Name:	Utilization Management Policy
Date of Origin:	10/23/2002
Current Effective Date:	2/17/2024
Scheduled Review Date:	2/17/2025

I. UTILIZATION MANAGEMENT POLICY

Capitol Dental Care (CDC) is committed to implementing effective utilization management practices by its staff and providers so that they can deliver quality dental care that is accessible, cost effective and serves Oregon's Triple Aim. In accordance with "best practices" CDC shall update its utilization management practices regularly as a result of internal and external changes that impact the dental plan, partner organizations, employees, and members.

II. UTILIZATION MANAGEMENT OVERVIEW

Utilization
The extent to which members use their benefits over a stated period of time; specifically measured as a percentage determined by dividing the number of covered members who have one or more paid claims by the total number of covered members. It is also an expression that represents the number, and types of services used by members over a specified period of time.

Utilization Management
The administrative practices of a dental plan in evaluating dental necessity, appropriateness of care based on accepted dental practices, utilization, quality, procedure code billing accuracy, level of service, and payment. Evaluation is both done on a member case-by-case basis by reviewing individual claims data and dental records and a population basis by identifying norms, trends, and outliers in utilization data.

Utilization Review System
An administrative system that examines the distribution of treatment procedures based on claims information. The system analyzes paid claims by various criteria such as dental provider, clinic, staff affiliated practice, specialty, panel provider, volume, geographic location, and category of services.

Utilization Management includes the evaluation of under and over utilization based on dental necessity, appropriateness, and efficiency of the use of health care services, procedures and facilities under the coverage provisions of the Oregon Health Plan.

Key Personnel engaged in CDC's Utilization Management are: CDC's Dental Director who shall have principal responsibility for overall utilization management implementation. In addition, the QI Committee, dental consultants, CDC's administrative staff, CDC's third party claims payer staff, CDC's Compliance Officer and the Executive Committee shall support the Dental Director

in program implementation All members of the Executive Staff Committee are members of the QI Committee. Decisions made by CDC are under the direct supervision of the Dental Director and other key personnel listed above. CDC makes most Utilization Management decisions within 2 - 4 weeks (unless an emergency – in which case it is handled immediately).

The evaluation of dental necessity, efficiency and appropriateness becomes an effort to confirm that instances of under- utilization or over-utilization are reduced to a minimum within the structure of dental plan benefits.

Underutilization is reflected by a lack of access to dental plan benefits, unreasonable scheduling time-frames and it can take the form of a provider selectively choosing to reduce or limit benefits the member is entitled to. These instances are unacceptable to CDC.

Overutilization is reflected by inefficiencies, both with respect to clinical practices and as well as with administrative aspects of a clinic or dental plan. For example, clinical over-utilization occurs where a provider intentionally reduces the delivery of preventive services to patients and focuses only on restorative care, or a clinician drills a tooth where the tooth has not yet decayed sufficiently to warrant the procedure. From an administrative standpoint, over-utilization can occur when a provider over utilizes services in order to secure higher levels of reimbursement, to the exclusion of other patients requiring fewer needs. It results in excess costs that otherwise would not be incurred, but for poor utilization of resources. Those costs can negatively impact the ability to serve the greatest number of members with the resources allocated.

While utilization management practices can positively/negatively affect the dental plan ultimately, it shall be the responsibility of CDC providers to ensure that any utilization policies and procedures are responsive to the individual needs of each member. While macro data is important, CDC's mission is to ensure that each and every member receives dental care consistent with the individual needs, and standards of care subject to OHP coverage guidelines.

CDC has determined that monitoring specific practices and processes of the delivery of care process will both reduce the risk of over-utilization and underutilization of services. To this end, CDC has established utilization criteria. Review of these criteria and the implementation of controls in response to deviations from this criteria, will ensure that members continue to receive quality of care.

These key utilization criteria are further discussed in section III below, and include:

- Focus on Preventive Services
- Provider Education
- Member Education
- Effective policies and procedures governing Prior Authorizations
- Effective policies and procedures to address Emergencies
- Partnership network that supports Special Needs Referrals
- Ongoing provider monitoring – underutilization.

III. UTILIZATION CRITERIA

Prevention Services

The QI Committee reviews data produced by CDC's administrative staff. The data captures both primary care and specialty providers with an emphasis on the delivery of preventive services consistent with the OHP guidelines. The QI Committee receives further input in this area from the CDC Dental Director and other staff as applicable.

Any unexpected outcomes are assessed by the QI Committee with further recommendations made by the QI Committee, as appropriate. The data in the quarterly utilization review is dentist-specific and allows for a comparative analysis of dentists to other dentists. On a case-by-case basis the data is shared with specific identified providers. If any issues arise, further action may be required such as requesting additional information from the provider, or implementing a monitoring protocol of a provider's data.

Corrective Action

In instances where the provider's practices and/or standards with respect to effective delivery of preventive services reflects poor utilization (over or under) the QI Committee will respond in writing to the provider within thirty (30) days of findings with appropriate recommendations. Simultaneously, the QI Committee will implement a follow-up monitoring protocol to confirm the provider has implemented into his or her practice the requested changes. The monitoring process will be reviewed for a period not to exceed ninety (90) days, at which point the QI Committee will re-evaluate the provider's progress. If it is determined that the provider has failed to implement the QI Committee's recommendations, the QI Committee will require the provider to appear at a closed-door session involving key personnel in CDC's Utilization management system to show cause why the Committee should not implement sanctions, as appropriate. If the provider agrees to renew his or her commitment to exercise "best practices" in utilization management, the QI Committee will postpone any sanctions for an additional ninety (90) days. During this period the Committee will randomly review a statistically relevant sample of providers' patients' records to confirm that appropriate practices have been implemented.

If, at the end of the second (90) day period, the provider has refused to implement the recommendations, the QI Committee will implement appropriate sanctions, including up to and including termination of the provider from the health plan. A provider's suspension for a period less than thirty (30) days for failure to implement effective preventive services for its members is not subject to appeal. A provider is entitled to certain appeal rights as provided in the Provider Manual for any sanction more severe than a one (1) month suspension.

In addition to the QI Committee's efforts, CDC has implemented an 'Action Plan' which includes prevention projects that focus on improved utilization for each calendar year.

Over and under-utilization monitoring is also reviewed in post payment review. As part of our routine QI activities a quarterly Utilization review is conducted of paid services for members. The review includes the top 20% general (based on volume) and 20% pediatric community panel

dentists based upon volume. It also includes separately the top 20% affiliated staff dentist providers and/or capitated dentist providers.

Provider Education
CDC has emphasized a treatment philosophy based on a foundation of preventive care involving a patient partnership between patient and dentist with the goal of improving a patient's oral health.

In an effort to ensure collaboration between provider and CDC all providers that request information on utilization protocols are provided the following:

- A description of the utilization profile methods used so dentists/hygienist can understand how their practices enhance utilization management.
- A dentist's personal utilization data within each code, so that he or she can verify the information and better understand utilization areas that may be subject to improvement
- A dentist's individual score (if one is assessed) according to the standards of the profile method used, and
- An explanation of how a dentist/hygienist utilization data compares with providers within the Plan

Member Education
Member education is important to appropriate utilization practices. CDC as applicable will send an oral health educational letter to a member and/or counsel him/her by phone to help the member gain a better understanding of the importance of effective oral health practices. The focus of this conversation/letter to the patient is the impact that good oral health practices (regular brushing, tobacco cessation, health diet) can have on the long term health of the patient.

For children and disabled adults, education is directed toward the parent/caretaker. Since accountability issues on the part of a parent or caretaker may exist for members that are minors or disabled, coverage of services is not dependent upon partnering. If it appears the parent/caretaker is unresponsive to the needs of the minor/disabled patient, CDC will notify the caseworker as part of its push for integration of behavioral and dental services and ask for further educational/clinical assistance from providers outside the dental profession.

Prior Authorizations
Effective policy and procedures are in place to ensure that CDC's administrative and clinical staff follow OHP guidelines requiring Prior Authorization for designated treatments or services. The Dental Reviewer reviews Prior Authorizations and Referrals on a weekly basis and considers over or under-utilization factors in all PA and Referral requests. In addition, over and under- utilization is reviewed as part of claims processing when evaluating for payment. Consistent with "best practices" CDC, from, time to time, utilizes a second Dental Reviewer to review the decision making process of the primary Dental Reviewer.

Emergency Services
Emergency Services is an area of the delivery of care model where the Plan must pay particular

attention to utilization. While the Plan provides that members have a right to coverage for emergency care, this care is to be limited to actual emergencies. CDC regularly monitors and reports quarterly to CCOs and OHA encounters involving members that have visited an Emergency Department for other than emergency care. In all cases where this has occurred, CDC contacts the member by phone and/or letter and communicates to the member the OHP guidelines governing when a member is eligible for dental care within an emergency setting. In addition, CDC confirms that the member has an identified a Primary Care Dentist and reminds the member that it is the PCD that is to be contacted in matters involving urgent care. The Member Guide distributed to all members provides educational information on how and when to access emergency dental services.

CDC is contracted with the Premanage vendor. We are using a dental word search to identify members who have gone to the emergency for a non-emergent dental condition. CDC is working with many of our partner coordinated care organizations (CCOs) in case managing members via our direct use of Pre-manage or by working a list sent to us by the CCO that identifies members who have had a dental emergency room encounter.

Frequently Changed PCDs

An additional factor leading to inappropriate utilization by a member is frequently changing PCDs. The risk of frequent changing of PCD is redundancy of services that occur when a provider, unable to obtain recent x-rays/patient chart is required to perform additional treatments and/or services beyond Plan guidelines. CDC has a policy that a member cannot change PCDs more than 1 time in a year. Once a member changes a PCD, a letter is sent informing the member that he/she is locked into his or her most recent PCD relationship, and that any further changes require the approval of CDC's dental director.

CDC actively identifies and monitors members who may be changing their PCD frequently. Often, these members qualify as high-utilizing members. In cases of high-utilizer members, CDC may require that all non-emergency services receive prior authorization. CDC will work collaboratively with the CCO to confirm that no other issues (behavioral) exist that may exacerbate utilization beyond what is appropriate.

Special Needs Referrals

CDC participates in a joint venture with Exceptional Needs Dentistry Services (ENDS) to ensure that our members with special needs receive quality of care in the most efficient means possible. An effective utilization practice involves the ability of CDC to transition special needs members to the appropriately skilled GP or specialist. We accomplish this through our relationship with the ENDS team.

The ENDS Board meets quarterly and, in addition to general administrative activities, also functions as a QI Committee. Each of the dental care organizations that participate in the ENDS venture receives a plan-specific quarterly utilization data. CDC reviews the data for over and under-utilization trends, with a special emphasis on prevention services. Any unexpected outcomes would be discussed at the ENDS Board meeting, or by CDC's QI Committee. Plan-

specific hospital dentistry data is reviewed at each quarterly Board meeting and is reflected in the minutes. END's Dental Director's clinical expertise is available when needed in analyzing information under review.

The review conducted by ENDS includes Phase 2 member prevention services for adults and children, specialty services, including any relationship to adverse or unexpected outcomes. Any adverse outcomes are noted with specific focus on members who are Aged, Blind, Disabled, or Children receiving SOSCF or OYA Services. ENDS has its own internal protocol should it determine that its specialized providers are practicing in ways that do not reflect effective utilization management.

CDC members also receive educational information regarding how to access special needs dental care. CDC's process for assisting a member with risk factor(s) is to gather information based on a set template. This template assesses needs, and then matches the member to the best fit for the delivery of the service within our system.

The Policy and Procedures for Referrals to Specialist Care, Consultations, Alternate Care Settings, and Hospitals further explains CDC's policy and procedures for referrals. CDC's process for assisting a member with risk factor(s) is to gather information to assess the member's health and then match the member to the best fit for the delivery of the service within our system.

Monitoring Over- and Underutilization

CDC has a 'Monitoring Plan" in place which identifies ongoing monitoring activities to measure over and under-utilization. While all aspects of the delivery system are monitored, monitoring of potential under-utilization is particularly important to ensure that patients receive all the plan benefits they are entitled to.

Key areas in which CDC monitors for under-utilization, include access and capacity monitoring; cultural/transportation barriers to care; and reasonable scheduling timeframes between initial call and 1st encounter based on OHP guidelines.

Monitoring of providers to confirm no deviations from accepted practices. Such deviations may indicate providers are reducing or limiting medically necessary services or may be disinclined to serve a particular member demographic. This monitoring may, but is not necessarily limited to, a review of

A selected group of general dentist providers to confirm that treatments and services provided to OHP members represent the full spectrum of preventive services and restorative care based on past data averages and are not skewed one way or another in the absence of clinical justification.

Selected audit of providers to ensure that general practice dentists are not billing excessively for services that typically would be billed by a specialist. E.g. a high level of surgical extraction procedures billed by a general dentist that would typically perform only simple extractions may

indicate unnecessary medical care.

Evidence that member encounters (for those members of a particular ethnic make-up) at a particular provider clinic (or within a designated region) fall far below expected averages may indicate a provider is disinclined to serve that member demographic. Alternatively, it may indicate the need for improved outreach efforts on the part of CDC to better convey plan benefits to a particular membership base.

Monitoring Review takes various forms and includes a review of specified procedure codes billed. Those codes are categorized into 8 levels or types of service. Level 1 - emergency care; Level 2 - preventive care; Level 3 – secondary care; Level 4 limited rehabilitation; Level 5 - rehabilitation; Level 6 – complex rehabilitation; Level 10 exclusions; and Level 11 - hospital. The report itself can provide a more detailed description of the procedure codes included in the levels.

IV. REVISION ACTIVITY

Modification Date	Change or Revision and Rationale	Effective Date of Policy Change
4/15/2005	Annual Update/Review	4/15/2005
10/1/2006	Annual Update/Review	10/1/2006
12/13/2007	Annual Update/Review	12/13/2007
2/24/2010	Bi-annual Update/Review	2/24/2010
6/28/2012	Bi-annual Update/Review	6/28/2012
10/22/2014	Bi-annual Update/Review	10/22/2014
12/14/2016	Bi-annual Update/Review	12/14/2016
12/13/2018	Bi-annual Update/Review	12/13/2018
12/13/2020	Review	12/13/2020
2/16/2022	Review	2/16/2022
2/15/2023	Review	2/15/2023
2/17/2024	Review	2/17/2024

V. AFFECTED DEPARTMENTS

All CDC Staff and Providers

VI. REFERENCES

CDC Policies and Procedures
CDC Access Plan
CDC Pre-Authorization Plan
Policies for Specialist Care
CDC Referral Policy
Emergency Policy