TIMEFRAME STANDARDS FOR UTILIZATION MANAGEMENT (UM) INITIAL DECISIONS

Policy Number: ADMINISTRATIVE 088.19 T0 **Effective Date**: November 1, 2018

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Related Policies

- Disclosure Policy
- Experimental/Investigational Treatment
- Experimental/Investigational Treatment for NJ Plans

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

PURPOSE

This policy identifies Oxford's initial utilization management decision and notification timeframes. This timeframe policy is based on State, Federal, Department of Labor (DOL), and National Committee for Quality Assurance (NCQA) guidelines.

DEFINITIONS

Term	Applicable State(s)	Definition
Acceptable Phone Notification	**NY**	The health plan makes: • Phone contact with the enrollee or their designee and communicates the review time extension for, or the approval, partial approval or denial of the requested service; **and** • Phone contact with the requesting provider or provider's representative and communicates the approval, partial approval, or denial of the requested services. **OR** • Phone contact with the requesting provider or provider's representative and communicates the approval, partial approval, or denial of the requested services and the provider has agreed to be responsible for promptly notifying the enrollee of the determination **OR** • A reasonable effort to make phone contact with the enrollee, their

Term	Applicable State(s)	Definition
		designee and/or the requesting provider or provider's representative, in accordance with this policy, and has not successfully confirmed notification.
Administrative Grievance/Appeal	**CT, NJ, & NY**	A request to reverse an administrative (non-clinical, non-utilization management) determination such as payment of claims, coverage of services, disenrollment or missing referrals.
Adverse Determination	**CT & NY**	A denial, reduction, termination, rescission of coverage, or failure to make payment (in whole or in part) of a benefit.
	NJ	A denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, denial of a request for an in-network exception, as well as a failure to cover an item or service for which benefits are otherwise provided because Oxford determine the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the HMO/carrier has rescinded the coverage.
Business Day	**CT, NJ, & NY**	A working day (not including weekends or holidays).
Calendar Day	**CT, NJ, & NY**	Business and non-business days (including weekends and holidays).
Claim	**CT & NY**	Any request for service submitted by a Claimant for pre-service, concurrent, or post service benefits.
	NJ	A request by a member, a participating health care provider or a nonparticipating health care provider who has received an assignment of benefits from the member, for payment relating to health care services or supplies covered under a health benefits plan issued by Oxford.
Claimant	**CT, NJ, & NY**	The covered member or the member's authorized designee.

Clinical Peer	**CT**	A physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.
		Note: For all requests involving:
		• A child or adolescent substance use disorder or a child or adolescent mental disorder the clinical peer must hold:
		  ○ A national board certification in child and adolescent psychiatry; **or**
		  ○ A doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable.
		• An adult substance use disorder or an adult mental disorder the clinical peer must hold:
		  ○ A national board certification in psychiatry, or psychology, **or**
		  ○ A doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

Concurrent Review	**CT, NJ, & NY**	A review conducted during the course of treatment and concomitant with a treatment plan. Included, but not limited to, concurrent review is the anticipation and planning for post hospital needs, arrangement for post hospital or acute treatment follow-up and support, ongoing review for chiropractic, mental health services and other ongoing therapies.
Emergent	**CT, NJ, & NY**	Sudden or unexpected onset of severe symptoms which indicate an illness or injury for which treatment may not be delayed without risking the member's life or seriously impairing the member's health

Term	Applicable State(s)	Definition
Expedited Review	**CT, NJ, & NY**	A modified review process for a Claim involving urgent or emergent care. **Note**: In addition, acute care inpatient admissions/stay in Connecticut, as per the Connecticut Managed Care Act dated 11/1/97, can result in expedited review requests from providers for members admitted to an acute care hospital. The request is used when an attending physician determines that the member's life will be endangered or other serious injury could occur if the member is discharged and/ or treatment is delayed.
Final Internal Adverse Determination	**NJ**	An adverse benefit determination that has been upheld by Oxford at the completion of the internal appeal process, an adverse benefit determination with respect to which Oxford has waived its right to an internal review of the appeal, an adverse benefit determination for which Oxford did not comply with the requirements of N.J.A.C. 11:24-8.4 or 8.5, and an adverse benefit determination for which the member or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.
Precertification, (Pre-Service) Claim	**CT & NY**	A request for services (Prospective) that requires approval by Oxford, in whole or in part, before the service can be rendered; a service that must be approved in advance before it is rendered.
	NJ	Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
Precertification, Urgent	**CT, NJ, & NY**	Requires immediate action, although it may not be a life-threatening circumstance an urgent situation could seriously jeopardize the life or health of the covered member or the ability of the member to regain maximum function or in the opinion of a physician with knowledge of the claimant's condition would subject the member to severe pain. An urgent care condition is a situation that has the potential to become an emergency in the absence of treatment.
Reasonable Effort to Notify (By Phone)	**NY**	• Two or more attempts, by phone, to advise an enrollee, or their designee, of the determination; **and** • Two or more attempts, by phone, to advise the provider or provider's representative of the determination **OR** • At least two attempted phone calls to notify the provider or provider's representative of the determination where the provider has agreed to be responsible for promptly notifying the enrollee of the determination. **Note**: In each of the scenarios above, the caller must wait until someone answers the phone, the call goes to voicemail, or ten rings have occurred (in that order). If the call goes to voicemail, the caller must leave a voicemail. At least one hour must pass between calls to consider the second call a new attempt.
Retrospective, (Post-Service) Claim	**CT, NJ, & NY**	A claim for services, which have already been rendered. Occurs when notification is after the fact of care/service/delivery. The need for "retro-review" is most often created by late or non-notification.
Urgent Behavioral Health Services	**CT**	Those for a service or treatment for: • Substance use disorder or co-occurring mental disorder; and • Inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental disorder.
Urgent Care Request	**CT**	• A request for a health care service or course of treatment for: ○ Which the time period for making a non-urgent care request determination: ▪ Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or ▪ In the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested. When determining whether a benefit request shall be considered an

Term	Applicable State(s)	Definition
Urgent Care Request *(continued)*	**CT *(continued)***	urgent care request, an individual acting on behalf of a health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any benefit request determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition shall be deemed an urgent care request. ○ A substance use disorder* or for a co-occurring mental disorder, or mental disorder. ○ Inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting in connection with a mental disorder. **Persons with substance use disorders, as defined by the state of Connecticut are alcohol dependent or drug dependent persons.*
	NJ	Any claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or that, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
	NY	A request for a health care service or course of treatment for which the time period for making a non-urgent care request determination could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or, in the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested.
Utilization Review	**NY**	The review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. **Exceptions** (not considered a utilization review): • Denials based on failure to obtain health care services from a designated or approved health care provider as required under a contract; • Where any determination is rendered pursuant to subdivision three-a of section twenty-eight hundred seven-c of the public health law; • The review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure; • Any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an Adverse Determination; and • Any determination of any coverage issues other than whether health care services are or were medically necessary.

POLICY

Oxford follows all State, Federal and NCQA guidelines regarding timeframes for Utilization Management initial determinations. This includes Behavioral Health and Pharmacy initial determinations, and excludes issues of fraud or abuse. Although Oxford's goal is to adhere to the strictest timeframe applicable to all of its lines of business (see the Timeframe Standards Comparison grid below), Oxford will meet the mandated timeframes applicable to the particular request. Failure to adhere to applicable state, federal or regulatory resolution timeframes for any state in which Oxford or its delegate is licensed to perform Utilization Management, may result in a technical reversal of the initial determination.

PROCEDURES AND RESPONSIBILITIES

Initial Determination Timeframes for Utilization Management Issues

- The timeframe for utilization management decisions, and notification of decisions, is calculated from the date of the request for services, or the date on which we receive all necessary information, whichever is shorter.
- The Department of Labor (DOL) regulations will supersede all state timeframes unless the state timeframe is more restrictive than the DOL regulations and does not prohibit application of the DOL regulations. This comparison is represented in the Timeframe Standards Comparison grid below.
- Initial determinations timeframes for utilization management issues includes *Medically Necessary* determinations as well as determinations involving treatment or services that are considered *Experimental or Investigational* (refer to policies titled Experimental/Investigational Treatment and Experimental/Investigational Treatment for NJ Plans).
- When additional information is necessary in order to make an initial determination, Oxford will notify the Member or the Member's designee of what specific information is needed.

Note: Oxford administers benefit coverage for behavioral health services in coordination with OptumHealth Behavioral Solutions. OptumHealth Behavioral Solutions has developed level of care (LOC) guidelines which are used for purposes of clinical guidance, utilization management and medical necessity determinations, where applicable. The LOC guidelines ensure that services are essential and appropriate, and reflect empirically validated approaches.

For additional information on Level of Care Guidelines and other topics, please refer to providerexpress.com and;

- Introduction to the OH/OHBSCA Level of Care Guidelines
- Common Criteria and Best Practices for All Levels of Care

NY Products Only

When conducting utilization management reviews, Oxford or its designated utilization review agent must create and retain documentation showing reasonable effort to notify enrollees, their designee, and providers of determinations, Adverse or not, by phone.

For details on what is considered a Reasonable Effort to Notify (By Phone) and for what constitutes an Acceptable Phone Notification, refer to the Definitions section for additional information.

CT Products Only

Utilization Management Reviews

When conducting utilization management reviews, Oxford or its designated utilization review agent must:

- Collect only information necessary, including pertinent clinical data, to make the utilization review or benefit determination.
- Ensure the review is conducted in a manner that ensures the independence and impartiality of the individual or individuals involved in making the utilization review determination.
  Note: All **adverse** utilization review determinations must be evaluated by an appropriate clinical peer (refer to the Definitions section) not involved in the initial or previous Adverse Determination.
- Make no decisions regarding the hiring, compensation, termination, promotion or other similar matters of such individual or individuals based on the likelihood that such individual or individuals will supports the denial of benefits.

Rescission of Authorizations

Prior authorizations for admissions, services, procedures, or extensions of hospital stays may **not** be reversed or rescinded if:

- Oxford failed to notify the insured or member's health care provider at least **three business days** before the scheduled date of the admission, service, procedure, or extension of stay that it was reversed or rescinded due to medical necessity, fraud, or lack of coverage; **and**
- The admission, service, procedure, or extension of stay took place in reliance on the prior authorization.

Timeframe Standards Comparison

Go to the appropriate table to compare timeframe standards for CT, NJ, NY, RI, and DOL.

- Pre-Service Requests
- Post-Service (Retrospective Review) Requests
- Con-Current (On-Going Course of Treatment) Requests
- Urgent Requests
- Urgent Con-Current (On-Going Course of Treatment) Requests

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Pre-Service Requests				
CT	Within 15 days after receiving the request. **Exception**: For certain urgent behavioral health services (*Definitions*), 24 hours after receiving the request (both initial and appeal determinations)*. *This timeframe will also apply to expedited external urgent reviews for the behavioral health services (*Definitions*).	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider.	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial determinations will be made in 2 business days from receipt of necessary information, not to exceed 15 calendar days from receipt of the request. • Oxford will notify within 2 business days that there is a lack of information to make the determination. The claimant will have 45 days to provide the additional information.
NJ	Determinations are rendered on a timely basis, as required by the exigencies of the situation, but in no event later than 72 hours for urgent care claims and no later than 15 calendar days from receipt of necessary information.	Written notification of denials or limitations will be given to the hospital or Provider.	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial determinations will be made in 2 business days from receipt of necessary information, not to exceed 15 calendar days from receipt of the request. • Oxford will notify within 2 business days that there is a lack of information to make the determination. The claimant will have 45 days to provide the additional information.
NY	Three (3) business days from receipt of necessary information.	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider. To the extent practicable, such written notification to the member's health care provider shall be transmitted electronically, in a manner and form agreed upon by the parties. **Note**: Effective for groups new or renewing on or after 04/01/2016 determinations for any request for court ordered mental health and or substance use disorder services must be made by telephone within **72**	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial determinations will be made in 2 business days from receipt of necessary information, not to exceed 15 calendar days from receipt of the request. • Oxford will notify within 2 business days that there is a lack of information to make the determination. The claimant will have 45 days to provide the additional information.

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Pre-Service Requests				
		hours of receipt of the request. Written notice of the determination to the member or member's designee shall follow within **3 business days.**		
DOL	Fifteen (15) calendar days from receipt of the request. Up to 15-day extension if requested within the initial timeframe for review.	To member or member's designee; written notice for Adverse Determinations.	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial determinations will be made in 2 business days from receipt of necessary information, not to exceed 15 calendar days from receipt of the request. • Oxford will notify within 2 business days that there is a lack of information to make the determination. The claimant will have 45 days to provide the additional information.
RI	Default to DOL.	Written notification will be given to the member or the member's designee and to the provider.	For RI residents and providers, the claimant will have 15 days to provide the additional information.	• RI residents and providers, the claimant will have 15 days to provide the additional information. • A decision will be made within 2 business days of receipt of the information, or 2 business days from the expiration of the time to provide it.

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Post-Service (Retrospective Review)				
CT	Within 30 calendar days after receiving the request.	To member or member's designee; written notice (DOL).	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial Determination will be made 30 days from receipt of the request. • Oxford will notify within 30 days that there is a lack of information and the claimant will have 45 days to provide the information.
NJ	Determinations are rendered on a timely basis, as required by the exigencies of the situation.	To member or member's designee; written notice (DOL).		
NY	Thirty (30) business days of receipt of necessary information.	Written notification will be sent to the member or the member's designee and the provider. To the extent practicable, such written notification to the member's health care	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Post-Service (Retrospective Review)				
		provider shall be transmitted electronically, in a manner and form agreed upon by the parties.		
DOL	Thirty (30) days from receipt of the request. Up to 15-day extension if requested within the initial timeframe for review.	To member or member's designee; written notice.	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	
RI	Thirty (30) days from receipt of the request. Up to 15-day extension if requested within the initial timeframe for review.	To member or member's designee; written notice.	For RI residents and providers, the claimant will have 15 days to provide the additional information.	• RI residents and providers, the claimant will have 15 days to provide the additional information. • A decision will be made within 15 days of receipt of the information or expiration of the time to provide it. • Notification to member, member's designee and provider in writing.

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Con-Current (On-Going Course of Treatment)				
CT	Fifteen (15) calendar days from receipt of the request. **Exception:** For certain urgent behavioral health services (*Definitions*), 24 hours after receiving the request (both initial and appeal determinations).* *This timeframe will also apply to expedited external urgent reviews for the behavioral health services (*Definitions*).	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider.	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial Determination will be made within 24 hours of receipt of necessary information. • If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.
NJ	Determinations are rendered on a timely basis, as required by the exigencies of the situation, but in no event later than 24 hours following receipt of necessary information for inpatient hospital services or care rendered in the emergency department of a hospital or 15 calendar days for	Written notification of denials or limitations will be given to the hospital or Provider.	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial Determination will be made within 24 hours of receipt of necessary information. • If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Con-Current (On-Going Course of Treatment)				
	other sites of service.			
NY	One (1) business day of receipt of necessary information.	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider. To the extent practicable, such written notification to the member's health care provider shall be transmitted electronically, in a manner and form agreed upon by the parties. **Note**: Effective for groups new or renewing on or after 04/01/2016 determinations for any request for court ordered mental health and or substance use disorder services must be made by telephone within **72 hours** of receipt of the request. Written notice of the determination to the member or member's designee shall follow within **3 business days**.	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial Determination will be made within 24 hours of receipt of necessary information. • If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.
DOL	Fifteen (15) calendar days from receipt of pre-service requests, or 72 hours from receipt of request for urgent care requests.	To member or member's designee; written notice.	If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.	• Initial Determination will be made within 24 hours of receipt of necessary information. • If additional information is required to make a determination of medical necessity the claimant will have 45 days to provide the information.
RI		Written notification will be given to the member within one business day of the Adverse Determination and to the provider prior to the end of the certified period.		

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Urgent Requests				
CT	72 hours after receiving request. Necessary additional information to be requested within 24 hours of receipt of the request. The Claimant will have 48 hours to provide the necessary information. A decision will be rendered within 48 hours after the earlier	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider (DOL).	Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.	• Not later than 24 hours after receipt of the request. • Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Urgent Requests				
	of the date the person provides the necessary information, or the date by which the information was to have been submitted. **Exception:** For certain urgent behavioral health services (*Definitions*), 24 hours after receiving the request (both initial and appeal determinations)*. *This timeframe will also apply to expedited external urgent reviews for the behavioral health services (*Definitions*).			rendered within 24 hours of receipt of the information or expiration of the original request.
NJ	Determinations are rendered on a timely basis, as required by the exigencies of the situation, but in no event later than 24 hours following receipt of necessary information for inpatient hospital services or care rendered in the emergency department of a hospital or 15 calendar days for other sites of service.	Written notification of denials or limitations will be given to the hospital or provider.	Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.	• Not later than 24 hours after receipt of the request. • Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 24 hours of receipt of the information or expiration of the original request.
NY	3 business days of receipt of necessary information.	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider. Written notification to the member's health care provider shall be transmitted electronically, to the extent practicable, in a manner and form agreed to by the parties. **Exception:** Determinations for any request for court ordered mental health and or substance use disorder services must be made by telephone within **72 hours** of receipt of the request. Written notice	Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.	• Not later than 24 hours after receipt of the request. • Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 24 hours of receipt of the information or expiration of the original request.

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Urgent Requests				
		of the determination to the member or member's designee shall follow within **3 business days**.		
DOL	Not later than 72 hours after the receipt of the request.	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider.	Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.	• Not later than 24 hours after receipt of the request. • Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 24 hours of receipt of the information or expiration of the original request.
RI	Not later than 72 hours after the receipt of the request.	Written notification will be given to the member or the member's designee and to the provider.	For RI residents and providers, the claimant will have 72 hours to provide the additional information.	

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Urgent Con-Current (On-Going Course of Treatment) Requests				
CT	Seventy two (72) hours after receiving request, provided that if the request is to extend a course of treatment beyond the initial period of time or number of treatments, such request is made at least 24-hours prior to the expiration of the prescribed period of time or number of treatment. Necessary additional information to be requested within 24 hours of receipt of the request. The Claimant will have 48 hours to provide the necessary information. A decision will be rendered within 48 hours after the earlier of the date the person provides the necessary information, or the date by which the information was to have been submitted. **Exception**: For certain urgent behavioral health services (*Definitions*), 24 hours after receiving the request (both initial and appeal determinations)*.	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider.	Information will be requested within 48 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.	• Initial Determination as soon as possible but not to exceed 24 hours of receipt of the request; provided that the request is made at least 24 hours prior to the expiration of the number of treatments. • Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request. • Expedited review for Inpatient acute care admission/stay; 3 hours to respond to physicians in CT.

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Urgent Con-Current (On-Going Course of Treatment) Requests				
	*This timeframe will also apply to expedited external urgent reviews for the behavioral health services (*Definitions*).			
NJ	As soon as possible but not to exceed 24 hours of receipt of the request; provided that the request is made at least 24 hours prior to the expiration of the number of treatments. *If notification hasn't been given within 24 hours prior to the expiration of the service, default to the Concurrent timeframes listed above. Default to DOL.	Written notification of denials or limitations will be given to the hospital or Provider.	Information will be requested within 48 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.	• Initial Determination as soon as possible but not to exceed 24 hours of receipt of the request; provided that the request is made at least 24 hours prior to the expiration of the number of treatments. • Additional information will be requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.
NY	As soon as possible but not to exceed 24 hours of receipt of the request; provided that the request is made at least 24 hours prior to the expiration of the number of treatments. *If notification hasn't been given within 24 hours prior to the expiration of the service, default to the Concurrent timeframes listed above. Default to DOL.	Verbal notification will be given to the requester, written notification will be sent to the member or the member's designee and the provider. To the extent practicable, such written notification to the member's health care provider shall be transmitted electronically, in a manner and form agreed upon by the parties. **Exception**: Determinations for any request for court ordered mental health and or substance use disorder services must be made by telephone within **72 hours** of receipt of the request. Written notice of the determination to the member or member's designee shall follow within **3 business days.**	Information will be requested within 48 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.	
DOL	As soon as possible but not to exceed 24 hours of receipt of the request; provided that the request is made at least 24 hours prior to the expiration of the number of treatments. *If notification hasn't been given within 24 hours prior to the expiration of the service,	To member or member's designee; written notice.	Information will be requested within 48 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.	• Initial Determination as soon as possible but not to exceed 24 hours of receipt of the request; provided that the request is made at least 24 hours prior to the expiration of the number of treatments. • Additional information will be

State	Initial Decision Timeframe	Notification	Additional Information	Strictest Timeframe/ Oxford Goal
Urgent Con-Current (On-Going Course of Treatment) Requests				
	default to the Concurrent timeframes listed above. Default to DOL			requested within 24 hours. The claimant will have 48 hours to provide the information. A decision will be rendered within 48 hours of receipt of the information or expiration of the original request.
RI	As soon as possible but not to exceed 24 hours of receipt of the request; provided that the request is made at least 24 hours prior to the expiration of the number of treatments. *If notification hasn't been given within 24 hours prior to the expiration of the service, default to the Concurrent timeframes listed above. Default to DOL	Written notification will be given to the member within one business day of the Adverse Determination and to the provider prior to the end of the certified period.	For RI residents and providers, the claimant will have 72 hours to provide the additional information.	For RI residents and providers, the claimant will have 72 hours to provide the additional information.

Notice of an Adverse Benefit Determination

Adverse Benefit determinations must include the following elements:

State	Elements
CT	• Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount, if known; • The specific reason(s) for the Adverse Determination, including, upon request, a listing of the relevant clinical review criteria including professional criteria and medical or scientific evidence used to reach the denial and a description of Oxford's standard, internal rule, guideline, protocol or other criterion, if applicable, that were used in reaching the denial; • Reference to the specific health benefit plan provisions on which the determination is based; • A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim; • A description of Oxford's internal appeals process, which includes: ○ Oxford's expedited review procedures, ○ A limits applicable to such process or procedures ○ Contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and ○ A statement that the member or, if applicable, the member's authorized representative is entitled, pursuant to the requirements of the Oxford's internal grievance process, to receive from Oxford, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the member's request. • If the Adverse Determination is based on: ○ An internal rule, guideline, protocol or other similar criteria: ▪ The specific rule, guideline, protocol or other similar criteria; or ▪ A statement that: - A specific rule, guideline, protocol or other similar criteria was relied upon to make the Adverse Determination and that a copy of such rule, guideline, protocol or other similar criteria will be provided to the covered person free of charge upon request; - Provides instructions for requesting a copy; and - The links to such rule, guideline, protocol or other similar criteria on Oxford's Internet web

State	Elements
	site. ○ Medical necessity or an experimental/investigational treatment: ▪ A written statement of the scientific or clinical rationale used to render the decision that applies the terms of the plan to the member's medical circumstance; ▪ Notification of the member's right to receive, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence not previously provided regarding the Adverse Determination under review; • A statement explaining the right of the member to contact the Office of the Healthcare Advocate at any time for assistance or, upon completion of the Oxford's internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include: ○ The contact information for said offices ; and ○ A statement that if the member or the member's authorized representative choses to file a grievance that: ▪ Appeals are sometimes successful; ▪ The member may benefit from free assistance from the Office of the Healthcare Advocate, which can assist a member with the filing of a grievance pursuant to 42 USC 300gg–93, as amended from time to time; ▪ The member is entitled and encouraged to submit supporting documentation for Oxford's consideration during the review of an Adverse Determination, including narratives from the member or from the member's authorized representative and letters and treatment notes from the member's health care professional, and ▪ The member has the right to ask the member's health care professional for such letters or treatment notes. • A health carrier is required to offer a covered person's health care professional the opportunity to confer with a clinical peer, as long as a grievance has not already been filed prior to the conference. The health carrier is required to notify the covered person's health care professional that this conference between the physician and the health care professional peer is not considered a grievance of the initial Adverse Determination as long as a grievance has not been filed.
NJ	• Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. Any request for such diagnosis and treatment information following an initial adverse benefit determination shall be responded to soon as practicable, and the request itself shall not be considered a request for a stage 1, stage 2 or stage 3 appeal; • The reason(s) for the adverse benefit determination, including denial code and corresponding meaning, as well as a description of the standard used by Oxford in the denial; • Any new or additional rationale, which was relied upon, considered or utilized, or generated by Oxford, in connection with the adverse benefit determination; and • Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external appeals, which shall include the address and telephone number at N.J.A.C. 11:24-8.7(b).
NY	• The specific reason for denial, reduction or termination of services. • Reference to the plan provision relied on in making the determination. • A description of any additional information needed to complete the claim. • A description of the appeal procedures including a description on the urgent appeal process if the claim involves urgent care. • If an internal rule, guideline or protocol was used in making the determination a copy of that information, or a statement that such information will be available to members free of charge. This includes copies of criteria used in medical necessity determinations or experimental treatments. Refer to Disclosure Policy.

Strict Adherence Required

If Oxford fails to adhere to the requirements for rendering decisions (above) the following rules apply to members enrolled in CT and NJ Products.

State	Elements
CT	The member is deemed to have exhausted Oxford's internal appeals process and may file an external review, regardless of whether Oxford could assert substantial compliance or deminimis error.
NJ	members are relieved of their obligation to complete the internal review process and may proceed directly to the External Review Process under the following circumstances: • We fail to comply with any of the deadlines for completion of the internal appeals process without

State	Elements
	demonstrating good cause or because of matters beyond Our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of noncompliance; • We for any reason expressly waives Our rights to an internal review of any appeal; or • The member and/or their Provider have applied for expedited external review at the same time as applying for an expedited internal review. **Note**: In such a case where Oxford asserts good cause for not meeting the deadlines of the appeals process, members or their Designee and/or their Provider may request a written explanation of the violation. Oxford must provide the explanation within 10 days of the request and must include a specific description of the bases for which we determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with Oxford and rejects the request for immediate review, the member will have the opportunity to resubmit their appeal.

ERISA Rights

ERISA Rights apply to all commercial plans except individuals, church groups and municipalities. After all levels of appeals have been exhausted, the member has the right to file a civil action under 502(a) of the Employee Retirement Income Security Act (ERISA).

REFERENCES

C.G.S.A. § 38a-226c

CT Public Act 11-58

CT Public Act 12-102

Department of Health and Human Services §147.136

Department of Labor Regulations 29CFR 2560.503.1

N.J.A.C. 11:24 & N.J.A.C. 11:24A

NCQA 2006 Utilization Management (UM) Standard 5 "Timeliness of UM Decisions"

New Jersey Health Claims Authorization, Processing and Payment Act (Public Law 2005, Chapter 352)

NJAC: 8:38-8.3(b)

N.J. Admin. Code § 11:24-1.2

N.J. Admin. Code § 11:24A-1.2

N.J. Admin. Code § 11:24A-2.3

NJSA 17B:30-51

NY Ins § 4903

NY Ins § Article 49 of the Public Health Law, 42 CFR 438

Public Act 13-3; Section 72(a), 72(b) & 72(d)

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

11/01/2018	• Added New York plan definition of:
	  ○ Acceptable Phone Notification
	  ○ Reasonable Effort to Notify (By Phone)
	• Revised procedures and responsibilities; added language for New York products only to indicate:
	  ○ When conducting utilization management reviews, Oxford or its designated utilization review agent must create and retain documentation showing reasonable effort to notify enrollees, their designee, and providers of determinations, Adverse or not, by phone
	  ○ For details on what is considered a Reasonable Effort to Notify (By Phone) and for what constitutes an Acceptable Phone Notification, refer to the *Definitions* section [of the policy] for additional information
	• Updated supporting information to reflect the most current references
	• Archived previous policy version ADMINISTRATIVE 088.18 T0