I. Description:

To ensure organization determinations provided by eviCore healthcare for Medicare enrollees are consistent with the requirements established by the *Centers for Medicare and Medicaid Services (CMS)* and the delegation agreement with the eviCore client.

II. Policy/Criteria/Definitions:

eviCore healthcare provides clinical certification services for certain Medicare enrollees. To ensure that services provided to these enrollees are consistent with CMS requirements, eviCore has established processes that include, but are not limited to, the following organization determination activities:

- Expedited
- Extensions
- Adverse Standard Pre-Service
- Favorable and Partially Favorable Standard Pre-Service
- Reconsideration (1st level appeal, if contractually delegated)

Processes for Medicare enrollees may vary by plan in accordance with their internal CMS policies.

eviCore does not withhold payment in cases where a Medicare member seeks emergency services without prior-authorization because he/she believes that a true emergency exists or if a provider identifies the services as emergent, even if such considerations are delegated to eviCore.

Organizational determinations, in whole or in part, are communicated in CMS compliant notices in accordance with client requirements.

Timeliness of decision making for utilization management (UM) requests includes Medicare Part B drugs, reviewed for Part C members.

Failure to provide the enrollee with timely notice of an organization determination, regardless of outcome or if decision has not yet been rendered, constitutes an adverse organization determination and is subject to appeal.

According to *Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*, the definition/description of urgent is met when the enrollee or his/her physician believe that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

In accordance with Title 42 § 422.631 Integrated organization determinations (c)(3), the applicable integrated plan must complete an expedited integrated organization determination when the applicable integrated plan determines (based on a request from the enrollee or on its own) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Pursuant to *Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*, written notice of determination is to be provided to the enrollee, or the enrollee's appointed or authorized representative, if a Medicare health plan decides to deny

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services or payments, in whole or in part, or discontinues/reduces a previously authorized ongoing course of treatment.

According to 42 CFR 438.210 Coverage and authorization of services, each contract between a State and an MCO, PIHP, or PAHP must specify what constitutes "medically necessary services" in a manner that addresses the extent to which the MCO, PINP, or PAHP is responsible for covering services that address (a) the prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability; (b) the ability for an enrollee to achieve age-appropriate growth and development; (c) the ability for an enrollee to attain, maintain, or regain functional capacity; (d) the opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice. ***[42 CFR 438.210(a)(5)(ii)(A)-(D)]***

Medical Exigency Standard

The medical exigency standard requires a plan and the independent review entity to make decisions as "expeditiously as the enrollee's health condition requires." This standard is set forth in regulations at Part 44 Subpart M and Part 423 Subpart M with respect to coverage requests and effectuation of favorable decisions.

This standard requires that the plan or the independent review entity apply, at a minimum, established accepted standards of medical practice in assessing an individual's medical condition. Evidence of the individual's condition can be obtained from the treating provider or from the individual's medical record (e.g., diagnosis, symptoms, or test results).

This standard was established by regulation to ensure that plans develop a standard for determining the urgency of coverage requests, triage incoming requests against established criteria, and prioritize each request according to these standards. Plans must treat each case in a manner that is appropriate for the facts and circumstances of the enrollee's medical condition. Plans should not routinely take the maximum time permitted for adjudicating coverage requests. ***[10.4.1 – Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance]***

Role of the Medical Director

In accordance with 42 CFR §422.562(a)(4) and 423.562(a)(5), all plans must employ a medical director who is responsible for ensuring the clinical accuracy of all coverage decisions made by the plan that involve medical necessity. CMS expects plans to have processes in place for elevating issues of clinical concern to the medical director; however, it is not expected that a plan's medical director will review every medical necessity decision. CMS considers the medical director to be fulfilling their responsibility through the plan's established process for when a medical director must be involved.

The medical director has overall responsibility for the plan's clinical decision-making, and as such, is expected to be involved in various aspects of related plan policies and operations which may include: medical and utilization review, benefits and claims management, formulary administration, processing coverage decisions in accordance with adjudication timeframes and notice requirements, provider/prescriber outreach, staff training, and oversight of delegated entities. The medical director must be a physician, as defined in section 1861(r) of the Act, with a current license to practice medicine in a state, territory, Commonwealth of the United States, or the District of Columbia. ***[10.4.2 – Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance]***

Prior Authorization and Other Utilization Management Requirements

When a plan processes a coverage request that involves a prior authorization (PA) or other utilization management (UM) requirement, such as step therapy for Part B drugs, the plan's determination on whether to grant approval of a service or a drug for an enrollee constitutes an initial determination and is subject to appeal. In addition, if a plan denies coverage of a

service or a drug because the enrollee failed to seek PA or failed to comply with similar limits on coverage, the denial also constitutes an initial determination and is subject to appeal. Partially adverse determinations include coverage decisions in which the MA plan approves a PA request at a reduced level (or approves an altogether different item or service) than the item or service requested. Thus, the adjudication timeframe, notice, and other requirements applicable to coverage determinations or organization determinations under Parts 422, subpart M & 423, subpart M apply to requests that involve a PA or other UM requirement in the same manner that they apply to all coverage requests. If an enrollee requests coverage of a service, item, or drug that involves PA, the plan must accept and process the request as a coverage determination or organization determination and should contact the physician or prescriber for information needed to satisfy the PA, in accordance with the outreach guidance at §10.6. Plans, however, should not use peer-to-peer discussions to solicit substantive modification to pending PA requests in order to improve likelihood for approval (e.g. a peer-to-peer discussion suggesting the physician or prescriber modify a pending PA request to a lower level of service in order to receive plan approval). Coverage and medical necessity decisions are initial determinations subject to notification and appeal requirements. MA plans may not interfere with an enrollee's right to receive a requested initial determination or obstruct the enrollee's access to the appeal process by any means. ***[40.4 – Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance]***

III. Definitions

1. **Part C Organization Determination**: The Part C regulations define an "organization determination" by reference to five (5) specific categories of decisions; this guidance provides additional guidance on what Medicare Advantage (MA) plan determinations are within that definition.

   An organization determination is any determination (i.e., an approval or denial) made by an MA plan, or its delegated entity with respect to the following:

   • Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;

   • Payment for any other health services furnished by a provider (other than the MA plan), that the enrollee believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MA plan.

   • Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the enrollee believes should be furnished or arranged by the MA plan;

   • Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment; or

   • Failure of the MA plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

2. **Part D Coverage Determinations**: A coverage determination is any determination made by the Part D plan sponsor, or its delegated entity, with respect to the following:

   • A decision about whether to provide or pay for a drug that an enrollee believes may be covered by the plan sponsor, including a decision related to a Part D drug that is:

      o not on the plan's formulary;

      o determined not to be medically necessary;

      o furnished by an out-of-network pharmacy; or

      o otherwise excluded under *§1862(a)* of the Act if applied to Medicare Part D.

   • A decision on the amount of cost sharing for a drug;

• Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the enrollee (see 40.11 for more information);

• Whether an enrollee has, or has not, satisfied a prior authorization or other utilization management requirement;

• A decision about a tiering exception request under *42 CFR §423.578(a);* or a decision about a formulary exception request under *42 CFR §423.578(b).*

Note: A plan sponsor is not required to treat the presentation of a prescription at the pharmacy as a request for a coverage determination. Accordingly, the plan sponsor is not required to provide the enrollee with a written denial notice at the pharmacy as a result of the transaction. However, as required under *42 CFR §423.562(a)(3),* plan sponsors must arrange with their network pharmacies to distribute the standardized pharmacy notice developed by CMS to notify enrollees of their right to request a coverage determination. See *§40.12.3* for information about required notification at the point of sale.

3. **Pre-Determination Consultation (PDC):** A PDC is part of the outreach process, outlined as best practice for Medicare beneficiaries, during the organization determination or coverage determination review process. The PDC is a process offered to ordering providers to discuss an organization or coverage determinations not demonstrating medical necessity after Medical Director review but prior to a final adverse determination being rendered.
4. **Medicare Advantage Medicare-Medicaid Plan (MMP)**: A MMP plan is a health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries. Decision making timeframes may be stricter than Medicare Advantage Organization Determination timeframes, dependent on contractual agreements with state Medicaid entities, the health plan, and the *Centers for Medicare and Medicaid Services (CMS)*.
5. **Calculation of Days for Assessing Plan Timeliness**: For the purpose of assessing the timeliness of a plan's completion of a grievance, initial determination, or level 1 appeal, the day a plan receives the request is not counted as "day one". "Day one" is the day after receipt of the request. (Day/days are calendar days unless otherwise specified and includes weekends and holidays). Timeframes measured in hours must be met within the number of hours indicated.

6. **When is a request considered received by the plan**: Plans must have processes in place to accept requests *(*grievance*,* coverage*,* and appeal requests*)* 24 hours a day, 7 days a week (including holidays) and retain documentation surrounding the request(s) within the case record. Requests (and for Part D, prescriber supporting statements for exception requests) are deemed "received" on the date and time:
   • The plan initially stamps a document received by regular mail (i.e., U.S. Postal Service);
   • A delivery service that has the ability to track when a shipment is delivered (e.g., U.S. Postal Service, UPS, FedEx, or DHL) delivers the document;
   • A faxed document is successfully transmitted to the plan, as indicated on the fax transmission report;
   • A verbal request is made by telephone with a customer service representative;
   • A message is left on the plan's voicemail system if the plan utilizes a voicemail system to accept requests or supporting statements after normal business hours; or
   • A request is received through the plan's website, provided the website and/or portal meets all applicable regulatory requirements.

Note: For standard requests, the processing timeframe begins when the plan, any unit in the plan, or a delegated entity (including a delegated entity that is not responsible for processing) receives a request. For expedited requests, the processing timeframe begins when the appropriate department receives the request. Plan material should clearly state where pre- and post-service requests should be sent, thus ensuring requests are received

at the correct location and giving the plan the greatest amount of time to process the request. Plan policy and procedures should clearly indicate how to route requests that are received in an incorrect location to the correct location as expeditiously as possible.

As it relates to written requests, eviCore will accept any type of request in written format and will not require requests to be on a specific form in order to be valid.

7. **When is notification considered delivered by the plan**: Unless otherwise specified (e.g., Section 40.8 of this guidance), written notification is considered delivered on the date (and time, if applicable) the notice has left the possession of the plan or delegated entity. Generally, this occurs when the notice has been deposited into the courier drop box or external outgoing mail receptacle (e.g., U.S. Postal Service or FedEx bin) or for electronic delivery of required materials, the date the plan sends the materials to the enrollee (see Section 100.2.2 of the Medicare Marketing Guidelines for requirements on delivering electronic materials to enrollees). Placement into the plan or delegated entity's internal outgoing mail receptacle is not considered delivered. For electronic payments (i.e., EFTs), delivery occurs on the date (and time, if applicable) the plan distributes the funds for payment.

   Verbal notification is considered delivered on the date (and time, if applicable) a plan speaks directly to or leaves a voicemail for an enrollee or enrollee's representative. Plans may initially provide verbal notification to enrollees prior to issuing written notification.

   In circumstances when verbal notification is permitted per regulatory requirements and the plan successfully provides verbal notice (e.g., spoke with the person that submitted the request or was able to leave a voicemail message), the required written notification must be sent by the plan within three (3) calendar days of the verbal notice. If the plan is not able to successfully provide verbal notice (i.e., when a plan has an enrollee's telephone number on file, but is unable to reach the enrollee at the number provided because, for example, it is either incorrect, out-of-service, or no person (or no voicemail system) answers), written notice must be sent within the applicable timeframe. Information regarding verbal notification for expedited requests can be found at §40.8 for initial determinations and §50.2.2 for level 1 appeals.

   The regulations applicable to adjudication timeframes for standard Part C plan reconsiderations at 42 CFR § 422.590(a) and (c) and standard Part D redeterminations at 42 CFR § 423.590(a) do not address verbal notification. However, the plan may choose to initially provide verbal notification of the decision, but the required written notification must be issued within the applicable adjudication timeframe. For Part C reconsiderations, the plan must issue the determination as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date it receives the request for a standard reconsideration.
   For Part D redeterminations, the plan must notify the enrollee in writing of its redetermination as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days from the date it receives the request for a standard redetermination.

See also *CMS Data Submission and Validation Policy (UM 0206), Medicare Reopen Policy (UM 0270)*

8. **Effect of Failure to Meet the Timeframe for an Initial Determination (40.11):**
Part C Only: The Medicare Advantage plan must explain in its annual Evidence of Coverage (EOC) that enrollees have the right to a level 1 appeal if the MA plan fails to provide timely notice of a decision. If a plan fails to provide the enrollee/representative with a timely notice of its decision, regardless of the medical necessity determination, this failure constitutes an adverse decision (i.e., untimely notification on a request that was determined to be medically necessary [authorized/partially authorized]). Additionally, if the plan has not made the

determination yet but fails to meet the adjudication timeframes for an initial determination, this still constitutes an adverse decision.

9. **Notification Requirements for Initial Determinations (40.12):**
Plans must provide notices for initial determinations using the most efficient manner of delivery to ensure the enrollee receives the notice in time to act. If the request was filed by the enrollee's representative, the representative must be notified in lieu of the enrollee. Plans may provide notice to both the representative and enrollee, but are not required.

10. **Part C Notification Requirements (40.12.1):**
Pre-Service Approvals
For favorable decisions on a pre-service request, notice may be provided verbally or in writing to the requesting party. Verbal or written notice of a favorable decision must explain any conditions of the approval, such as the duration of the approval. As a best practice, Medicare Advantage (MA) plans are encouraged to provide written notice of favorable decisions (again, including any applicable conditions/parameters of the approval). If a provider submits the request on behalf of the enrollee, the MA plan must notify the enrollee as well as the provider of its determination. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may provide notice to both the representative and enrollee, but are not required. If the enrollee agrees, the MA plan may send the notice by fax or e-mail. The Medicare Marketing Guidelines outline the process for electronic communication with enrollees.

Denials and Discontinuation/Reduction of Previously Authorized Ongoing Course of Treatment
A written denial notice is required to be sent to the enrollee (and physician involved, as appropriate) whenever a Medicare Advantage (MA) plan's determination is partially or fully adverse to the enrollee. For Part C organization determination denials, MA plans must use approved notice language when issuing written denial notices to enrollees. The standardized denial notice is the Notice of Denial of Medical Coverage or Payment (Form CMS-10003-NDMCP), also known as the Integrated Denial Notice (IDN). MA plans may use a separate written notice of denial document, such as a plan-generated claims statement to the enrollee or provider, but must use the approved standard language. An example of a plan-generated statement is an Explanation of Benefits (EOB), detailing what the MA plan has paid on the enrollee's behalf, and/or the enrollee's liability for payment.

If an MA plan uses its existing system-generated notification (i.e., EOB) regarding payment denials as its written notice of determination, the MA plan must ensure that the EOB contains the OMB-approved language of the IDN verbatim in its entirety and meets the content requirements as described in the IDN form instructions and listed below. When issuing an EOB in place of the IDN, the MA plan must notify the enrollee via the EOB within the required timeframe. When providing the decision, the MA plan must also take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any.

When using the standardized IDN, the MA plan must provide:

- A specific and detailed explanation of why the medical services, items or Part B drugs were denied, including a description of the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable;
- Information regarding the enrollee's right to appeal and the right to appoint a representative to file an appeal on the enrollee's behalf;
- For service denials, a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process;

• For payment denials, a description of the standard reconsideration process and timeframes, and the rest of the appeals process;
• The enrollee's right to submit additional evidence in writing or in person; and
• An explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).

MA plans are not required to issue an IDN if there is no enrollee liability beyond the applicable cost sharing. An EOB would be issued and indicate any applicable cost sharing.

IV. Responsibility:
Utilization Management staff

V. Process:

A. Initial Screening/Intake Process

Intake is conducted by non-clinical staff who verify member eligibility, review requests for completeness of information, collect and transfer non-clinical data, and may acquire structured clinical data that does not require evaluation or interpretation of clinical data. Initial screening may lead to a certification/authorization if the information collected matches the structured clinical questions.

A licensed health care professional monitors, directs and is available to all utilization review administrative staff while they perform all applicable administrative screening review processes to ensure that staff perform within the scope of their review responsibilities.

1. Requests Initiated by Phone, Mail or Fax
   Verbal requests are thoroughly documented in the case record upon receipt. When the requesting physician or attending health care professional (or any reasonably reliable source that can assist in the certification process) initiates a request for a service requiring clinical certification by phone, mail or fax, non-clinical staff provide the initial screening. This may include acquisition of structured clinical data by CDS staff or processing cases with incomplete administrative data (eligibility, physician or health care professional participation, benefits).
2. Requests Initiated on the Web
   Physicians or health care professionals who have previously registered with eviCore to submit clinical certification requests in a password protected environment may access the web based clinical certification option on eviCore's web site. Users are prompted to complete the required intake and structured clinical data information and, as necessary, submit the request for clinical review.

   Requests initiated through the web site do not require processing by staff but are evaluated in a similar manner as telephonic, mail or fax initiated requests. They are subject to the same determination time requirements. In some circumstances, certifications can be obtained directly through the web application without further clinical evaluation if all of the information matches the structured clinical algorithms. Requests received directly from the web application that were not certified during the web process may be routed to a Clinical Reviewer or Clinical Peer Reviewer to further evaluate the information provided.

   Requests for certification that are noncertified for administrative reasons where the decision is based on a patient's ineligibility or exhaustion of benefits can be processed by the non-clinical staff, where applicable.

B. Organization Determinations (Part C) or Coverage Determinations (Part D): An enrollee or their representative may make a request for all types of decisions about coverage under both Part C and Part D by phone, web or in writing. Other parties that may request an initial determination are: a contract or non-contract provider/physician

that furnishes, or intends to furnish, services to the enrollee, or the staff of said provider/physician's office acting on said physician's behalf (e.g. request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider).

42 CFR 422.629 General requirements for applicable integrated plans.
(k) Review decision-making requirements –
(3) Integrated organization determinations. If the applicable integrated plan expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the integrated organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated organization determination. Any physician or other health care professional who reviews an integrated organization determination must have a current and unrestricted license to practice within the scope of his or her profession.
*[see also: **40.9.a(2)(a/b) Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans]***

42 CFR § 422.631 Integrated organization determinations.
(b) Requests. The enrollee, or a provider on behalf of an enrollee, may request an integrated organization determination orally or in writing, except for requests for payment, which must be in writing (unless the applicable integrated plan or entity responsible for making the determination has implemented a voluntary policy of accepting verbal payment requests).
(c) Expedited integrated organization determinations.
(1) An enrollee, or a provider on behalf of an enrollee, may request an expedited integrated organization determination.
*[see also: **40.8.a(3) Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans]***

40.6.a– Who May Request an Integrated Initial Determination.
For applicable integrated plans:
(1) Where an enrollee can make a request involving Medicare Part C, the enrollee may also make a request involving Medicaid coverage.
(2) The regulation controlling who is a party to an integrated appeal and who may request an integrated organization determination and integrated reconsideration is 42 CFR § 422.629(l).
[Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans]

1. Service Organization Determinations (Authorizations):

Type of request:

1. Preservice Organization Determinations: Requests that are processed before the service is rendered.
2. Concurrent Organization Determinations: Concurrent review is any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments.
3. Post-service Organization Determinations: These are requests for services that are processed after the service is rendered. This includes both Retrospective and late Preservice requests.

Outcome:

1. "*Fully Favorable*" Organization Determinations are cases that are fully approved in the initial review, where the date of the authorization approval notice falls in the reporting period.
2. "*Partially Favorable*" Organization Determinations are requests where some, but not all of the services requested, are approved and some are non-certified in the initial review, where the date of the notification (the denial letter date) falls in the reporting period.
3. "*Adverse Determinations*" are cases that are fully non-certified in the initial review, where the date of the notice (denial letter date) falls in the reporting period.
4. "*Withdrawn*" requests for services are where the member or the provider as the designee, specifically asks that the request be withdrawn, prior to the decision being rendered.
5. *"Dismissed"* A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

C. <u>Organization Determinations-</u><u>Expedited (in whole or in part)</u>

1. All requests for an urgent pre-service review for a Medicare enrollee, whether requested by the enrollee or the ordering provider, are expedited through the review process and are not downgraded to a routine review status. Such requests are documented in the clinical certification record and assigned an urgent priority.
    a. To prevent any unnecessary delay in care for the member, to ensure that urgent requests are processed within contractual and regulatory timeframes, and to allow for the escalated gathering of clinical information necessary to demonstrate medical necessity the ImageOne platform's *Carrier* web portal and ISAAC platform's "2.0" portal enable the ability to submit an expedited/urgent Medicare request via the web portal electronically. Specific real-time instructions accompany each individual web request to ensure complete and accurate submission in addition to an expedited/urgent attestation completed by the requester.
    b. For eviCore's eP clinical platform, the associated web portal does not allow a request to be initiated for an expedited/urgent request. The web portal requester is given real-time instructions to call eviCore if the request needs to be processed under the expedited/urgent timeframe. The applicable telephone number is provided with the instructions.
    c. For eviCore's PAC Manager clinical platform, the associated web portal does not allow a request to be initiated for an expedited/urgent request. The requester must attest that the request is not clinically expedited/urgent to submit the request in the web portal. The web portal requester is given real-time instructions, to call eviCore, if the request needs to be processed under the expedited/urgent timeframe.
2. Enrollees or their appointed or authorized representative can submit oral or written requests for expedited organization determinations.
3. Oral requests are thoroughly documented in the case record.
4. If the request requires medical information from *non-contract* providers to make a decision, the necessary information will be requested from the *non-contract* provider within twenty-four (24) hours upon receipt of the expedited request. Regardless of whether information is needed from the non-contract provider, eviCore is responsible for meeting the timeframe and notice requirements for expedited determinations.
5. The decision to issue a partially or fully adverse decision must be made by a physician or other appropriate healthcare professional with sufficient medical expertise including knowledge of Medicare coverage criteria.

6. The expedited determination notice of organization review is sent in writing as soon as the enrollee's health requires but no later than seventy-two (72) hours after receipt of the request (*reference *Medicare Part B* exception below):
    a. To ensure notification of the authorization or non-certification is completed and received by the provider and enrollee no later than seventy-two (72) hours from the receipt of the request, eviCore will attempt to provide oral notification first when consistent with plan policy.
        i. **Successful** Notification: If the member is successfully notified orally within the seventy-two (72) hour timeframe, written notice is then issued to the member within three (3) calendar days of the date/time of oral notification.
            1. Per NCQA requirements, successful oral notification is only achieved if a "live person" conversation is obtained; voicemail does not suffice as successful notification.
            2. Per CMS requirements, a voicemail is sufficient and considered successful oral notice.
        ii. **Unsuccessful** Notification: In the event oral notice to the member is unsuccessful, a written letter is issued expeditiously to the member to ensure receipt by the enrollee within seventy-two hours (72) from the date/time of receipt of the request. Unsuccessful calls not completed on Friday will be made on the following Saturday and holidays, as needed. Where required based on health plan agreement or contractual obligation, calls not completed on Saturday, will be completed on Sunday between 10am and 6pm per the member's time zone.
    b. Oral notification is documented and includes the date and time of delivery. eviCore will make two to three (2) - (3) outbound verbal notification attempts until successfully reaching the member, 60-90 minutes apart, dependent on eviCore case management platform and/or contractual obligation, to reach the member and notify of the request determination.
    c. Written notice of an expedited adverse decision is provided via the CMS and health plan-approved *Integrated Denial Notice (IDN)* and includes the services denied, the specific reason for denial and information about standard and expedited reconsideration (appeal). Detailed requirements for use with the standardized IDN are listed below:
        i. When using the standardized IDN, the MA plan must provide:
        • A specific and detailed explanation of why the medical services, items *or Part B drugs* were denied, including a description of the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable;
        • Information regarding the enrollee's right to appeal and the right to appoint a representative to file an appeal on the enrollee's behalf;
        • For service denials, a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process;
        • For payment denials, a description of the standard reconsideration process and timeframes, and the rest of the appeals process;
        • The enrollee's right to submit additional evidence in writing or in person; and

• An explanation of a provider's refusal to furnish an item, service, *or Part B drug* (if applicable).

d. The determination notice is faxed electronically to the provider.

7. If there is ever a decision to downgrade a request for an expedited review for a Medicare enrollee, the request is automatically transferred to the standard timeframe to issue a determination within fourteen (14) calendar days. Prompt oral and written notice is required which includes:
   a. An explanation that the review will be processed within the fourteen (14) calendar day standard review timeframe
   b. Notice of the enrollee's right to file an expedited grievance if the member disagrees with the decision to downgrade the priority
   c. Instruction/information on the expedited grievance process and timeframes
   d. Notice of the enrollee's right to re-submit a request for an expedited determination and that if the enrollee gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the enrollee, or the enrollee's ability to regain maximum function, the request will be expedited automatically.
8. For MMP plans, eviCore will adhere to the relevant and/or required MMP contract turnaround time for case decision making to ensure that requests for service are completed timely. State specific requirements for MMP plans are outlined in the State Specific Requirements section of the *Clinical Certification of Services (UM 0045)* eviCore policy.

Change to Priority Review (40.8) (Part C and D)
After a request is initiated as a standard or expedited review, a provider may contact the plan to change the review priority.

If the provider indicates that the enrollee's health requires an expedited decision, the plan must begin the applicable expedited review period at the time they receive the physician's request to expedite the decision.

Note: A change of priority does not allow for extra review time. If the remaining standard review period is less than the applicable expedited review period, the original standard deadline still applies.

How to Process Requests for Integrated Plan Expedited Initial Determinations (40.8.a)
(1) Applicable integrated plans must use the same processes for Medicaid-related requests as used for Medicare-related requests. See 42 CFR § 438.402(a).
(2) Payment requests are not treated differently than non-payment requests for expedited integrated determinations.
a. Applicable integrated plans should apply the same process to assess a request to expedite a payment request as they do to assess requests to expedite non-payment cases. The standard for deciding whether to expedite a payment request is the same as for non-payment cases (e.g., the standard timeframe could seriously jeopardize the life or health or the enrollee, or their ability to regain maximum function, in accordance with 42 CFR 422.631(c)). Decisions in payment cases:

i. Must be provided as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date of the request, in accordance with 422.631(d)(2)(iv) (following the same timelines as are required for items and services in Section 40.8) unless an extension is taken.
ii. May include an extension (in standard and expedited payment cases) that meet the criteria specified in 422.631(d)(2)(ii)).

b. Note: providing notice of the decision does not mean the payment must be made to the enrollee within that timeframe; in accordance with 422.634(d), the payment must be authorized or provided within 72 hours, and thus authorizing the payment in the applicable integrated plan's system is sufficient action within 72 hours.

(4) Applicable integrated plans may only extend the 72-hour timeframe for providing an expedited integrated organization determination for covered benefits by up to 14 additional days under the conditions listed in 42 CFR § 422.631(c)(2)(iii), specifically:

- o The enrollee or provider requests the extension; or
- o The applicable integrated plan can show that the extension is in the enrollee's interest; and
- o There is a need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

(5) If an applicable integrated plan needs information from a non-contract provider it should follow the same procedures as indicated in Section 40.8 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. However, the plan should refer to the regulatory requirements at t 42 CFR § 422.631(d)(2)(iv)(C).

[Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans]

Medicare Part B

A request for an expedited Medicare Part B organization determination is sent electronically or in writing to the member and practitioner as soon as the enrollee's health requires but no later than twenty-four (24) hours from receipt of the request. The twenty-four (24) hour timeframe includes obtaining information, rendering a decision and providing notice to the member. The Part D (coverage determination) decision timeframe will be used to manage Part B drug reviews for Part C members.

If successful oral member notification is obtained within the timeframe, written notification will be sent within three (3) calendar days from date/time of oral notification.

D. Organization Determinations - Standard (in whole or in part)

1. Non-urgent pre-service organization determinations are processed within the timeframe designated for standard organization determinations.
2. The decision for a standard organization determination is made and notification sent in writing, as soon as the enrollee's health requires, but no later than fourteen (14) calendar days from the date of receipt of the request (*reference *Medicare Part B* exception below).
3. The decision to issue a partially or fully adverse decision must be made by a physician or other appropriate healthcare professional with sufficient medical expertise including knowledge of Medicare coverage criteria.
4. The notice of the determination will be in writing and includes:
   a. Use of the CMS and health plan- approved *Integrated Denial Notice (IDN)*
   b. The service denied, the specific denial reason and information regarding the right to standard or expedited appeal, the right to appoint a representative to file an appeal on the enrollee's behalf and the beneficiary's right to submit additional evidence in writing or in person, written in a manner that is understandable to the enrollee. Detailed requirements for use with the standardized IDN are listed below:

      When using the standardized IDN, the MA plan must provide:

      - A specific and detailed explanation of why the medical services, items or Part B drugs were denied, including a description of the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable;
      - Information regarding the enrollee's right to appeal and the right to appoint a representative to file an appeal on the enrollee's behalf;

- For service denials, a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process;
- For payment denials, a description of the standard reconsideration process and timeframes, and the rest of the appeals process;
- The enrollee's right to submit additional evidence in writing or in person; and
- An explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).

5. If the decision is partially adverse, the notice to the member and provider includes information about the services authorized.
6. For MMP plans, eviCore will adhere to the relevant and/or required MMP contract turnaround time for case decision making to ensure that requests for service are completed timely. State specific requirements for MMP plans are outlined in the State Specific Requirements section of the *Clinical Certification of Services (CM 0045)* eviCore policy.

Medicare Part B

A request for standard/routine Medicare Part B organization determinations is sent electronically or in writing to the member and practitioner as soon as the enrollee's health requires but no later than seventy-two (72) hours from receipt of the request. This timeframe includes obtaining information, rendering a decision and providing notice to the member. The Part D (coverage determination) decision timeframe will be used to manage Part B drug reviews for Part C members.

If successful oral member notification is obtained within the timeframe, written notification will be sent within three (3) calendar days from date/time of oral notification.

E. Organization Determinations – Post-Service

1. Post-Service organization determinations are processed within the timeframe designated for standard organization determinations. Post-service requests are not processed as expedited/urgent given the study has already been performed.
2. The decision for a post-service organization determination is made and notification sent in writing, as soon as the enrollee's health requires, but no later than thirty (30) calendar days from the date of receipt of the request (*reference *Medicare Part B* exception below) unless a health plan client follows the more stringent pre-service standard organization determination timeframe of fourteen (14) calendar days (refer to #1 above).
3. The decision to issue a partially or fully adverse decision must be made by a physician or other appropriate healthcare professional with sufficient medical expertise including knowledge of Medicare coverage criteria.
4. The notice of the determination will be in writing and includes:
   a. Use of the CMS and health plan- approved *Integrated Denial Notice (IDN)*
   b. The service denied, the specific denial reason and information regarding the right to standard or expedited appeal, the right to appoint a representative to file an appeal on the enrollee's behalf and the beneficiary's right to submit additional evidence in writing or in person, written in a manner that is understandable to the enrollee
   c. If the decision is partially adverse, the notice to the member and provider includes information about the services authorized.

Medicare Part B

A request for post-service Medicare Part B organization determination is sent electronically or writing to the member and practitioner as soon as the enrollee's health requires but no later than fourteen (14) calendar days from receipt of the request. This

timeframe includes obtaining information, rendering a decision and providing notice to the member.

If successful oral member notification is obtained within the timeframe, written notification will be sent within three (3) calendar days from date/time of oral notification.

F. Organization Determinations – Concurrent

1. A concurrent review request determination is made, and notification given, as soon as the enrollee's health requires, but no later than:

a. **Decision**: Within 24 hours of receipt if the request is received at least 24 hours or more before the initial certification expires; Within 72 hours if the request is not received at least 24 hour or more before the initial certification expires.
b. **Verbal or e-Notification**: Within 24 hours of receipt if the request is received at least 24 hours or more before the initial certification expires; Within 72 hours if the request is not received at least 24 hour or more before the initial certification expires.
c. **Written Notification to Provider and Member**: Within 24 hours of receipt if the request is received at least 24 hours or more before the initial certification expires; Within 72 hours if the request is not received at least 24 hour or more before the initial certification expires.
d. **Notification of concurrent review of previously approved services: A Medicare provider or health plan (Medicare Advantage plans and cost pla**ns , collectively referred to as "plans") must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. Note: The two day advance requirement is not a 48 hour requirement. This notice fulfills the requirement at 42 CFR 405.1200(b)(1) and (2) and 42 CFR 422.624(b)(1) and (2). Additional guidance for Original Medicare and Medicare Advantage can be found, respectively, at Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual.
e. eviCore delivers the NOMNC to the provider for delivery to the beneficiary, if contractually required to do so. If not contractually required to deliver the NOMNC to the provider for delivery to the beneficiary, the provider treating the beneficiary is responsible for delivery of the NOMNC.
f. Telephonic calls to the provider are also delivered once the concurrent review decision has been completed communicating the concurrent review determination.

G. Organization Determinations – Withdrawal of a Request for Initial Determination

Withdrawal: A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

A request for an initial determination be withdrawn at any time before the decision is issued. This request must come from the party who requested the initial determination. If a request to withdraw is filed with the plan, the plan will dismiss the initial determination request. The request to withdraw may be either written or verbal.

Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective 8/3/2022)

40.15 – Dismissal of an Initial Determination Request

Plans must dismiss requests for an initial determination under any of the following circumstances:
• The individual or entity making the request is not permitted to request an initial determination under the applicable regulation.

• The plan determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a). In addition, under Part D, an enrollee may not request a tiering exception for an approved non-formulary prescription drug. See: 42 CFR § 423.578(c)(4)(iii). In this circumstance, a plan would dismiss the request and issue a dismissal notice in accordance with the notice requirements at § 40.15.1.
• The enrollee dies while the request is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
• The individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with the plan.

When the plan's dismissal is due to a timely withdrawal request, the plan is required to dismiss the initial determination request and issue a dismissal notice in accordance with the notice requirements at section 40.15.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal.

The guidance in 40.15 does not alter reporting requirements. Withdrawn requests and dismissals should continue to be reported separately in their distinct categories, per existing reporting requirements.

40.15.1 – Dismissal Notice
If a plan dismisses an initial determination request, the plan must mail or otherwise transmit a written notice of the dismissal to the parties at their last known address by the conclusion of the applicable adjudication timeframe.
The dismissal notice must state all of the following:
(1) The reason for the dismissal;
(2) The right to request that the plan vacate the dismissal action; and
(3) The right to request review of the dismissal.

Consistent with the timeframe for requesting a timely appeal of an initial determination, a request for review of a dismissal must be filed within 60 calendar days from the date of the plan's dismissal notice.
Plans may use, and modify as necessary, the model Coverage Dismissal Notice when notifying an enrollee of a dismissal.

40.15.2 – Dismissal Binding Unless Modified, Reversed or Vacated
A plan's dismissal of an initial determination request is binding unless it is modified or reversed by the plan upon appeal or the dismissal is vacated for good cause. Upon receipt of a request to review a dismissal, the plan will conduct an appeal in accordance with §50 of this guidance, including the applicable adjudication timeframes for redeterminations and reconsiderations.

Requests for Review of a Dismissal of an Initial Determination Request
If a party appeals a plan's dismissal of an initial determination request and the plan determines that its dismissal was in error, the plan reverses the dismissal and processes the request for coverage in accordance with applicable adjudication timeframes and notice requirements. See: Section 40.10. The timeframe for the initial determination begins on the date/time of the plan's decision to reverse its dismissal.
If a party appeals a plan's dismissal of an initial determination request and the plan upholds its dismissal, there is no further right to appeal the dismissal to a higher-level adjudicator. However, in addition to the right to appeal a dismissal, an enrollee has the right to request that the plan vacate the dismissal action.

Requests to Vacate Dismissal of an Initial Determination Request

A plan may vacate its own dismissal if good cause is established within 6 months of the date of the notice of the dismissal. A plan may find good cause to vacate a dismissal if, for example, the plan determines the dismissal was issued in error because the documentation in the administrative case file shows the reason for dismissing the request was incorrect. For examples of where good cause may exist, please see § 50.3. If a party submits a request to vacate a dismissal of an initial determination request and the request contains sufficient evidence or other documentation that supports a finding of good cause for vacating, the plan makes a favorable good cause determination. Once the plan makes a favorable good cause determination, it vacates its prior dismissal action and performs an initial determination consistent with the timeframes at § 40.10. Where a finding for good cause is made, the plan should document the reason for that finding in the case file.
If the plan does not find good cause to vacate the dismissal, the dismissal remains in effect. The plan issues a letter (not a dismissal notice) explaining that good cause has not been established and the dismissal cannot be vacated. The plan should explain in clear language why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

42 CFR 422.568 Standard timeframes and notice requirements for organization determinations.

(g) Dismissing a request. The MA organization dismisses an organization determination request, either entirely or as to any stated issue, under any of the following circumstances:

(1) The individual or entity making the request is not permitted to request an organization determination under § 422.566(c).

(2) The MA organization determines the party failed to make out a valid request for an organization determination that substantially complies with paragraph (a) of this section.

(3) An enrollee or the enrollee's representative files a request for an organization determination, but the enrollee dies while the request is pending, and both of the following apply:

(i) The enrollee's surviving spouse or estate has no remaining financial interest in the case.

(ii) No other individual or entity with a financial interest in the case wishes to pursue the organization determination.

(4) A party filing the organization determination request submits a timely request for withdrawal of their request for an organization determination with the MA organization.

(h) Notice of dismissal. The MA organization must mail or otherwise transmit a written notice of the dismissal of the organization determination request to the parties. The notice must state all of the following:

(1) The reason for the dismissal.

(2) The right to request that the MA organization vacate the dismissal action.

(3) The right to request reconsideration of the dismissal.

(i) Vacating a dismissal. If good cause is established, the MA organization may vacate its dismissal of a request for an organization determination within 6 months from the date of the notice of dismissal.

(j) Effect of dismissal. The dismissal of a request for an organization determination is binding unless it is modified or reversed by the MA organization upon reconsideration or vacated under paragraph (i) of this section.

(k) Withdrawing a request. A party that requests an organization determination may withdraw its request at any time before the decision is issued by filing a request with the MA organization.

42 CFR 422.570 Expediting certain organization determinations.

(g) Dismissing a request. The MA organization dismisses an expedited organization request in accordance with § 422.568.

42 CFR 422.631 Integrated organization determinations.

(e) Dismissing a request. The applicable integrated plan dismisses a standard or expedited integrated organization determination request, either entirely or as to any stated issue, under any of the following circumstances:

(1) The individual or entity making the request is not permitted to request an integrated organization determination under § 422.629(l).

(2) The applicable integrated plan determines the party failed to make out a valid request for an integrated organization determination that substantially complies with paragraph (b) of this section.

(3) An enrollee or the enrollee's representative files a request for an integrated organization determination, but the enrollee dies while the request is pending, and both of the following apply:

(i) The enrollee's surviving spouse or estate has no remaining financial interest in the case.

(ii) No other individual or entity with a financial interest in the case wishes to pursue the integrated organization determination.

(4) A party filing the integrated organization determination request submits a timely request for withdrawal of their request for an integrated organization determination with the applicable integrated plan.

(f) Notice of dismissal. The applicable integrated plan must mail or otherwise transmit a written notice of the dismissal of the integrated organization determination request to the parties. The notice must state all of the following:

(1) The reason for the dismissal.

(2) The right to request that the applicable integrated plan vacate the dismissal action.

(3) The right to request reconsideration of the dismissal.

(g) Vacating a dismissal. If good cause is established, the applicable integrated plan may vacate its dismissal of a request for an integrated organization determination within 6 months from the date of the notice of dismissal.

(h) Effect of dismissal. The dismissal of a request for an integrated organization determination is binding unless it is modified or reversed by the applicable integrated plan or vacated under paragraph (g) of this section.

(i) Withdrawing a request. A party that requests an integrated organization determination may withdraw its request at any time before the decision is issued by filing a request with the applicable integrated plan.

H. Organization Determinations- Lack of Information or Insufficient Information (Used for plans not following the unable to approve process)

1. Requests for prior authorization that do not include any clinical information are placed in pend or hold status/activity pending the necessary clinical information to make a determination.
2. Requests that include some clinical information are evaluated by a Clinical Reviewer:
   a. If the information received is adequate to render a medical necessity determination and meets medical necessity criteria, the request is approved by the Clinical Reviewer and appropriate notification issued within two (2) business days of the request.
   b. If the information received is not sufficient to satisfy the medical necessity criteria, additional information is requested from the referring provider.
3. Requests with insufficient information are placed in a pended or hold status/activity and written notice is sent to the provider informing them of the specific additional information that must be received to complete the request.
   - If additional information is submitted, the request is processed and a determination issued within the applicable timeframe.
   - If additional information is not submitted, up to three (3) outreach attempts will be made by telephone to contact the provider to obtain the necessary information required to complete the case and offer a peer-to-peer discussion to the ordering provider.

a. For routine/standard requests, the calls are placed during normal working hours every other business day, starting the day after the case enters hold status.
b. For urgent/expedited requests, up to three (3) calls will be placed within forty-eight (48) hours during normal working hours.
    - Outreach attempts will be thoroughly documented in the record and continue unless one of the following occurs:
        i. the provider responds to the request, or
        ii. a peer-to-peer consultation results in a determination, or
        iii. the provider's office staff refuses a peer-to-peer opportunity
        iv. outreach attempts are exhausted

4. For standard requests, if clinical information is not received, the case will be placed in a queue to determine if the case was processed correctly and that all the outreach had been completed. If the outreach has been completed and the information is still required, an extension may be initiated, according to the direction of the health plan.

I. Unable to Approve Process (the use of this process may vary by health plan):

1. **Expedited Requests**: For expedited requests received and reviewed where additional clinical information is needed to render a medical necessity determination, eviCore will follow the below process to obtain information, render a decision and provide notice to the member within seventy-two (72) hours of receipt of the request.
    a. **Verbal outreach**: eviCore will make two (2) verbal outreach attempts to reach the requesting provider to offer a pre-determination consultation (PDC) and provide why the request is recommended for a denial determination. The first call will be completed within two (2) hours of the request entering into the *unable to approve* process, after Medical Director review and recommendation for denial. The recommended denial will be documented in the case record. The verbal outreach offer will be documented in the case record with a date/time stamp and the name of the person completing the call with the provider. If the first call is not successful, a second call will be made within two (2) hours of the 1st attempted verbal outreach.
    b. **Written outreach:** eviCore will fax written correspondence to the requesting provider upon the case entering the *unable to approve* process, after Medical Director review and recommendation for denial. The fax will include notice that the request has been reviewed and a denial recommendation has been determined. The fax will also provide an offer of a PDC discussion, the denial recommendation, contact information, and will be signed by the eviCore Chief Medical Officer (CMO).
2. **Standard Requests:** For standard requests received and reviewed where additional clinical information is needed to render a medical necessity determination, eviCore will follow the below process to obtain information, render a decision and provide notice to the member within fourteen (14) calendar days of receipt of the request.
    a. ***Hold/pend* verbal outreach:** If the request does not contain enough clinical information to render a medical necessity determination, eviCore will make one (1) *hold/pend* verbal outreach attempt to reach the requesting provider specifying what information is needed to complete the review process. The verbal outreach will be conducted within one (1) business day of the request being held/pended for information. The call outreach will specify the information needed, date/time of outreach, and the name of the person speaking with the ordering provider.
        i. If the request contains sufficient information to render a medical necessity determination, and the initial review would demonstrate a denial for medical necessity, the request will move directly to the *unable to approve* verbal and written outreach process.
    b. ***Hold/pend* written outreach:** If the request does not contain enough clinical information to render a medical necessity determination, eviCore will fax a written

hold/pend fax to the requesting provider outlining what information is needed to move forward with the clinical review process. The written fax will be sent immediately upon the request entering a hold/pend status or activity.

i. If the request contains sufficient information to render a medical necessity determination, and the initial review would demonstrate a denial for medical necessity, the request will move directly to the *unable to approve* verbal and written outreach process.

c. ***Unable to approve*** **verbal outreach:** Once a request has completed the hold/pend process, or the request contained sufficient clinical information to render a medical necessity determination, and the request has been reviewed by an eviCore Medical Director, and the recommendation is to issue an adverse determination, eviCore will follow the *unable to approve* process for verbal outreach. eviCore will make a verbal outreach to the ordering provider to provide the recommended denial determination and to offer the ordering provider the opportunity for the provider to engage in a PDC discussion. The verbal outreach will be made on the 2nd day after the case enters the unable to approve process. The verbal outreach will document the denial recommendation, the date/time of call, and the person speaking to the ordering provider.

d. ***Unable to approve*** **written outreach:** eviCore will send a written fax to the ordering provider every day a request is in the *unable to approve* status/activity. The written fax will offer a PDC discussion, outline the denial recommendation, include the date/time of call, the person speaking to the ordering provider, and will be signed by the eviCore Chief Medical Officer (CMO).

Outreach for Additional Information to Support Coverage Decisions (10.6):

Plans must have processes in place for making timely coverage decisions (initial requests and appeals), which includes soliciting clinical documentation, such as medical records, when necessary. If a plan does not have enough information to make a pre-service or pre-benefit coverage decision, it should make reasonable and diligent efforts to obtain all necessary information.

Plans are only required to conduct outreach to request additional information from a provider if the plan does not have all necessary information to make a coverage or appeal decision. In instances when outreach is necessary to make a coverage or appeal decision, a minimum of one attempt to obtain additional information is sufficient. Plans may adopt best practices for outreach, such as making multiple attempts, using multiple methods for requesting information (e.g., telephone, fax, e-mail, etc.), and/or and involving plan physicians in order to increase the likelihood of obtaining necessary information. If the plan does not receive any additional information, the plan should make the best decision it can based on the information available within the required adjudication timeframes. Plans are not required to conduct outreach prior to denying claims payments if they believe they have all the necessary information needed to make a coverage decision.

Part C Only

For expedited organization determination and reconsideration requests, if medical information is needed from a non-contract provider, the MA plan must request the necessary information within 24 hours of receipt of the request.

Part D Only

For expedited redetermination requests, if medical information is needed, the Part D plan sponsor must request the information within 24 hours of receipt of the request.

Plans should document all requests for information and maintain that documentation within the case file. If the plan issues an adverse decision due to the inability to obtain clinical information needed to approve coverage, the plan should clearly identify that basis and the necessary information in the written denial notice. See §§ 422.568(d) and (e), 422.570(d), and 422.572(d) for denials related to Part A and B services, items and Part B drugs, and 423.568(f) and (g) for denials related to Part D benefits.

J. Organization Determinations-Extensions**:**

1. The timeframe for the organizational determination may be extended up to fourteen (14) calendar days for standard and expedited organization determinations, according to the direction of the health plan. eviCore does not issue extensions unless:
   a. The enrollee requests an extension
   b. The extension is justified, in the enrollee's best interest, and additional medical evidence from a non-contract provider is needed in order to a make a decision favorable to the enrollee (i.e., an extension should not extend the timeframe to get evidence to deny the coverage request); or
   c. The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest
   d. Part B drug review timeframes cannot be extended.
2. Notification of extension must:
   a. Be a "*MA-Extension*" Standard or Expedited CMS and Health Plan-approved template
   b. Be sent in writing within the initial fourteen (14) calendar days of the receipt of the request or seventy-two (72) hours of receipt of the request in the event the request is expedited
   c. Include the reason for the delay and the right to file a grievance (oral or written) if the enrollee disagrees with the delay.
   d. eviCore must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon the expiration of the extension.
   e. If eviCore first notifies an enrollee of an adverse expedited determination orally, it must mail written confirmation to the enrollee within three (3) calendar days of the oral notification.
   3. Requests should not be generally or regularly extended for expedited organization determinations to seek information or records from a contract provider, but may be done if it is justified in the enrollee's best interest and due to extraordinary, exigent, or other non-routine circumstances.

K. <u>Organization Determinations-</u><u>Reconsideration</u>

1. eviCore correctly distinguishes between Organization Determinations, Reconsiderations and Re-Opens:
   a. **Organization Determination:** See definition of an organization determination under Section III. Definitions #1**. Reconsideration:** Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by a Medicare Advantage (MA) plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains. The term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.
   b. **Reopen** (see *Medicare Reopen Policy UM 0270*)**:** A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
      i. Clerical errors (which include minor errors and omissions) are processed as reopens
      ii. eviCore cooperates with the health plan to ensure reopens and appeals do not occur simultaneously

iii. Reopens may be accepted verbally or in writing. The request must clearly state the reason for reopen. A statement of dissatisfaction with the initial decision is not grounds for a reopen.
iv. A reopen request must be for a service not yet provided and submitted within one (1) year of the original decision for any reason or four (4) years from the original decision for good cause

L. Organization Determinations – Dismissals

Dismissal: A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective 8/3/2022)

40.15 – Dismissal of an Initial Determination Request

Plans must dismiss requests for an initial determination under any of the following circumstances:

• The individual or entity making the request is not permitted to request an initial determination under the applicable regulation.

• The plan determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a). In addition, under Part D, an enrollee may not request a tiering exception for an approved non-formulary prescription drug. See: 42 CFR § 423.578(c)(4)(iii). In this circumstance, a plan would dismiss the request and issue a dismissal notice in accordance with the notice requirements at § 40.15.1.

• The enrollee dies while the request is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.

• The individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with the plan.

When the plan's dismissal is due to a timely withdrawal request, the plan is required to dismiss the initial determination request and issue a dismissal notice in accordance with the notice requirements at section 40.15.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal.

The guidance in 40.15 does not alter reporting requirements. Withdrawn requests and dismissals should continue to be reported separately in their distinct categories, per existing reporting requirements.

40.15.1 – Dismissal Notice

If a plan dismisses an initial determination request, the plan must mail or otherwise transmit a written notice of the dismissal to the parties at their last known address by the conclusion of the applicable adjudication timeframe.

The dismissal notice must state all of the following:

(1) The reason for the dismissal;

(2) The right to request that the plan vacate the dismissal action; and

(3) The right to request review of the dismissal.

Consistent with the timeframe for requesting a timely appeal of an initial determination, a request for review of a dismissal must be filed within 60 calendar days from the date of the plan's dismissal notice. Plans may use, and modify as necessary, the model Coverage Dismissal Notice when notifying an enrollee of a dismissal.

40.15.2 – Dismissal Binding Unless Modified, Reversed or Vacated
A plan's dismissal of an initial determination request is binding unless it is modified or reversed by the plan upon appeal or the dismissal is vacated for good cause. Upon receipt of a request to review a dismissal, the plan will conduct an appeal in accordance with §50 of this guidance, including the applicable adjudication timeframes for redeterminations and reconsiderations.

Requests for Review of a Dismissal of an Initial Determination Request
If a party appeals a plan's dismissal of an initial determination request and the plan determines that its dismissal was in error, the plan reverses the dismissal and processes the request for coverage in accordance with applicable adjudication timeframes and notice requirements. See: Section 40.10. The timeframe for the initial determination begins on the date/time of the plan's decision to reverse its dismissal.
If a party appeals a plan's dismissal of an initial determination request and the plan upholds its dismissal, there is no further right to appeal the dismissal to a higher-level adjudicator. However, in addition to the right to appeal a dismissal, an enrollee has the right to request that the plan vacate the dismissal action.

Requests to Vacate Dismissal of an Initial Determination Request
A plan may vacate its own dismissal if good cause is established within 6 months of the date of the notice of the dismissal. A plan may find good cause to vacate a dismissal if, for example, the plan determines the dismissal was issued in error because the documentation in the administrative case file shows the reason for dismissing the request was incorrect. For examples of where good cause may exist, please see § 50.3. If a party submits a request to vacate a dismissal of an initial determination request and the request contains sufficient evidence or other documentation that supports a finding of good cause for vacating, the plan makes a favorable good cause determination. Once the plan makes a favorable good cause determination, it vacates its prior dismissal action and performs an initial determination consistent with the timeframes at § 40.10. Where a finding for good cause is made, the plan should document the reason for that finding in the case file.
If the plan does not find good cause to vacate the dismissal, the dismissal remains in effect. The plan issues a letter (not a dismissal notice) explaining that good cause has not been established and the dismissal cannot be vacated. The plan should explain in clear language why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

42 CFR 422.568 Standard timeframes and notice requirements for organization determinations.

(g) Dismissing a request. The MA organization dismisses an organization determination request, either entirely or as to any stated issue, under any of the following circumstances:

(1) The individual or entity making the request is not permitted to request an organization determination under § 422.566(c).
(2) The MA organization determines the party failed to make out a valid request for an organization determination that substantially complies with paragraph (a) of this section.
(3) An enrollee or the enrollee's representative files a request for an organization determination, but the enrollee dies while the request is pending, and both of the following apply:
(i) The enrollee's surviving spouse or estate has no remaining financial interest in the case.
(ii) No other individual or entity with a financial interest in the case wishes to pursue the organization determination.
(4) A party filing the organization determination request submits a timely request for withdrawal of their request for an organization determination with the MA organization.

(h) Notice of dismissal. The MA organization must mail or otherwise transmit a written notice of the dismissal of the organization determination request to the parties. The notice must state all of the following:

(1) The reason for the dismissal.

(2) The right to request that the MA organization vacate the dismissal action.

(3) The right to request reconsideration of the dismissal.

(i) Vacating a dismissal. If good cause is established, the MA organization may vacate its dismissal of a request for an organization determination within 6 months from the date of the notice of dismissal.

(j) Effect of dismissal. The dismissal of a request for an organization determination is binding unless it is modified or reversed by the MA organization upon reconsideration or vacated under paragraph (i) of this section.

(k) Withdrawing a request. A party that requests an organization determination may withdraw its request at any time before the decision is issued by filing a request with the MA organization.

42 CFR 422.570 Expediting certain organization determinations.

(g) Dismissing a request. The MA organization dismisses an expedited organization request in accordance with § 422.568.

42 CFR 422.631 Integrated organization determinations.

(e) Dismissing a request. The applicable integrated plan dismisses a standard or expedited integrated organization determination request, either entirely or as to any stated issue, under any of the following circumstances:

(1) The individual or entity making the request is not permitted to request an integrated organization determination under § 422.629(l).

(2) The applicable integrated plan determines the party failed to make out a valid request for an integrated organization determination that substantially complies with paragraph (b) of this section.

(3) An enrollee or the enrollee's representative files a request for an integrated organization determination, but the enrollee dies while the request is pending, and both of the following apply:

(i) The enrollee's surviving spouse or estate has no remaining financial interest in the case.

(ii) No other individual or entity with a financial interest in the case wishes to pursue the integrated organization determination.

(4) A party filing the integrated organization determination request submits a timely request for withdrawal of their request for an integrated organization determination with the applicable integrated plan.

(f) Notice of dismissal. The applicable integrated plan must mail or otherwise transmit a written notice of the dismissal of the integrated organization determination request to the parties. The notice must state all of the following:

(1) The reason for the dismissal.

(2) The right to request that the applicable integrated plan vacate the dismissal action.

(3) The right to request reconsideration of the dismissal.

(g) Vacating a dismissal. If good cause is established, the applicable integrated plan may vacate its dismissal of a request for an integrated organization determination within 6 months from the date of the notice of dismissal.

(h) Effect of dismissal. The dismissal of a request for an integrated organization determination is binding unless it is modified or reversed by the applicable integrated plan or vacated under paragraph (g) of this section.

(i) Withdrawing a request. A party that requests an integrated organization determination may withdraw its request at any time before the decision is issued by filing a request with the applicable integrated plan.

M. **Organization and Coverage Determinations** – Medicare Misdirected Organization Determination Process (includes requests received for Part C, Part B drugs, and Part D, if applicable)

1. The process below will be followed to ensure alignment with section 10.5.2 (When is a request considered received by a plan) of the *Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* document.

2. eviCore will actively manage incoming telephonic requests for organization and coverage determinations or reconsiderations, as well as, incoming mail and facsimiles (Fax) that are received for non-delegated services. The focus of this section of the policy will be to ensure that organization and coverage determinations and reconsideration (appeal) requests are properly handled and forwarded to the correct entity for accurate and timely processing by the correct entity, when the service (s) requested are not delegated to eviCore.

3. Telephonic requests: Requests received in the eviCore contact center for services not delegated to eviCore for review will be warm transferred to the health plan for the member identified in the request. eviCore will warm transfer the call directly to the health plan using the intake or customer service number provided by the health plan for this purpose. This will ensure a real-time transfer of the request.

4. Mail/Fax requests: Requests received by fax, from a requesting provider or health plan, in error, for services that are not delegated to eviCore to review, will be faxed back to the sender, and to the health plan. The cover sheet will indicate the fax was received in error, for non-delegated services, and the fax submission will include the original information that was received at eviCore, which will include the fax received date/time stamp. eviCore will use the fax number provided to eviCore, by the health plan, for the purpose of directing misdirected fax requests, when sending the fax to a health plan. For the fax to the provider, the fax the provider used during their submission to eviCore will be used to direct the information back to the provider. Requests received by mail, for services that are not delegated to eviCore to review, will be scanned and transferred to electronic format for prompt transfer to the health plan using health plan provided contacts. Similar to the above outlined fax process, eviCore will use the cover sheet to indicate the mailed request was received in error, for non-delegated service(s), and will include the original information that was received at eviCore, including the manual date/time stamp of receipt.

5. Misdirected requests will be forwarded, as expeditiously as possible, to the appropriate entity to take action on the request.

N. **Business Continuity – Emergency Declaration**:

During a declaration of emergency, as defined below, eviCore healthcare, as a First Tier, Downstream, or Other Related Entity (FDR), will follow the direction of any declaration guidance, as provided by our delegated entities who are contracted Medicare Advantage Organizations (MAOs). The information below will be followed at the direction of the MAO client to align with the emergency declaration, if applicable to eviCore delegated services:

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, but absent, or prior to the issuance of, an 1135 waiver by the Secretary, Medicare Advantage Organizations (MAOs) are expected to:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A/B benefits must, per 42 CFR § 422.204(b)(3), be furnished at Medicare certified facilities);
- Waive in full, requirements for gatekeeper referrals where applicable (suspend requirements for authorization or referral from a primary care physician);
- Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts (apply in network benefits to out of network claims during the effected time period); and
- Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.
- No exception has been made to pay Medicare Opt Out Providers; other than, in the event of Emergency and/or Urgent Care, which GJ modifier is appended to codes on the claim.
- No exception to timely filing of claim unless otherwise specified by CMS or MA Claims Management approval to waive the timely filing limit.

Emergency Disaster 2023 Final Rule - CMS-4192: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency (CMS-4192-F) 42 CFR 422.100(m)(1) and 42 CFR 422.100(m)(3)

CMS published final rule CMS-4192-F, in which they clarify that an MA plan must comply with the special requirements when there is both a declaration of disaster or emergency (including a public health emergency) and disruption in access to health care in the MA plan's service area.

A disruption of access to health care is defined as an interruption or interference in the service area such that enrollees do not have the ability to access contracted providers or contracted providers do not have the ability to provide needed services to enrollees, resulting in MA plans failing to meet the normal prevailing patterns of community health care delivery in the service area.

When a disaster or emergency occurs, enrollees may have trouble accessing services through network providers or sometimes must physically relocate to locations that are outside of their MA plan’s service area. Under this final rule, MA organizations must ensure access for enrollees to covered services throughout the disaster or emergency period, including when the end date is unclear and the period renews several times, so long as there is a disruption of access to healthcare.

During a state of disaster or emergency, MA organizations must continue to meet MA access and availability requirements consistent with the pre- disaster/emergency normal prevailing community pattern of health care delivery in the areas where the network is being offered.

The requirement is not intended to be limited to physical barriers to access, it encompasses any interruption or interference caused by a disaster or emergency, below are some examples:

- Physical barriers e.g. road disruptions or electrical outages
- Providers offices being closed due to quarantine requirements
- Hospital beds being unavailable

When a disaster or emergency is declared and there is disruption of access to health care, an MA organization must, ensure access to covered benefits (Part A or Part B or supplemental benefits, or any combination of those) for 30 days after the earlier of:

- All sources that declared a disaster or emergency that include the service area declare an end (30 days after end date in declaration)

- All applicable emergencies or disasters declared for the area have ended, including through expiration of the declaration or any renewal of such declaration (30 days after expiration of original or renewal)
- There is no longer a disruption of access to health care (30 days after disruption ends)

The intent of these modifications is to clarify that if there is a current state of disaster or emergency that is not contributing to a disruption in health care services, then MA organizations would not be required to follow the requirements at § 422.100(m)(1)(i) through (iv).

Medicare/Medicaid Dual Special Needs Plans	
Medicare/Medicaid Dual Special Needs Plans (DSNP), Highly Integrated Dual Eligible Special Needs Plan (HIDE), or Fully Integrated Dual Eligible Special Needs Plan (FIDE)	The following information is only applicable, where and if, eviCore healthcare is delegated the management of DSNP, HIDE, or FIDE members by a contracted health plan. Effective 1/1/2020, eviCore will support and comply with the CMS Final Rule for DSNP membership for reasonable assistance, in resolving Medicaid coverage problems and the coordination of delivery of Medicare and Medicaid Services, if so delegated, by a CMS contracted health plan. Actions may include, if delegated, those listed below: • Recognize a member's need and provide assistance and information on Medicaid-related service (s) • Transfer or refer a member to a CMS contracted health plan using the telephone number on the back of the member's identification card • Document actions taken in the assistance of the Medicaid member in the member's record • Provide reasonable assistance with grievance and requesting appeals • Provide reasonable assistance with resolving coverage and authorization issues • Provide coordinated delivery of Medicaid benefits for individuals who are eligible for such services

Revision Dates

04/14/2023
02/13/2023
01/30/2023
10/04/2022
09/18/2022

Approved by: Pamela Dougherty **Date: 05/09/2023**

eviCore healthcare Compliance Officer