2020
Utilization Management Program Description

Of

Dental Benefit Providers, Inc.

For Utilization Review Licenses

SECTION A – INTRODUCTION, MISSION, OBJECTIVES AND SCOPE

This summary of the Utilization Management Program Description ("UMPD") summarizes the philosophy, structure and standards that govern medical management and utilization review responsibilities and functions and provides a structure to monitor the efficiency and quality of intake and prior authorization services. Dental Benefit Providers, Inc. ("DBP") is an organization that conducts or arranges for the provision of UM activities for dental products, including those offered by the following United business segments: Employer and Individual (E&I) including Marketplace, Medicare and Retirement (M&R) and Community and State (C&S). Legal entity, state, product and client specific addenda and operational policies and procedures detailing processes and staff responsibilities supplement this description and further explain specific program implementation.

I. UTILIZATION REVIEW

Utilization Review (UR) activities are supported by evidence–based, nationally recognized dental policies, clinical guidelines and criteria. These policies, guidelines and criteria promote delivery of appropriate care in the most appropriate setting at the appropriate time. Dental directors and staff work closely with providers to optimize health care outcomes.

II. MISSION AND SCOPE

The UM program provides a structure to monitor and facilitate the delivery of high quality, individualized care to program participants. The program includes end-to-end processes such as:

- Intake/Notification
- Prior Authorization/Prospective/Pre-Service Review/Clinical Coverage Review
- Letter Management Program
- Post-Service Review
- Dental Technology Assessment Reviews
- External Review Services
- Provider Consultation
- Clinical Appeals/Quality of Care/Peer Review

III. OBJECTIVES

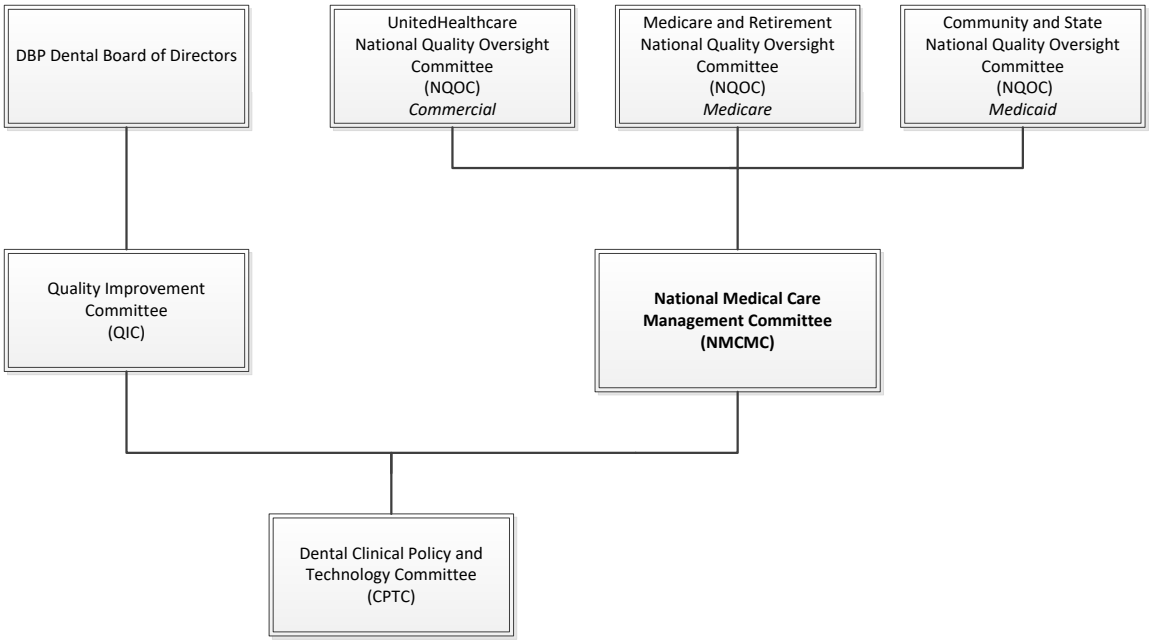
Program-focused objectives are to:

- Provide appropriate training and development opportunities to UM Staff:
- Standardize the implementation of the UM Program:
- Monitor staff and vendor participation in inter-rater reliability testing and evaluate/address outcomes:
- Monitor and evaluate the efficiency and effectiveness of processes through analysis and review of various metrics, including but not limited to timeliness and accuracy of decision-making, communication of decisions and satisfaction with UM processes and
- Maintain compliance with applicable laws, regulations and accreditation requirements.

SECTION B – PROGRAM STRUCTURE

IV. QUALITY OVERSIGHT COMMITTEE STRUCTURE

The UM program activities are monitored through the UnitedHealthcare National Quality Oversight Committee structure for commercial business, the Community and State National Quality Oversight Committee for Medicaid and the Medicare and Retirement National Quality Oversight Committee structure for Medicare business and other committees described below.



V. DESCRIPTION OF COMMITTEES

National Medical Care Management Committee (NMCMC)

The National Medical Care Management Committee (NMCMC), with input from senior physicians and Regional Chief Medical Officers is responsible for overseeing the development, implementation and evaluation of the UM Program. The E&I, M&R and C&S National Quality Oversight Committees have delegated NMCMC the authority to approve the UMPD. Functions of the NMCMC include, but are not limited to, the following:

- Review and approval of the Utilization Management Program Description (UMPD) on an ongoing basis and no less than annually;
- Oversee implementation of the UM Program;
- Evaluation of the UM Program, no less than annually;
- Review and approval for the dental criteria and guidelines recommended by the Dental Clinical Policy and Technology Committee;
- Approve UCS UM/UR operational policies
- Oversight of the activities of the Document Oversight Committee, which recommends UR operational policies that impact multiple departments and approves UR functional area procedural documents;
- Promote compliance with regulatory and accreditation requirements, including oversight of market conduct corrective actions, as applicable;
- Monitor and evaluate call center metrics, denial rates, clinical appeals including top clinical diagnosis, overturn rates, and overturn reasons, consumer concerns about the UM/UR process; inter-rater reliability testing, under and over utilization and satisfaction with UM/UR processes;
- Provide feedback and recommendations to the UM/UR process and UM quality improvement activities.

The NMCMC meets quarterly but may convene on a more frequent basis, as needed. The NMCMC reports to the E&I, M&R and C&S National Quality Oversight Committees.

Dental Clinical Policy and Technology Committee (CPTC)

The Dental Clinical Policy and Technology Committee (CPTC) is responsible for:

- Providing evidence-based position statements on selected medical technologies;
- Assessing the evidence supporting new and emerging technologies;
- Reviewing externally licensed guidelines;
- Considering and incorporating nationally accepted consensus statements into the establishment of national standards for the program;
- Monitoring for consistent clinical decisions regarding the safety and efficacy of medical care;
- Managing Dental Policy development and adoption.

Quality Improvement Committee (QIC)

The Dental Board of Directors delegates authority to coordinate and monitor the functions of quality improvement, utilization management, credentialing, members' rights, dental records and preventive health services throughout the network and with oversight to the Quality Improvement Committee. This committee provides summary reports to the Board of Directors on all QI activities quarterly.

The QIC meets quarterly but may convene on a more frequent basis as required for expedited review. Minutes are taken at each meeting and kept on file in Dental Quality Management Department. The Chairperson will certify the minutes.

The activities of the Quality Improvement Committee are:

- Determine what Quality Improvement projects or activities to undertake;
- Design, oversee and evaluate the Quality Improvement activities including dental health management programs for multiple lines of business;
- Endorse performance benchmarks and goals;
- Receive reports from committees including the Clinical Affairs Committee, the Clinical Policy & Technology Committee, Peer Review Committee, or Credentialing Committee;
- Approve action plans and follow-up to ensure actions are effective;
- Review reports of network-wide quality measurements, including annual Satisfaction Survey Reports, and identify opportunities for improvement;
- Receive reports on patient care indicators;
- Conduct annual review of quality improvement effectiveness; and
- Oversee all survey data and action plans that result from those surveys.

The UM program strategy, initiatives, metrics and outcomes are monitored through the QIC. The goal of this quality oversight committee is to provide a consistent and structured process for monitoring program activities, analyzing data and identifying opportunities to improve the effectiveness and efficiency of processes.

SECTION C – PROGRAMS, REVIEWS & SERVICES

VI. DESCRIPTION OF PROGRAMS

Intake

Intake is defined as receipt of communication from the provider/ /consumer advising of planned and unplanned services as required by provider contract or member benefit plan. The Intake process supports varied administrative processes within DBP including prior authorization. Intake

involves obtaining member demographic information, provider identifying information, requested services, and network status of providers. This information is used to build a case file related to the specific planned service and individual cases are distributed further to the Delegated UR Agent for utilization review

Clinical Review – Overall Process

1. DBP or its delegated UR Agent receives a request for dental services or claim for payment on a standard ADA claim form along with certain supporting documentation including:
    A. The member's name and address.
    B. The name, address, state license number of the dentist providing the dental services.
    C. Relevant patient history.
    D. Identity of the tooth or site and the problem including the type of tooth damage, presenting condition and diagnosis.
    E. Current treatment plan and dental procedures using current ADA CDT codes.
    F. Provider's dental notes/narrative, x-rays, or other clinical documentation, as may be reasonably required.

2. The claim information is entered into the DBP and/or its delegated UR Agent's system.

3. The claim and supporting documentation are made available to the utilization review department for assignment to the appropriate delegated UR Agent.

4. The claim is reviewed using the Clinical Criteria Review Standards. A determination to authorize non-emergency services, modify or deny services will be made within two (2) working days of receipt of the information necessary to make the recommendation. Upon reaching the adjudication decision, DBP's delegated UR Agent will update the UR system. The DBP claims processor will enter the decision into Facets, (DBP claims management system) and issue an Explanation of Benefits (EOB). DBP or its delegated UR Agent will generate the appropriate notification letter as prescribed by state or federal law, statute or act or the plan.

5. Notice of adverse determination letter, if prescribed by state or federal law, statute or act, will include the following:
    A. The principal, specific reason for any adverse determination;
    B. A description of the procedure for the appeal process by which an member or provider of record may appeal the adverse determination;
    C. Internal appeals address, telephone and facsimile numbers to initiate the appeal process; and
    D. Information on the external appeals process and related contact information, as applicable; and
    E. Internal appeals address to submit a request to obtain UM criteria used for any adverse determination.

6. All clinical guidelines and review criteria for the review of claims are established by Dental Benefit Providers, Inc. as approved by its Clinical Policy and Technology, and Clinical Affairs Committees.

Prospective/Pre-Service Review – Process

Prospective or pre-service review is defined as an administrative or clinical review. The basic elements of pre-service review include eligibility verification, benefit interpretation and may

include review of medical necessity and appropriateness of care for making UR determinations are conducted by clinicians.

Prior Authorization – Process

Medical necessity determinations may be made for specific entities that require the process within their contract, Certificate of Coverage or Summary Plan Description. Prior Authorization is defined as a prior assessment that based on the information provided, proposed services meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the provisions of the applicable health benefits plan. Licensed Dentists use applicable benefit plan documents, evidence-based medical policy, standardized coverage determination guidelines Notice of all review determinations is communicated in accordance with applicable state or federal requirements.

Post-Service Review – Process

Post-service review assesses the appropriateness of dental services on a case-by-case or aggregate basis after the service has been provided but prior to payment of services. Post-service review is conducted by clinical staff based on established review guidelines and includes:

- Review of medical necessity
- Identifying claims issues.
- Eligibility determination.
- Initiation of appropriate follow-up actions for utilization and quality issues.

Dental Technology Assessment Reviews

The Dental Policies Team completes dental technology assessment reviews for current, new and emerging technologies in the form of dental policies. Content is prepared using best available clinical evidence and is approved by the Dental Clinical Policy and Technology Committee (CPTC).

The Dental CPTC reviews clinical information that is needed to support the use of benefit documents used to make coverage determinations and also review clinical information that is used to support clinical programs required for accreditation or regulatory compliance. Evaluation of clinical evidence and development of policies occurs in a consistent and timely manner in order to assist with the provision of safe and effective services for all enrollees.

The review of clinical guidelines defines the process used for review of locally developed or nationally recognized clinical guidelines by the CPTC. It describes the operational procedures for deciding when a local or nationally recognized clinical guideline is needed, and for moving the identified topic through the steps necessary for review, acceptance and adoption.

The Dental CPTC makes recommendations to be used in development of standards by providing:

- Evidence-based position statement on selected dental technologies
- Assessment of the evidence supporting new and emerging technologies
- Review of externally licensed guidelines for clinical accuracy
- Assessments of the evidence supporting disease specific guidelines

SECTION D – DEPARTMENTAL ROLES & RESPONSIBILITIES

VII. Departmental Resources

The staffing model that supports the UMPD consists of clinical, non-clinical, and administrative personnel. Distinct job functions, with defined roles, responsibilities, and accountabilities have been developed. The Program ensures that all providers hold active unrestricted licenses. Peer clinical reviewers have an active unrestricted license as well as education, training or professional experience in dental or clinical practice that is appropriate to render a clinical opinion for the conditions, procedures and treatment that will be reviewed. Licensure specialty and jurisdiction of issuance follow state and federal specific requirements as outlined under Policies DBP UCSMM 02 10 Staff Qualifications and Credentials and DBP UCSMM 02 13 Senior Leadership.

- Vice President,Enterprise Clinical Services Dental Operations: Provides overall clinical leadership and supervision of medical policy, compliance, regulatory affairs and technology assessment.
- Dental Director UM-UR/G&A, Enterprise Clinical Services: Responsible for the clinical leadership of the Dental Team, UR functions based on medical necessity, ensuring integrity of functional areas for compliance with state and federal requirements, ensuring Affordability on behalf of members and providers through innovative Quality / Utilization Management and clinical product solutions and for the ongoing review and evaluation of programs related to Qualtiy of Care and Service
- Chief Dental Officer: Responsible for driving strategic priorities, advancing Network transformation and supports clinical policy.
- Quality Assurance Director: Responsible for the ongoing review and evaluation of related to Quality Programs
- Dental Clinical Operations Director: Responsible for UR functions for business based on medical necessity, including prospective/pre-service decisions and ensuring compliance with state and federal requirements.

STAFF RESOURCES

Intake/Pre-Service
Intake Coordinators and Pre-Service staff are non-clinical staff members who receive the initial review request/notification and may perform initial screening of certain emergent or scheduled services identified by Summary Plan Descriptions, Evidence of Coverage or Certificates of Coverage prior to dental services being rendered. They are also responsible for opening a case in DBP's and/or Delegated UR Agent's System with basic information.

Clinical Review
DBP delegates utilization review of claims and prior authorizations to a third party, unaffiliated utilization review agent. The Delegated UR Agent supports the review of determining clinical coverage for services in accordance to client benefit programs and clinical criteria guidelines.

All denials for coverage decisions are made by licensed dentists in good standing with unrestricted licenses. Notice of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements.

Non-clinical Staff
Staff Members who do not possess a dental license, but are trained to receive review requests or to review cases for covered dental services.

SECTION E – SERVICE INITIATIVES/PATIENT SAFETY

VIII. CLINICAL REVIEW CRITERIA

Clinical Staff utilize the National Standard Commercial Dental Claims Utilization Review Criteria which dictates appropriate levels of care. Application of clinical review criteria is integral to the process of clinical coverage review and UR. Clinical coverage decisions are based on the eligibility of the member, state and federal mandates, the member's certificate of coverage, evidence of coverage or summary plan description and dental policy, dental technology assessment information, and other evidenced-based clinical literature. Clinical review criteria are located in the Knowledge Library, an internal web-based resource, and on a fully licensed internet based site that is available to all clinical staff. Internal clinical review criteria are developed with review and input from appropriate providers and are based on current clinical principles and processes and evidence based practices. The clinical review criteria are reviewed, evaluated and approved on an annual basis with updates by the Dental Clinical Policy and Technology Committee.

The Dental Clinical Policy and Technology Committee (CPTC) makes clinical recommendations focusing on practice guidelines and new technologies, based on principles of evidence based dentistry. The Committee consists of internal clinical and non-clinical staff as well as participating network dentists representing a range of dental specialties and geographic areas. Historically, Committee recommendations have served a range of functions including support for UM Clinical Review Guidelines, claim review criteria, new clinical products and programs such as our medical-dental integration program Bridge2Health, benefit recommendations, member education and Marketing/Public Relations materials. Committee recommendations have been disseminated internally as well as to network dentists through communications outlets such as the provider newsletter and provider manual.

IX. APPEALS

The United Appeals & Grievances Unit manages appeal requests for UHC E&I, M&R and C&S lines of business. Operational Policies and procedures describe the specific processes involved with appeals; for example, required turnaround times, administrative requirements, letter content, and reviewer requirements. All processes meet Department of Labor (DoL) regulations. State laws are followed if they are more stringent than the DoL regulations.

Affiliated health plans manage appeal requests for their commercial businesses as described in their individual UM Program Descriptions. Appeals for UHC medical government programs are managed under a separate process within their Appeals & Grievances that is compliant with applicable Medicare and Medicaid requirements.

Clinical input into the appeal process is provided by Dental Directors in the clinical Appeals and Grievance division. Decision makers are distinct from those making initial adverse determinations.

X. PROCESS IMPROVEMENT

Process improvement is a structured, disciplined approach to maintain consistent application of UM processes. It is designed to provide objective and systematic assessment of the programs by measuring the adherence to policies and procedures, licensing/regulatory standards and customer services. Effective implementation of the UMPD is overseen by the National Medical Care Management Committee. The program includes:

- Inter-rater reliability assessments;
- Provider surveys conducted by an external vendor;
- Participation in activities to meet regulatory requirements; and
- Development of targeted, relevant action plans for continuous process improvement activities

Dental directors, who are responsible for determinations, both benefit coverage determinations and medical necessity; participate in inter-rater reliability exercises, no less than annually, to ensure that benefit document language and clinical review criteria are being applied in a consistent manner. Results for inter-rater reliability programs are monitored and tracked for coaching opportunities.

SECTION F - ACCOUNTABILITY

XI. Measurement and Reporting

Measurement and Reporting is designed to support the operational and regulatory requirements. Reporting includes clinical, operational and key performance metrics to ensure a comprehensive and balanced value approach.

Key performance indicators are monitored that reflect the impact of the program activities for UCS, within the business segments. Measures include, but are not limited to:

- Timeliness of decision-making,
- Notification of decisions,
- Communication regarding MM/UM/UR activities with providers and members/enrollees, as applicable,
- Under and over utilization, and
- Satisfaction with UM/UR processes

When possible, data is collected centrally and systematically from the systems. Some selected process measures may be collected at the local level. Self-reported measures are subject to audit. The entire process is structured to ensure that consistent methodology and appropriate interpretation of data are achieved.

XII. DELEGATION OF UTILIZATION REVIEW FUNCTIONS

When Utilization Management activities are delegated to another organization, an evaluation of the organization's capacity to perform the proposed delegated activities is performed prior to entering into a delegation agreement. This pre-delegation evaluation may include, but are not limited to:

- The formal, written agreement or description of delegated activities;
- The delegated organization's UMPD and related policies and procedures;
- The delegated organization's annual UM Evaluation; and
- Activity reports, files and other relevant documentation, as applicable.

The delegated organization's ongoing ability to perform delegated activities is evaluated at least annually. Reports of selected activities are reviewed on a periodic basis. As applicable, opportunities to improve performance are monitored on a regular basis. The delegation oversight

sits within UnitedHealthcare Networks (UHN) and there are regional committees which meet on a quarterly basis and to review current delegated entities and any corrective action plans.

XIII. CONFIDENTIALITY

The UMPD is designed to comply with the policies of UHG related to Ethics and Integrity. Through application of the policies related to Privacy, the Program seeks to retain the trust and respect of our customers and the public in handling of private information including health, financial, and other personal information in the conduct of our activities.

All employees, contracting practitioners/providers and agents of UnitedHealth Group are required to maintain the confidentiality of protected health information, including member demographic information, medical records, peer review and quality improvement records. All information used for UM activities is maintained as confidential in accordance with federal and state laws and regulations, including HIPAA Privacy requirements. Reasonable efforts are made to limit access to protected health information and other personal information to the minimum necessary to conduct operations.

XIV. SPECIALTY BENEFITS

Dental
The UHC UM Program collaborates with UHC Specialty Benefits to ensure compliance with all federal and state UM/UR regulations. The UHC UM staff provides legislative research, maintains and updates operational policies, and reviews letters to confirm the contents comply with regulations.

XV. CONFLICT OF INTEREST

All employees are prohibited from engaging in any activities that conflict with the responsibilities of the company or may be used for personal gain. Employees received information and training on conflict of interest upon hire, and must disclose any real or potential conflicts of interest to the company. If the company does not waive conflict of interest, employees must eliminate the conflict or resign their position within the company.

XVI. FINANCIAL COMPENSATION

Financial compensation plans for professionals who make utilization decisions are not based on the quantity or types of adverse decisions rendered and do not contain incentives, direct or indirect, for any type of UR decision. Financial incentives for clinical decision-makers do not encourage decisions that result in under or over utilization of care or service.

XVII. ANNUAL EVALUATION

An annual evaluation (the “UM Evaluation”) of the UM Program is conducted to ensure that it remains current and appropriate. The UM Evaluation reviews the program structure, the program scope, and member and practitioner experience data. Each year, staff representatives from areas performing key UM functions participate in a collaborative effort to complete the UM Evaluation. These include Intake/Notification, Prospective and Retrospective Turn-Around Time, Clinical Appeals, Operational Projects, and Quality/Accreditation. Recommendations from senior UM leadership, are also incorporated. The UM Evaluation is then presented to the QIC for final review and approval. Based on the final UM Evaluation, appropriate revisions to the UM Program Description are made for the following year.