Policy: **Medical Necessity Review – Non-Credentialed Practitioners**

Date of Implementation: **September 16, 2010**

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.

Non-Credentialed Practitioner – Non-credentialed practitioners considered to be out of network (OON) or out of area (OOA) include those practitioners not credentialed with ASH and those practitioners who are credentialed but are not participating in the member's health plan.

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

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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 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 Vice President, Clinical Services, the Vice President, Rehab Services, or a Medical Director. The Vice President, Clinical Services, Vice President, Rehab Services and 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 Vice President, Clinical Services, Vice President, Rehab Services and 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 a clinical quality evaluator 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 who made the actual determination is included in the communication of the determination to the practitioner. Practitioners are encouraged to contact that clinical quality evaluator to 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 quality evaluators are not permitted to interfere with the referral process as it
10 relates 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 **Evaluation of Medical Necessity of Treatment/Services**
20 Depending on contractual arrangement between ASH and the client, a practitioner's
21 performance evaluation may allow the practitioner to render certain treatment/services to
22 members without submitting those treatment/services and appropriate documentation to
23 ASH for verification of medical necessity. If the member requires more treatment/services
24 than are available under a health plan's No MNR visits, a Medical Necessity Review Form
25 (MNR Form), Clinical Information Summary Sheet (CISS) or medical records must be
26 submitted for verification of medical necessity of those additional treatment/services by a
27 clinical quality evaluator.
28
29 ASH encourages practitioners to utilize ASH MNR Forms or CISSs to communicate the
30 details of the member's signs and symptoms to the clinical quality evaluator. This
31 information is used in evaluating the clinical information and making a determination
32 regarding the requested treatment/services based on professionally recognized standards of
33 care. The ASH forms have been designed and implemented to provide a consistent
34 reporting format. This consistent reporting format facilitates clear communication between
35 the practitioner and the clinical quality evaluator, helps to ensure that data submitted by all
36 practitioners are evaluated equitably, and is essential in allowing the clinical quality
37 evaluator to respond to the submission of treatment/services accurately and timely. Forms
38 may be obtained by contacting ASH's Customer Service department or visiting
39 www.ashlink.com.

Practitioners may submit medical records in lieu of the forms provided by ASH. If a practitioner chooses to submit medical records for evaluation of medical necessity, the medical records must include, at a minimum, the following elements:

- Demographic information including:
  - Patient name
  - Patient date of birth
  - Patient gender
  - Health plan name
  - Employer group name or number
  - Treating Practitioner name, address, and phone number (fax number if available)
  - Treating Practitioner license number, tax identification number, and NPI number
- Diagnosis and Applicable Treatment/Services Submitting for Review:
  - Diagnosis or diagnoses (preferably by applicable ICD code and narrative description)
  - Date range of services submitting for medical necessity review (from and through dates)
  - Number of visits (dates of service)
  - Number and type of therapies/modalities/procedures
  - Examination/Evaluation services including rationale and findings, if already performed.
  - Durable medical equipment by HCPC code including rationale for services.
  - Imaging/other studies by CPT code including rationale for studies
- Clinical history including:
  - Chief complaint
  - Onset date/type
  - Past history/general health
- Clinical evaluation including:
  - All findings that support the diagnoses and justify the treatment/services submitted. This may include observation, palpation, ortho/neuro, special tests, x-ray, lab results, etc.
  - Response to care if treatment/services have already been rendered to the patient.

Clinical quality evaluators evaluate the relevant member and clinical information submitted on MNR Forms, CISSs or medical records 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.

ASH recommends that the provider/practitioner submit required MNR Forms, CISS s or medical records within three (3) days of the date(s) of service.

Medical Necessity/Benefit Administration (MNA) processes submitted forms, CISSs or medical records 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.

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.

If MNR Forms, CISSs or medical records 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

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.

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

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

- If the member does not have an out of network benefit and 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.

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1 **Reopen (Peer-to-Peer Conversation)**
2 The reopen process offers an opportunity to submit additional information, via telephone,
3 fax or mail, on a Reopen/Modification Form or through medical records, to support the
4 medical necessity of treatment/services that were previously evaluated and resulted in an
5 adverse benefit determination and to request a re-evaluation of those treatment/services.
6
7 Decisions and notifications of reopens are completed within timelines established in the
8 "Clinical Services Timelines Standards" chart. The reopen process provides the
9 opportunity for the practitioner to discuss an adverse benefit determination with the clinical
10 quality evaluator. If the practitioner continues to disagree with the determination, the
11 provider/practitioner may appeal the determination in accordance with the guidelines in the
12 *Provider and Practitioner Appeals and Grievances (UM 5 – S)* policy. The reopen process
13 is an optional and voluntary process and does not inhibit the right of the
14 provider/practitioner to appeal any adverse benefit determination.
15
16 **Additional Service Request (Modifications)**
17 Medical necessity verification may be requested for additional treatment/services or
18 additional time to render treatment/services, beyond those already submitted, reviewed,
19 and decided. This may include a date extension or the submission of additional
20 treatment/services not requested at the time of the original submission (e.g., x-rays,
21 supports, office visits). As these services were never previously submitted for medical
22 necessity review, this is considered a new request (i.e., new services or new dates of
23 service). Additional services are managed in the same manner as an initial request,
24 inclusive of submission, decision, and notification timeframes. The request may be
25 submitted via telephone, fax, or mail. If the request includes any services previously
26 reviewed and determined not to be medically necessary, the request is processed according
27 to the reopen process as defined in this policy.
28
29 **Right to File an Appeal or Grievance**
30 If the member, member's authorized representative, or provider/practitioner acting on
31 behalf of the member with the member's written consent chooses to appeal an adverse
32 benefit determination or payment determination, the procedure explained in the *Member*
33 *Appeals and Grievances (UM 4 – S)* policy is followed.
34
35 If the provider/practitioner, acting on his/her own behalf, chooses to appeal an adverse
36 benefit determination or payment determination, the procedure explained in the *Provider*
37 *and Practitioner Appeals and Grievances (UM 5 – S)* policy is followed.
38
39 **NOTIFICATION OF DETERMINATIONS**
40 **Treatment/Service Approval**
41 If verification of medical necessity results in a 100% approval of services, a MNRF is
42 generated and provided by fax or mail 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 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 within one business day of the practitioner's request or with a different clinical peer if the reviewing clinical quality evaluator 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 (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 may access information on a member's appeal rights using ASH's publicly available ASHLink website. ASH will mail a hard copy letter containing the member's appeal rights to those provider/practitioners that are not registered on ASHLink.

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 (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.

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 applicable state law.

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

1 When conducting medical necessity reviews, ASH requires only the sections(s) of the
2 medical record necessary in that specific case to verify medical necessity of submitted
3 treatment/services. ASH does not routinely request copies of all medical records on all
4 patients reviewed.
5
6 **Transition of Care**
7 ASH assists members in the transition of care in the event the member's benefits end or
8 are exhausted during an active course of treatment. The member is notified of additional
9 benefits that may be available to them through their health plan/medical plan carrier at the
10 time benefits are no longer available through ASH.
11
12 **Clinical Services Timelines Standards**
13 Commercial (Non-Medicare)
14
15 Timeframes may vary by state. For specific state timeframes, please refer to appropriate
16 state-specific Medical Necessity Review policy.
17

Type of Submission	Decision Time Frame	Notification Time Frame
Non-Urgent Pre-Service	Within two (2) business days of receipt of the MNR Form, CISS or medical records submission.	Practitioner: Within 24 hours of making the decision by: • Secure ASH/practitioner web portal; or • 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.

Type of Submission	Decision Time Frame	Notification Time Frame
	          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, CISS or medical records 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:	<u>Member and Practitioner</u>: By fax or mail within two (2) business days of making the decision, not to exceed five (5) calendar days from receipt of the MNR Form, CISS or medical records submission. ***Requests for Additional Information*** Within two (2) business days of the receipt of the MNR Form, CISS or medical record submission, ASH will notify the Member by writing 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.

Type of Submission	Decision Time Frame	Notification Time Frame
	• 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.	
Urgent Pre-Service	Within 24 hours of receipt of the MNR Form, CISS or medical records submission.	Practitioner: Within 24 hours of making the decision, 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.

Type of Submission	Decision Time Frame	Notification Time Frame
	      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, CISS or medical records 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. 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	<u>Member and Practitioner</u>: By telephone or fax within 24 hours of the MNR Form, CISS or medical records submission. ***Requests for Additional Information*** Within 24 hours of the receipt of the MNR Form, CISS or medical records 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.

Type of Submission	Decision Time Frame	Notification Time Frame
	• 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.	
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, CISS or medical records 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.

Type of Submission	Decision Time Frame	Notification Time Frame
		Member and Practitioner: By fax or mail within 30 calendar days of the MNR Form, CISS or medical records submission. If a post-service evaluation is partially approved and the member is not at financial risk, ASH is not required to notify the member.
	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, CISS or medical records 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	***Requests for Additional Information*** Within 30 calendar days of the receipt of the MNR Form, CISS or medical records 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.

Type of Submission	Decision Time Frame	Notification Time Frame
	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.	

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