

# UTILIZATION MANAGEMENT

Utilization Management is the process by which PreferredOne evaluates, on a prospective, concurrent, or retrospective basis, the Medical Necessity and Medical Appropriateness of health care services rendered or prescribed to members and includes a comprehensive effort to monitor and promote effective, efficient, and timely use of Covered Services.

The purpose of PreferredOne's Utilization Management procedures is to encourage the most appropriate method of treating a member based on prevailing standards of medical treatment which best meets the needs of the member.

The Utilization Management (UM) Program description summarizes procedures, processes and standards that govern the PreferredOne UM Program. The mission of the UM Program is to deliver the finest quality health care to the members enrolled in PreferredOne.

Because each member's individual health care needs is of primary importance, PreferredOne is committed to:

- Promoting health education and initiating preventive health care measures;
- Maintaining the good health of members;
- Early diagnosis and treatment of acute illnesses;
- Maximizing the quality of life for members diagnosed with chronic illnesses.

## Goal

The goal of the UM Program is to assure effective utilization of facilities and services through the use of an ongoing monitoring program designed to identify patterns of over and under utilization and inefficient use of resources.

## Program Structure

The UM Program is comprised of the following areas/functions:

1. Outpatient Services
  - Intake
  - Referrals
  - Authorizations
  - Pre-certification
  - Ancillary Services
  - Reconciliation and Newborn enrollment
  - Adverse Determination Process
2. Inpatient Services
  - Telephonic Concurrent Review

- On-site Concurrent Review
  - Skilled Nursing Facility Concurrent Review
  - Concurrent Review Referrals
3. Health Management Services
    - Case Management (catastrophic)
    - Disease Management
  4. Quality Assurance

### **Staff Qualifications**

- All staff that performs utilization review is appropriately qualified and licensed or are under the direct supervision of a licensed staff member.
- All licensed staff is monitored to ensure licensure is current.
- UM staff attends ongoing educational/informational sessions throughout the year.
- Inter-rater reliability is performed quarterly on all staff that performs utilization review to ensure consistency of the application of utilization criteria.

### **Pre-Certification (Prior Authorization)**

Pre-Certification is the review and authorization of elective/non-urgent admissions and ambulatory services which require medical record review.

- Pre-Certification is performed by licensed personnel utilizing appropriate criteria in the decision making process.
- Each request is reviewed for member eligibility, utilization of participating providers and medical necessity of request.
- All required information regarding the authorization is maintained indefinitely in the PreferredOne database.
- If the requested service meets medical necessity criteria, the authorization is approved and the requestor is notified via facsimile or telephone.
- If the pre-certification nurse is unable to determine the medical necessity of the service requested, the request is forwarded to the Medical Director for final determination. UM staff may not make an adverse determination on issues regarding medical necessity.
- Adverse determinations of services requested are communicated in writing to the member, provider and primary care physician. This communication contains detailed instructions on accessing the grievance process.
- The following services require pre-certification:
  - i. Alcohol, substance abuse programs and behavioral health (contact CompCare, Inc.)
  - ii. Selected Ambulatory surgery
  - iii. Cosmetic
  - iv. Selected ENT (rhinoplasty, Septoplasty, LAUP), Laminectomy, Laminotomy, sleep studies

- v. Cardiac rehabilitation programs
- vi. Durable medical equipment (including orthotics/prosthetics) over \$150.00
- vii. Factor 8 administration
- viii. Hemodialysis (outpatient)
- ix. Home health care services
- x. Hospice services
- xi. Hospital inpatient admissions – elective
- xii. Magnetic Resonance Imaging
- xiii. Non-emergent services rendered by a non-participating provider
- xiv. Non-routine dental and vision treatment
- xv. Nutritional counseling
- xvi. Pain management programs
- xvii. Physical rehabilitation programs
- xviii. Skilled nursing facility services, sub-acute admissions
- xix. Synagis administration
- xx. Temporomandibular Joint Syndrome treatment
- xxi. Weight management programs
- xxii. Gamma knife surgery
- xxiii. Hyperbaric oxygen therapy
- xxiv. PET scan

**Referrals** (only necessary to NON-participating specialists or for Par Specialists for Pain Management, Cosmetic Surgery, and Neuro-Psych Testing)

The members PCP may request a consult with a non-participating provider. This service must be ordered using a PreferredOne referral form, which can be mailed or faxed to PreferredOne.

### **Ancillary Services**

This area of the UM Program reviews and authorizes all home health, durable medical equipment and therapy services requests. RN's, and referral coordinators, utilizing appropriate review criteria perform ancillary service authorization review. Treatment plans for home health and therapies and medical necessity information for DME must be submitted with all requests, with the exception of DME of \$150.00 or less. If the staff is unable to determine medical necessity or the request does not meet criteria, the request is sent to the Medical Director for final determination.

### **Inpatient Services**

Concurrent review involves oversight of members admitted to hospitals, rehabilitation centers and skilled nursing facilities. The concurrent review nurse follows the clinical status of the member on an ongoing basis through telephonic or on-site chart review and communication with the physicians and/or other healthcare professional involved in the members care. The concurrent review process incorporates the use of InterQual guidelines to assess for quality of care and the appropriate level of care for continued

medical treatment. Reviews are performed by licensed nurses under the direction of the Medical Director.

Reviews are not performed more frequently than is reasonably required to assess whether the continued stay under review is appropriate. If the continued stay is determined to meet criteria, the stay is authorized and the facility is notified of the length of the authorization. If the stay does not meet medical criteria for continued stay, the case is referred to the Medical Director for review and final determination of medical necessity. An adverse determination is communicated in writing to the member and provider and contains detailed instructions on accessing the grievance process.

Discharge planning is an essential part of the concurrent review process. It includes coordinating services required to assist in arranging for and implementing a member's transition to a lower level of care. The concurrent review nurse coordinates services with the Primary Care Provider, attending physician and/or the discharge planning personnel at the facility.

### **Review Process**

The Preferred *One* Health Services Department uses InterQual criteria when making review decisions.

#### Adverse Determination Process

- Only the Medical Director may perform initial adverse determinations that involve issues of medical necessity. UM staff is not permitted to make this determination.
- Initial adverse determinations that involve issues of benefit administrative coverage are made by the UM staff.
- Adverse determinations are issued in writing to the member, primary care physician, requestor and the provider. The letter contains a detailed explanation of the reason and rationale used in making the determination as well as steps needed to access the grievance and appeal procedure. A hard copy of the adverse determination is archived and maintained for a period of ten (10) years.

### **Retrospective Review**

A retrospective review is performed when a service has been provided and no authorization has been given.

- Retrospective authorization requests are reviewed for participating provider, continuity of care, date of enrollment and prior receipt of a claims denial.
- If the retrospective request for authorization is due to a denied claim, all records are forwarded to the appeals department for completion.
- If no claim has been submitted, the final determination is rendered by the UM management staff for approval or denial of payment.

- Approvals and authorizations are sent in writing to the requestor.
- Adverse determinations are communicated in writing to the provider and include information on accessing the grievance and appeals procedure.
- Retrospective reviews are completed within thirty (30) days of the receipt of the request.

### **Authorization Processing Timeframe**

The Health Services Department shall make authorization decisions and issue a written notice of action and notice to the provider as expeditiously as the Member's health condition requires, but not to exceed fourteen (14) calendar days following receipt of the request for service. This standard 14 day authorization period may be extended one time only by an additional fourteen (14) days if:

- The Member or requesting provider asks for an extension; or
- PreferredOne documents that the extension is in the Member's best interest because additional information is needed to authorize the service and the failure to extend the timeframe will result in the denial of the service.
- PreferredOne gives the Member written notice of the reason for the decision to extend the timeframe and informs the Member of the right to file a grievance if he or she disagrees with the decision to extend the timeframe.

PreferredOne may expedite its authorization decision if a provider indicates, or PreferredOne determines that following the timeframe indicated above could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. In such circumstances PreferredOne shall issue a decision no later than three (3) working days after the receipt of the request for service.

### **New Medical Technology**

All requests for services that are considered experimental in nature, not in accordance with accepted medical practice, or have no pre-established criteria are reviewed by the Medical Director. The services are extensively researched in consultation with board certified specialists in the specialty of the service requested. In addition, federal, state and local regulations are considered in regards to experimental treatment. The Medical Director makes an initial determination that applies to the requested case only. A draft Coverage and Referral Guideline is then developed and presented to the Medical Advisory Board for final approval. Following approval by the President/CEO, the guideline is disseminated to the UM staff to assist with any future requests.

### **Delegated Entities**

All participating providers or entities delegated for Utilization Management are to use the same standards as defined in this section. Compliance is monitored on a regular basis and formal audits are conducted annually.

## **GRIEVANCE SYSTEM**

PreferredOne maintains a grievance system that meets all statutory and regulatory requirements. PreferredOne's grievance system includes a grievance process, an appeal process and access to and participation in the DSS's administrative hearings process.

### **Grievances**

PreferredOne has a system in place to handle all grievances. Grievances are defined as expressions of dissatisfaction about any matter, other than those matters that qualify as an action. The subject matters of grievances may include, but are not limited to, quality of care, rudeness by a provider or PreferredOne staff person or failure to respect a member's rights.

PreferredOne shall maintain adequate records to document the filing of a grievance, the actions taken, the personnel involved and the resolution. The DSS prescribes a reporting format for tracking of grievances.

A member, or a provider acting on a member's behalf, may file a grievance either orally or in writing. PreferredOne shall acknowledge the receipt of each grievance and provide reasonable assistance with the process, including but not limited to providing interpreter services and toll free numbers with TTY/TTD and interpreter capability.

If the grievance involves a denial of expedited review of an appeal or some other clinical issue, the grievance is reviewed by a health care professional with appropriate clinical expertise.

### **Notices of Action (NOA)**

The Plan/PreferredOne or its subcontractor shall mail a NOA to a Member when it takes action upon a request for services from the Member's treating PCP, or other treating provider, functioning within his or her scope of practice as defined under state law. For purposes of this requirement, an "action" includes:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to act within the timeframes for utilization review decisions; and

5. The failure to provide access to services in a timely manner as required in DSS contract or the failure to provide access to consultations and specialist referrals within three (3) months.

The NOA requirements shall apply to all categories of covered services including transportation to medically necessary appointments.

It is a requirement to issue a NOA described in (3) above if the denial of payment for services already rendered may or will result in the Member being held financially responsible. Such circumstances include, but are not limited to, the provision of emergency services that do not appear to meet the prudent layperson standard, the provision of services outside of the United States without prior authorization, and the provision of non-covered services with the Member's written consent.

It is not a requirement to issue a NOA for the denial of payment for covered services that have already been provided to the Member if the denial is based on a procedural or technical issue, including but not limited to a provider's failure to comply with prior authorization rules for services that the Member has already received, incorrect coding, or late filing by a provider for services that the Member has already received. In these circumstances, coverage of the service is not at issue and the Member may not be held financially liable for the services.

The descriptions above shall not relieve PreferredOne from its responsibility to issue a NOA in all circumstances in which a provider requests prior authorization for a service and the request is denied in whole or in part, as required in (1) above. In addition, nothing shall relieve the Plan from its responsibility to hold a Member harmless for the cost of Medicaid covered services and its responsibility to ensure that the network providers hold a Member harmless for the cost of Medicaid covered services.

It is a requirement to issue a NOA for actions described in (5) above, only if the Member notifies PreferredOne of his or her inability to obtain timely access to services. In such instances, the Member will be provided with immediate assistance in accessing the services. If PreferredOne is unable to access emergency services, an NOA will be issued immediately. For non-emergent services, if a Member contacts PreferredOne concerning the inability to access a covered service within the timeframes referenced in (5) above, and three (3) business days later the Member has not accessed or made arrangements for receiving the services that are satisfactory to them, a NOA will be issued.

A NOA will be issued if a good or service is approved that is not the same type, amount, duration, frequency or intensity as that requested by the provider, consistent with current DSS policy.

It will be identified if the Member reads only a language other than English. For Members who do not read English, the NOA shall be provided in accordance with the contract between the Plan and DSS.

Except as provided in (a) below, PreferredOne will mail an advance NOA for a termination, suspension or reduction of a previously authorized service to a Member at least ten (10) days before the date of any action described above, consistent with current DSS policy. PreferredOne may shorten the period of advance notice to five (5) days before the date of action if: 1) it has facts indicating that the action should be taken because of probable fraud by the Member; and 2) the facts have been verified, if possible, through secondary sources.

All notices related to actions described above shall clearly state or explain:

- 1) the action PreferredOne intends to take or has taken;
- 2) the reasons for the action;
- 3) the statute, regulation, DSS's Medical Services Policy section, or when there is no appropriate regulation, policy or statute, the DSS contract provision that supports the action;
- 4) the address and toll-free number of the Member Services Department;
- 5) the Member's right to challenge the action by filing an appeal and requesting an administrative hearing;
- 6) the procedure for filing an appeal and for requesting an administrative hearing;
- 7) how the Member may obtain an appeal form and, if desired, assistance in completing and submitting the appeal form;
- 8) the Member will lose his or her right to an appeal and administrative hearing if he or she does not complete and file a written appeal form with DSS within sixty (60) days from the date PreferredOne mailed the initial NOA;
- 9) a decision regarding an appeal must be issued by the date that the administrative hearing is scheduled, but no more than thirty (30) days following the date DSS receives it;
- 10) if the Member files an appeal he or she is entitled to meet with or speak by telephone with a representative who will decide the appeal, and is entitled to submit additional documentation or written material for consideration;
- 11) the Member may proceed automatically to an administrative hearing if he or she is dissatisfied with the appeal decision concerning the denial

of coverage for goods or services or a reduction, suspension, or termination of ongoing goods or services, or if PreferredOne fails to render an appeal decision by the date the administrative hearing is scheduled;

- 12) that at an administrative hearing, the Member may represent himself or herself or use legal counsel, a relative, a friend, or other spokesperson;
- 13) if the Member obtains legal counsel who will represent the Member during the appeal or administrative hearing process, the Member must direct his or her legal counsel to send written notification of the representation to PreferredOne and DSS;
- 14) that if the circumstances require advance notice, the Member's right to continuation of previously authorized goods and services, provided that the Member files an Appeal/Request for Administrative Hearing form with DSS on or before the intended effective date of PreferredOne's action or within ten (10) calendar days of the date the NOA is mailed to the Member, whichever is later;
- 15) the circumstances under which expedited resolution is available and how to request expedited resolution; and
- 16) any other information specified by DSS.

In the case of a child who is under the care of the Department of Children and Families (DCF), the NOA will be sent to the child's foster parents and the DCF contact person specified by DSS.

A NOA is mailed within the following timeframes:

- 1) for termination, suspension, or reduction of previously authorized Medicaid covered services, ten (10) days in advance of the effective date;
- 2) for standard authorization decisions to deny or limit services, as expeditiously as the Member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for services;
- 3) if PreferredOne extends the fourteen (14) day time frame for denial or limitation of a service as permitted in the contract between the Plan and DSS, as expeditiously as the Member's condition requires and no later than the date the extension expires;

- 4) for service authorization decisions not reached within the timeframes specified in the contract between the Plan and DSS (which constitutes a denial and thus is an adverse action), on the date the timeframe expires;
  - 5) for expedited service authorization decisions as expeditiously as the Member's health condition requires and no later than three (3) business days after receipt of the request for services;
  - 6) for denial of payment where the Member may be held liable, at the time of any action affecting the claim;
  - 7) for failure to provide timely access to services as expeditiously as the Member's health requires, but no later than three (3) business days after the Member contacts *PreferredOne*.
- a.) An NOA does not need to be sent to the Member ten (10) days in advance of the action, but may be sent no later than the date of action and will be considered an exception to the advance notice requirement, if the action is based on any of the following circumstances:
- 1) a denial of services;
  - 2) *PreferredOne* has received a clear, written statement signed by the Member that:
    - a) the Member no longer wishes to receive the goods or services; or
    - b) the Member gives information which requires the reduction, suspension, or termination of the goods or services, and the Member indicates that he or she understands that this must be the result of supplying that information; and
  - 3) the Member has been admitted to an institution where he or she is ineligible for the goods or services. In this instance, the Member will be notified on the notice of admission that any goods or services being reduced, suspended, or terminated will be re-evaluated for medical necessity upon discharge, and the Member will have the right to appeal any post-discharge decisions.

If the circumstances are an exception to the advance notice requirement as set forth above the Member does not have the automatic right to continuation of ongoing goods or services. In these circumstances, however, and in any instance in which *PreferredOne* fails to issue an advance notice when required, the reduced, suspended, or terminated goods and services are reinstated if the Member files a written appeal form with DSS within ten (10) days of the date the notice is mailed to the Member.

The right to continuation of ongoing goods or services applies to the scope of services previously authorized. The right to continuation of services does not apply to subsequent requests for approval that result in denial of the additional request or re-authorization of

the request at a different level than requested. For example, the right to continuation of services does not apply:

- 1) when a prescription (including refills) runs out and the Member requests a new prescription for the same medication; or
- 2) to a request for additional home health care services following the expiration of the approved number of home health visits.

PreferredOne will treat such requests as a new service authorization request and provide a denial notice.

A NOA is not required if the treating physician or PCP, using his or her professional judgment, refuses to prescribe (or prescribes an alternative to) a particular service sought by a Member. A NOA is also not required if the treating physician or PCP, using his or her professional judgment, orders the reduction, suspension, or termination of goods or services. Such decisions do not constitute an action by PreferredOne. If, however, the Member disagrees with the provider and contacts PreferredOne to request authorization for the service, an expedited review of the request will be conducted, according to the timeframe referenced in the contract between the Plan and DSS. If PreferredOne affirms the provider's action to deny, terminate, reduce or suspend the service, it will issue a NOA. If the Member requests an appeal and hearing, PreferredOne shall continue authorization for the services, to the extent services were previously authorized, unless it is determined that continued provision of the services could be harmful to the Member. The Member will also be advised of his or her right to a second opinion from another provider. Because only a licensed health care provider may prescribe or provide medical services, the Member may not be able to receive some or all of the requested goods or services while the appeal is pending. If the Member's request is approved for the good or service, the Member will be informed of the approval and will also be informed of the right to a second opinion.

### **Appeals and Administrative Hearing Processes**

The appeals process is available for resolution of disputes concerning actions as defined above. There is a record keeping system for appeals that includes a copy of the appeal, the response, the resolution and supporting documentation.

It is clearly specified in the Member Handbook the procedural steps and timeframes for filing an appeal and administrative hearing request, including the timeframe for maintaining benefits pending the conclusion of the appeal and administrative hearing process. Both Spanish and English versions of the NOA's and appeal forms are made available to Member's. The Member handbook lists the addresses, office hours, and toll-free numbers for the Member Services department.

A Member may request an appeal either orally or in writing. When requesting an appeal orally, unless the Member is seeking an expedited appeal review, the Member must

follow up an oral request with a written, signed appeal form. When the Member requests an appeal orally, they will be advised that they must file a written appeal form within sixty (60) days of the NOA in order to receive an administrative hearing. The Member must file an appeal form within ten (10) days of the mailing of the NOA or the effective date of the intended action in order to continue previously authorized services pending the appeal and hearing. In all other respects, the process for pursuing an appeal and for requesting an administrative hearing is unified. Attempts to resolve appeals are made at the earliest point possible. If a decision is not able to be rendered by the time the administrative hearing is scheduled, the Member will automatically proceed to the administrative hearing.

Appeals may be filed by the Member, the Member's authorized representative, or the Member's conservator on a form approved by DSS. A provider, acting on behalf of the Member and with the Member's written consent, may file an appeal. A provider may not file an administrative hearing request on behalf of a Member unless the authorized representative requirements in DSS Uniform Policy Manual Section 1525.05 are met. This section states, "A Member may designate a medical services provider as an Authorized Representative for that Member at a DSS Administrative hearing". This is accomplished by the Member completing and signing the **Designation of Authorized Representative for Administrative Hearing Form** (23-Office of Legal Counsel, regulations and Administrative Hearings "23-OLCRAH"). The signed 23-OLCRAH allows the provider as the Authorized Representative to represent the Member at the Administrative Hearing. The Member must also complete and sign an accompanying **Authorization for Disclosure of Information** through which the Member authorizes DSS to disclose Protected Health Information (PHI). Appeals are to be mailed or faxed to a single address within DSS. If an appeal is received directly from a Member or the Member's authorized representative or conservator, it will be forwarded to the appropriate fax number at DSS within two (2) business days.

Upon receipt of a written appeal, DSS will schedule an administrative hearing and notify the Member and Preferred *One* of the hearing date and location. If a Member is disabled, the hearing may be scheduled to be conducted in the Member's home, if requested by the Member.

The review of the appeal is carried out by an individual or individuals having final decision making authority. Any appeal stemming from an action based on a determination of medical necessity or another clinical issue is decided by one or more physicians who were not involved in making that particular medical determination.

An appeal may be decided on the basis of the written documentation available unless the Member requests an opportunity to meet with the individual or individuals making the determination on behalf of the Plan. The Member can also request the opportunity to submit additional documentation or other written material. The Member shall have a right to review his or her Health Plan record, including medical records and any other documents or records considered during the appeal process. The Member's right to

access medical records shall be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and any applicable state or federal law.

If the Member wishes to meet with the decision maker, the meeting can be held via the telephone or at a location accessible to the Member, including the Member's home if requested by a disabled Member. Any of DSS's office locations may be available for video conferencing, with prior approval from DSS. A representative of DSS must be invited to attend any such meeting.

A written appeal decision is mailed to the Member, described below, with a copy to DSS, by the date of DSS's administrative hearing as expeditiously as the Member's health condition requires, but no later than thirty (30) days from the date on which the appeal was received by DSS. If the Member is dissatisfied with the decision, or if the Plan does not render a decision by the time of the administrative hearing, the Member may automatically proceed to the administrative hearing.

The written appeal decision includes the Member's name and address; the provider's name and address; The Plan's name and address; a complete description of the information or documents reviewed; a complete statement of the findings and conclusions, including the section number and text of any contractual provision or DSS policy provision that is relevant to the appeal decision; and a clear statement of the disposition of the appeal.

Along with its written appeal decision, the Member is reminded that:

- 1) if they are dissatisfied with the appeal decision, DSS has already reserved a time to hold an administrative hearing concerning that decision;
- 2) that the Member has the right to automatically proceed to the administrative hearing, and that PreferredOne must continue previously authorized goods and services pending the administrative hearing decision;
- 3) if the appeal pertains to the suspension, reduction, or termination of goods or services which have been maintained during the appeals process, and the appeals decision affirms the suspension, reduction, or termination of goods or services, those goods or services will be suspended, reduced, or terminated in accordance with the appeals decision unless the Member proceeds to an administrative hearing; and
- 4) if the Member fails to appear at the administrative hearing, the reserved hearing time will be cancelled and any disputed goods or services that were maintained will be suspended, reduced, or terminated in accordance with the appeals decision.

If the Member proceeds to an administrative hearing, the entire file concerning the Member and the appeal, including any materials considered in making its decision, is made available to DSS.

If an appeal decision is not issued by the date that an administrative hearing is scheduled, but no later than thirty (30) days following the date the appeal was received by DSS, an administrative hearing will be held as originally scheduled. At the hearing, PreferredOne must prove good cause for having failed to issue a timely decision regarding the appeal. Good cause shall include, but not be limited to, documented efforts to obtain additional medical records necessary for the decision on the appeal and the Member's refusal to sign a release for medical records necessary for the decision on the appeal.

The inability to prove good cause shall constitute a sufficient basis for upholding the appeal, and the hearing officer, in his or her discretion, may uphold the appeal solely on that basis. If good cause is proven for having failed to issue a timely appeal decision, the hearing officer may order a continuance of the hearing pending the issuance of the appeal decision by a certain date, or the hearing officer may proceed with the hearing.

If the Member is represented by legal counsel at the hearing and has not informed anyone of the representation, a request for a continuance of the hearing may be made or the hearing officer may be asked to hold the hearing record open for additional evidence or submissions. The decision as to whether a continuance will be granted or the record will be held open is within DSS's hearing officer's discretion.

If DSS's hearing officer reverses the decision to deny, limit or delay services that were not furnished while the appeal was pending, PreferredOne will authorize or provide the disputed services as promptly and as expeditiously as the Member's health condition requires.

### **Expedited Review and Administrative Hearings**

An expedited appeal is performed when the standard timeframes for determining an appeal could seriously jeopardize the life or health of the Member or the Member's ability to attain, maintain or regain maximum function. An expedited review is performed in all cases in which the Member's provider indicates, in making the request for expedited review on behalf of the Member or supporting the Member's request, that taking the time for a standard appeal review could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, and if DSS requests an expedited review because they believe a specific case meets the criteria for expedited review.

If a request for expedited review is denied, the review will be performed within the standard timeframe and reasonable efforts will be made to give the Member prompt oral notice of the denial and follow up within two (2) calendar days with a written notice.

An expedited review is completed and an appeal decision is issued within a timeframe appropriate to the condition or situation of the Member, but no more than three (3)

business days from DSS's receipt of the written appeal or three (3) business days from an oral request received by PreferredOne.

The timeframe for decisions can be extended by up to fourteen (14) days if:

- 1) the Member requests the extension or,
- 2) it can be demonstrated that the extension is in the Member's interest because additional information is needed to decide the appeal and if the timeframe is not extended, the appeal will be denied.

A written appeal decision will be issued for expedited appeals. The written notice of the resolution must meet the requirements of those stated above. Reasonable efforts will also be made to provide the Member oral notice of an expedited appeal decision.

DSS also provides expedited administrative hearings for Members, where required. A Member is entitled to an expedited hearing for the denial of a service if the denial met the criteria for expedited appeal but was not resolved within the expedited appeals timeframe or was resolved within the expedited appeals timeframe, but the appeals decision was wholly or partially adverse to the Member.

