Policy: **Clinical Services Program – New Jersey**

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

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 American Specialty Health - Specialty (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.

Hospital Outpatient Physical Therapy, Occupational Therapy, or Speech Language Therapy Providers – A Hospital Outpatient Physical Therapy (PT), Occupational Therapy (OT), or Speech Language Therapy (SLP) provider delivers health care services in a hospital-based outpatient setting.

Site of Care Programs - A Hospital Outpatient Physical Therapy, Occupational Therapy, or Speech Language Therapy Site of Care (SOC) Program operationalizes medical policy which document the clinical presentation and situations where care of the patient appropriately continues service in the Hospital Outpatient PT, OT, and SLP department or affiliated clinic. If criteria are not met, patients are redirected/transitioned to an in-network non-hospital based PT/OT/SLP clinic setting or virtual setting.

PURPOSE

The Clinical Services Program (CS Program) defines the process for monitoring and evaluating treatment/services provided to members by credentialed practitioners. The CS

Program provides a structured approach to positively influencing provider behavior toward conservative, evidence-based practices which may include verification of the medical necessity of diagnostic and treatment services delivered to members. This approach includes dissemination of clinical guidelines, peer-to-peer dialogue, peer review of data submitted on Medical Necessity Review Forms (MNR Forms) and supporting documents, and clinical decision communications that reference the applicable guidelines and clinical literature.

Every medical necessity verification decision is evaluated against established clinical guidelines and review criteria which are supported by credible scientific evidence that meets industry standard research quality criteria and are adopted as credible by an ASH clinical peer review committee. Further, the use of these practice parameters provides acceptable, scientifically valid, professionally ethical, and responsible support for the decisions made in the management of clinical services rendered to members. The CS Program defines the process for peer review evaluation of the appropriateness and effectiveness of submitted treatment/services, which include visits, examinations, diagnostic tests and/or procedures, and plan of care, including but not limited to intervention and goals.

Written policies and procedures govern all aspects of the CS Program.

State mandates, regulatory requirements, accreditation standards, and/or specific health plan delegation agreements may require modification of some sections of the CS Program for compliance. Where this occurs, the CS Program is modified and approved as applicable.

MISSION

The mission of the CS Program is to enhance the quality of treatment/services rendered to members through:

- Direction and oversight of the continuity of treatment/services provided to the member;
- Detection of trends, patterns of performance, or potential problems related to member health and safety issues;
- Management of quality, clinical efficacy, and utilization of member benefits to encourage optimal clinical and cost effectiveness;
- Education of practitioners to utilize appropriate, efficient, and professionally recognized standards of practice for medically necessary care through the dissemination of standards and guidelines, educational materials, and through outreach by clinical staff;
- Assurance that clinical staff who verify the medical necessity of treatment/services are not compensated or given other incentives to make clinical adverse benefit determinations nor for rendering decisions that encourage or result in under-utilization;

- Assurance that quality assurance and medical necessity review decisions are based only on appropriateness of care and treatment/services; and
- Assurance that quality assurance and medical necessity review decisions are conducted consistently and according to professionally recognized standards of practice and ASH policy.

SCOPE

The CS Program defines the process for monitoring and evaluation of treatment/services provided to members by contracted providers/practitioners. The CS Program provides a structured approach to verify the medical necessity and appropriateness of treatment/services delivered to members through review of clinical data submitted by the provider/practitioner on MNR Forms and/or supporting documents. Clinical decisions are made by peer clinicians, when allowed by state regulations, who are appropriately licensed and credentialed and who have experience in direct-contact patient management. The CS Program also outlines ASH's clinical and administrative services in support of the medical necessity review process.

GOALS AND OBJECTIVES

The goals and objectives of the CS Program include:

- Maintenance of accreditation by URAC and the National Committee for Quality Assurance (NCQA);
- Operation of a fully staffed peer review system using credentialed, clinical quality evaluators for timely clinical decision-making, consistency, and efficiency;
- Evaluation of the appropriateness and effectiveness of clinical treatment/services provided to members as well as monitoring over-utilization, under-utilization, continuity and coordination of care, and safety through verification of medical necessity;
- Ensure equitable accessibility and availability to all members for medically necessary care;
- Satisfaction of the demands of operational process efficiencies necessary to manage business growth, reduce administrative expenses, and fulfill quality and service expectations of customers, national accreditation agencies, and regulatory entities;
- Clear and timely communication of quality assurance and medical necessity review decisions, which are based on peer-reviewed literature, educational based textbooks, clinical practice guidelines and clinical services guidelines, to practitioners and members;
- Analysis of member demographics and diagnoses to facilitate a better understanding of the health status of ASH members as well as to determine disease incidence and chronic conditions in the member population;
- Analysis of member service utilization data including but not limited to initial exams/evaluations, subsequent exams/re-evaluations, office visits, x-rays, laboratory tests, and other adjunctive services;

- Direction and oversight of clinical services data through the tracking and analysis of data reflecting verification of medical necessity of treatment/services submitted, as applicable;
- Evaluation of satisfaction with the clinical services process through the Patient Satisfaction Survey. The data are analyzed annually for systemic performance management opportunities and on a real-time basis for patient-specific issues and areas of dissatisfaction;
- Evaluation of satisfaction with the clinical services management process through the annual Practitioner Satisfaction Survey. The data are analyzed annually to identify opportunities for practitioner service improvement;
- Evaluation of complaints from parties involved in the CS (UM) process;
- Development of systems to evaluate and determine which treatment/services are consistent with accepted standards of practice;
- Coordination of timely and thorough investigations and responses to member, practitioner and provider grievances and appeals related to the clinical services process, if delegated;
- Initiation of systems and processes to identify and limit recurring issues related to quality assurance and medical necessity reviews;
- Development and maintenance of systems processes to monitor clinical outcomes of care through satisfaction and outcomes survey methods; and
- Maintenance of systems processes to encourage member health education by making member health education information available on the company website and by making specialty health information available for use by clients in their member education programs.

ORGANIZATIONAL STRUCTURE/ACCOUNTABILITY

The CS Program has been established with input and active participation of key staff and management. The Quality Oversight Committee (QOC) has responsibility for the development and oversight of the CS Program. The QOC includes, among others, the Chief Health Services Officer (CHSO), Senior Vice President, Operations, Senior Vice President, Clinical Services, Senior Vice President, Rehab Services, Senior Vice President, Health Services Administration, Senior Medical Directors and at least one credentialed practitioner.

The CS Program is reviewed, assessed, and approved annually and as necessary by the appropriate quality committees, including the QOC. The responsibility for assessing and monitoring the quality of care provided to members is delegated by the Board of Directors (BOD) to the QOC. The CS Program is approved by the QOC, monitored by ASH senior management, and the outcomes are reported to QOC and the BOD at least annually.

Clinical services activities and reports are integrated into the Quality Improvement Program (QI Program), Quality Improvement Work Plan (QI Work Plan), and Annual

Quality Improvement Evaluation (Annual QI Evaluation) to ensure continuous quality improvement. The Clinical Services department is responsible for coordinating the cross-departmental development, approval, and reporting of the CS Program. The Corporate Compliance Committee (CCC) is responsible for coordinating the cross-departmental development, approval, and reporting of the QI Work Plan and necessary updates, Annual QI Evaluation, and the Clinical Performance Program, and supports quality initiatives under the direction of operations management and the QOC.

STAFF RESPONSIBILITIES

ASH's organizational chart accurately reflects the clinical staff, the Medical Necessity/Benefit Administration (MNA) staff, and reporting structures. Staff position descriptions and committee charters explain the associated oversight and transactional responsibilities and duties. The staff ratios are equivalent to ASH's needs. Reporting relationships are clearly defined. Interdepartmental coordination of medical necessity review is clearly delineated in committee charters, team descriptions, department responsibilities, and position descriptions.

Information is evaluated periodically from URAC, NCQA, Department of Labor (DOL), and Centers for Medicare and Medicaid Services (CMS) in order to analyze internal processes and ensure compliance. Staff are provided documentation, education, and training to understand external regulatory and accreditation standards/requirements and receive education and training in the standards and principles of these organizations as they relate to their responsibilities during initial orientation and at least annually thereafter.

Chief Health Services Officer

The CHSO serves on the QOC as executive sponsor and oversees the Clinical Services departments, which includes Clinical Quality Administration (CQA), Clinical Quality Evaluation (CQE), and Health Services (HLS), which includes Health Services Research. The CHSO serves on the BOD. The CHSO oversees approval and adoption of the CS Program and supporting policies regarding the operations, outcomes, and quality improvement initiatives affected by or related to the CS Program. In conjunction with CQE management staff and clinical quality committees, the CHSO oversees CS Program implementation through the development of key goals, oversight of clinical operations, ensuring timely completion of clinical services activities and management of clinical decision-making. The CHSO supports the development and implementation of the QI Program, QI Work Plan, and Annual QI Evaluation, including development of key goals and quality strategies in conjunction with senior management and ASH's clinical committees. The integral role includes directing, managing, and ensuring timely completion of clinical quality improvement activities performed by the HLS team. The CHSO is responsible for outcomes research and evidence review activities in support of the development of clinical guidelines and criteria that support ASH programs, including the CS Program. The CHSO has oversight of the clinical quality sub-committees, the

Quality Improvement Committee (QIC), and the Practice Review Committee (PRC). The CHSO holds an active, current, valid and unrestricted license to practice in his/her respective healthcare field and meets ASH credentialing criteria.

The CHSO has the authority for ad hoc approval of policy on behalf of the QOC to meet regulatory, accreditation, or client requirements when time constraints for filings or other stakeholder expectations require rapid review and approval of policy. These ad hoc approvals are reviewed and adopted by the QOC.

Senior Vice President, Clinical Services and Senior Vice President, Rehab Services

The Senior Vice President, Clinical Services and the Senior Vice President, Rehab Services, whose oversight includes chiropractic, acupuncture, therapeutic massage, naturopathy and rehabilitation services report to the BOD, by means of the CHSO, and are responsible for the oversight of clinical operations, clinical staffing and training, and clinical decision-making processes and procedures provided by the clinical review staff. The Senior Vice President, Clinical Services and the Senior Vice President, Rehab Services hold active, current, valid and unrestricted licenses to practice in their respective healthcare fields and meet ASH credentialing criteria.

Additional responsibilities include:

- Development and implementation of the CS Program;
- Oversight of the organization and management of the CS Program's financial viability, including the allocation of resources and staffing;
- Oversight of clinical services staff and practitioner educational activities;
- Oversight of the Clinical Services Investigation Team (CSIT) and Health and Safety Investigation Team (HSIT);
- Management of the clinical operational linkage between the corporate strategy and the implementation of the CS Program;
- Deployment of corporate mission, development of vision, and strategic operational plan to the CS Program;
- Development and implementation of clinical policy and guidelines, in conjunction with the Clinical Quality Team (CQT) and the QIC;
- Voting member of CCC;
- Voting member of the QIC (the Senior Vice President, Clinical Services also serves as the Co-Chairperson of QIC);
- Voting member of the QOC;
- Provision of adequate resources to support and oversee the development of quality improvement activities related to the clinical services process;
- Analysis of the effectiveness of the CS Program; and
- Oversee the evaluation of consistency and quality audits in the medical necessity review process at least semi-annually.

Senior Medical Directors

A physician (medical doctor) who holds a current and valid license to practice medicine in the State of New Jersey is designated to serve as a Medical Director for medical treatment/services provided to members in New Jersey. The Senior Medical Director, Health Services and the Senior Medical Director, Clinical Services report to the CHSO, and are responsible, as defined in applicable job descriptions, for clinical operations, clinical staffing and training, and/or clinical decision-making processes and procedures provided to the clinical review staff for specialties managed by ASH. Senior Medical Directors hold active, current, valid and unrestricted licenses to practice in medicine [Medical Doctor or Doctor of Osteopathic Medicine (MD/DO)] in a state, territory or commonwealth of the United States, requisite certifications as required by state regulation(s) and meet ASH credentialing criteria.

Additional responsibilities include, as applicable:

- Overseeing the continuing in-service education of professional staff;
- Providing clinical direction and leadership to the continuous quality improvement and medical necessity review programs;
- Establishing policies and procedures covering all medical necessity review determination criteria and protocols applicable to healthcare treatment/services for which benefits are payable under ASH's benefit plans;
- Establishing policies and procedures covering all healthcare treatment/services provided to members when ASH is authorized, and elects, to engage in the direct or indirect provision of healthcare treatment/services.
- Contributing to the development and implementation of the CS Program in collaboration with the CHSO, the Senior VP of Clinical Services, and Clinical Services management staff;
- Participates in the Clinical Quality Team (CQT), which have responsibility for the development of Clinical Practice Guidelines (CPG);
- Advising Clinical Services management regarding appropriate professional staffing and training for the clinical review staff;
- Reviewing and providing direction regarding the identification and management of clinical matters that require allopathic-complementary practitioner co-management.
- Performance of medical necessity review and quality assurance activities in accordance with accreditation and regulatory requirements;
- Examination and provision of direction regarding the identification and management of clinical matters that require allopathic-specialty practitioner co-management;
- Co-chair of Quality Improvement Committee (QIC); and supports clinical decision making while participating in clinical committees as assigned;

- Provides management decision-making and participates in decision-making regarding the clinical operational administration of the programs assigned;
- Supports the development of clinical practice guidelines, credentialing criteria, and other clinical decision assist tools;
- Provides medical support to the development of clinical programs and serves on project management teams collaborating with operations and other administrative departments as assigned;
- Voting member of the QIC (the Senior Medical Director, Clinical Services also serves as the Co-Chairperson of QIC); and
- Voting member of the QOC, which is responsible for review, approval, and adoption of policies, including the CS Program, and other policy/operational documentation.

Senior Management of Clinical Services Departments

Senior management staff of the Clinical Services department report to the Senior Vice President, Clinical Services, the Senior Vice President, Rehab Services or a Senior Medical Director and maintain active, current, valid and unrestricted licenses, certifications, or registrations and meet ASH's credentialing criteria used for the applicable specialty.

Senior management staff of the Clinical Services department are available to staff on site or by telephone and are responsible for clinical services activities, interaction with MNA, and evaluation of clinical services appeals.

Additional responsibilities include:

- Development of processes to support and enhance clinical services;
- Coordination of clinical appeals with external clinical consultants and appropriate peer review committees;
- Identification of practice patterns that may warrant inquiry letters or clinical Corrective Action Plans (CAPs);
- Assisting with CAP compliance through educational activities;
- Providing input into the development and review of clinical service and practice guidelines, decision-making criteria, outcome assessment tools, and clinical policy;
- Identification and development of educational topics and materials for distribution and/or presentation to practitioners;
- Participation in clinical committees as assigned by the BOD;
- Participation in interdepartmental key process teams as assigned by the Senior Vice President, Clinical Services, the Senior Vice President, Rehab Services or a Senior Medical Director;
- Support and implementation of quality improvement initiatives related to clinical services;

- Resolution of clinical issues and oversight of the evaluation process of clinical decision-making including monitoring documentation for adequacy and monitor consistency and appropriateness in medical necessity decision making for each level and type of clinical services (UM) decision;
- Clinical training and day to day supervision of clinical quality evaluators; and
- Evaluation of performance and counseling of staff.

Clinical Quality Evaluators

Clinical quality evaluators report to Clinical Services senior management staff. Clinical quality evaluators maintain an active, current, valid and unrestricted license, registration, or certification applicable to the medical necessity verification and other quality review work they are assigned to perform. ASH staff will meet the credentialing criteria for the applicable specialty. Their professional education, training, and experience are commensurate with the clinical evaluations they conduct. Clinical quality evaluators are qualified and knowledgeable to perform medical necessity verifications.

Written job descriptions for the clinical quality evaluators are maintained in personnel records. Responsibilities include:

- Evaluation of the medical necessity of submitted treatment/services;
- Approval of medically necessary and appropriate treatments/services;
- Enhancement of continuity and coordination of services whenever possible;
- Recommendation of continuous quality improvement clinical services initiatives;
- Identification of quality of care or treatment/service concerns;
- Provision of outreach and education to practitioners as needed;
- Endorsement of the principles and procedures of clinical services and the DOL, NCQA, URAC, and CMS standards;
- Provision of clinical opinions regarding the medical condition, procedures, and treatment under review, as necessary; and
- Identification of psychosocial or other co-morbid conditions or the presence of symptoms or conditions that suggest the need for redirection to or co-management with a physician or other appropriate healthcare practitioner through the evaluation of MNR Forms and medical records. When evidence of such a need is identified, the clinical quality evaluator may, as appropriate, consult with the Senior Management staff of the Clinical Services department and notify the practitioner to facilitate coordination of care with other appropriate healthcare practitioners.

All personnel that make medical necessity review decisions and those who supervise them are apprised that:

- No punitive action may be taken against a practitioner for supporting a member in a standard or expedited appeal request;

- Medical necessity review decisions are based on an evaluation of submitted clinical information and adopted clinical standards of practice, and is solely for the purpose of determining whether the submitted services can be approved for benefit coverage based on appropriateness and medical necessity;
- Clinical decisions made by clinical quality evaluators are non-discriminatory of any personal characteristics of the practitioner or member;
- Clinical quality evaluators, practitioners, or other individuals who make medical necessity review decisions are not rewarded for issuing denials of benefit coverage for health care services; and
- Clinical quality evaluators are not eligible for, nor do they receive, financial incentives that encourage or result in under-utilization; and their decisions to withhold, delay, or not approve medically necessary treatment/services are not connected to any bonus or incentive program.

Medical Necessity/Benefit Administration Staff

MNA staff are responsible for coordinating the administrative management of the review process by entering administrative information into the clinical services database system, Integrated Health Information Systems (IHIS). MNA staff evaluate demographic and administrative compliance components of the MNR Form submission process. ASH clinical quality evaluators are available to MNA staff during this process. The MNA staff do not influence or make decisions regarding medical necessity of treatment/services or interpret clinical decisions, and ASH does not issue adverse benefit determinations of medical necessity based on administrative review of MNR Forms. The MNA Director is responsible for evaluating administrative data entry accuracy, in accordance with client and regulatory requirements and ASH policy and procedures.

Additional responsibilities include:

- Verification of member eligibility and benefit coverage;
- Verification that practitioners are credentialed and verification that providers are contracted;
- Data entry of MNR Form information into IHIS;
- Coordination of evaluations with clinical quality evaluators and data entry of clinical decisions into the database as necessary;
- Coordination of communication of decision responses to practitioners and members; and
- Collection of member documentation for clinical quality evaluators as necessary to evaluate member history and previous treatment.

MNA staff receive training about data collection requirements and ensure data are entered in a timely manner. When MNA staff identify contractual, practitioner education, practitioner non-compliance, or administrative issues, the issues are communicated to the

appropriate department for management. The MNA staff also receive training regarding external regulatory, accreditation, and client requirements affecting their position responsibilities.

The Senior Vice President, Clinical Services, the Senior Vice President, Rehab Services and a Senior Medical Director oversee the operational process via the MNA management staff of and, in collaboration with the Clinical Services team, oversee the interface between MNA staff and the Clinical Services department.

Credentialed Practitioners

Initial treatment/services may be available to members on a direct access basis, where allowed by state law and/or scope of practice regulations. However, health plan delegation agreements, benefit design, state mandates, and regulatory requirements may necessitate a referral. Members may change practitioners at any time. If the member requires more treatment/services than are available within the applicable tier level, an MNR Form must be submitted for verification of medical necessity of those additional treatment/services by a clinical quality evaluator. These requirements are detailed in the Operations Manual as part of the services agreement and client summaries.

Practitioners submit information that is necessary to evaluate and verify the medical necessity of submitted treatment/services to MNA within submission time frames. Required information is limited to only that necessary to identify the member and practitioner and to conduct the clinical review. This includes:

- Patient information: name, address, telephone number, date of birth, sex, member ID number, plan ID number, and subjective complaint(s);
- Member information (if different from patient information): name, employee ID number, relationship to patient, employer, group number, and other coverage available;
- Attending practitioner information: name, address, telephone number, fax number, degree/license/certification/registration, Tax ID number or National Provider Identifier (NPI);
- Appropriate clinical information: diagnoses, examination/assessment findings, symptoms, type of treatment/services submitted or provided, duration of treatment/services submitted or provided, number of treatment/services submitted or provided, supports and appliance(s) (if applicable), rationale for initiation or continuation of care, measurable outcome of care information, discharge plan (anticipated release date); and coordination of care or referral; and
- History and clinical evaluation findings sufficient to substantiate the diagnoses (if applicable) and support the level of treatment/services submitted or provided.

COMMUNICATION SERVICES

Availability During Business Hours

Customer Service representatives are available by fax, electronic, or telephonic communications, including voicemail, to respond to inquiries from members, practitioners, and/or facility personnel.

Member Services Hours

Between October 1 and March 31: Sunday - Saturday (7 days a week) from 8:00 am – 8:00 pm local time, for each time zone in which ASH provides service (closed Thanksgiving Day and Christmas Day)

Between April 1 and September 30: Monday-Friday from 5:00 am – 8:00 pm PST (closed for all ASH observed holidays)

Provider Services Hours

Monday – Friday from 5:00 am – 6:00 pm PST (closed for all ASH observed holidays)

Such inquiries may include general clinical services administrative questions and requests for information regarding specific medical necessity review requirements and procedures. Customer Service representatives document inbound communications and their response in the ASH proprietary communication log. Customer Service representatives may refer specific inbound clinical services communications to the MNA staff or clinical quality evaluators, as appropriate.

MNA staff and clinical quality evaluators are available at least eight (8) hours a day during normal business hours to receive inbound and perform outbound communication regarding clinical services issues. MNA staff and clinical quality evaluators provide telephone and fax numbers and/or secure electronic access to practitioners for inbound communication.

- Outbound communications may include directly speaking with practitioners and members or fax, electronic, or other telephonic communications, including secure electronic mailbox and voicemail;
- Staff identifies themselves by name, title, corporate name, and license/certification number, where applicable, when initiating or returning calls regarding clinical services issues; and
- Inquiries and responses are documented in the ASH proprietary communication log. ASH provides a toll-free number for calls regarding clinical services issues and the ability to speak to a clinical quality evaluator.

Communications received after normal business hours are returned on the next business day and communications received after midnight on weekdays (Monday – Friday) are responded to on the same business day.

Inbound and outbound telephone calls may be monitored or recorded for quality assurance purposes.

Availability Outside Normal Business Hours

ASH provides a toll-free number and e-mail address for communications regarding clinical services issues. Customer Service, MNA, and clinical quality evaluators retrieve or respond to all routine, non-urgent messages no later than the next business day.

A contracted answering service screens after-hours calls. If a member or practitioner states the issue is urgent, ASH's "on call" Customer Service supervisor is contacted. The "on call" supervisor returns the member's or practitioner's call and provides assistance. If the issue is of an urgent clinical nature, an ASH senior clinician is contacted immediately and notified of the issue for resolution. The member or practitioner call and resolution are documented in the ASH proprietary communication log the next business day.

Capacity of voicemail service, answering machine, or e-mailbox is monitored and adjusted as needed to accept the volume of incoming communications.

Disclosure Regarding Access to Clinical Services

Information regarding the process for accessing clinical services is disclosed in member and practitioner materials and includes:

- Normal business hours of operation for the Customer Service, MNA, and CQE departments;
- ASH's toll-free number(s) as appropriate for clinical services inquires; and
- Information regarding the after normal business hours communication process.

Member Assistance

ASH ensures that members have access to a representative by providing assistance to those with limited English proficiency or with a visual or other communicative impairment. ASH maintains a toll-free telephone number answered by representatives who are trained to facilitate interpretation services. ASH representatives have access to a language line that offers over-the-phone interpretation from English into more than 300 languages. When a representative identifies a need for language assistance, a three-way call to the interpreter is usually initiated within 60 seconds or less. ASH is also prepared to receive TDD calls from members with communicative impairments.

APPLICATION OF STANDARDIZED CLINICAL GUIDELINES

In an effort to assist in the management of a positive clinical outcome and provide fairness and consistency, clinical guidelines are developed and adopted with involvement of appropriate, actively practicing practitioners with current knowledge for criteria applicability. Practitioners may also be employees of in- network providers. Actively practicing practitioners also have the opportunity to comment on the instructions for

applying the evidence-based criteria. Clinical services decisions are based on clinical guidelines that:

- Reflect sound clinical evidence;
- Are developed from an evaluation of current applicable scientific literature;
- Represent consensus of committees comprised of credentialed practitioners;
- Incorporate expert opinion, when applicable; and
- Allow for modification secondary to consideration of the individual needs of the member and characteristics of the local delivery system.

Criteria based on individual contributing factors such as age, co-morbidities, complications, and clinical progress are applied when making individual clinical services decisions.

Clinical decision-making guidelines are evaluated annually and updated when appropriate. Guidelines may be reviewed by clinical committees and modified any time there is new clinical evidence that changes the clinical opinion regarding a given disease, condition, or procedure. The CQT is an internal workgroup that provides research and recommendations for clinical decision-making guidelines development and criteria for appropriateness of utilization. Clinical decision-making guidelines are reviewed and approved by QIC and QOC on behalf of the BOD prior to implementation.

Clinical quality evaluators are provided with clinical decision-making guidelines and receive training in the application of the criteria. These guidelines enable clinical quality evaluators to evaluate the medical necessity of diagnostic procedures and therapeutic interventions submitted by practitioners or provided to members. Clinical guidelines and revisions are made available on the ASH public website, through a secured practitioner website, or provided to all practitioners, as applicable.

Members and the public may request (free of charge) these clinical decision-making guidelines by contacting Customer Service. The following disclosure statement will be included in the cover letter to the requesting individual: “The materials provided are guidelines used by ASH to verify the medical necessity of treatment/services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered by your contract.” The clinical guidelines are also available on the ASH public website.

When used as clinical adverse benefit determination criteria, clinical guidelines may be shared with practitioners or members to explain the rationale for the adverse benefit determination of a given treatment/service. It is the responsibility of the clinical quality evaluator to apply his/her clinical expertise when using these guidelines as individual findings such as severity factors or co-morbidities may influence medical necessity decisions.

An executive summary of the CS Program is available on the ASH public website. Members and the public may also request a copy of the process by which ASH verifies the medical necessity of submitted treatment/services by contacting ASH by telephone, fax, or email. The contact information for each method is also on the ASH public website.

MEDICAL NECESSITY REVIEW

Medical necessity review decisions are made by peer clinical quality evaluators and, where applicable, Board Certified consultants. Clinical quality evaluators maintain an active, current, valid and 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 medical necessity reviews they conduct. Unless otherwise 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. Decisions include approval or denial for benefit coverage of services based on an evaluation and verification of medical necessity, assessment of quality of care, coordination and provision of alternate levels of care, and evaluation of appropriate levels of care.

A medical physician conducts medical necessity review of physical medicine therapy services (PT, OT, SLP) when the referring provider and/or patient requests that a physician conduct the review. In addition, a medical physician conducts the medical necessity review of physical medicine therapy services when a patient's response to treatment requires physician intervention as indicated by medical or scientific evidence or clinical practice guidelines, such as when a patient:

- Has an adverse reaction to the treatment; or
- Is not responding to treatment (failure to progress); or
- Regresses to an earlier level of functioning or disease state (i.e., morbidity increases).

Pre-service medical necessity review decisions are made based solely on the information available to the practitioner and communicated to ASH at the time that clinical care was requested.

Concurrent/post-service medical necessity review decisions are made based solely on the information available to the practitioner and communicated to ASH at the time that clinical care was provided.

Denial decisions may be overturned when the practitioner submits additional clinical information not available to the clinical reviewer at the time of the initial decision. ASH encourages peer to peer conversations when appropriate regarding medical necessity determinations.

Approval decisions may only be reversed when additional identifies fraud committed by the member, provider or practitioner. Such reversal shall not result in additional cost to an innocent member, provider or practitioner. In the case of a reversal, ASH would continue to provide coverage and make payment for the currently approved ongoing course of treatment while an internal appeal or grievance is under review.

Members and practitioners are notified, as applicable, of service evaluation decisions within time frames specified in the *Medical Necessity Review – New Jersey (NJ UM 2 – S)* policy.

For information on urgent/emergent services please see the *Urgent/Emergent Services – New Jersey (NJ UM 13 – S)* policy.

ASH does not conduct on-site (facility-based) medical necessity reviews.

ASH Utilization Management processes

ASH is contracted by Payors to provide medical necessity verification of services rendered to members through various forms of medical necessity verification (a.k.a. medical necessity review or utilization management) processes. Below is a list of medical necessity verification protocols that ASH may implement based on needs of a Payor contract.

Site of Care Review

SOC reviews operationalize medical policy which document the clinical presentation situations where care of the patient can continue in the Hospital Outpatient PT, OT, and SLP department or affiliated clinic. If criteria are not met, patients are redirected/transitioned to an in-network, non-hospital based PT/OT/SLP clinic setting or virtual setting.

Review of SOC criteria may be supported by automated protocols considering provider submitted clinical case data. Automation systems analyze patient data presented by the treating provider against a binary set of criteria for consideration of approval for medically necessary services to be provided in the Hospital Outpatient PT, OT, and SLP setting. For any situation where policy criteria are not met, provider clinical case data is sent to a credentialed clinical peer for review against policy criteria. At no time are AI based machine learning or algorithm supported processes used to make clinical denials or redirection/transitioning care final decisions or appeal decisions.

Prior Authorization Review

Prior authorization means the process by which a payer determines the medical necessity of an otherwise covered services prior to the rendering of the service including, but not limited to, preadmission review, pretreatment review, utilization review, and case

management. Prior authorization also includes a payer's requirement that a covered person or health care provider notify the payer prior to providing a health care service.

ASH does not require prior authorization, prospective review, or pre-service review. ASH recommends that the provider/practitioner submit requests for treatment/services, when necessary, within three (3) days of the date(s) of service; however, requests must be submitted no more than 180 calendar days from the date(s) of service. The provider/practitioner has the option of submitting the requests for treatment/services prior to the delivery of treatment/services, but it is never required to be submitted prior to rendering care for health care services to be paid. Providers are required to provide medically necessary services when the member presents for services. Providers have options, as noted, when they engage with the ASH medical necessity verification process.

True Pre-Service Review

When all treatment/services submitted by the practitioner for verification of medical necessity that are submitted prior to the provision of any treatment/services are managed under the definition of true pre-service review.

Pre-Service Review

When treatment/services are voluntarily submitted by the practitioner for verification of medical necessity when some treatment/services have been initiated and there are still treatment/services to be rendered within the proposed plan of care are managed under the definition of pre-service review.

Concurrent Review

Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. A concurrent review decision is any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. 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 time frame appropriate to the type of decision (i.e., non-urgent pre-service, urgent pre-service or post-service).

Post-Service Review

All treatment/services submitted after the ending date of service (DOS) for verification of medical necessity are managed under the definition of post-service review.

Urgent Service Review

For credentialed practitioners/providers, urgent services are defined as covered services for non-life-threatening conditions that require care by a contracted practitioner within 24 hours.

For non-credentialed practitioners/providers, urgent services are requests for healthcare services or treatments that require an expedited review and medical necessity determination because the time period allowed for non-urgent care determination is too lengthy and could present a health and safety issue.

Clinical Performance System

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 arrangements, 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.

The CPS, by applying appropriate levels of clinical MNR oversight, is designed to reduce burdensome authorization requirements for providers that demonstrate consistent compliance with ASH guidelines. Please see the *Clinical Performance System (UM 9 – S)* policy for additional information on the tier determination criteria and progression.

Approval Decisions and Adverse Benefit Determinations

Only a clinical quality evaluator who holds an active, current, valid and unrestricted license/certification/registration and is successfully credentialed may verify medical necessity of submitted treatment/services.

All adverse determinations based on medical necessity for chiropractic benefits are made by a New Jersey licensed chiropractor identified as a Clinical Quality Evaluator with oversight by a New Jersey licensed physician (MD/DO).

For all specialties other than chiropractic, all adverse determinations based on medical necessity are made by a physician (medical doctor) who holds a current and valid license in the State of New Jersey.

Requests for Additional Information

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 practitioner. If ASH is unable to make a determination due to missing necessary information, the time period for making the decision may be suspended according to the time frames specified in the *Medical Necessity Review – New Jersey (NJ UM 2 – S)* policy.

Second Opinions

As members have the right to change practitioners at any time, a member may seek a second opinion by seeing another credentialed practitioner in the member's service area.

The credentialed practitioner consulted for the second opinion will comply with the conditions referenced in services agreements.

Reopen (Peer-to-Peer Conversation)

ASH providers/credentialed practitioners may submit information in support of a reopen if one or more treatment/services previously submitted resulted in an adverse benefit determination due to a failure to provide sufficient supporting documentation.

Additional Service Requests (Modifications)

ASH providers/credentialed practitioners may request a modification of an approved course of care to request additional treatment/services beyond those already submitted for verification of medical necessity for the episode of care (e.g., x-rays, procedures/modalities, and office visits) or to request a modification to the time period already submitted for the delivery of treatment/services.

USE OF ARTIFICAL INTELLIGENCE IN MEDICAL NECESSITY REVIEW

For purposes of ASH policies, "Artificial Intelligence" (AI) is defined as "an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments."

ASH does not use Artificial Intelligence" (AI) to make medical necessity determinations.

ASH employs AI to improve clinical quality evaluator efficiency, and reduce time to review, improving the timely review processes by a human being. ASH uses a Large Language AI Module (LLM) system to highlight, link, and extract key clinical information from large (voluminous page counts) submitted medical records. The key clinical information is not altered and is presented as an excerpted extraction with active links to the medical record so that the clinical quality evaluator may access, navigate, and evaluate the clinical information efficiently. The original medical records are kept intact, the extraction is only used to facilitate the review process, and the clinical quality evaluator always has access to the original medical records. This LLM process is limited to a subset of the medical necessity reviews in which PT/OT practitioners submit over 5 pages.

COORDINATION OF CARE

During the clinical quality evaluators' evaluation of member and clinical information submitted on MNR Forms to verify the medical necessity of submitted treatment/services, the clinical quality evaluators also review for appropriate coordination of care. This may include referral information, contraindications to care, and/or communication with the member's physician or other health care practitioners, as applicable. Should coordination with or without referral to another health care practitioner be indicated, and no evidence of coordination of care is documented in the MNR Form or the medical records submitted,

the clinical quality evaluator will take the appropriate steps to ensure patient safety and optimum outcomes of care. Options available to the clinical quality evaluator include, but are not limited to, contacting the practitioner to ensure coordination has occurred, notifying the practitioner in an MNR Form that coordination of care appears indicated, and/or taking no action if the coordination appears beneficial, but would have no direct impact on patient safety or clinical outcomes. ASH encourages interprofessional communication between its credentialed practitioners and the member's physician or other health care practitioners, as applicable.

CLINICAL SERVICES INVESTIGATION TEAM

The CSIT facilitates the identification and investigation of potential utilization and quality issues.

The primary function of the CSIT is the identification of instances or patterns of practitioner behavior that may fail to meet professionally recognized standards of practice or are non-compliant with the clinical services process and the investigation of these potential clinical services alerts. In addition to this function, the CSIT investigates potential issues related to utilization of services, facilitates routine medical records evaluations, and assists peer review committees in drafting and monitoring CAPs. [See the applicable *Clinical Services Alerts, Clinical Performance Alerts, and Corrective Action Plans (Practitioner/Provider Clinical Issues) (QM 2 – S)* policy for additional information.]

A list of clinical indicator codes is provided to each clinical quality evaluator. If during the verification of medical necessity, a clinical quality evaluator identifies a potential clinical services alert issue or notes a pattern of submissions that suggests that the member is receiving unsupported care that is not medically necessary, the MNR Form number, practitioner name, member name, and clinical indicator are entered into the CSIT database.

The CSIT reviews entered data and, when appropriate, initiates an investigation of the issue. This investigation may include a request for medical records, x-rays, or other clinical documentation and may result in the need for no further action, an education letter, an inquiry letter, or a clinical services alert reported to PRC for determination of further action.

In addition, when medical records are received from a practitioner as part of clinical services, quality management, appeals, grievances, or other processes, the records are subjected to the standard medical records documentation evaluation process and, if issues are identified that may warrant an investigation or an education letter, a copy of the records is forwarded to the CSIT to determine if further action is necessary. Results of medical records evaluations are reported to the PRC, as necessary.

If the CSIT identifies an apparently egregious health and safety issue that cannot be resolved by HSIT protocols (see below)**,** the issue is presented to the CHSO or designee for immediate review and recommended action.

If a CAP is issued by the PRC or the CHSO, the provider/practitioner is given a detailed summary of the issue. The CAP may also include educational materials and/or a requirement for the provider/practitioner to complete a remedial education course specified by the PRC or the CHSO, if applicable. The PRC determines any applicable timeline for follow-up on the identified issue; the CSIT may request medical records and/or x-rays, as necessary to perform the follow-up activities recommended. CAPs are tracked and trended, as well as reviewed at the time the practitioner is recredentialed.

HEALTH AND SAFETY INVESTIGATION TEAM

The HSIT operates as a cross-functional team within CQE and the CQA processes. The HSIT identifies potential health and safety issues where documentation for treatment/services submitted by the practitioner indicates the possibility of an underlying condition that may require further investigation and/or referral for co-management or alternate management. The HSIT manages these cases to resolution. In addition, the HSIT investigates issues related to child and elder abuse and/or neglect. ASH has implemented protocols for managing cases involving abuse and/or neglect in compliance with state laws and regulations. HSIT activities are tracked through ASH's information systems and aggregate data is reported to QIC and QOC on a quarterly basis in the clinical performance management report. Analysis of results is trended to identify potential opportunities for improvement relating to health and safety. The Senior Vice President, Clinical Services, the Senior Vice President, Rehab Services and a Senior Medical Director advise the HSIT, as needed.

If the HSIT identifies an apparently egregious health and safety issue that cannot be resolved by standard HSIT protocols, the issue is presented to the CHSO or designee for immediate review and recommended action. [See the applicable *Clinical Services Alerts, Clinical Performance Alerts, and Corrective Action Plans (Practitioner/Provider Clinical Issues) (QM 2* – S) policy for additional information regarding Alerts and CAPS; and the *Practitioner Clinical Denials, Terminations, and Appeals (CR 3 – S)* policy regarding practitioner terminations or decredentialing.]

EVALUATION OF NEW TECHNOLOGIES

The CQT, in conjunction with either the Internal Evidence Evaluation Committee (IEEC) or the External Evidence Evaluation Committee (EEEC) and QIC, are responsible for evaluating new clinical technologies used in practice and new application of existing technologies and whether to recommend the new technology or new application as an appropriate addition to the benefit package. Committee members assist in the evaluation of information obtained from appropriate government regulatory bodies and published

scientific evidence. Input is solicited from relevant specialists and professionals who have expertise in the technology. Decision variables considered include health risks, improvements in health outcomes, and/or improved health benefits as compared to existing covered technology.

Any benefit change related to clinical procedures and new technologies will be evaluated and approved by QOC and the BOD. ASH will communicate with contracted clients, as stipulated by delegation agreements, prior to implementation of any changes in benefit related to clinical procedures and new technologies to ensure a mutually agreeable determination. The clinical procedures and new technologies, that, in the opinion of ASH clinical committees/teams, are not clinically effective and/or do not have an improved health benefit over existing technology may not be recommended for addition to the benefit package. For more information, please see the *Evidence Based Health Information Evaluation Technology Assessment (QM 32 – ALL)* policy.

CLINICAL SERVICES PROGRAM MONITORING

Ongoing monitoring of the CS Program is conducted through evaluation of Performance Standards reports, Clinical Performance reports, and the Annual QI Evaluation. Monitoring activities may be specific to administrative processes, clinical practices, providers, practitioners, members, populations, or product lines. Quality Improvement initiatives may be recommended to eliminate deficiencies and enhance outcomes related to clinical services activities. These reports are presented to QOC quarterly and, once approved, are provided to external customers according to contract and/or delegation agreements. Areas evaluated may include but are not limited to:

- Member visits and services rendered;
- Average radiology service approvals per member;
- Average number of exams/evaluations per patient, dates of service or interventions approved/utilized per member per condition;
- Clinical appeals from members, providers and practitioners;
  - 1st level appeals upheld
  - 1st level appeals overturned
  - 2nd level appeals upheld
  - 2nd level appeals overturned
- Distribution of diagnosis codes by category/specialty;
- Adverse outcome indicators;
- Member grievances;
- Clinical services alert and clinical performance alert clinical indicators;
- Number of service approvals (certifications), adverse benefit determinations (non-certifications/denials), Site of Care approvals and Site of Care denials rendered;
- Clinical services decision profile (MNRF codes);
- Access and availability of clinical services; and

- Clinical services profile (evaluations, clerical error rates, clinical consistency, and education program).

Patient and Practitioner Satisfaction

In an effort to assess patient and practitioner satisfaction, a statistically significant representation of practitioner and patient populations is surveyed annually. The following elements are included in the satisfaction evaluation:

- Medical necessity review processes;
- Quality of care and member services;
- Identified sources of dissatisfaction; and
- Practitioner accessibility and availability.

Barriers to care, potential problems, and opportunities for improvement identified from information gathered about satisfaction with the clinical services process are assessed on an ongoing basis and reported at least annually to QIC, CCC, and QOC for analysis. Where opportunities for improvement are identified, action is taken in an effort to meet satisfaction goals and member and practitioner expectations. The annual survey is compared to survey results from previous years to assess trends and assist in evaluating improvements and opportunities.

Over-Utilization and Under-Utilization

Over-utilization and under-utilization are monitored daily by clinical quality evaluators. Utilization patterns are evaluated to identify issues of concern that may affect clinical outcomes. Practitioner specific or aggregate data analysis and clinical performance monitoring are used to educate practitioners whose utilization patterns indicate over-utilization or under-utilization. Practitioners who consistently demonstrate behavior patterns inconsistent with professionally recognized standards and approved policy are identified through a clinical services alert and are evaluated by the PRC. Intervention such as practitioner education or CAPs may be implemented, monitored, and measured when appropriate. These clinical services indicators are included in the quarterly Performance Standards reports.

Clinical quality evaluators are aware of the potential health risks of under-utilization. Clinical quality evaluation management decision-making is based on appropriateness of care and service and existence of coverage only. There are no financial incentives paid to clinical quality evaluators that encourage decisions resulting in under-utilization.

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

Monitoring the Consistency and Appropriateness in Medical Necessity Decision Making

ASH monitors the consistency and appropriateness with which ASH clinical quality evaluators make and document clinical decisions. When appropriate, ASH implements applicable training to improve clinical decision making.

For each specialty with active business that includes Medical Necessity Reviews (MNRs), a formalized annual Quality Assurance (QA) Audit will be conducted of each clinical quality evaluator and, for applicable specialties, Team Manager medical necessity decision making.

- All specialties with active business and all clinical quality evaluators, including those that are newly hired who have completed the training process and are actively reviewing MNRs.
- Collaborative processes with clinical quality evaluators and management will ensure audit observations and recommendations are agreed upon. An evidence-informed consensus process is followed by management for adjudicating differences of opinion in the audit. This may include leadership team members as well as clinical quality evaluator input.
- Passing benchmark aggregately by specialty and individual is ninety percent (90%) or higher. Appropriate remediation/training actions will be taken for those that do not pass benchmark of 90%. Benchmark may be increased by ASH senior management if necessary to improve results.
- CAPs are used by management to help outline improvement opportunities and expectations. CAPs can be utilized by management if there are trends observed that would benefit from a more formalized improvement action plan. A CAP will be initiated by management if a clinical quality evaluator demonstrates continued failure to meet benchmark(s) following remediation/training actions.

In addition to the annual QA audit for each specialty with active business and MNRs, Team Managers or designated management will conduct monthly random reviews of each clinical quality evaluator/peer reviewer's medical necessity decision making during production. This is part of an ongoing QI process performed outside of the formal annual QA audit.

Results of the formal annual QA audits are reported to appropriate ASH clinical leadership for both the specialty in aggregate and by individual. Specialty-wide results are tabulated and trended to identify opportunities for improvement, including development of additional clinical guidelines, rationale codes, and/or development of consensus related to application of existing guidelines.

Individual results are tabulated and trended in order to identify opportunities for improvement related to errors in the application of existing guidelines or rationale coding. As needed, corrective actions are implemented to improve process or individual performance. Specialty results of the formal annual QA audits are also included as part of the 3rd quarter ASH Clinical Performance Management (CPM) reports and the California Health Plan Assessment (CAHPA) report, as applicable, and presented to QIC. Summaries of the formal annual QA audits will be prepared and available to health plan clients upon request in November/December.

For additional information on the auditing process for clinical quality evaluators during their initial training, see the *Orientation, Training, and Evaluation of Clinical Quality Evaluators (UM 7 – S)* policy.

CLINICAL COMMITTEE STRUCTURE

The clinical committee structure and membership are identified in the committee charters for PRC and QIC. Each charter for these committees contains detailed information such as chairperson, voting membership, functions, meeting frequency, quorum, staff participation, and reporting structure.

Practice Review Committee

Functions

The PRC is primarily responsible for the following functions:

- Provide peer review functions for clinical practice review, quality assurance and medical necessity review, and clinical performance review;
- Review and approve clinical policy related to clinical practice review;
- Review and approve the Clinical Performance Systems quantitative and qualitative measures;
- Review Clinical Service and Clinical Performance Alerts and determines necessary action;
- Perform initial credentialing and re-credentialing review and determines participation;
- Review and make recommendations regarding quality of care grievances;
- Issue and monitor Clinical Corrective Action Plans and Sanctions;
- Issue Clinical Quality Termination and de-credentialing decisions;
- Report practitioners to applicable agencies as appropriate (e.g., State Examining Boards, NPDB);
- Provide recommendations for quality improvement activities; and
- Provide reports to CHSO/QIC and, as appropriate, recommendations to QOC with regard to clinical quality, quality assurance, or quality improvement activities.

Quality Improvement Committee

Functions

The QIC is primarily responsible for the following functions:

- Peer review for initial credentialing practitioner denial appeals;
- Peer review for Practitioner Clinical Termination and de-credentialing Appeals – 1st level;
- Peer review for Clinical Performance Tier appeals;
- Peer review for medical necessity review appeals – 3rd level;
- Review and approve clinical policy and clinical practice guidelines;
- Review CQA and BOD reports of immediate terminations and de-credentialing;
- Provide reports to the BOD and, as appropriate, the with regard to clinical quality, quality assurance, or quality improvement activities which may include but are not limited to:
    - Clinical Performance reports;
    - Quality Improvement studies;
    - Clinical elements of Annual QI Work Plan;
    - Clinical elements of Annual QI Evaluation;
    - Practitioner and Member Satisfaction Survey results;
    - Quality audits;
    - CSIT reports;
    - Consistency and appropriateness in medical necessity decision making;
    - Clinical Performance Reports;
    - Aggregate outcomes of peer review decisions; and
    - Delegation oversight reports.

Chairperson Responsibilities

The committee chairperson or official designee is responsible for effective meeting management, priority setting for agenda items, approval of guest attendance, signing approved documents as applicable on behalf of the committee, ensuring committee tasks are completed in a timely manner, calling for votes, following up on issues identified by the committee, ensuring that accurate meeting minutes are maintained, and reporting to supervisory committees.

Meeting Minutes

Committee meeting minutes are taken contemporaneously, dated, and signed by the chairperson and, in some instances, the recording secretary. Confidentially maintained minutes reflect all committee business, including key discussions, recommendations, decisions, actions, review and evaluation of activities, and evaluation of policies. Minutes also include actions instituted by the committee, including appropriate follow up, evaluation of documents, and active practitioner participation. Subcommittee reports are evaluated on a regular basis, when applicable.

Minutes are reviewed and approved by vote of the appropriate committee in a timely manner, with best effort made to finalize at the next scheduled meeting. All agendas, minutes, reports, and documents presented to committees are maintained in a confidential electronic format and are available upon request, as appropriate.

Term of Membership

The BOD appoints committee chairpersons and annually approves committee charters and membership. Each member serves at the request of the BOD and may be removed at any time. All employees are bound by the company confidentiality policy. External committee members must sign an annual confidentiality statement. Credentialed practitioners may not currently serve on committees if they are a principal owner, board member, consultant, clinical quality evaluator, or committee member of another managed care organization or independent practitioner association. All members are required to disclose in writing any potential conflicts of interest that may arise during the course of their service on the committee. Committee members may not copy or distribute any documents without the expressed written consent of the committee chairperson.

Urgent Issues Between Meetings

Ad hoc meetings may be called when pressing issues require immediate resolution. The committee chair reports the issue and resolution to the committee at the next meeting. Committee members may also be reached via teleconference, fax, and/or e-mail when committee input is necessary. The unanimous written consent process may be used when members are unavailable for a meeting.

Guest Attendance at Committee Meetings

Health plan representatives and other guests may attend committee meetings with permission of the President/Chief Operations Officer and/or committee chair. All non-staff guests sign a confidentiality statement for each meeting attended. Guests may only attend portions of the committee meeting pertinent to their business issues.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

ASH strives to comply with all applicable HIPAA requirements and maintains policies relating to HIPAA compliance. All HIPAA-related policies are posted and accessible to all employees for review on the ASH Intranet site. Ongoing mandatory educational seminars are afforded to staff.

CONFIDENTIALITY

ASH defines confidential information as non-public, proprietary information. The guidelines established in the *Confidentiality (QM 8 – S)* policy are followed to ensure this information is held in strict confidence, to safeguard the information received, and to protect

against defacement, tampering, or use by unauthorized persons or for unauthorized purposes.

DELEGATION OF CLINICAL SERVICES

If clinical services activities are delegated to contractors, there is a documented oversight and evaluation process of these activities, including the exercise of oversight of delegated or subcontracted functions in accordance with DOL, URAC, NCQA, and health plan medical necessity review standards. For example, a mutually agreed upon description of the delegated CS Program includes:

- Clinical services activities for which each party is responsible;
- Delegated activities;
- Reporting requirements (including frequency);
- Evaluation process of the contractor's performance;
- Approval of the delegated contractor's CS Programs;
- The process for providing member experience and clinical performance data to its delegates when requested;
- The delegate's clinical services UM information integrity in place to protect data from unauthorized modification;
- How the delegate monitors its clinical services UM information integrity denials and appeals at least annually;
- How ASH monitors the delegate's clinical services UM information integrity denials and appeals at lease annually; and
- The remedies, including revocation of the delegation, if the contractor does not fulfill its obligations.

Evidence shows that:

- The contractor's capacity to perform the delegated activities prior to delegation is evaluated;
- The delegated contractor's CS Program is approved at least annually;
- Regular reports as specified in the delegation agreement are reviewed and approved according to the report submission and frequency of reporting specified; and
- The delegated activities are evaluated annually to ensure they are being conducted in accordance with established ASH policy and expectations, applicable accreditation standards (URAC and NCQA), as well as applicable state and federal laws and regulations.

For delegates that store, create, modify or use clinical services (UM) denial or appeal data for ASH:

- ASH will annually monitor the delegate's clinical services UM information integrity denials and appeals in place to protect data from unauthorized modification;

- ASH will ensure that the delegate annually monitors its adherence to the delegation agreement or its own policies and procedures;
- ASH will review and document all modifications made by the delegate that did not meet the modification criteria allowed by the delegation agreement or by the delegates' policies and procedures; and
- If the ASH delegates processing of UM denial or appeal requests, the organization or the delegate annually audits (as applicable) the delegate's UM denial and appeal files separately for inappropriate documentation and inappropriate updates to:
    - UM request receipt dates.
    - UM denial decision notification dates.
    - UM appeal request receipt dates.
    - UM appeal decision notification dates.
- For each delegate, the audit universe includes UM denial and appeal files (based on the denial and appeal decision notification dates) processed by the delegate during the look-back period.
- If the organization conducts the annual audit, it audits each delegate using one of the following methods:
    - 5% or 50 files, whichever is less, or
    - The NCQA "8/30 methodology"
        - Either methodology is allowed, for consistency with other delegation oversight requirements for annual information integrity audits.
- The organization provides an auditing and analysis report that includes:
    - The date of the report.
    - Title of staff who conducted the audit.
    - The audit methodology:
        - The "5% or 50 files" method or the "8/30" method, as applicable.
        - Audit period.
        - Audit universe size (audit universe is described above).
        - Audit sample size.
    - File identifier (case number).
    - Type of dates audited (receipt date, notification date).
    - Findings for each file.
    - Draw a conclusion if inappropriate documentation and updates occur.
    - The number or percentage and total inappropriate documentation and updates by date type.
- The delegate or organization must provide a completed audit report even if no inappropriate findings were found.
- If the organization uses the delegate's audit results, it must provide evidence (e.g., report, meeting minutes) that it reviewed and evaluated the delegate's findings.
- The organization or the delegate may implement corrective actions.

- For each delegate with inappropriate documentation and updates (findings) identified, the organization documents corrective actions taken or planned, including the time frame for actions, to address all findings identified. One action may be used to address more than one finding, if appropriate.
- The organization's or delegate's corrective action plan identifies staff (by title who are responsible for implementing corrective actions.
- The organization reviews (e.g., report, meeting minutes) and approves a corrective action plan developed and implemented by a delegate.
- The organization or delegate audits the effectiveness of corrective on findings for each delegate within 3–6 months of the annual audit completed.
- For each delegate, the audit universe includes 3–6 months of UM denial and appeal files processed by the delegate since the annual audit. Denial and appeal files are audited separately.
- The organization or delegate conducts a qualitative analysis if it identifies integrity issues during the follow-up audit.
- If the organization uses the delegate's audit results, the organization must provide evidence (e.g., a report, meeting minutes, other evidence) that it reviewed and evaluated the delegate findings.
- The organization draws conclusions on the actions' overall effectiveness.

The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.

NON-DISCRIMINATION

ASH does not discriminate against a member, provider, or practitioner for any reason and does not support any discriminating against members for any reason, including but not limited to age, sex, gender, gender identification (e.g., transgender person), gender expression, gender transition, gender dysphoria, marital status, religion, ethnic background, national origin, ancestry, race, color, sexual orientation, patient type (e.g., Medicaid), mental or physical disability, health status, veteran status, military service, claims experience, medical history, genetic information, evidence of insurability, source of payment, geographic location within the service area or based on political affiliation. ASH renders credentialing, clinical performance, and medical necessity decisions in the same manner, in accordance with the same standards, and within the same time availability to all members, providers, practitioners, and applicants.