

1 **Policy:** **Medical Necessity Review – New Jersey**

2
3 **Date of Implementation:** **July 14, 2005**

4
5 **Product:** **Specialty**

6
7
8 **DEFINITIONS:**

9
10 *Credentialed Practitioner* – A credentialed practitioner is an employee, independent
11 contractor or is associated with a contracted provider in some way and in some instances;
12 a contracted provider may be a credentialed practitioner. A credentialed practitioner is a
13 practitioner who has been credentialed with ASH and is duly licensed, registered or
14 certified, as required, in the state in which services are provided.

15
16 *Contracted Practitioner* – A contracted practitioner is a practitioner of health care services,
17 a group practice, or a professional corporation which or who has both been credentialed by
18 and contracted with ASH for the purpose of rendering professional services that are widely
19 accepted, evidence based, and best clinical practice within the scope of the contracted
20 practitioner’s professional licensure.

21
22 *Contracted Provider* – A contracted provider is any legal entity that (1) has contracted with
23 ASH for the provision of services to members; (2) operates facilities at which services are
24 provided; (3) is a credentialed practitioner or employs or contracts with credentialed
25 practitioners.

26
27 *Member* - A member or a member’s authorized representative, and a practitioner or facility,
28 if the practitioner or facility is acting on behalf of the member and with the member’s
29 written consent, collectively referred to as the “Member” throughout this policy.

30
31 *Adverse Benefit Determination* – A declination (which includes a denial, reduction, or
32 termination of, or a failure to make partial or whole payment) for a benefit, including any
33 such declination for that plan.

34
35 Additionally, with respect to group health plans, a declination for a benefit resulting from
36 the application of any medical necessity review, as well as a failure to cover an item or
37 service for which benefits are otherwise provided because it is determined to be
38 experimental or investigational or not medically necessary or appropriate.

39
40 **OVERVIEW**

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

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

11
12 Clinical quality evaluators report either directly to, or through their clinical Team Manager,
13 to the Senior Vice President, Clinical Services, the Senior Vice President, Rehab Services,
14 or a Senior Medical Director. The Senior Vice President, Clinical Services, Senior Vice
15 President, Rehab Services and Senior Medical Directors are responsible for the oversight
16 of clinical operations, clinical staffing and training, and clinical decision-making processes
17 and procedures by the clinical review staff. The Senior Vice President, Clinical Services,
18 Senior Vice President, Rehab Services and Senior Medical Directors ensure that clinical
19 review staff are qualified to render a clinical opinion about the medical condition, treatment
20 and procedures under their review.

21
22 All submitted treatment/services for evaluation and verification of medical necessity are
23 processed according to approved policies and procedures. American Specialty Health –
24 Specialty (ASH) Clinical Practice Guidelines used to support determinations are available
25 free of charge to practitioners and members at ASH’s website or upon request.

26
27 Practitioners are assigned to a team of clinical reviewers who evaluate submissions for
28 treatment/services. This promotes consistent dialogue between the clinical reviewers and
29 the practitioners. Clinical reviewers become familiar with practitioner practice patterns and
30 may identify opportunities for improvement.

31
32 Practitioners have the opportunity to contact their clinical reviewers management team at
33 any time during normal operating hours to discuss service evaluation determinations,
34 including clinical adverse benefit determinations.

35
36 The name, telephone number, and telephone extension of the clinical reviewer and/or
37 licensed physician (MD/DO), as applicable, who made the actual determination is included
38 in the communication of the determination to the practitioner. Practitioners are encouraged
39 to contact that clinical reviewer and/or licensed physician (MD/DO), as applicable, to
40 discuss clinical services issues related to the determination.

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

- 3 • Hiring
- 4 • Compensation
- 5 • Termination
- 6 • Promotion, or
- 7 • Any other similar matters

8
9 ASH clinical reviewers are not permitted to interfere with the referral process as it relates
10 to patient care.

11
12 **Pre-certification**

13 Pre-certification (mandatory pre-service medical necessity verification) may be required
14 for certain services under applicable client benefit plans or as required by state law. Pre-
15 certification determinations are made by appropriately trained clinical personnel relying on
16 professionally recognized standards of care and current evidence-based criteria.

17
18 **MEDICAL NECESSITY REVIEW**

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

22
23 **Evaluation of Medical Necessity of Treatment/Services**

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

33
34 Clinical reviewers evaluate the relevant member and clinical information submitted on
35 MNR Forms to verify the medical necessity of submitted treatment/services. The clinical
36 reviewers follow approved clinical practice guidelines and criteria when verifying the
37 medical necessity of submitted treatment/services and will accept information from any
38 reasonably reliable source that will assist in the evaluation process. If a submitted
39 treatment/service is exceptionally specialized, ASH will consult with specialists in the
40 identified area of expertise to assist in the evaluation. In such cases where the consultation
41 is done by a MD/DO, the expert reviewer will hold applicable board certification. ASH
42 will provide the identity of the expert reviewer to the member upon request.

1 ASH will not deny reimbursement to a provider/practitioner for covered services rendered
2 to a member on grounds of medical necessity in the absence of fraud or misrepresentation
3 in the following cases:

- 4 • ASH authorized treatment/services prior to the provision of care.
- 5 • The practitioner requested authorization from ASH for treatment/services prior to
6 the provision of care, and ASH failed to respond within the established timeframes
7 established in the “Clinical Services Timelines Standards” chart.

8
9 The practitioner received authorization for the treatment/services for a member who is no
10 longer eligible to receive coverage from ASH, and it is determined that the member is
11 covered by another payer, in which case the subsequent payer, based on the subsequent
12 payer’s benefits plan, will accept the authorization and reimburse the practitioner.

13
14 There are no financial or other incentives paid to clinical reviewers or expert reviewers that
15 encourage decisions resulting in under-utilization. ASH does not make decisions regarding
16 hiring, promoting or terminating clinical reviewers or other individuals based on the
17 likelihood or perceived likelihood that the clinical reviewers or other individuals would
18 support or tend to support the denial of benefits.

19
20 Providers/practitioners are paid on a contracted fee-for-service basis and do not receive
21 financial or other incentives that result in under-utilization.

22
23 ASH recommends that the provider/practitioner submit required MNR Forms within three
24 (3) days of the date(s) of service; however, forms must be submitted no more than 180
25 calendar days from the date(s) of service. The provider/practitioner has the option of
26 submitting the MNR Forms prior to the delivery of treatment/services. The
27 provider/practitioner is contractually required to deliver all medically necessary
28 treatment/services.

29
30 The following exceptions apply to the 180 calendar day submission timeline:

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

39
40 Medical Necessity/Benefit Administration (MNA) processes submitted forms and verifies
41 member eligibility. MNA enters the frequency, duration, and type of treatment/service

1 information into ASH’s proprietary Integrated Health Information System (IHIS) and
2 assigns the file to a team of clinical quality evaluators.

3
4 ASH documents the date when it receives an MNR Form from a Member, even if the MNR
5 Form does not have all the information necessary to make a decision, and the date of the
6 decision notification, in ASH’s proprietary database. The request is considered to be
7 received upon arrival to ASH, even if it is not first received by the ASH MNA department.

8
9 A peer clinical reviewer evaluates the clinical information submitted by the
10 provider/practitioner to verify medical necessity, taking into consideration the local
11 delivery system and the individual needs of the member. The evaluation determination
12 made by the clinical quality evaluator is entered and tracked in IHIS.

13
14 In the event clinical reviewers’ determination is to approve all submitted treatment/services
15 as medically necessary, the evaluation determination is entered and tracked in IHIS. In the
16 event, upon preliminary assessment, the clinical quality evaluator is unable to approve all
17 submitted treatment/services as medically necessary, the request will be forwarded to a
18 licensed physician (MD/DO) for determination, according to the adverse determination
19 section below.

20
21 If MNR Forms are submitted without the necessary clinical or administrative information,
22 clinical reviewers or MNA staff attempt to obtain the missing information by calling the
23 provider/practitioner. If ASH is unable to make a determination due to missing necessary
24 information, the time period for making the decision may be extended (see “Clinical
25 Services Timelines Standards” chart).

26
27 If a practitioner, member or the member’s authorized representative does not follow ASH’s
28 reasonable filing procedures for requesting a pre-service verification of the medical
29 necessity of submitted treatment/services, ASH notifies the practitioner or member of the
30 failure and informs them of the proper procedures to follow when requesting services. For
31 urgent pre-service reviews, ASH notifies the practitioner or member within 24 hours of
32 receiving the request for services. For non-urgent pre-service reviews, ASH notifies the
33 practitioner or member within five (5) calendar days of receiving the request for services.
34 Notification may be verbal, unless the practitioner, member or the member’s authorized
35 representative requests written notification.

36
37 ASH will not deny a Non-Urgent Pre-Service or Urgent Pre-Service request that requires
38 medical necessity review for failure to follow filing procedures.

39
40 ASH does not routinely require physicians and other practitioners to numerically code
41 diagnoses or procedures to be considered in the evaluation but may request such codes, if
42 available.

1 ASH administers a process through proprietary information tracking systems to allow
 2 access to all clinical and demographic information on individual patients among its various
 3 clinical and administrative departments that have a need to know, to avoid duplicate
 4 requests for information from members or practitioners.

5
 6 **Experimental or Investigational Treatment**

7 Services related to experimental or investigational treatments for a terminal, life
 8 threatening, or seriously debilitating condition are evaluated according to approved ASH
 9 clinical criteria. If a case requires specialty evaluation, an appropriate referral of either the
 10 case evaluation or the patient to a clinical expert in the applicable specialty is made when
 11 ASH is delegated for this function. In cases where ASH is not delegated, the case is referred
 12 to the member’s health plan.

13
 14 **Adverse Benefit Determination**

15 **Chiropractic**

16 During the verification of medical necessity, clinical quality evaluators may determine that
 17 the submitted treatment/services are not medically appropriate, are not necessary, or do not
 18 meet ASH-approved clinical guidelines. These determinations are based solely on medical
 19 necessity and reflect the appropriate application of approved professionally recognized
 20 standards of practice guidelines and criteria.

21
 22 All adverse determinations based on medical necessity for chiropractic benefits are made
 23 by a New Jersey licensed chiropractor identified as a clinical quality evaluator with
 24 oversight by a New Jersey licensed physician (MD/DO).

25
 26 Administrative adverse determinations may occur for reasons other than medical necessity
 27 and may not require peer review.

28
 29 Administrative adverse determinations are typically made on treatment/services submitted
 30 for verification for the following reasons:

- 31 • The practitioner/provider is not contracted.
- 32 • The member is not eligible during all or part of the dates of treatment/service.
- 33 • The treatment/service is not a covered benefit.
- 34 • The member’s benefits have been exhausted.

35
 36 Clinical quality evaluators will not issue an adverse determination due to missing necessary
 37 information without first attempting to obtain this information from the treating
 38 practitioner.

39
 40 **All Other Treatment/Services**

41 During the verification of medical necessity, clinical reviewers may make preliminary
 42 assessments that the submitted treatment/services are not medically appropriate, are not

1 necessary, or do not meet ASH-approved clinical guidelines. In the event, upon preliminary
2 assessment, the clinical evaluator is unable to approve all submitted treatment/services as
3 medical necessary, the request will be forwarded to a physician (MD/DO) who holds a
4 current and valid license to practice medicine in the state of New Jersey for determination.
5 These determinations are based solely on medical necessity and reflect the appropriate
6 application of approved professionally recognized standards of practice guidelines and
7 criteria.

8
9 Only licensed, certified, or registered peer practitioners, or medical doctors (MD/DO) as
10 required by law, make clinical adverse benefit determinations, based on medical
11 appropriateness.

12
13 Administrative adverse benefit determinations may occur for reasons other than medical
14 necessity and may not require peer review.

15
16 Administrative adverse benefit determinations are typically made on treatment/services
17 submitted for verification for the following reasons:

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

22
23 ASH will not issue an adverse benefit determination due to missing necessary information
24 without first attempting to obtain this information from the provider or treating practitioner.

25
26 **Reopen (Peer-to-Peer Conversation)**

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

32
33 A request for a reopen must be received within 60 calendar days of the returned date or
34 within 60 calendar days of the last approved date of service on the MNR Response Form
35 (MNR). Decisions and notifications of reopens are completed within timelines
36 established in the “Clinical Services Timelines Standards” chart. The reopen process
37 provides the opportunity for the practitioner to discuss an adverse benefit determination
38 with the clinical reviewer or licensed physician (MD/DO), as applicable. If the practitioner
39 continues to disagree with the determination, the provider/practitioner may appeal the
40 determination in accordance with the guidelines in the *Provider and Practitioner Appeals*
41 *and Grievances – New Jersey (NJ UM 5 – S)* policy. The reopen process is an optional and

1 voluntary process and does not inhibit the right of the provider/practitioner to appeal any
 2 adverse benefit determination.

3
 4 **Additional Service Request (Modifications)**

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

16
 17 **Right to File an Appeal or Grievance**

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

22
 23 If the provider/practitioner, acting on his/her own behalf, chooses to appeal an adverse
 24 benefit determination or payment determination, the procedure explained in the *Provider*
 25 *and Practitioner Appeals and Grievances – New Jersey (NJ UM 5 – S)* policy is followed.

26
 27 **NOTIFICATION OF DETERMINATIONS**

28 **Treatment/Service Approval**

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

33
 34 The notification letter is written in a manner that is understandable to the member and
 35 includes:

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

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

3
 4 **Treatment/Service Adverse Benefit Determination**

5 Adverse determinations are directly communicated by fax, mail, or secure electronic
 6 mailbox to the treating practitioner by the physician (MD/DO) who made the decision. For
 7 chiropractic care, an adverse determination is directly communicated by fax, mail, or
 8 secure electronic mailbox to the treating practitioner by the chiropractor (DC) who made
 9 the decision.

10
 11 If direct telephonic communication is not possible, practitioners are notified of the adverse
 12 benefit determination via the MNRF, by:

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

20
 21 The MNRF contains the clinical rationale and/or benefit provision for the determination,
 22 information on how to appeal, and the licensed physician’s (MD/DO) name, toll-free
 23 telephone number and telephone extension. The MNRF will identify:

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

31
 32 ASH provides the practitioner the opportunity to discuss the adverse benefit determination
 33 with the clinical quality evaluator within one business day of the practitioner’s request or
 34 with a different clinical peer if the reviewing clinical quality evaluator cannot be available
 35 within one business day. The provider/practitioner may appeal the determination in
 36 accordance with the guidelines in the *Provider and Practitioner Appeals and Grievances*
 37 – *New Jersey (NJ UM 5 – S)* policy.

38
 39 When a practitioner is registered on ASHLink (a secure ASH/practitioner web portal) to
 40 receive benefit determinations, the practitioner is given the option to receive the
 41 notification via secure electronic mail. The practitioner is advised to check the web portal

1 regularly. ASH also documents the date and time when the benefit determinations are
2 posted to the web portal.

3
4 The physician will be immediately available in emergent/urgent cases to discuss the
5 adverse determinations and available with one (1) business day in all other situations.

6
7 The provider/practitioner may access information on a member's appeal rights using
8 ASH's ASHLink website. ASH will mail a hard copy letter containing the member's appeal
9 rights to those provider/practitioners that are not registered on ASHLink.

10
11 Members are informed of adverse benefit determinations of submitted treatment/services
12 according to applicable state, federal, accreditation, and/or contract or delegation
13 requirements. The notification letter includes information regarding the member's appeal
14 rights and process based on delegation agreements.

15
16 The notification letter is written in a manner that is culturally and linguistically appropriate
17 and understandable to the member and includes:

- 18 • The unique case reference number;
- 19 • Date of service, or if pre-service review, then an indication that a pre-service
20 authorization request has been denied;
- 21 • The specific reason(s) for the determination;
- 22 • Reference to the specific plan provisions on which the determination is based;
- 23 • A description of any additional material or information necessary to complete the
24 submission and an explanation of why such material or information is necessary;
- 25 • A description of the member's appeal rights, including the right to representation,
26 and the time limits to submit an appeal [according to the timelines specified in the
27 *Member Appeals and Grievances – New Jersey (NJ UM 4 – S)* policy];
- 28 • A statement that the member may pursue an appeal with an independent utilization
29 review organization (IURO) through Maximus Federal as designated by the New
30 Jersey Department of Banking and Insurance if the member is dissatisfied with
31 ASH's final appeal review decision;
- 32 • Information regarding the right to submit a request for an expedited appeal
33 determination with any practitioner's support;
- 34 • The designated Appeal and Grievance department's mailing address, telephone
35 number, and fax number, based on delegation agreements;
- 36 • A statement that the member will be provided, upon request and free of charge,
37 reasonable access to and copies of any documentation related to the determination;
- 38 • Clinical rationale associated with the decision including the following:
 - 39 ○ The internal rule guideline, protocol, benefit provision or other similar criterion
40 relied upon in making the determination; or

- 1 ○ A statement that such rule, guideline, protocol, benefit provision, or other
- 2 similar criterion was relied upon in making the determination and a statement
- 3 that a copy of such will be provided to the Member, upon request and free of
- 4 charge by contacting the Customer Service Department at 800-678-9133 or on-
- 5 line at www.ashlink.com;
- 6 • An explanation of the scientific or clinical judgment for the determination, applying
- 7 the terms of the plan to the Member’s medical circumstances if the adverse benefit
- 8 determination is based on the medical necessity or experimental treatment or
- 9 similar exclusion or limitation;
- 10 • Information regarding the availability of, and contact information for, any
- 11 applicable office of health insurance consumer assistance or ombudsman to assist
- 12 members with the appeals and external review processes;
- 13 • Information regarding the availability of diagnosis and treatment codes and
- 14 descriptions;
- 15 • A notice regarding the availability of language assistance; and
- 16 • As applicable, additional member health information.

17

18 Notification will also include a statement that informs members and their treating

19 practitioners that expedited external review can occur simultaneously with the internal

20 appeals process for urgent care.

21

22 ASH provides written notification for all determinations and will provide additional copies

23 of the determination notification upon request from the practitioner or member.

24

25 **Decision and Notification Time Frames**

26 Decisions to approve or not approve reimbursement for health care treatment/services are

27 made in a timely fashion appropriate for the nature of the member’s condition, taking into

28 account the urgency of individual situations. Decisions are made in accordance with the

29 “Clinical Services Timelines Standards” chart. If the practitioner chooses to submit clinical

30 information for the purpose of an optional pre-service verification of medical necessity, the

31 ASH decision is made in a timely fashion appropriate for a pre-service evaluation but no

32 later than time frames required by accreditation standards and/or state and/or federal

33 regulation in accordance with the “Clinical Services Timelines Standards” chart.

34

35 For decision and notification time frames of service evaluations, ASH adheres to applicable

36 regulations and standards as mandated by the Department of Labor (DOL), URAC,

37 National Committee for Quality Assurance (NCQA), and Centers for Medicare and

38 Medicaid Services (CMS) – Medicare Advantage, and applicable New Jersey state law.

39

40 To meet state mandates and regulatory requirements, the time frames for processing MNR

41 Forms for the verification of medical necessity of submitted treatment/services may require

42 modification.

1 If ASH fails to respond to an authorization request within the time frames established in
 2 the “Clinical Services Timelines Standards” chart, the request is deemed approved and
 3 ASH is responsible for the payment of the covered services delivered.

4
 5 When conducting medical necessity reviews, ASH requires only the sections(s) of the
 6 medical record necessary in that specific case to verify medical necessity of submitted
 7 treatment/services. ASH does not routinely request copies of all medical records on all
 8 patients reviewed.

9
 10 **Transition of Care**
 11 ASH assists members in the transition of care in the event the member’s benefits end or
 12 are exhausted during an active course of treatment. The member is notified of additional
 13 benefits that may be available to them through their health plan/medical plan carrier at the
 14 time benefits are no longer available through ASH.

15
 16 **Clinical Services Timelines Standards**
 17 Commercial (Non-Medicare)
 18

| Type of Submission | Decision Time Frame | Notification Time Frame |
|---------------------------|---|---|
| Non-Urgent Pre-Service | Within two (2) business days of receipt of the MNR Form submission. | <p><u>Practitioner:</u> Within 24 hours of making the decision by:</p> <ul style="list-style-type: none"> • 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. <p><u>Member and Practitioner:</u> Written or electronic</p> |

| Type of Submission | Decision Time Frame | Notification Time Frame |
|--------------------|---|---|
| | <p><i>Requests for Additional Information</i> 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:</p> <ul style="list-style-type: none"> • Within two (2) business 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. <p>The extension period within which a decision must be made by ASH and notification sent to the member and practitioner begins:</p> <ul style="list-style-type: none"> • On the date when ASH receives the member’s response (even if not all the | <p>confirmation within two (2) business days of making the decision, not to exceed five (5) calendar days from receipt of the MNR Form submission.</p> <p><i>Requests for Additional Information</i> 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.</p> <p>In addition, the notification will include the expected date of ASH’s determination.</p> <p>For notification timeframes related to extensions, please see the Request for Additional Information section in the Decision Time Frame column to the left.</p> |

| Type of Submission | Decision Time Frame | Notification Time Frame |
|--------------------|---|--|
| | <p>information is provided); or</p> <ul style="list-style-type: none"> At the end of the time period given to the member to provide the information, if no response is received from the Member. <p>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.</p> | |
| Urgent Pre-Service | Within 24 hours of receipt of the MNR Form submission. | <p><u>Practitioner:</u> Within 24 hours of making the decision, by:</p> <ul style="list-style-type: none"> 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. <p><u>Member and Practitioner:</u> Verbal, electronic, or written notification within 24 hours of the MNR Form</p> |

| Type of Submission | Decision Time Frame | Notification Time Frame |
|--------------------|---|---|
| | <p><i>Requests for Additional Information</i> 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:</p> <ul style="list-style-type: none"> • 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 hours to provide the information. <p>The extension period within which a decision must be made by ASH and notification sent to the member and practitioner begins:</p> <ul style="list-style-type: none"> • On the date when ASH receives the member’s response (even if not all the information is provided); or | <p>submission. If initial notification was verbal, electronic or written notification will be sent no later than 72 hours of the MNR Form submission.</p> <p><i>Requests for Additional Information</i> 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.</p> <p>In addition, the notification will include the expected date of ASH’s determination.</p> <p>For notification timeframes related to extensions, please see the Request for Additional Information section in the Decision Time Frame column to the left.</p> |

| Type of Submission | Decision Time Frame | Notification Time Frame |
|--------------------|---|---|
| | <ul style="list-style-type: none"> At the end of the time period given to the member to provide the information, if no response is received from the Member. <p>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.</p> | |
| 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 | <p>Within 30 calendar days of receipt of the MNR Form submission.</p> <p><i>Requests for Additional Information</i> If ASH is unable to make a decision due to lack of necessary information, ASH may extend the</p> | <p><u>Member and Practitioner:</u> Electronic or written notification within two business days of a decision not to exceed 30 calendar days of the MNR Form submission.</p> <p>If a post-service evaluation is partially approved and the member is not at financial risk, ASH is not required to notify the member.</p> <p><i>Requests for Additional Information</i> Within 30 calendar days of the receipt of the MNR Form submission, ASH will notify the Member of</p> |

| Type of Submission | Decision Time Frame | Notification Time Frame |
|--------------------|--|---|
| | <p>decision time frame for up to 15 calendar days under the following conditions:</p> <ul style="list-style-type: none"> • 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. <p>The extension period within which a decision must be made by ASH and notification sent to the member and practitioner begins:</p> <ul style="list-style-type: none"> • 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. <p>ASH may deny the request if it does not receive the information needed to make a decision within this time frame. At this point,</p> | <p>what specific information is necessary to make the decision. ASH will specify the time period given to the Member to provide the information.</p> <p>In addition, the notification will include the expected date of ASH’s determination.</p> <p>For notification timeframes related to extensions, please see the Request for Additional Information section in the Decision Time Frame column to the left.</p> |

| Type of Submission | Decision Time Frame | Notification Time Frame |
|--------------------|-----------------------------------|-------------------------|
| | the Member can request an appeal. | |

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