KANSAS CITY LIFE

GROUP BENEFITS

POLICY AND PROCEDURES
UTILIZATION REVIEW POLICY

Subject: Utilization Review Policy	
Policy # D4.1	
Department: Dental Claim Accuracy	**Page**: 1 of 3
Effective Date: est. October 2006	**Last Revised**: 02/13/2024
Last Reviewed: 02/13/2024	**Approval Authority**: Dental Director

POLICY:

1. Cotiviti Utilization Review policies and procedures have been established to ensure consistent application of the dental claims analysis rules editor. This, along with review of flagged procedures by the Dental Analyst Coding Specialists and Licensed Professional Claim Specialist's, maximizes claims payment accuracy and validates correct procedure code submission. Utilization Review encompasses prospective, concurrent, and retrospective determinations.

2. Utilization Review Scope

a) Cotiviti collects the minimal necessary information, including pertinent clinical data, to make the utilization review determination.
b) All reviews as to the necessity or appropriateness of a service or procedure are reviewed by, or a determination made, in accordance with the guidelines approved by a licensed dentist/physician.
c) All appeals are conducted and evaluated by a clinical peer not involved in the initial or previous adverse determination.
d) Will make no decisions regarding the hiring, compensation, termination, promotion, or other similar matters of such clinical peers based on the likelihood that such peers will support the denial of benefits.
e) Are in state required compliance with time limits and notification processes for initial reviews (standard and expedited/urgent)
f) Certification determinations are not reversed based on existing documentation. Only when Cotiviti receives new information relevant and not available at the original determination.
g) Accepts information from any reliable source that will assist in the certification process;
h) Collects only the information necessary to certify the admission, procedure or treatment, frequency, or duration of services
i) Does not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;
j) Does not routinely request copies of all medical records on all patients reviewed;
k) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and

l) Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or providers.
m) Requests a review of all records on all patients. This shall not preclude a request for copies of relevant clinical records retrospectively for clinical review for several purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or utilization review provisions. Except for reviewing records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers shall be entitled to reimbursement for the reasonable direct costs of duplicating requested records.
n) Health care providers shall be entitled to reimbursement for the reasonable direct costs of duplicating requested records, unless specified in the contract between the health plan, URO, and provider.

Prospective and Concurrent Review Determinations

- For prospective and concurrent review, the organization bases review determinations solely on the medical information obtained by the organization at the time of the review determination.

Retrospective Review Determinations

- For retrospective review, Cotiviti bases review determinations solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

Lack of Information

Cotiviti implements policies and procedures to address situations in which it has insufficient information to conduct a review. Such policies and procedures provide for:

A) Procedural time limits that are appropriate to the clinical circumstances of the review (i.e., prospective, concurrent, retrospective reviews);
(b) Resolution of cases in which the necessary information is not provided to the organization within specified time limits; and
(c) Processes by which the organization issues an administrative non-certification due to lack of information.

3. Utilization Review Process

3.1 Cotiviti screens daily all dental claims (retrospective reviews) and pre-authorizations (prospective reviews) submitted in daily batch exports to Cotiviti by Client prior to payment to identify those claims that may be inconsistent with industry standards or with usual, customary, and reasonable billing and reimbursement methodology/claims payment, as well as Benefit Plan specifics. Cotiviti provides daily analytic services to include overpayment prevention identification. For each daily batch of processed dental claims or pre authorizations data provided by Client, Cotiviti reviews and process such data using Cotiviti's dental claims analysis system, as well as review by dental coding analysts under the direction of Cotiviti's licensed Dental Director and licensed dental consultants, to screen and review claims (after adjudication and immediately prior to payment) pre-authorizations and any appeals for claims on which Cotiviti has made payment recommendations (after adjudication, initial review and claim payment) for the following:

3.2 Claims or pre-authorizations that are incorrect or that are inconsistent with industry standards or inconsistent with usual, customary, and reasonable adjudication and reimbursement methodology; and;

3.3 Claims or pre-authorizations that are incorrect or inconsistent with Benefit Plan specifics, except that Cotiviti is not responsible for tracking benefit accumulator amounts or deductibles.

3.4 Cotiviti does not retrospectively deny pre- authorizations unless:

a) An authorization was based upon inaccurate information pertinent to the review; or

b) The health care services were not provided consistent with the provider's submitted plan of care and/or any restrictions included in the Cotiviti's prior authorization.

4. Professional Dental Claims/Pre-authorization Review

Cotiviti has a consulting staff of licensed Dental Professional claim specialists that perform Standard Professional Claim Review Services as requested by the Client. These Professional Review Services are inclusive in the comprehensive services provided to the client. The Client may direct Cotiviti to review all claims or pre-authorizations that include services from the standard comprehensive list of dental procedures that Cotiviti designates as the Standard Dental Professional Review Service List, or they may customize reviewed procedures to include or exclude dental services they designate.