SMSO Policy Manual
Part 'C' Reporting Organizational Determination and Reconsiderations

Executive Sponsor: Chief Medical Officer

Issuing Department: Health Services Management (HSM) - Clinical Management

Gate Keeper: Director - Clinical Management

COMPLIANCE STATEMENT:

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

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

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

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

APPLIES TO:

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

LINE(S) OF BUSINESS:

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

1.0 **Purpose:** The purpose of this policy is to create a summary report of Medicare pre-service and post service authorizations grouped by determination or withdrawal status for member notification or withdrawal dates within the reporting period.

2.0 **Policy:** To maintain Medicare authorization statistics for Part C reporting.

3.0 **Procedure:** This procedure captures determinations, timeliness of notification, withdrawal, dismissals and re-openings. Administrative and informational authorizations are not included as they are for claims payment issues. Reconsiderations are captured in another procedure. Information gathered in this process will be gathered to help complete the Medicare 'Part C' reporting.

3.1 Authorizations/Determinations/Notifications are entered in accordance with the Medicare Preservice Organization Determinations and Utilization Management (UM) policies.
Authorizations/Determinations are coded for fully favorable, partially favorable and adverse determinations. Authorizations are grouped by determination and Medicare contract.

Withdrawals requested by a member or provider prior to the plan's final determination are considered both a Withdrawal and a Dismissal. Cases dismissed by the plan are considered Dismissals.

If a provider (e.g., a physician) declines to provide a service an enrollee has requested or offers alternative service, the provider is making a treatment decision, not an organization determination on behalf of the plan. In this situation, if the enrollee disagrees with the provider's decision, and still wishes to obtain coverage of the service or item, the enrollee must contact the Medicare health plan to request an organization determination.

This is a quarterly report that will run no later than the 18th day of the 1st month following the quarter. For example, the report covering a period for the first quarter of 2021 will be run on or before April 18, 2021.

	For each case that was reopened, the following information will be uploaded in a data file:
B	Contract Number
C	Plan ID
D	Case ID
E	Case level (Organization Determination or Reconsideration)
F	Date of original disposition
G	Original disposition (Fully Favorable; Partially Favorable or Adverse)
H	Was the case processed under the expedited timeframe? (Y/N)
I	Case type (Service or Claim)
J	Status of treating provider (Contract, Non-contract)
K	Date case was reopened
L	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
M	Additional Information (Optional)
N	Date of reopening disposition (revised decision)*
O	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

eviCore: The vendor to whom the Plan delegates UM decision-making (organizational determinations) for outpatient diagnostic imaging.

Delta Dental: The vendor to whom the Plan delegates UM decision-making (organizational determinations) for prior authorized dental procedures.

Security: All work files are password protected and stored in a secure folder with limited access on the Plan's network. It is located at: Q:\Clinical Management\Authorization Unit\MCARE Part C Reporting.

Backup and Recovery: All work files will be kept on a network drive (drive Q), therefore; all files will be backed up along with all other network files according to the IT department's backup procedures. Please see the Manager of the IT Department for complete backup and recovery procedures of network files.

3.2 Operator procedures:

Create a new folder for the reporting period using "YYQX" format in a secured network area: Q\Clinical Management\Authorization Unit\MCARE Part C Reporting.

The eviCore "Medicare Advantage Part C Quarterly Report Organization Determinations (UM Services) report is received by the 15th of the month following the end of the quarter. The Delta Dental Part C Quarterly Organization Determination Service Determinations are received by the end of the month following the quarter.

CBI validates the element totals using the supporting detail. The written notification date and time (columns Y and Z) are checked for NA values which may be an indicator that the Plan prepared the out-of-network letter. CBI will search for the auth ID in the SharePoint denial mail log and update the letter date and time if applicable with the values from the log. CBI also verifies the Reported as Timely column (AI) has the correct value based on the timeliness of the letter.

If the totals do not match the detail OR any discrepancy is noted, CBI and Clinical Management will contact eviCore or Delta Dental to discuss and review the data and correct if necessary.

The element totals and supporting detail are imported into CBI's data warehouse on server SCWPCBIDB002.PROD_Prod.

The eviCore and Delta Dental data are automatically combined with the corresponding Plan data elements for final submission via the reporting process outlined below.

Open the report from the Reporting Services website: DVA - Organization Determinations

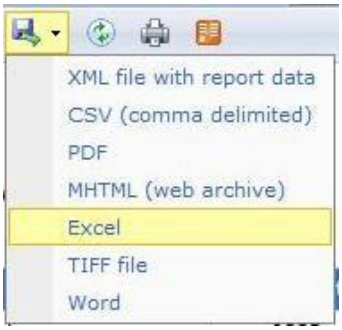
Enter the Start Date and End Date for the applicable quarter date range or select the start and end dates from the calendar control.

Select the applicable System (HealthEdge, Guiding Care, eviCore or Delta Dental) or leave the default of "All" to report the results from both.

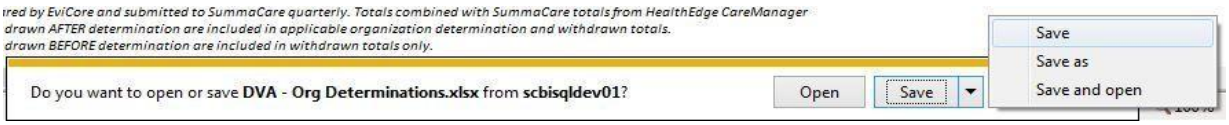
Select the desired element number from the Element (Detail Only) parameter or leave the default of "All" to report the results of all elements. Note the selection(s) only apply to the detail; all elements will continue to be displayed on the summary report.

Click the View Report button to produce the on-screen results.

Click the Export icon and select Excel to save the report to the network folder location. A pop-up window is displayed.



Click the arrow within the Save button and select Save As. Navigate to Q:\Clinical Management\Authorization Unit\MCARE Part C Reporting and then to the newly created folder for the current quarter and click Save.



Password protect the files

a. Select the Files tab
b. Click on Protect Workbook
c. Select **Encrypt with Password** and enter the assigned password and click OK d. Resave the document.

Quality Assurance Audit

The report is reviewed for Quality before it is submitted.

Step 1: The report is processed through the Reporting Services website.
Step 2: The report is reviewed for accuracy by the Manager of Administrative Services, HSM Clinical Management using the quality audit checklist below.

Part C Reporting QA Checklist		
Report Name: Authorization Determination Part C 2020 Q1		
Report Produced By: Clinical Business Informatics Personnel		
Reviewed By: Manager of Administrative Services, Clinical Management		
Reviewed Completed Date:		
Reviewer's Comments:		
Report Template	**YES**	**NO**
The document structure is consistent with the format and content.		
The report is for the correct date range per quarter.		
The date the report is completed shows above the data elements.		

Data Elements	YES	NO
Total Number of Organizational Determinations Made in Reporting Time Period matches the report.		
Of the Total Number of Organizational Determination, Number Processed Timely matches the report.		
Number of Requests for Organization Determinations- Withdrawn matches the report.		
Number of Requests for Organization Determinations -Dismissals matches the report.		
Number of Organization Determinations requested by enrollee/representative or provider on behalf of the enrollee (Services)		
Number of Organization Determinations requested by Non-Contract Provider (Services)		
Number of Organization Determinations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee		
Number of Organization Determinations – Fully Favorable (Services) Requested by Non-contract Provider		

Number of Organization Determinations – Partially Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee		
Number of Organization Determinations- Partially Favorable (Services) Requested by Non- contract Provider		
Number of Organization Determinations – Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee		
Number of Organization Determinations – Adverse (Services) Requested by Noncontract Provider		
Total Number of Reopened (revised) decisions, for any reason, in Time Period matches the report.		

Final submission is located at S:\Part C and D Reporting\YYYY\SC\Q_\Org Determinations and Reconsiderations….\Authorizations. A copy of the "Final" report and supporting detail are also saved at Q:\Clinical Management\Authorization Unit\MCARE Part C Reporting.

Enter the element totals from the HealthEdge only report and eviCore only report into the Part C template saved on S:\Part_C_and_D_Reporting\YYYY SC\Part C\HPMS Forms and verify the total of both systems match the combined report.

Submit template for quality review to second reviewer (CBI or Director, Clinical Management). Second reviewer to confirm numbers manually entered on template are accurate and will provide findings via email to original preparer. Save a copy of the template in S:\Part C and D Reporting\YYYY\SC\Q_\Org Determinations and _Reconsiderations….\Authorizations and Q:\Clinical Management\Authorization Unit\MCARE Part C Reporting.

Notify designated HPMS submitter that "service" numbers are entered in Template. HPMS submitter enters all totals into HPMS and a second person will observe and verify entries are accurate.

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Part C Organization Determination

SummaCare Medicare (Contract H3660)

Member Notification or Withdrawn Date Between 7/1/2019 - 9/30/2019

Source: CBI HealthEdge Data Warehouse as of 11/19/2019 and EviCore Part C Report; See criteria below

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A	Total Number of Organization Determinations Made in the Reporting Period Above	3915
B	Number of Organization Determinations - Withdrawn	180
C	Number of Organization Determinations - Dismissals	0
D	Number of Organization Determinations requested by enrollee/representative or provider on behalf of the enrollee (Services)	3646
F	Number of Organization Determinations requested by Non-Contract Provider (Services)	269
Subsection 2: Disposition – All Organization Determinations		
A	Number of Organization Determinations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee	3396
B	Number of Organization Determinations – Fully Favorable (Services) Requested by Non-contract Provider	244
E	Number of Organization Determinations – Partially Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee	5
F	Number of Organization Determinations – Partially Favorable (Services) Requested by Non-contract Provider	5
I	Number of Organization Determinations – Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee	245
J	Number of Organization Determinations – Adverse (Services) Requested by Non-contract Provider	20
Subsection 5: Re-Openings		
A	Total number of reopened (revised) decisions, for any reason, in Time Period Above	1

DVA - Org Determinations v2019 Specifications:

-Date filter based on earliest member notification date or withdrawn date for withdrawn authorizations

-Authorizations withdrawn AFTER determination are included in applicable organization determination element totals and are reported in the quarter based on the earliest member notification. The withdrawal is reported in the quarter based on the withdrawn date and are reported in the withdrawn totals.

-Authorizations withdrawn BEFORE determination are reported in the quarter based on the withdrawn date and are included in withdrawn totals only.

-Excludes Medicare Supplemental

-EviCore totals prepared by EviCore and submitted to SummaCare quarterly. Totals combined with SummaCare totals from HealthEdge CareManager

The summary report shown above is displayed in the Summary worksheet tab. The supporting detail is included on the detail tabs shown below:

The **Duplicates for Review** worksheet tab displays auth numbers appearing more than once in the detail. The reviewer will discuss any shown duplicates with Clinical Business Informatics (CBI) to determine the root cause. Once the cause of the duplication is established, the auth will be corrected and the report rerun. If the cause is unknown but all reported fields are identical, one of the duplicated records will be removed.

Program Logic (Overview)

The following is the logic behind the authorization process:

Step 1: Establish a new data set for the reporting period: Define a reporting period by entering the beginning and ending dates of the quarter to be reported, which is the period that the member notification of the request for authorization was completed by the Plan and/or eviCore.

Step 2: Determine whether the request for authorization is a covered benefit. If the request is not covered, such request will be recorded as 'Adverse'.

Step 3: If it is covered, determine whether the request for authorization is denied or not. If the request is denied, such request will be recorded as 'Adverse'.

Step 4: If the request is covered benefit and not denied, determine whether such request will be recorded as 'Fully Favorable' or 'Partially Favorable'. If not, it will be recorded as 'Unknown'.

Step 5: Due to data error or other conditions, a few records will not meet the three determination categories. They will be categorized as 'Unknown' and will be investigated for proper status.

Step 6: Manually add the eviCore totals from the eviCore quarterly report and the Plan's totals together to validate the totals on the "Final" report.

Step 7: Compare the current final totals with previous quarter's final totals. If they are not consistent with previous quarter's totals work with Clinical Business Informatics to review data and identify and correct errors. If errors were corrected and/or reporting logic was changed, rerun the report and repeat steps 6 and 7.

Step 8: Final report will be forwarded to Medicare Compliance Unit for submission. A copy will be stored in secured network area for storage.

Program Logic (Details)

See Attachment 07 PP Auth Codes.doc for detail. The following tables are used:

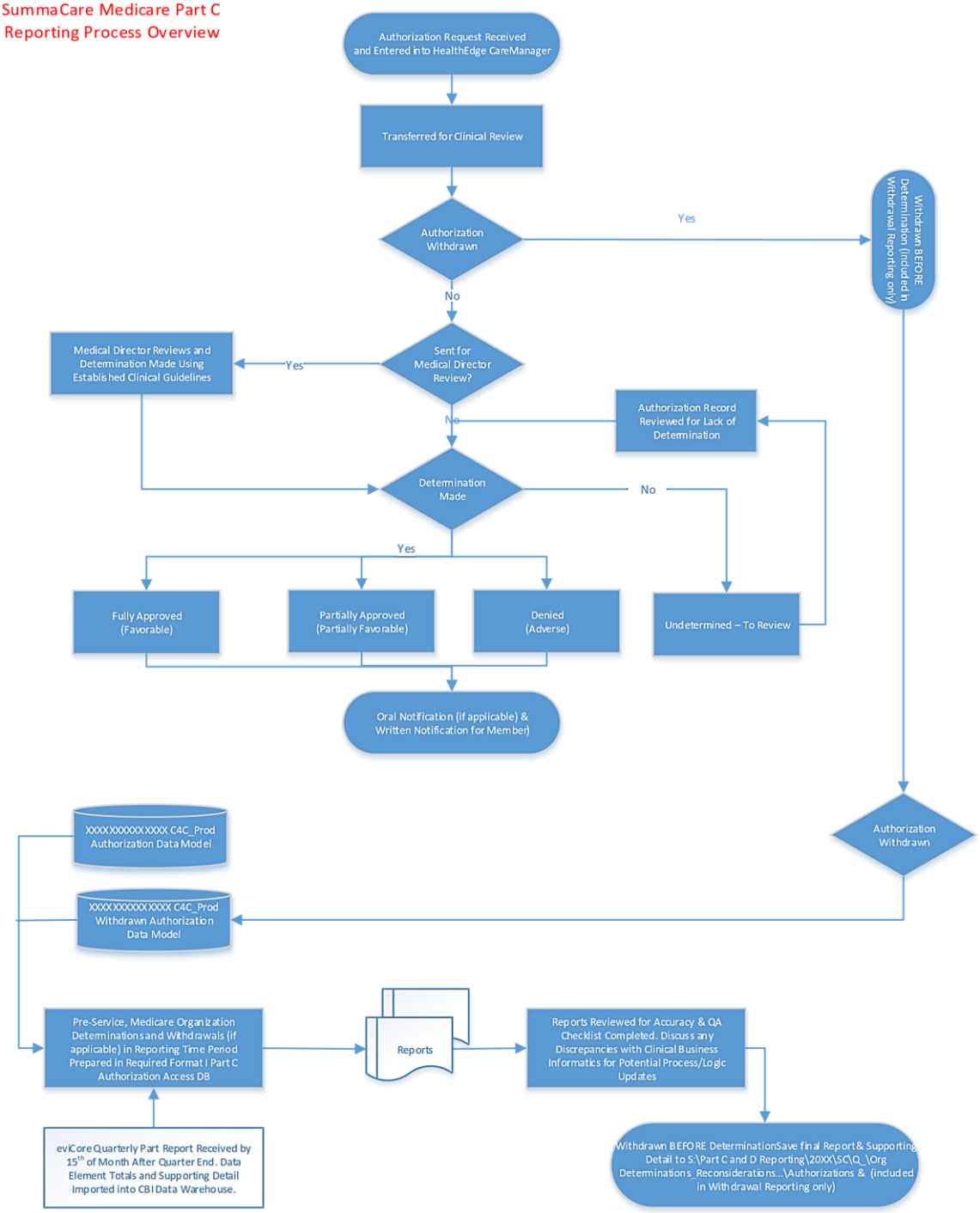
1. HealthEdge CareManager – Medical Management System
2. Scwp-cbidb002. PROD_Prod.dbo.Authorizations

3. Scwp-cbidb002. PROD_Prod.dbo.Authorizations_Withdrawn
4. Scwp-cbidb002.GuidingCare.GC.Authorizations
5. Scwp-cbidb002. PROD_Prod.dbo EviCore_ODR_Report_Summary
6. Scwp-cbidb002. PROD_Prod.dbo. EviCore_ODR_Report_Detail
7. Scwp-cbidb002. PROD_Prod.dbo. DeltalDental_ODR_Report_Summary
8. Scwp-cbidb002. PROD_Prod.dbo. DeltaDental_ODR_Report_Detail

Below is the list of queries that create the Part C Organization Determination report

1. SCWP-CBIDB002.PROD_Prod.dbo.ssrs_rpt_CMS_DVA_ODR_Summary
2. SCWP-CBIDB002.PROD_Prod.dbo.ssrs_rpt_CMS_DVA_ODR_Detail
3. SCWP-CBIDB002.PROD_Prod.dbo.ssrs_rpt_CMS_DVA_ODR_Duplicates
4. SCWP-CBIDB002.GuidingCare.dbo.ssrs_rpt_CMS_DVA_ODR_Summary
5. SCWP-CBIDB002.GuidingCare.dbo.ssrs_rpt_CMS_DVA_ODR_Detail
6. SCWP-CBIDB002.GuidingCare.dbo.ssrs_rpt_CMS_DVA_ODR_Duplicates

SummaCare Medicare Part C Reporting Process Overview



3.3 Who has the authority and responsibility for the activities in this policy or procedure: Director, HSM, Clinical Management.

3.4 Who is responsible for monitoring/enforcing the compliance with this policy: Manager of Administrative Services, HSM, Clinical Management.

4.0 References:

4.1 Change Control/CMS Requirement Updates:

HPMS Release Date	HPMS Memo Title	CFR Referenced (if applicable)	Effective Date of Requirement
06/03/2010	Update to the Technical Specifications for Part C Medicare Advantage and 1876 Cost Plan Reporting		06/03/2010
08/04/2010	Part C Reporting Requirements – Organization Determinations and Reconsiderations		08/04/2010
05/19/2011	Update to the Technical Specifications for Part C Medicare Advantage and 1876 Cost Plan Reporting		05/19/2011
09/28/2011	2011 Medicare Part C Plan Reporting Requirements Technical Specifications Document		09/2011
01/2012	2012 Medicare Part C Plan Reporting Requirements Technical Specifications Document		01/2012
02/13/2013	Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2013		01/01/2013
04/2014	Medicare Part C Plan Reporting Requirements Technical Specifications Document		01/01/2014

	Contract Year 2014		
05/2014	Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2014 – Version Dt May 2014		01/01/2014
03/2015	Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2015 – Version Dt 3/12/2015		01/01/2015
12/2015	Medicare Part C Plan Reporting Requirements Technical Specifications Document		01/01/2015
	Contract Year 2015 – Version Dt 12/14/2015		
2/2016	Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2015 – Version Dt 2/26/16		1/1/2016
4/2016	Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2016 – Version Dt 4/22/2016		1/1/2016
7/2016	Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2016		1/2016
8/2016	Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2016		1/2016
5/2017	DRAFT Medicare Part C Plan Reporting Requirements Technical Specifications Document		1/1/2017

	Contract Year 2017 – Version Dt 5/11/2016		
2018	Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2018		1/1/2018
2019	Medicare Part C Plan: Technical Specification Document; Medicare Part C Reporting Requirements		1/1/2019
2020	Medicare Part C Plan: Technical Specification Document; Medicare Part C Reporting Requirements		1/1/2020
2021	Medicare Part C Reporting Requirements Document		1/1/2021
2022	Medicare Part C Plan: Technical Specification Document; Medicare Part C Reporting Requirements		1/1/2022
2023	Medicare Part C Plan: Technical Specifications Document Contract Year 2023		1/1/2023

Fully favorable is approval in whole, for the service or item requested (including requested quantity or number of visits, if applicable).

Partially favorable is approval of a portion of the request.

Adverse is denial of request. Authorizations are grouped by determination and Medicare contract.

Withdrawals, for this reporting, are requests for service or claim where the member or the provider as the designee, specifically asks that the request be withdrawn.

Dismissal for this reporting, are actions taken by a Medicare health plan when an organization determination request or reconsideration request lacks required information or otherwise does not meet CMS requirements to be considered a valid request. For example, an individual requests a reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf.

Replaces:	
Review Date:	9/8/2010, 9/30/2011, 10/23/2012, 6/27/2014, 12/5/2014, 10/20/2015, 04/11/2016, 10/20/16, 3/14/2017, 12/4/2017, 11/12/2018, 12/20/2019, 11/17/2020,
Definitions:	Medicare Managed Care Manual, Medicare Part C Plan: Technical Specification Document; Medicare Part C Reporting Requirements
	Standards:

Revised Date:	9/8/2010, 9/30/2011, 10/23/2012, 6/27/2014, 12/5/2014, 10/20/2015, 3/14/2017, 12/04/2017, 11/12/2018, 12/20/2019, 11/17/2020,10/18/2022, 12/1/2023, 1/30/2024

Related Policy(ies)

UM Policy

Related Document(s)

Source Code