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.

Unless noted otherwise in this policy, the processes outlined hereunder for the Medicare population also apply to Dual-Eligible Special Needs Plans (DSNP) that do not meet the definition of an Applicable Integrated Plan (AIP) pursuant to 42 CFR 422.561, effective 1/1/2023. The processes outlined hereunder also apply to those plans which do meet the definition of an Applicable Integrated Plan under 42 CFR 422.561 with DSNP enrollees but may have additional requirements and/or exceptions to below processes; these additional requirements and/or exceptions are outlined in the section of this policy titled "Applicable Integrated Plans".

II. Policy/Criteria:

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 Requests for Items/Services/Drugs
- Favorable and Partially Favorable Standard Requests for Items/Services/Drugs
- 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.

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 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 mandatory 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, item, or Part B or D drug for an enrollee constitutes an initial determination and is subject to appeal. In addition, if a plan denies coverage of a service, item, or Part B or D 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 service, item, or Part B or D drug) than the service, item, or Part B or D drug requested. Thus, the adjudication timeframe, notice, and other requirements applicable to coverage determinations or organization determinations under Part 422, subpart M & Part 423, subpart M apply to requests that involve a PA or other UM requirements in the same manner that they apply to all coverage requests. If an enrollee requests coverage of a service, item, or Part B or D drug that involves PA, the plan is to respond to the PA request, 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]***

42 CFR 422.138 Prior authorization. [Effective until June 3, 2025]
(a) Requirement. When a coordinated care plan, as specified in § 422.4(a)(iii) (including MSA network plans), uses prior authorization processes in connection with basic benefits or supplemental benefits, the Medicare Advantage (MA) organization must comply with the requirements in this section. (MA PFFS are not permitted to use prior authorization policies or "prior notification" policies that reduce cost sharing for enrollees based on whether the enrollee or provider notifies the PFFS plan in advance that services will be furnished). Prior authorization processes include all policies and procedures used in prior authorization unless otherwise noted.
(b) Application. Prior authorization processes for coordinated care plans may only be used for one or more the following purposes:

(1) To confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service; or
(2) For basic benefits, to ensure an item or service is medically necessary based on standards specified in § 422.101(c)(1), or
(3) For supplemental benefits, to ensure that the furnishing of a service or benefit is clinically appropriate.

(c) Effect of prior authorization or pre-service approval. If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at § 405.986 of this chapter) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616. The definitions of the terms "reliable evidence" and "similar fault" in § 405.902 of this chapter apply to this provision.

422.138 Prior authorization. [Effective June 3, 2025]

(a) Requirement. When a coordinated care plan, as specified in § 422.4(a)(iii) (including MSA network plans), uses prior authorization processes in connection with basic benefits or supplemental benefits, the MA organization must comply with the requirements in this section. (MA PFFS are not permitted to use prior authorization policies or "prior notification" policies that reduce cost sharing for enrollees based on whether the enrollee or provider notifies the PFFS plan in advance that services will be furnished). Prior authorization processes include all policies and procedures used in prior authorization unless otherwise noted.

(b) Application. Prior authorization processes for coordinated care plans may only be used for one or more the following purposes:

(1) To confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service; or

(2) For basic benefits, to ensure an item or service is medically necessary based on standards specified in § 422.101(c)(1), or

(3) For supplemental benefits, to ensure that the furnishing of a service or benefit is clinically appropriate.

(c) Effect of prior authorization, pre-service, or concurrent approval. If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, or a concurrent determination made during the enrollee's receipt of inpatient or outpatient services, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at § 405.986 of this chapter and § 422.616) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616. The definitions of the terms "reliable evidence" and "similar fault" in § 405.902 of this chapter apply to this paragraph (c).

42 CFR § 422.122 Prior authorization requirements.

(c) Publicly reporting prior authorization metrics. Beginning in 2026, following each calendar year that it offers an MA plan, an MA organization must report prior authorization data, excluding data on drugs as defined in § 422.119(b)(1)(v), at the MA contract level by March 31. The MA organization must make the following data from the previous calendar year publicly accessible by posting them on its website:

(1) A list of all items and services that require prior authorization.

(2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services.

(3) The percentage of standard prior authorization requests that were denied, aggregated for all items and services.

(4) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.

(5) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.

(6) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.

(7) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.

(8) The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, aggregated for all items and services.

(9) The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, aggregated for all items and services.

42 CFR 422.562 General provisions

(b) Rights of Medicare Advantage enrollees. In accordance with the provisions of this subpart, enrollees have the following rights:

(1) The right to have grievances between the enrollee and the MA organization heard and resolved, as described in § 422.564 or, beginning January 1, 2021, § 422.630, as applicable.

(2) The right to a timely organization determination, as provided under § 422.566 or, beginning January 1, 2021, § 422.631(c), as applicable.

(3) The right to request an expedited organization determination, as provided under §§ 422.570 or, beginning January 1, 2021, § 422.631(e), as applicable.

(4) If dissatisfied with any part of an organization determination, the following appeal rights:

(i) The right to a reconsideration of the adverse organization determination by the MA organization, as provided under § 422.578 or, beginning January 1, 2021, § 422.633, as applicable.

(ii) The right to request an expedited reconsideration, as provided under § 422.584 or, beginning January 1, 2021, § 422.633(e), as applicable.

(iii) If, as a result of a reconsideration, an MA organization affirms, in whole or in part, its adverse organization determination, the right to an automatic reconsidered determination made by an independent, outside entity contracted by CMS, as provided in § 422.592.

(iv) The right to an ALJ hearing if the amount in controversy is met, as provided in § 422.600.

(v) The right to request Council review of the ALJ hearing decision, as provided in § 422.608.

(vi) The right to judicial review of the hearing decision if the amount in controversy is met, as provided in § 422.612.

III. Definitions

1. **Coverage Determinations, Organization Determinations (Initial Determinations)**: A coverage determination/organization determination (i.e., initial determination) is a decision made by the plan, or its delegated entity, concerning the payment or provision of an item, service, or drug.

   Plans must adhere to all applicable requirements set forth in 42 CFR Part 422, Subpart M and Part 423, Subpart M when making initial determinations regardless of whether:

   - Coverage is requested for an item/service/drug that is subject to a plan's prior authorization requirement;
   - Coverage is requested for an item/service/drug that is NOT subject to a plan's prior authorization requirement;
   - A plan makes a decision related to coverage of an item/service/drug without first receiving a party's request for coverage;
   - A plan receives a request for coverage before the provision of the item/service/drug that is the subject of the request to the enrollee;
   - A plan receives a request for coverage during or after the provision of the item/service/drug that is the subject of the request to the enrollee; and/or
   - A plan's decision related to coverage of an item/service/drug will be issued during or after the provision of the item/service/drug to the enrollee.

2. **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.

In circumstances where there is a question whether or not the plan will cover an item or service, the enrollee, enrollee's representative, or the provider on behalf of the enrollee, has the right to request approval from the plan. Such approval requests to the plan (even if to an agent or contractor of the plan, such as a network provider) are requests for an organization determination and must comply with the applicable regulatory requirements. Whenever an enrollee contacts an MA plan to request a service, the request itself indicates that the enrollee believes the MA plan should provide or pay for the service. However, when a provider declines to furnish a service requested by an enrollee, this is not an organization determination because the provider is making a treatment decision (which may be based on the provider's judgment about whether the item or service should be part of the enrollee's treatment plan or whether the provider is willing to furnish the item or service, regardless of coverage by the plan).

3. **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. **Applicable Integrated Plan (AIP):**
Pursuant to 42 CFR § 422.561, effective January 1, 2023, an AIP means either of the following:
(A) A fully integrated dual eligible special needs plan or highly integrated dual eligible special needs plan with exclusively aligned enrollment; and
(B) The Medicaid managed care organization, as defined in section 1903(m) of the Act, through which such dual eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual eligible special needs plan and such Medicaid managed care organization; or
(ii) A dual eligible special needs plan and affiliated Medicaid managed care plan where—
(A) The dual special needs plan, by State policy, has enrollment limited to those beneficiaries enrolled in a Medicaid managed care organization as described in paragraph (2)(ii)(B) of this definition;
(B) There is a capitated contract between the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization; and
(1) A Medicaid agency; or
(2) A Medicaid managed care organization as defined in section 1903(m) of the Act that contracts with the Medicaid agency; and
(C) Through the capitated contract described in paragraph (2)(ii)(B) of this definition, Medicaid benefits including primary care and acute care, including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries, and at a minimum, one of the following: Home health services as defined in § 440.70 of this chapter, medical supplies, equipment, and appliances as described in § 440.70(b)(3) of this chapter, or nursing facility services are covered for the enrollees.

5. **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)*.

6. **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.

7. **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 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.

8. **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 seven (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:**
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. ***[42 CFR 422.568; 42 CFR 422.572; Section 40.11 of Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance]***

9. **Notification Requirements for Initial Determinations:**
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. ***[Section 40.12 of Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance]***

10. **Part C Notification Requirements (40.12.1):**
Item, Service, or Part B Drug Approvals
For favorable decisions on a request for an item, service, or Part B drug, 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 Communications and Marketing Guidelines outline the process for electronic communication with enrollees. ***[Section 40.12.1 of Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance]***

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.

Note: The Advanced Beneficiary Notice of Non-Coverage (ABN), Form CMS-R-131, does not comply with MA organization determination requirements of 42 CFR, Part 422, Subpart M and, therefore, shall not be used by MA plans or contracted providers. When a MA plan wishes to inform an enrollee that a service is not covered, in whole or in part, it must issue the IDN or include the same OMB-approved standardized language in its EOB. If a provider believes an item, service or Part B drug may not be covered, the provider must advise the enrollee to request prior approval from the MA plan or the provider may request prior approval on the enrollee's behalf. The failure to provide notice via the OMB-approved standardized language contained in the IDN or via a clear exclusion in the plan's EOC, consistent with the beneficiary protection provisions in Chapter 4, means the enrollee is not liable for items, services or Part B drugs provided by a contracted provider or upon referral from a contracted provider (see 42 CFR 422.105; see also Chapter 4, Section 160, of the Medicare Managed Care Manual for more information on beneficiary protections related to plan-directed care, including enrollee liability protections).

When using the standardized IDN (see 42 CFR, 422.568(e)), 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.

11. **Health Equity:** The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes ***[CY2024 – CMS Final Rule]***

IV. Responsibility: Utilization Management staff

V. Process:

A. <u>Initial Screening/Intake Process</u>

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 as follows:

Type of Request	Who May Request
Part C, Standard Request for Item, Service, or Part B Drug	•Contract or non-contract provider/physician that furnishes, or intends to furnish, services to the enrollee, •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)
Part C, Expedited Request	•A physician or staff of said physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead).
Part C, Payment Request	•Contract or non-contract provider
Part D, Standard or Expedited Request	•An enrollee's prescribing physician or other prescriber* •Staff of said prescriber's office acting on said prescriber's behalf (e.g., request is on said prescriber's letterhead or otherwise indicates staff is working under the direction of the prescriber)
Part D, Payment Request	•For direct member reimbursement, only an enrollee or an enrollee's representative (which may be the prescribing physician or other prescriber*) may request reimbursement under Part D

*Pursuant to 423.56, "other prescriber" means a health care professional other than a physician who is authorized under State law or other applicable law to write prescriptions. It is the Part D plan

sponsor's responsibility to identify the types of health care professionals that have prescribing authority in the states in which the Part D plan sponsor operates.

Service Organization Determinations (Authorizations):

Type of request:

1. Pre-service 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 Pre-service requests.

*Please see *Definitions* above: Coverage Determinations, Organization Determinations (Initial Determinations)

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. Organization Determinations-Expedited (in whole or in part)

1. All requests for an urgent approval decision on an item, service, or drug request, 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, both the ImageOne and ISAAC electronic platforms allow 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 based on medical necessity must be made by a physician or other appropriate healthcare professional with sufficient medical and other expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare coverage criteria, and a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States, or the District of Columbia. The physician or health care professional reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider. **[*40.9 – Who Must Review an Initial Determination; 42 CFR 422.566(d)*]**

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: If 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 of Review Priority (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.

***Medicare Part B**

Requests for expedited Medicare Part B drugs are 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 requests for items or services are processed within the timeframe designated for standard organization determinations.
2. **Until January 1, 2026**, 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).

   ****Beginning on or after January 1, 2026**, for a service or item subject to the prior authorization rules in § 422.122, the decision for a standard organization determination is made and notification sent in writing no later than seven (7) calendar days after receiving the request for the standard organization determination. ***[42 CFR 422.568(b)(1)(ii)]***
3. The decision to issue a partially or fully adverse decision based on medical necessity must be made by a physician or other appropriate healthcare professional with sufficient medical and other expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare coverage criteria, and a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States, or the District of Columbia. The physician or health care professional reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider. **[*40.9 – Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance; 42 CFR 422.566(d)*]**

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 item/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 EviCore's *Clinical Certification of Services (UM 0045)* policy.

***Medicare Part B**

Requests for standard/routine Medicare Part B drugs are 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 [*Please see *Definitions* above: Coverage Determinations, Organization Determinations (Initial Determinations)]. Post-service requests are not processed as expedited/urgent as the requested item or service has already been received/performed.
2. **Until January 1, 2026**, 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 standard organization determination timeframe of fourteen (14) calendar days (refer to #1 above).
   ****Beginning on or after January 1, 2026**, for a service or item subject to the prior authorization rules in § 422.122, the decision for a post-service organization determination is made and notification sent in writing not later than seven (7) calendar days after receiving the request for the standard organization determination. ***[42 CFR 422.568(b)(1)(ii)]***
3. The decision to issue a partially or fully adverse decision based on medical necessity must be made by a physician or other appropriate healthcare professional with sufficient medical and other expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare coverage criteria, and a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States, or the District of Columbia. The physician or health care professional reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider. **[*40.9 – Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance; 42 CF 422.566(d)*]**

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 item/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**
Requests for post-service Medicare Part B drugs are sent electronically or 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.
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 plans, 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 (2) 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 (2) 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.
   [*Please see *Definitions* above: Coverage Determinations, Organization Determinations (Initial Determinations)].

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 can 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 provided via written or verbal method. **[*40.14 – Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*]**

A withdrawal of a request for initial determination is classified as a dismissal under 42 CFR 422.568 and Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance: 40.15 – Dismissal of an Initial Determination Request. Please reference section L. Organization Determinations - Dismissals, of this policy, for additional information regarding the process to dismiss a withdrawal, provide notice of the withdrawal, or the process to modify, reverse or vacate a dismissed request.

H. Organization Determinations - Lack of Information/Insufficient Information

Requests for authorization of services must include clinical information sufficient to demonstrate medical necessity. If a standard/routine priority request is not accompanied by adequate information to verify if the clinical guideline(s) have been met, the request will be pended for a specified period of time to allow for the submission of clinical information.

Standard Requests: Standard/routine priority requests with insufficient information are placed in a pend/hold status. Once the service request enters into the pend/hold status, written notification is immediately issued to the requesting healthcare provider informing them of the specific additional information that must be submitted to complete the request along with the amount of time in which to submit.

- In addition to the written notification being issued, an outreach attempt will be made by telephone to contact the provider to obtain the necessary information required to complete the case. A pre-determination consultation (PDC) may also be offered to the requesting healthcare provider, if agreed upon client workflows permit.
  - The telephone outreach attempts are completed during normal working hours, every other business day, starting the day after the case enters the pend/hold status, if processing timeframes/request maturity allow.
- If additional information is submitted by the healthcare provider within the permitted timeframe, the request is processed and a determination issued within the applicable timeframe based upon all of the information present in the request.
- If additional information is not submitted by the healthcare provider within the permitted timeframe, the request is processed and a determination issued based upon the information originally provided in the request.

Expedited Requests: Expedited/urgent priority requests with insufficient information are not placed in a pend/hold status. Given the stringent processing timeframes associated with expedited/urgent requests, they are facilitated through the Unable to Approve (UTA) Process as outlined below in section I.(1) where the additional clinical information is requested during the UTA outreach process.

I. Unable to Approve Process

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 (UTA) process, after Clinical Peer 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 first (1st) attempted verbal outreach.

b. **Written outreach:** EviCore will issue written correspondence to the requesting provider upon the case entering the UTA process, after Clinical Peer review and recommendation for denial. The written notice will reflect that the request has been reviewed and a denial recommendation has been determined along with any clinical information that is needed. The written notice will also provide an offer of a PDC discussion, the denial recommendation, contact information, and will be signed by an EviCore Medical Director.

2. **Standard Requests:** Until January 1, 2026, for standard requests where sufficient information is present, the request has been reviewed by an EviCore Clinical Peer Reviewer, and the recommendation is to issue an adverse determination, EviCore will follow the UTA process. The UTA process allows for additional clinical information to be submitted and a PDC to be conducted prior to issuing a determination within the fourteen (14) calendar days from receipt of the service request from the healthcare provider. **Beginning on or after January 1, 2026**, for standard requests where sufficient information is present, the request has been reviewed by an EviCore Clinical Peer Reviewer, and the recommendation is to issue an adverse determination, EviCore will follow the UTA process, if delegated to do so. The UTA process allows for additional clinical information to be submitted and a PDC to be conducted prior to issuing a determination within seven (7) calendar days after receiving the request for the standard organization determination. ***[42 CFR 422.568(b)(1)(ii)]***

a. **Unable to Approve 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 to engage in a PDC discussion. The verbal outreach will be made on the second (2nd) day after the case enters the UTA process. The verbal outreach will document the denial recommendation, the date/time of call, and the person speaking to the ordering provider.

b. **Unable to Approve Written Outreach:** EviCore will issue written notification to the ordering provider every day a request is in the UTA status/activity. The written notice will offer a PDC discussion, outline the denial recommendation, contact information, and will be signed by an EviCore Medical Director.

Outreach for Additional Information to Support Coverage Decisions

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 an approval decision on an item, service, or drug request, 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.

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.
[*10.6 - Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*]

Based on guidance received on August 14, 2023 from the CMS Part C Appeals division, the outreach process outlined above (Section 10.6 of the *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*) will also be exercised during EviCore's dismissal outreach process.

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.

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 (*seven (7) calendar days effective January 1, 2026) 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.
      [42 CFR 422.568(b)(2)]

K. Organization Determinations - Reconsideration

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**.**
   b. **Reconsideration** (see policy titled *Medicare Appeals-Utilization Management UM 0209-Medicare UM*)**:** 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.
   c. **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 7/19/2024)
40.15 – Dismissal of an Initial Determination Request
Plans must dismiss a request 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). A valid request, as contemplated in §§422.568(a) and 423.568(a), includes sufficient information to identify the enrollee to allow the plan to adjudicate the request (or, at a minimum, make contact with the enrollee to clarify the request), including a full name or member ID number or at least one means of contact (e.g., address, telephone number, email). 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.

NOTE: The above list of circumstances (taken from the applicable regulations) under which a plan must dismiss a request for an initial determination is exhaustive. A plan may not deem a request invalid or dismiss a request for an initial determination for any reason not explicitly included in §§42 CFR 422.568(g) and 423.568(i), as applicable.

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.

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 is Considered Received by the 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).

Health Equity - 2024 Final Rule - (CMS-4201-F): Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (§§ 422.111 and 422.112). Applicable January 1, 2024.

42 CFR 422.112(a)(8): Ensuring equitable access to Medicare Advantage (MA) Services.
Ensure that services are provided in a culturally competent manner and to promote equitable access to all enrollees, including the following:
(i) People with limited English proficiency or reading skills.
(ii) People of ethnic, cultural, racial, or religious minorities.
(iii) People with disabilities.
(iv) People who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
(v) People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
(vi) People living in rural areas and other areas with high levels of deprivation.
(vii) People otherwise adversely affected by persistent poverty or inequality.

Applicable Integrated Plans (AIPs)
The below additional procedures apply to those beneficiaries enrolled in a Dual-Eligible Special Needs Plan (DSNP) plan demonstration that meets the definition of an "applicable integrated plan" as defined above in section *III. Definitions* and congruent with 42 CFR 422.561. Applicable Integrated Plans follow the requirements outlined in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance document with additional provisions/exceptions outlined in the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans.
[42 CFR Part 422 Subpart M; 42 CFR Part 423 Subparts M and U]

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 in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated organization determination. The physician or health care professional reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider. 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.
(l) Parties.
(1) The following individuals or entities can request an integrated grievance, integrated organization determination, and integrated reconsideration, and are parties to the case:
(i) The enrollee.
(ii) The enrollee's representative, including any person authorized under State law.
(2) When the term "enrollee" is used throughout §§ 422.629 through 422.634, it includes providers that file a request and authorized representatives consistent with this paragraph, unless otherwise specified.
(3) A provider who is providing treatment to the enrollee may, upon providing notice to the enrollee,

request a standard or expedited pre-service integrated reconsideration on behalf of an enrollee.
(4) The following individuals or entities may request an integrated reconsideration and are parties to the case:

(i) An assignee of the enrollee (that is, a physician or other provider who has furnished or intends to furnish a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service).
(ii) Any other provider or entity (other than the applicable integrated plan) who has an appealable interest in the proceeding.

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.
(2) The request can be oral or in writing.
(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.

(d) Timeframes and notice—

(1) Integrated organization determination notice.

(i) The applicable integrated plan must send an enrollee a written notice (and notify the physician or provider involved, as appropriate) of any adverse decision on an integrated organization determination (including a determination to authorize a service or item in an amount, duration, or scope that is less than the amount previously requested or authorized for an ongoing course of treatment) within the timeframes set forth in this section.
(ii) For an integrated organization determination not reached within the timeframes specified in this section (which constitutes a denial and is thus an adverse decision), the applicable integrated plan must send a notice to the enrollee (and notify the physician or provider involved, as appropriate) on the date that the timeframes expire. Such notice must describe all applicable Medicare and Medicaid appeal rights.
(iii) Integrated organization determination notices must be written in plain language, be available in a language and format that is accessible to the enrollee, and explain the following:

(A) The applicable integrated plan's determination.
(B) The date the determination was made.
(C) The date the determination will take effect.
(D) The reasons for the determination.
(E) The enrollee's right to file an integrated reconsideration and the ability for someone else to file an appeal on the enrollee's behalf.
(F) Procedures for exercising enrollee's rights to an integrated reconsideration.
(G) Circumstances under which expedited resolution is available and how to request it.
(H) If applicable, the enrollee's rights to have benefits continue pending the resolution of the integrated appeal process.

(2) Timing of notice—
(i) Standard integrated organization determinations.

(A) The applicable integrated plan must send a notice of its integrated organization determination at least 10 days before the date of action (that is, before the date on which a termination, suspension, or reduction becomes effective), in cases where a

previously approved service is being reduced, suspended, or terminated, except in circumstances where an exception is permitted under §§ 431.213 and 431.214 of this chapter.

(B) For other integrated organization determinations that are not expedited integrated organization determinations, the applicable integrated plan must send a notice of its integrated organization determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from when it receives the request for the integrated organization determination until January 1, 2026.

****Beginning on or after January 1, 2026,** for a service or item subject to the prior authorization rules in § 422.122, the applicable integrated plan must send a notice of its determination no later than 7 calendar days after receiving the request for the standard integrated organization determination.

(ii) Extensions. The applicable integrated plan may extend the timeframe for a standard or expedited integrated organization determination by up to 14 calendar days if—

(A) The enrollee or provider requests the extension; or

(B) The applicable integrated plan can show that—

(1) The extension is in the enrollee's interest; and

(2) There is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

(iii) Notices in cases of extension.

(A) When the applicable integrated plan extends the timeframe, it must notify the enrollee in writing of the reasons for the delay as expeditiously as the enrollee's health condition requires but no later than upon expiration of the extension, and inform the enrollee of the right to file an expedited integrated grievance if he or she disagrees with the applicable integrated plan's decision to grant an extension.

(B) If the applicable integrated plan extends the timeframe for making its integrated organization determination, it must send the notice of its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(iv) Expedited integrated organization determinations.

(A) The applicable integrated plan must provide notice of its expedited integrated organization determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

(B) If the applicable integrated plan denies the request for an expedited integrated organization determination, it must:

(1) Automatically transfer a request to the standard timeframe and make the determination within the timeframe established in paragraph (d)(2)(i)(B) for a standard integrated organization determination. The timeframe begins with the day the applicable integrated plan receives the request for expedited integrated organization determination.

(2) Give the enrollee prompt oral notice of the denial and transfer and subsequently deliver, within 3 calendar days, a written letter that—

(i) Explains that the applicable integrated plan will process the request using the timeframe for standard integrated organization determinations;

(ii) Informs the enrollee of the right to file an expedited integrated grievance if he or she disagrees with the applicable integrated plan's decision not to expedite;

(iii) Informs the enrollee of the right to resubmit a request for an expedited integrated organization determination with any physician's support; and

(iv) Provides instructions about the integrated grievance process and its timeframes.

(C) If the applicable integrated plan must receive medical information from noncontract providers, the applicable integrated plan must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited

integrated organization determination. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the applicable integrated plan in meeting the required timeframe. Regardless of whether the applicable integrated plan must request information from noncontract providers, the applicable integrated plan is responsible for meeting the timeframe and notice requirements of this section.

(3) Timeframe for requests for payment. The applicable integrated plan must process requests for payment according to the "prompt payment" provisions set forth in § 422.520.

(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.

Appointment of Representative (AOR) Form or Equivalent Written Notice

The guidance in Section 20.2 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance applies to applicable integrated plans, except that for cases involving only a Medicaid-covered benefit, an applicable integrated plan may accept a written authorization from an enrollee that complies with state Medicaid requirements, even if such an authorization does not contain every element described under Section 20.2.

[Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans section 20.2.a]

How to Process Requests for Integrated Plan Expedited Initial Determinations

(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.

(3) In addition to the enrollee and the enrollee's representative, a physician or other provider on behalf of the enrollee may make the request for an expedited integrated determination. This information supplements the table with column headers "Who May Request an Expedited Determination" and "Plan Requirements," with respect to who may request an expedited integrated determination. See 42 CFR §§ 422.629(l)(2) and 422.631(c)(1).

(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 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 section 40.8.a]

Medicaid and Medicare Part C Notification Requirements

For integrated organization determination denials, applicable integrated plans must use the approved integrated denial notice, rather than the standard Integrated Denial Notice when issuing written denial notices to enrollees. The standardized integrated denial notice for applicable integrated plans is the *Applicable Integrated Plan Coverage Decision Letter (Form CMS-10716)*, also known as the *Coverage Decision Letter*.

In cases where the Applicable Integrated Plan is reducing, suspending or terminating a previously approved service (except in circumstances where an exception is permitted under §§431.213 and 431.214), the plan must send the notice least 10 days before the date of action (that is, before the date on which a termination, suspension, or reduction becomes effective), consistent with 42 CFR § 422.631(d)(2)(i)(A);

<u>Denial of a Request for an Expedited Organization Determination</u>

Notice of denial of a request for an expedited integrated organization determination will comply with section 40.12.1 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance except that a specialized integrated notice for notifying the enrollee will be used.

[Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans section 40.12.1.a]

42 CFR 422.634 Effect.

(a) Failure of the applicable integrated plan to send timely notice of a determination. If the applicable integrated plan fails to adhere to the notice and timing for an integrated organization determination or integrated reconsideration, this failure constitutes an adverse determination for the enrollee.

(1) For an integrated organization determination, this means that the enrollee may request an

integrated reconsideration.

For Dual Eligible Special Needs Plans – Applicable Integrated Plans (DSNP-AIP): ODAG Program Audit Protocol & Data Request in compliance standard 1.3: CMS conducts a timeliness test at the universe level on expedited pre-service organization determinations to determine whether the sponsoring organization provided notification of the determination no later than 72 hours after receipt of the request. For Dual Eligible Special Needs Plans – Applicable Integrated Plans (DSNP-AIP), written notice of the denial must be provided within 3 days of receipt of the request. The additional 3-day allowance to deliver the written notification after providing oral notice does not apply.

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

References:

- Medicare Advantage/DSNP
  - 42 CFR Part 422 Medicare Advantage Program
    - Subpart M – Grievances, Organization Determinations and Appeals
  - 42 CFR Part 423 Voluntary Medicare Prescription Drug Benefit
    - Subpart M – Grievances, Coverage Determinations, Redeterminations, and Reconsiderations
  - Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans – Effective July 2024

- Applicable Integrated Plan
  - § 422.629 General requirements for applicable integrated plans.
  - § 422.631 Integrated organization determinations.
  - § 422.634 Effect.

- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans – Effective August 2022
- Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans - Updated August 2022

Revision Dates

05/22/2025-CMS 2026 Final Rule for Medicare and Medicaid requirement for publicly reporting prior authorization metrics, on prior year. (c) 42 C.F.R. § 422.122 § 422.122 Prior authorization requirements. 422.138 Prior authorization. [Effective June 3, 2025] CMS standard decision turnaround time revision
08/13/2024 – Revisions to policy to align with 2024 Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance document effective 7/19/24
02/26/2024 – Added language from 42 CFR 422.629 and 422.566 re: appropriate professional to render decision;
11/08/2023 – Added Applicable Integrated Plan section; added language to clarify DSNP applicability; insertion of 42 CFR 422.562 General provisions language.
10/31/2023 – Additional language under Section 10.6 Outreach for Additional Information to Support Coverage Decisions surrounding the dismissal outreach process
10/10/2023 – Added regulation 42 CFR 422.138. Prior authorization
08/31/2023 - For Dual Eligible Special Needs Plans – Applicable Integrated Plans (DSNP-AIP): ODAG Program Audit Protocol & Data Request in compliance standard 1.3 added to policy.
07/31/2023
04/14/2023
02/13/2023
01/30/2023
10/04/2022
09/18/2022

Approved by: Kate Keller, Managing Director, EviCore Compliance

Date: 05/30/2025