, retrospective review, referral management, appeals or discharge planning performed by another entity. If any UM activities are delegated, the entity must meet the following criteria:

- Comply with Plan Program Standards.
- Comply with all federal/state laws, regulatory and accrediting agency standards that provide certification/accreditation of the UM program.
- Allow oversight by UM personnel, including an annual assessment/audit.
- Provide regular reports of review and quality improvement activity as required.

Note: Delegation of utilization review (UR) activities shall not relieve the Plan of full responsibility for compliance with Department of Insurance regulations for utilization review agents, including the conduct of those to whom UR has been delegated. Delegation of UM Program shall not relieve the Plan of full responsibility for compliance with accreditation standards and/or federal/state regulatory requirements.

V. Confidentiality

Policies and procedures have been established to ensure the confidentiality of patient information. Internal policies on confidentiality are outlined in employee and management handbooks, corporate policy manual and Health Insurance Portability and Accountability Act (HIPAA) Privacy policies. Employees receive training upon hire and must also sign a confidentiality statement during corporate orientation and annually thereafter.

VI. UM Program Role in the Quality Improvement Program

The UM program is integrated with the Plan Quality Improvement Program and the BH UM program is integrated with the BH Quality Program, both of which promote objective monitoring and evaluation methods that are based on the use of both clinical and service indicators. The Quality Improvement Program oversees the following activities:

a. Quality of Clinical Care Projects
b. Quality of Service Projects
c. Safety of Clinical Care Projects
d. Member Experience Surveys
e. Primary Care Provider/Practitioner Surveys
f. UM Complaints
g. Utilization Data

Annually, the UM program Clinical and Service indicators and initiatives are evaluated based on outcomes and any federal/state regulatory changes.

VII. Provider/Practitioner/Member Education of UM Requirements and Member Beneficiary Health Plan Reference

There are multiple resources available to educate providers, practitioners and members on Utilization Review requirements. Having multiple modalities allows the provider, practitioner or member to engage in ways that are meaningful to them. Resources may include, but are not limited to:

Provider/Practitioner Education

Provider/Practitioner educational tools are developed to enhance provider knowledge of the UM Program and Utilization Review requirements. Education is provided by the following means:

- Educational programs;
- Quick reference guides;
- Newsletters and bulletins;
- Provider Manuals;
- Internet website which provides access to resources including BCBSMT Medical Policies, Utilization Management Prior Authorization Requirements; and
- Evidence based guidelines of care.

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Member Education

Member educational materials are developed to increase knowledge and encourage active participation when making informed decisions regarding health care options. Member educational materials include:

- Member guide/handbooks (Members rights and responsibilities);
- Health and wellness literature;
- Contract booklets (prior authorization requirements);
- Provider directories;
- Web-based education; and
- Internet website, including:
    - Utilization Review – Prior authorization and Recommended Clinical Review (Predetermination) information
    - Sample Policy Documents for Qualified Health Plans-On and Off Exchange, Standard Insured Plans, and Custom Large Group Plans are available at: https://www.bcbsmt.com/member/policy-forms/

Members with disabilities, special needs, and/or language barriers, and their authorized representatives, can request this information via alternate means or in another language.

VIII. UM Program Evaluation and Authority

The BCBSMT Chief Medical Officer (CMO), provides clinical supervision, oversight and participates in the development, implementation and evaluation of the Medical Management UM Program.

The Chief Medical Officer (CMO) Behavioral Health provides clinical oversight and participates in the development implementation and evaluation of the Behavioral Health UM Program.

The BCBSMT CMO, BCBSMT Policy & Procedure Committee, and BH QIC perform review and approval of the UM policies and procedures annually and when updates occur.

Utilization goals are established using recognized benchmarks and are approved by the designated BCBSMT QIC and BH QIC. Potential/actual trends of over/under utilization and interventions to improve utilization are reported to the BCBSMT QIC and BH QIC respectively. The QICs makes recommendations, as applicable and approve interventions to improve utilization trends.

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The UM Program Description is updated at least annually and approved by the BCBSMT CMO and the BCBSMT Quality Improvement Committee (QIC). The Behavioral Health Care Management Program Description is reviewed and approved by the Behavioral Health QIC at least annually.

Ultimate authority and oversight of the UM program for BCBSMT rests with the BCBSMTQIC.

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Attachment 1
Dental Utilization Review Program – Dental Network of America (DNoA)

A. CRITERIA

BCBSMT uses the following Criteria for its Utilization Review activities in general. Any entities to which BCBSMT delegates Utilization Review activities are required to use the same Criteria for BCBSMT business.
'BCBSMT business' means BCBSMT's fully-insured individual and group blocks of business and its third-party administrative services business.

- MCG Criteria for observation level of care and medical/surgical inpatient admission review, rehabilitation, sub-acute, long-term care reviews, and psychiatric care both inpatient and outpatient.
- BCBSMT Medical Policy. The complete BCBSMT Medical Policy Manual can be found on the web at www.bcbsmt.com.
- The American Society of Addiction Medicine (ASAM) Criteria is utilized as the behavioral health clinical screening criteria for patients with addiction disorders for all levels of care.
- Dental Policies, criteria from Dental Networks of America (DNoA) can be found at www.dnoa.com/claimsresources.htm.

B. DENTAL UTILIZATION REVIEW PROGRAM – DENTAL NETWORK OFAMERICA (DNOA)

PURPOSE

This Dental Network of America (DNoA) Utilization Review Plan shall define the policies, standards, criteria and procedures followed when processing and paying dental claims for and on behalf of BCBSMT.

RESPONSIBILITY

All dental claims processing personnel and dental consultants shall be required to follow these criteria and procedures.

UTILIZATION REVIEWAPPLICATION

Dental benefits are rendered by contracted and non-contracted dentists who are compensated for services on a fee-for-service basis. Even though dentists are not required to submit claims for

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Prior authorization of services, Utilization Review occurs both prospectively and retrospectively.

ADVERSE DETERMINATIONS

A decision to deny or partially deny a claim payment is an Adverse Determination. BCBSMT maintains appeal and review procedures for Members and providers who wish to appeal or dispute an Adverse Determination.

DENTALLY NECESSARY

Dentally Necessary services are services that are Medically Necessary and Appropriate for the diagnosis or treatment of a Member's dental condition according to accepted standards of dental practice and that are not provided only as a convenience. Most utilization decisions are limited to determinations of whether services are covered under the terms of the plan contract. Evidence of Coverage distributed to BCBSMT enrollees include a list of covered dental services, exclusions, limitations and other relevant information that define Member dental benefits. A denial or rejection of a Prior authorization or payment request in most instances indicates only that the service is either not a covered service or is subject to an exclusion and/or limitation. The determination is not intended to reflect any opinion of whether the service is medically/dentally required.

BCBSMT abides by applicable federal and state (Montana) laws and regulations concerning Utilization Review and Medical/Dental Necessity determinations. Medical/dental necessity decisions are made only by a dental consultant, who:

Is in possession of an active and unrestricted license to practice dentistry; and

Requests information relevant to the dental condition and bases decisions upon standards which are objective, valid and consistent with accepted professional standards for dentistry.

BCBSMT DENTAL RECOMMENDED CLINICAL REVIEW (PREDETERMINATON)

A Recommended Clinical Review (Predetermination) is recommended for some services to help providers and Members avoid unexpected expenses, benefit reductions, or claim denials. Coverage for Medically Necessary services, supplies, or treatment is determined through the recommended clinical review (predetermination) process. If a Recommended Clinical Review (Predetermination) is not obtained, a retrospective review is performed to determine whether the services, supplies, or treatment were Medically Necessary or were a benefit of the Member's contract.

Documentation Requirements

The Recommended Clinical Review (Predetermination) process may require additional documentation from the dental services provider for some services and should include:

- Pertinent documentation explaining the proposed services;

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- Functional aspects of the treatment;
- Projected outcome;
- Treatment plan and any other supporting documentation (e.g., study models, photographs, and x-rays); and
- Appropriate CDT codes.

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