SMSO Policy Manual
PRE-SERVICE ORGANIZATION DETERMINATIONS

Executive Sponsor: Chief Medical Officer

Issuing Department: Clinical Management

Gate Keeper: Director, HSM Clinical Management

COMPLIANCE STATEMENT:

Enforcement: All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.

Review Schedule: This policy will be reviewed and updated as necessary and no less than every two years.

Monitoring and Auditing: The Issuing/Collaborating Department(s) is responsible for monitoring and compliance with this policy.

Documentation: Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare Apex
- ☐ Summa Management Service Organization (SMSO)
- ☒
- ☒ Summa Insurance Company

Line of Business:

- ☒ Commercial Groups Medicare
- ☐ Medicare Supplemental On-
- ☒ Off-Exchange Self-Funded
- ☒
- ☒ Exchange
- ☒

1.0 Purpose:

1.1

1.2 To ensure all staff understand the procedures that enable our Medicare beneficiaries to access the medical services they need and to ensure that we are in compliance with CMS requirements.

1.3 To ensure members and providers that the Plan follows and adheres to all federal and state guidelines pertaining utilization and prior authorizations.

2.0 Policy:

2.1 The Prior Authorization Unit promptly receives, tracks, and provides timely organization determinations in response to requests for services by beneficiaries or providers.

2.2 The Plan expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request. The organization determination is reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before the health plan issues the organization determination.

2.3 For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance.

2.4 For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate

3.0 Procedure:

3.1 Verbal or written organization determination requests are received by the Prior Authorization Unit via phone, fax, website, electronically, or by mail. Receipt of a standard request is determined by the date and time the request is received by the Plan. Receipt of an expedited request is determined by the date and time the request is received by the Plan. An organization determination is reviewed upon receipt to ensure that determinations are handled in accordance with CMS guidance of timeliness and appropriate clinical decision-making.

3.2 Responding to Requests for Care

3.2.1 The Plan makes decisions as quickly as the beneficiary's health condition requires. It applies to both standard and expedited organization determinations. Upon receiving a request for service or covered benefit, either via a beneficiary, authorized representative or provider request, the Prior Authorization Unit makes a decision as quickly as necessary given the health of the beneficiary and within the regulatory

timeliness guidelines. Standard organization determinations are made within 10 to 14 calendar days after the Plan receives the request, or more quickly if the beneficiary's health condition requires a faster decision. Expedited pre-service organization determinations are made within 24 to 72 hours after the Plan receives the request, or more quickly if the beneficiary's health condition requires a faster decision.

3.2.2 SummaCare makes reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits. If the determination requires medical necessity review and there is not enough information provided to make a determination, 1 attempt are made to obtain the necessary information. Requests for clinical information will be made by different methods (telephone, fax, email, mail). Staff make at least 1 attempt to obtain the missing information from the appropriate ***or***

3.2.3 provider(s) or to verify that the needed information is not available. When there is still lack of response, SummaCare will contact the member, when appropriate, for records ***or***

3.2.4 Assistance in reaching the provider. When efforts have been exhausted and a decision is required to meet timeliness, the determination will be made according to the information available and the member's available benefits. The plan will track the number of request made for additional information by providers. Provider Service will contact the providers that the plan had to make 1 attempt to request information. Extensions are taken following the appropriate regulatory/accreditation guidelines if the member requests them (see section below)

3.2.5 When the plan has to request information they will document the attempts. Documentation should include the following:

3.2.5.1 A specific description of the required information;

3.2.5.2 The name, phone number, fax number, e-mail, and/or mailing address, as applicable, for the point of contact at the plan; and

3.2.5.3 The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission, or e-mail. Call records should include specific information about who was contacted, what was discussed/requested, and what information was obtained by the plan.

3.3 Standard Organization Determinations

3.3.1 The Plan maintains an efficient and convenient method for beneficiaries and providers to request standard organization determinations. The Plan maintains records of all requests in an electronic authorization record.

3.3.2 Either a beneficiary, beneficiary representative or a provider may request a standard organization determination by fax, online, or verbally.

3.3.3 Upon receipt of an standard request, the Plan:

3.3.3.1 Creates a record of the request, including the date and time received by the Plan.

3.3.3.2 Attaches any incoming fax and associated records to the electronic record in the utilization management software system.

3.3.3.3 Documents the conversation to record what was requested (if the request was received verbally).

3.3.3.4 Promptly reviews the request and decides if the situation requires medical necessity review.

3.3.3.5 Requests additional clinical documentation, if needed. Escalates to utilization management nurse, physician, psychiatrist, pharmacist, or dentist (as appropriate for the type of request) for lack of response as stated earlier.

3.3.3.6 Either approves or denies the request as outlined below, or performs outreach for any additional information. All denials are made by a utilization management nurse, physician, psychiatrist, pharmacist or dentist, as appropriate for the type of request.

3.3.3.7 Notifies the beneficiary and provider of the determination.

3.4 Notification of the plan decision on requests for services

3.4.1 The Plan notifies beneficiaries (or their representatives) of standard determinations in the most efficient manner (mail, fax, courier/hand delivery) that allows the beneficiary time to act. Requesting providers are notified by SummaCare Authorization Portal and also receive a copy of the beneficiary letter.

3.4.2 Approval notifications contain the following:

3.4.2.1 Service or item requested,

3.4.2.2 Date(s) approved, and

3.4.2.3 Name of the requesting provider.

3.4.3 Denial notifications are written using the CMS Integrated Denial Notice and contain the following:

3.4.3.1 Service or item requested

3.4.3.2 Date(s) requested

3.4.3.3 Name of the requesting provider

3.4.3.4 Reason for the denial; the reason for the denial takes into consideration the Beneficiary's presenting medical condition, disabilities, and special language requirements, if any. The explanation of the denial must be written in a manner that the beneficiary can understand why the request was denied, be specific to the beneficiary's case, and provides enough detail to guide the beneficiary on any further action, if indicated

3.4.3.5

3.4.3.6 Reference to the medical criteria or benefit coverage document(s) used to help make the determination.

3.4.3.7 Standardized OMB notice of denial and appeal rights and a description of the standard and expedited reconsideration processes

3.4.3.8 Description of the beneficiary's right to submit additional evidence in writing or in person.

3.4.4 When the Plan approves a request for expedited determination it must make the determination and notify the enrollee and the physician involved, as appropriate, of its determination as expeditiously as the enrollee's health condition requires, but no later than 24 to 72 hours after receiving the request.

3.4.5 When the determination is adverse, although The Plan may notify the enrollee verbally or in writing, the enrollee must be notified within the 24 to 72 hour time frame. Mailing the determination within 24 to 72 hours in and of itself is insufficient. The enrollee must receive the notice in the mail within 72 hours. If The Plan first verbally notifies an enrollee of an adverse expedited determination, the Medicare health plan must mail written confirmation to the enrollee within three calendar days of the oral notification.

3.5 Extensions

3.5.1 An extension of 14 calendar days may be taken once for a Standard request and one 48 hour extension for an Expedited request. The extension may be requested by the beneficiary, or by the plan, if for reasons outside the control of the health plan, the plan feels that extending the time frame is in the best interest of the beneficiary.

3.5.2 **Note:** Awaiting documentation from a contracted provider does not qualify for an extension. Organization determinations from contract providers must be completed within the 10 to 14 days for a standard request and 24 to 72 hours for an expedited request.

3.5.3 Upon a decision to extend the determination time frame, the Plan:

3.5.3.1 Documents the decision to extend as a beneficiary request or a plan decision.

3.5.3.2 Documents the reason to extend.

3.5.3.3 Notifies the beneficiary by sending a letter which explains the reason for the extension and the beneficiary's right to file an expedited grievance if he or she disagrees with the extension.

3.5.3.4 Handles the request within the standard 14-day timeframe or as expeditiously as the enrollee's condition requires.

3.6 Expedited organization determinations

3.6.1 The Plan maintains an efficient and convenient method for beneficiaries and providers to request expedited organization determinations. The Plan maintains records of all requests in an electronic authorization record.

3.6.2 Either a beneficiary or a provider may ask orally or in writing that an organization determination request be expedited if he or she feels that waiting for a decision under the standard timeframe could place the beneficiary's life, health or the ability to regain function in serious jeopardy.

3.6.3 **Note:** Expedited determinations may not be requested for cases in which the only issue involves a claim for payment or services that the beneficiary has already received. Refer to policy "Prompt Payment of Claims" – Medicare.

3.6.4 Upon receipt of an expedited request, the Plan:

3.6.4.1 Creates a record of the request, including the date and time received in the Prior Authorization Unit.

3.6.4.2 Documents the conversation to record what was requested (if the request was received orally).

3.6.4.3 Promptly reviews and decides if the situation requires an expedited decision.

3.6.4.4 Requests additional clinical documentation, if needed. Escalates to utilization management nurse, physician, psychiatrist, pharmacist, or dentist (as appropriate for the type of request) for lack of response.

3.6.4.5 Either approves or denies the request as outlined below, or performs outreach for any additional information. All denials are made by a utilization management nurse, physician, psychiatrist, pharmacist or dentist, as appropriate for the type of request.

3.6.4.6 Notifies the member and provider of the decision.

3.7 Approval of the request to expedite

3.7.1 The Plan makes an expedited decision as quickly as the beneficiary's clinical situation requires, but no later than 24 to 72 hours after receipt of the request. The Plan promptly notifies the beneficiary (or his/her representative) of the determination by telephone within 24 to 72 hours of receipt of the request and follows up with a letter explaining the determination and is mailed within 72 hours of the telephone notification.

3.7.2 **Note:** The Plan automatically provides an expedited decision if a physician states or writes that the standard timeframe would seriously jeopardize the beneficiary as described above.

3.7.3 If the request was received from a non-contracted provider, the Plan notifies the requesting provider within 24 hours of the need for any additional clinical information.

3.7.4 If the Plan decides to expedite the decision, but declines to provide the service or covered benefit, the beneficiary is sent written notification that includes the same elements as the standard organization determination.

3.8 Denial of request to expedite a determination

3.8.1 If the Plan decides not to expedite the organization determination, the request is transferred to the 10 to 14-day standard determination process and the following steps occur:

3.8.1.1 The Plan notifies the beneficiary (or their representative) verbally of the decision not to expedite, the reason, the right to file an expedited grievance if the beneficiary disagrees with our decision, the right to resubmit a request for an expedited determination and that if the beneficiary obtains a physician's support to expedite that the request will be automatically expedited, and instructions about the grievance process and time frames.

3.8.1.2 The Plan follows up with a written letter explaining the above information. The letter is sent via courier to ensure that the beneficiary receives the letter within 24 to 72 hours of the request being received.

3.9 Opportunity to Discuss Denial Decisions (Peer to Peer Discussion)

3.9.1 Requesting Providers may speak with the physician reviewer or pharmacist reviewer at any time for the purpose of understanding why a request was denied. At the time of denial notification, the Plan explains to Providers they have the opportunity to discuss the decision with the Reviewer. Providers requesting a change on an organization determination are directed to follow the beneficiary appeals process.

3.10 Notice to Beneficiary

3.10.1 If the plan denies services or payments in whole or in part, or discontinues/reduces previously authorized treatment, it must give the beneficiary written notice If the Plan fails to provide timely notice to the beneficiary, this is considered an adverse organization determination and may be appealed.

3.11 Jacquie Potelicki, Director, HSM Clinical Management, has the authority and responsibility for the activities in this policy or procedure.

3.12 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

3.12.1

3.12.2 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

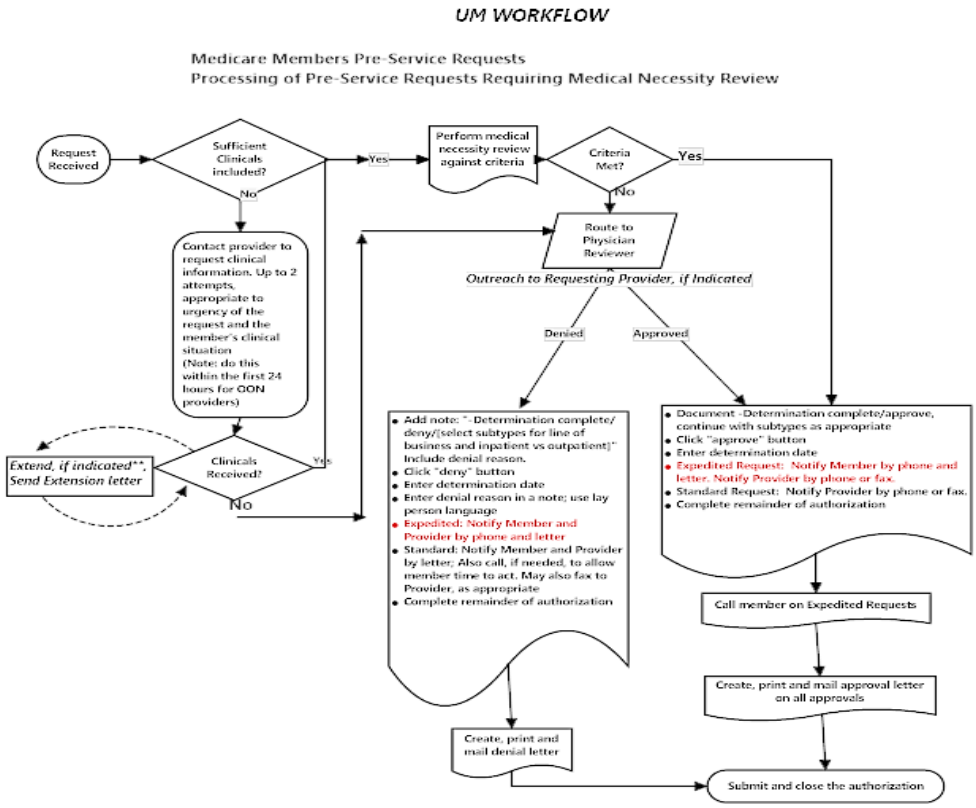
4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, and internal standard)

4.1.1 NCQA UM 4.C; Medicare Managed Care Manual, Chapter 13 §10.3.2, §40.
4.1.2 CMS Standard: Medicare Managed Manual: Chapter 13 Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeal Guidance 40

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 Prompt Payment of Claims – Medicare
4.2.2 Utilization Management Policy



* Expedited determinations made within 72 hours of receipt
Standard determinations made within 14 days after receipt of the request

**Awaiting documentation from a contracted provider does not qualify for the 14 day extension. Organization determinations for contracted providers must be completed no later than 72 hours for an expedited request and no later than 14 calendar days for a standard request. Refer to policy "Medicare Preservice Organization Determinations"
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4.3 Are there other policies that work in conjunction with this policy?

4.3.1 None

4.4 Replaces (if applicable):

4.4.1 Timeliness of Non-Behavioral Health and Behavioral Health Utilization Management Decisions

4.4.2 Denial Notices

4.4.3 Clinical Information for Medical and Behavioral Health Utilization Management Decisions

5.0 Definitions:

5.1 **Organization Determination:** Any decision, either an approval or denial, made by the Plan with respect to timely authorization, provision, or payment of services or covered benefits, in whole or in part, which the beneficiary believes should be furnished or arranged by the Plan. This includes basic benefits, mandatory and optional supplemental benefits, and any cost sharing by the beneficiary.

5.2 **Standard Organization Determination:** A decision by the Plan or a delegated entity regarding whether or not to provide or pay for a healthcare service or covered benefit.

5.3 **Expedited Organization Determination:** A decision that is made more quickly than in the standard determination process because using the standard timeframe could place the beneficiary's health at risk. Situations which determinations can be expedited are pre-service requests and situations where the Plan is reducing or prematurely discontinuing a previously authorized course of treatment. Expedited determinations may not be requested for cases in which the only issue involved is a claim for services that the beneficiary has already received.

5.4 **CMS Integrated Denial Notice**: The CMS's OMB approved Integrated Denial Notice combines and replaces the standardized Medicare Part C denial notices entitled "Notice of Denial of Payment" and "Notice of Denial of Medical Coverage" (Form CMS-10003-NDP and Form CMS-10003-NDMC, respectively).

6.0 Key Words or Aliases (Optional):

6.1 Medicare pre-service organization determinations

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