Policy: **Medical Necessity Review – Arkansas**

Date of Implementation: **February 4, 2004**

Product: **Specialty**

DEFINITIONS:

Credentialed Practitioner – A credentialed practitioner is an employee, independent contractor or is associated with a contracted provider in some way and in some instances; a contracted provider may be a credentialed practitioner. A credentialed practitioner is a practitioner who has been credentialed with ASH and is duly licensed, registered or certified, as required, in the state in which services are provided.

Contracted Practitioner – A contracted practitioner is a practitioner of health care services, a group practice, or a professional corporation which or who has both been credentialed by and contracted with ASH for the purpose of rendering professional services that are widely accepted, evidence based, and best clinical practice within the scope of the contracted practitioner's professional licensure.

Contracted Provider – A contracted provider is any legal entity that (1) has contracted with ASH for the provision of services to members; (2) operates facilities at which services are provided; (3) is a credentialed practitioner or employs or contracts with credentialed practitioners.

Member **-** A member or a member's authorized representative, and a practitioner or facility, if the practitioner or facility is acting on behalf of the member and with the member's written consent, collectively referred to as the "Member" throughout this policy.

Adverse Benefit Determination – A declination (which includes a denial, reduction, or termination of, or a failure to make partial or whole payment) for a benefit, including any such declination for that plan.

Additionally, with respect to group health plans, a declination for a benefit resulting from the application of any medical necessity review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

OVERVIEW

Medical necessity review determinations are based on professionally recognized standards of care and are made by appropriately trained, peer clinical quality evaluators or Arkansas-

licensed physicians (MD/DO), as applicable, who work within their scope of practice. These determinations include verification of medical necessity, assessment of quality of care, evaluation of appropriate levels of care, and coordination and provision of alternate care. Clinical quality evaluators maintain an active, unrestricted license, certificate, or registration in their specialty in a state or territory of the United States, with professional education, training, and experience commensurate with the clinical service evaluations they conduct. Unless expressly allowed by state or federal laws or regulations, clinical quality evaluators are located in a state or territory of the United States when evaluating a medical necessity review determination.

Clinical quality evaluators report either directly to, or through their clinical Team Manager, to the Senior Vice President, Clinical Services, the Senior Vice President, Rehab Services, or a Senior Medical Director. The Senior Vice President, Clinical Services, Senior Vice President, Rehab Services and Senior Medical Directors are responsible for the oversight of clinical operations, clinical staffing and training, and clinical decision-making processes and procedures by the clinical review staff. The Senior Vice President, Clinical Services, Senior Vice President, Rehab Services and Senior Medical Directors ensure that clinical review staff are qualified to render a clinical opinion about the medical condition, treatment and procedures under their review.

All submitted treatment/services for evaluation and verification of medical necessity are processed according to approved policies and procedures. American Specialty Health – Specialty (ASH) Clinical Practice Guidelines used to support determinations are available to practitioners and members at ASH's website or upon request.

Practitioners are assigned to a team of clinical quality evaluators who evaluate submissions for treatment/services. This promotes consistent dialogue between the clinical quality evaluators and the practitioners. Clinical quality evaluators become familiar with practitioner practice patterns and may identify opportunities for improvement.

Practitioners have the opportunity to contact their clinical quality evaluation management team and/or Arkansas-licensed physicians (MD/DO) at any time during normal operating hours to discuss service evaluation determinations, including clinical adverse benefit determinations.

The name, telephone number, and telephone extension of the clinical quality evaluator or Arkansas-licensed physicians (MD/DO) who made the actual determination is included in the communication of the determination to the practitioner. In the event of a pre-service adverse benefit determination, the written notice shall identify each state in which the Arkansas-licensed physician (MD/DO), is licensed and the license number issued by each state . Practitioners are encouraged to contact that clinical quality evaluator to discuss clinical services issues related to the determination.

Practitioners are ensured independence and impartiality in making referral decisions that will not influence:

- Hiring
- Compensation
- Termination
- Promotion, or
- Any other similar matters

ASH clinical quality evaluators are not permitted to interfere with the referral process as it relates to patient care.

Pre-certification

Pre-certification (mandatory pre-service medical necessity verification) may be required for certain services under applicable client benefit plans or as required by state law. Pre-certification determinations are made by appropriately trained clinical personnel relying on professionally recognized standards of care and current evidence-based criteria. At this time, there are no programs that require pre-certification in the state of Arkansas.

MEDICAL NECESSITY REVIEW

Members have direct access to credentialed practitioners for treatment/services unless benefit design, client agreements, state mandates, and/or regulatory requirements necessitate a referral.

Evaluation of Medical Necessity of Treatment/Services

ASH maintains a Clinical Performance System (CPS) that defines the appropriate level of quality and clinical services oversight required for each practitioner based on both clinical and administrative criteria. Depending on contractual arrangement, a practitioner performance evaluation may allow the practitioner to render certain treatment/services to members without submitting those treatment/services and appropriate documentation to ASH for verification of medical necessity. If the member requires more treatment/services than are available within the applicable tier level, a Medical Necessity Review Form (MNR Form) must be submitted for verification of medical necessity of those additional treatment/services by a clinical quality evaluator.

Clinical quality evaluators evaluate the relevant member and clinical information submitted on MNR Forms to verify the medical necessity of submitted treatment/services. The clinical quality evaluators follow approved clinical practice guidelines and criteria when determining the medical necessity of submitted treatment/services and will accept information from any reasonably reliable source that will assist in the evaluation process. If a submitted treatment/service is exceptionally specialized, ASH will consult with specialists in the identified area of expertise to assist in the evaluation. In such cases where the consultation is done by a MD/DO, the expert reviewer will hold applicable board

certification. ASH will provide the identity of the expert reviewer to the member upon request.

There are no financial or other incentives paid to clinical quality evaluators or expert reviewers that encourage decisions resulting in under-utilization. ASH does not make decisions regarding hiring, promoting or terminating clinical quality evaluators or other individuals based on the likelihood or perceived likelihood that the clinical quality evaluators or other individuals would support or tend to support the denial of benefits.

Providers/practitioners are paid on a contracted fee-for-service basis and do not receive financial or other incentives that result in under-utilization.

ASH recommends that the provider/practitioner submit required MNR Forms within three (3) days of the date(s) of service; however, forms must be submitted no more than 180 calendar days from the date(s) of service. The provider/practitioner has the option of submitting the MNR Forms prior to the delivery of treatment/services. The provider/practitioner is contractually required to deliver all medically necessary treatment/services.

The following exceptions apply to the 180 calendar day submission timeline:

1. If there is third party liability and the third party denies reimbursement, the provider/practitioner may submit the MNR Form to ASH within 30 calendar days of the date of the third-party denial notice.
2. If extraordinary circumstances exist and are demonstrated upon appeal. An extraordinary circumstance is when a health care practitioner or facility has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a timely manner and to submit MNR Forms on a timely basis.

Medical Necessity/Benefit Administration (MNA) processes submitted forms and verifies member eligibility. MNA enters the frequency, duration, and type of treatment/service information into ASH's proprietary Integrated Health Information System (IHIS) and assigns the file to a team of clinical quality evaluators.

ASH documents the date when it receives an MNR Form, and the date of the decision notification, in ASH's proprietary database. The request is received upon arrival to ASH, even if it is not first received by the ASH MNA department.

For post-service requests, a peer clinical quality evaluator evaluates the clinical information submitted by the provider/practitioner to verify medical necessity, taking into consideration the local delivery system and the individual needs of the member. The

evaluation determination made by the clinical quality evaluator is entered and tracked in IHIS.

For pre-service requests, if the clinical quality evaluator's determination is to approve all submitted treatment/services as medically necessary, the evaluation determination is entered and tracked in IHIS. In the event, upon preliminary assessment, the clinical quality evaluator is unable to approve all submitted treatment/services as medically necessary, the request when applicable will be forwarded to an Arkansas-licensed physician (MD/DO) for determination, according to the Adverse Determination description below.

If MNR Forms are submitted without the necessary clinical or administrative information, clinical quality evaluators or MNA staff attempt to obtain the missing information by calling the provider/practitioner. If ASH is unable to make a determination due to missing necessary information, the time period for making the decision may be extended (see "Clinical Services Timelines Standards" chart).

If a practitioner, member or the member's authorized representative does not follow ASH's reasonable filing procedures for requesting a pre-service verification of the medical necessity of submitted treatment/services, ASH notifies the practitioner or member of the failure and informs them of the proper procedures to follow when requesting services. For urgent pre-service reviews, ASH notifies the practitioner or member within 24 hours of receiving the request for services. For non-urgent pre-service reviews, ASH notifies the practitioner or member within five (5) calendar days of receiving the request for services. Notification may be verbal, unless the practitioner, member or the member's authorized representative requests written notification.

ASH will not deny a Non-Urgent Pre-Service or Urgent Pre-Service request that requires medical necessity review for failure to follow filing procedures.

ASH does not routinely require physicians and other practitioners to numerically code diagnoses or procedures to be considered in the evaluation but may request such codes, if available.

ASH administers a process through proprietary information tracking systems to allow access to 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 members or practitioners.

Experimental or Investigational Treatment

Services related to experimental or investigational treatments for a terminal, life threatening, or seriously debilitating condition are evaluated according to approved ASH clinical criteria. If a case requires specialty evaluation, an appropriate referral of either the

case evaluation or the patient to a clinical expert in the applicable specialty is made when ASH is delegated for this function. In cases where ASH is not delegated, the case is referred to the member's health plan.

Adverse Benefit Determination

For post-service requests, during the verification of medical necessity, clinical quality evaluators may determine that the submitted treatment/services are not medically appropriate, are not necessary, or do not meet ASH-approved clinical guidelines. These determinations are based solely on medical necessity and reflect the appropriate application of approved professionally recognized standards of practice guidelines and criteria.

Only licensed, certified, or registered peer practitioners, or medical doctors (MD/DO) as required by law, make clinical adverse benefit determinations, based on medical appropriateness.

For pre-service requests, during the verification of medical necessity, clinical quality evaluators may make preliminary assessments that the submitted treatment/services are not medically appropriate, are not necessary, or do not meet ASH-approved clinical guidelines. The review will then be forwarded to an Arkansas-licensed physician (MD/DO) who holds a current and valid license to practice medicine in the state of Arkansas for determination. These determinations are based solely on medical necessity and reflect the appropriate application of approved professionally recognized standards of practice guidelines and criteria.

Only licensed, certified, or registered peer practitioners, or medical doctors (MD/DO) as required by law, make clinical adverse benefit determinations, based on medical appropriateness.

Administrative adverse benefit determinations may occur for reasons other than medical necessity (nonmedical denial) and may not require peer review.

Administrative adverse benefit determinations are typically made on treatment/services submitted for verification for the following reasons:

- The provider is not contracted and/or the practitioner is not credentialed.
- The member is not eligible during all or part of the dates of treatment/service.
- The treatment/service is not a covered benefit.
- The member's benefits have been exhausted.

Clinical quality evaluators will not issue an adverse benefit determination due to missing necessary information without first attempting to obtain this information from the provider or treating practitioner.

Reopen (Peer-to-Peer Conversation)

The reopen process offers providers/practitioners an opportunity to submit additional information, via telephone, fax or through the secure electronic submission of a Reopen/Modification Form, to support the medical necessity of treatment/services that were previously evaluated and resulted in an adverse benefit determination and to request a re-evaluation of those treatment/services.

A request for a reopen must be received within 60 calendar days of the returned date or within 60 calendar days of the last approved date of service on the MNR Response Form (MNRF). Decisions and notifications of reopens are completed within timelines established in the "Clinical Services Timelines Standards" chart. The reopen process provides the opportunity for the practitioner to discuss an adverse benefit determination with the clinical quality evaluator or Arkansas-licensed physician (MD/DO), as applicable. If the practitioner continues to disagree with the determination, the provider/practitioner may appeal the determination in accordance with the guidelines in the *Provider and Practitioner Appeals and Grievances – Arkansas (AR UM 5 – S)* policy. The reopen process is an optional and voluntary process and does not inhibit the right of the provider/practitioner to appeal any adverse benefit determination.

Additional Service Request (Modifications)

ASH providers/practitioners may request verification of medical necessity for additional treatment/services or additional time to render treatment/services, beyond those already submitted, reviewed, and decided. This may include a date extension or the submission of additional treatment/services not requested at the time of the original submission (e.g., x-rays, supports, office visits). As these services were never previously submitted for medical necessity review, this is considered a new request (i.e., new services or new dates of service). Additional services are managed in the same manner as an initial request, inclusive of submission, decision, and notification timeframes. The request may be submitted via telephone, fax, or through the secure electronic submission portal. If the request includes any services previously reviewed and determined not to be medically necessary, the request is processed according to the reopen process as defined in this policy.

Right to File an Appeal or Grievance

If the member, member's authorized representative, or provider/practitioner acting on behalf of the member with the member's written consent chooses to appeal an adverse benefit determination or payment determination, the procedure explained in the *Member Appeals and Grievances – Arkansas (AR UM 4 – S)* policy is followed.

If the provider/practitioner, acting on his/her own behalf, chooses to appeal an adverse benefit determination or payment determination, the procedure explained in the *Provider and Practitioner Appeals and Grievances – Arkansas (AR UM 5 – S)* policy is followed.

NOTIFICATION OF DETERMINATIONS

Treatment/Service Approval

If verification of medical necessity results in a 100% approval of services, a MNRF is generated and provided by fax, mail, or secure electronic mailbox to the practitioner, and a Member Response Form (MRF) is generated and mailed to the member, according to applicable state, federal, accreditation, and/or contract or delegation requirements.

The notification letter is written in a manner that is understandable to the member and includes:

- The unique case reference number;
- The specific reason(s) for the determination;
- Reference to the specific plan provisions on which the determination is based; and
- Date of service, or if pre-service review, then an indication that a pre-service authorization request has been approved.

ASH provides written notification for all determinations and will provide additional copies of the determination notification upon request from the practitioner or member.

Treatment/Service Adverse Benefit Determination

Practitioners are notified of the adverse benefit determination via the MNRF, by:

- Secure ASH/practitioner web portal, or
- Secure electronic mailbox; or
- Fax; or
- Mail; or
- Telephone, including leaving a voicemail, if ASH documents the name of the individual at ASH who notified the treating practitioner or left the message and date and time of the notification or voicemail.

The MNRF contains the clinical rationale and/or benefit provision for the determination, information on how to appeal, and the clinical quality evaluator's or the Arkansas-licensed physician's (MD/DO) name, toll-free telephone number and telephone extension. The MNRF will identify:

- The unique case reference number;
- The enrollee and the nature of his/her medical condition;
- The medical service, treatment, or procedure in question; and
- The basis or bases on which the utilization review agent determined that the service, treatment, or procedure is or was not medically necessary or experimental/investigational, which shall demonstrate that the agent considered enrollee-specific clinical information in its determination.

ASH provides the practitioner the opportunity to discuss the adverse benefit determination with the clinical quality evaluator or the Arkansas-licensed physician (MD/DO), as applicable, within one business day of the practitioner's request or with a different clinical peer if the reviewing clinical quality evaluator or Arkansas-licensed physician (MD/DO), as applicable, cannot be available within one business day. The provider/practitioner may appeal the determination in accordance with the guidelines in the *Provider and Practitioner Appeals and Grievances – Arkansas (AR UM 5 – S)* policy.

When a practitioner is registered on ASHLink (a secure ASH/practitioner web portal) to receive benefit determinations, the practitioner is given the option to receive the notification via secure electronic mail. The practitioner is advised to check the web portal regularly. ASH also documents the date and time when the benefit determinations are posted to the web portal.

The provider/practitioner has access to the member's adverse benefit determination notification, which includes appeal rights, using ASH's ASHLink website. For provider/practitioner that are not registered on ASHLink, ASH will mail a hard copy of the member's adverse benefit determination notification, which includes the member's appeal rights.

Members are informed of adverse benefit determinations of submitted treatment/services according to applicable state, federal, accreditation, and/or contract or delegation requirements. The notification letter includes information regarding the member's appeal rights and process based on delegation agreements.

The notification letter is written in a manner that is culturally and linguistically appropriate and understandable to the member and includes:

- The unique case reference number;
- Date of service, or if pre-service review, then an indication that a pre-service authorization request has been denied;
- The specific reason(s) for the determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary to complete the submission and an explanation of why such material or information is necessary;
- A description of the member's appeal rights, including the right to representation, and the time limits to submit an appeal [according to the timelines specified in the *Member Appeals and Grievances – Arkansas (AR UM 4 – S)* policy];
- The right to submit written comments, documents, or other information relevant to the appeal;
- Information regarding the right to submit a request for an expedited appeal determination with any practitioner's support;

- The designated Appeal and Grievance department's mailing address, telephone number, and fax number, based on delegation agreements;
- A statement that the member will be provided, upon request and free of charge, reasonable access to and copies of any documentation related to the determination;
- Clinical rationale associated with the decision including the following:
  - The internal rule guideline, protocol, benefit provision or other similar criterion relied upon in making the determination; or
  - A statement that such rule, guideline, protocol, benefit provision, or other similar criterion was relied upon in making the determination and a statement that a copy of such will be provided to the Member, upon request and free of charge by contacting the Customer Service Department at 800-678-9133 or on-line at www.ashlink.com;
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Member's medical circumstances if the adverse benefit determination is based on the medical necessity or experimental treatment or similar exclusion or limitation;
- Information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist members with the appeals and external review processes;
- Information regarding the availability of diagnosis and treatment codes and descriptions;
- A notice regarding the availability of language assistance; and
- As applicable, additional member health information.

For pre-service requests, the name, title, address, toll-free telephone number and telephone extension of the Arkansas-licensed physician (MD/DO) responsible for making the adverse determination, along with a listing of each state in which the Arkansas-licensed physician (MD/DO), is licensed and the license number issued by each state.

Notification will also include a statement that informs members and their treating practitioners that expedited external review can occur simultaneously with the internal appeals process for urgent care.

ASH provides written notification for all determinations and will provide additional copies of the determination notification upon request from the practitioner or member.

Decision and Notification Time Frames

Decisions to approve or not approve reimbursement for health care treatment/services are made in a timely fashion appropriate for the nature of the member's condition, taking into account the urgency of individual situations. Decisions are made in accordance with the "Clinical Services Timelines Standards" chart. If the practitioner chooses to submit clinical information for the purpose of an optional pre-service verification of medical necessity, the

ASH decision is made in a timely fashion appropriate for a pre-service evaluation but no later than time frames required by accreditation standards and/or state and/or federal regulation in accordance with the "Clinical Services Timelines Standards" chart.

For decision and notification time frames of service evaluations, ASH adheres to applicable regulations and standards as mandated by the Department of Labor (DOL), URAC, National Committee for Quality Assurance (NCQA), and Centers for Medicare and Medicaid Services (CMS) – Medicare Advantage, and Arkansas applicable state law.

To meet state mandates and regulatory requirements, the time frames for processing MNR Forms for the verification of medical necessity of submitted treatment/services may require modification.

When conducting medical necessity reviews, ASH requires only the sections(s) of the medical record necessary in that specific case to verify medical necessity of submitted treatment/services. ASH does not routinely request copies of all medical records on all patients reviewed.

Transition of Care

ASH assists members in the transition of care in the event the member's benefits end or are exhausted during an active course of treatment. The member is notified of additional benefits that may be available to them through their health plan/medical plan carrier at the time benefits are no longer available through ASH.

Clinical Services Timelines Standards

Commercial (Non-Medicare)

Type of Submission	Decision Time Frame	Notification Time Frame
Non-Urgent Pre-Service	Within two (2) business days of receipt of all necessary information to make the authorization or adverse benefit determination.	Member and Practitioner: Within two (2) business days of receipt of all necessary information to make the authorization or adverse benefit determination.: • Secure ASH/practitioner web portal; or • Secure ASH/practitioner web portal; or

Type of Submission	Decision Time Frame	Notification Time Frame
		• Secure electronic mailbox; or • Fax; or • Mail; or • Telephone, including leaving a voicemail, if ASH documents the name of the individual at ASH who notified the treating practitioner or left the message and date and time of the notification or voicemail. <u>Member and Practitioner</u>: Written or electronic confirmation within two (2) business days of making the decision, not to exceed five (5) calendar days from receipt of the MNR Form submission.
	Requests for Additional Information If ASH is unable to make a decision due to lack of necessary information, ASH may extend the decision time frame for up to 15 calendar days under the following conditions: • Within two (2) business days of the MNR Form submission, ASH asks the Member for the specific information necessary to make the decision.	***Requests for Additional Information*** Within two (2) business days of the receipt of the MNR Form submission, ASH will notify the Member of what specific information is necessary to make the decision. ASH will specify the time period given to the Member to provide the information. In addition, the notification will include the expected date of ASH's determination.

Type of Submission	Decision Time Frame	Notification Time Frame
	• ASH gives the Member at least 45 calendar days to provide the information. The extension period within which a decision must be made by ASH and notification sent to the member and practitioner begins: • On the date when ASH receives the member's response (even if not all the information is provided); or • At the end of the time period given to the member to provide the information, if no response is received from the Member. ASH may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the Member can request an appeal.	For notification timeframes related to extensions, please see the Request for Additional Information section in the Decision Time Frame column to the left.
Urgent Pre-Service	Within 24 hours of receipt no later than one (1) business day after receiving all information needed to complete the review.	Practitioner: Within 24 hours of making the decision, by: • Secure ASH/practitioner web portal; or • Secure electronic mailbox; or • Fax; or

Type of Submission	Decision Time Frame	Notification Time Frame
		• Mail; or • Telephone, including leaving a voicemail, if ASH documents the name of the individual at ASH who notified the treating practitioner or left the message and date and time of the notification or voicemail. <u>Member and Practitioner</u>: Verbal, electronic, or written notification within 24 hours of the MNR Form submission. If initial notification was verbal, electronic or written notification will be sent no later than 72 hours of the MNR Form submission.
	Requests for Additional Information If ASH is unable to make a decision due to lack of necessary information, ASH may extend the decision time frame once for up to 48 hours, under the following conditions: • Within 24 hours of the MNR Form submission, ASH asks the Member for the specific information necessary to make the decision. • ASH gives the Member at least 48	***Requests for Additional Information*** Within 24 hours of the receipt of the MNR Form submission, ASH will notify the Member of what specific information is necessary to make the decision. ASH will specify the time period given to the Member to provide the information. In addition, the notification will include the expected date of ASH's determination.

Type of Submission	Decision Time Frame	Notification Time Frame
	hours to provide the information. The extension period within which a decision must be made by ASH and notification sent to the member and practitioner begins: • On the date when ASH receives the member's response (even if not all the information is provided); or • At the end of the time period given to the member to provide the information, if no response is received from the Member. ASH may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the Member can request an appeal.	For notification timeframes related to extensions, please see the Request for Additional Information section in the Decision Time Frame column to the left.
Emergent	N/A	<u>Member and Practitioner</u> The member or practitioner has 24 hours to notify ASH (or the next business day after a holiday or weekend) that emergency services were provided. <u>Practitioner:</u> Written notification is required from the practitioner to ASH within

Type of Submission	Decision Time Frame	Notification Time Frame
		72 hours to certify medical necessity of the emergency services provided.
Concurrent	A request to extend a course of treatment beyond the period of time or number of treatments previously approved by ASH is handled as a new request and decided within the timeframe appropriate to the type of decision (i.e., non-urgent pre-service, urgent pre-service and post-service).	
Post-Service	Within 30 calendar days of receipt of the MNR Form submission.	Practitioner: Within 30 calendar days of the MNR Form submission by: • Secure ASH/practitioner web portal; or • Secure electronic mailbox; or • Fax; or • Mail; or • Telephone, including leaving a voicemail, if ASH documents the name of the individual at ASH who notified the treating practitioner or left the message and date and time of the notification or voicemail. Member and Practitioner: Electronic or written notification within 30 calendar days of the MNR Form submission. If a post-service evaluation is partially approved and the member is not at financial risk, ASH is not

Type of Submission	Decision Time Frame	Notification Time Frame
		required to notify the member. ***Requests for Additional Information*** Within 30 calendar days of the receipt of the MNR Form submission, ASH will notify the Member of what specific information is necessary to make the decision. ASH will specify the time period given to the Member to provide the information. In addition, the notification will include the expected date of ASH's determination. For notification timeframes related to extensions, please see the Request for Additional Information section in the Decision Time Frame column to the left.
	Requests for Additional Information If ASH is unable to make a decision due to lack of necessary information, ASH may extend the decision time frame for up to 15 calendar days under the following conditions: • Within 30 calendar days of the MNR Form submission, ASH asks the Member for the specific information necessary to make the decision. • ASH gives the Member at least 45 calendar days to provide the information. The extension period within which a decision must be made by ASH and notification sent to the member and practitioner begins: • On the date when ASH receives the member's response (even if not all the information is provided); or • At the end of the time period given to the member to provide the information, if no	

Type of Submission	Decision Time Frame	Notification Time Frame
	response is received from the Member. ASH may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the Member can request an appeal.	

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