No. UM-012	Medicare Consistency and Timeliness for UM Decisions	canopy HEALTH
Effective Date: 1/1/2020	POLICY AND PROCEDURE	
Previous Versions: N/A		
CMS: Managed Care Manual Chapter 13 Sections: 50.4 (4-20-12) and 90.3 (4-20-12)		

Oversight of MEDICARE Utilization Management Timely Decision Making and Notification Policy

Canopy Health's delegated IPAs, medical groups and contracted Pharmacy Benefit Manager (PBM) make Medicare UM decisions in a timely manner to accommodate the clinical urgency of the situation by following the CMS Medicare and accreditation requirements.

Canopy Health Delegation Oversight Committee reviews and provides oversight of the delegated IPAs, medical groups and PBM's decision making and referral management regarding decision timeliness. This is done by reviewing annual and semi-annual ICE reports from each IPA and by auditing records from denial logs, applying the following CMS timeliness standards summarized here.

In all cases, the determination will be made as expeditiously as the enrollee's health condition requires and within the following decision turn-around times:

ICE Medicare Advantage UM TAT grid 06-10-11;

Revised 6-5-03; 5/17/04, 4/26/06, 9/13/07, 6/10/11

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	▪ Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. ***<u>Extension Notice:</u>*** ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***<u>Decision Notification After an Extension:</u>*** ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination **- If Expedited Criteria are not met**	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written)	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations;

Type of Request	Decision	Notification Timeframes
	or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination - If No Extension Requested or Needed (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ <u>Approvals</u> – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ <u>Denials</u> – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	▪ Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. ***<u>Extension Notice:</u>*** ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***<u>Decision Notification After an Extension:</u>*** ▪ <u>Approvals</u> – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider no later than upon expiration of the extension. ▪ <u>Denials</u> – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

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<tr><th>Type of Request</th><th>Decision</th><th>Important Message from Medicare

(IM)</th><th>Detailed Notice of Discharge (DND)</th></tr>
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<td>Hospital Discharge Appeal Notices

(Concurrent)</td>
<td>Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained.

Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM):
1) within 2 calendar days of admission to a hospital inpatient setting.
2) not more than 2 calendar days prior to discharge from a hospital inpatient setting.

Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).</td>
<td>Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time.

Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital.

▪ NOTE: Follow up copy of IM is not required:
▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge.
▪ When member is being transferred from inpatient to inpatient hospital setting.
▪ For exhaustion of Part A days, when applicable.

If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.</td>
<td>Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO.

The DND must include:
▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered.
▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization.
▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based.
▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.
▪ Any other information required by CMS.</td>
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Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)** ▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative ▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. **Note:** Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

Valid Oral Notification: The following are considered valid oral notification attempts:

1. Speaking with the Member or Representative directly;
2. Attempting to contact the Member or Representative and leaving a HIPAA approved voicemail on the Member's or Representative's preferred phone number; or
3. Making a good faith attempt to contact the Member or Representative at the preferred phone number, however, there is no answer, no answering machine, or the phone number is invalid. When a good faith attempt has been made, the date and time of the attempt must be properly documented in the delegate's system.

Make at least one attempt at oral (verbal) notification.

- If successful (including voicemail), provide written notification within three (3) calendar days of oral notification.
- If not successful (including getting a busy signal), document the good faith attempt:
  - When/How attempted to communicate the decision
  - Resolution outcome or type of decision: Coverage Determination with appeal rights (for denials)
  - Comments documenting the details of the good faith attempt, e.g., Good faith notification to <member name> at <phone number>. Attempt unsuccessful due to <no answer/answering machine, number invalid, member unavailable, phone busy/line unavailable>.

Envelope Requirements for Mail Notices

All UM Correspondence to a Medicare Advantage member must be sent in an envelope pre-printed with the statement "Important Plan Information." Delegates may use pre-printed labels or ink stamps instead of pre-printed envelopes.

Revision History:

Version Date	Edited By	Reason for Change
1/1/2020	R. Scott	Initial Policy Creation