2026 Utilization Management Accreditation

Note: References to other standards within the elements use the 2025 UM Accreditation element titles.

Core UM Standards: Required for all Evaluation Options

UM 1: Internal Quality Improvement Process

The organization clearly defines its quality improvement ~~(QI)~~ structures and processes.

Intent

The organization has ~~the~~ an internal quality improvement infrastructure ~~needed to~~ for improving ~~the~~ UM functions and services provided to ~~its~~ members.

Applicable Elements

Element A: Quality Improvement Program Structure

The organization has a written QI plan ~~or written comprehensive policies and procedures~~ that includes:

1. **A defined scope of activities.**
2. **A defined goals and objectives.**
3. **~~A d~~ A defined process for assessing performance.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source

Documented process

Scope of review

NCQA reviews the organization's QI program description that was in place throughout the look-back period.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate.

This element may not be delegated.

Factors 1–3

The QI program description is a comprehensive document or a set of documents that includes, in plain language:

- The scope of UM activities covered by the QI program.
- Defined goals and objectives for the program.
  - and for each quality indicator.
- Indicators and analysis used to measure performance.
- A defined process for resolving client complaints and issues, including procedures for timely response to client concerns.

Exception

This element is NA if the organization is not seeking NCQA Accreditation in UM.

Examples

QI indicators

- Interrater reliability of UM decision making.
- Turnaround time of UM decision making.
- Telephone statistics, such as call abandonment rates and average speed of answer.
- Client complaint-handling turnaround times.
- Appeal-handling turnaround times.

Element B: Analysis of Quality Activities

The organization's analysis of data from its QI indicators includes:

1. **Evaluation of aggregate data and trends.**
2. **Assessment of performance.**
3. **Assessment of opportunities for improvement.**
4. **Assessment of barriers to improvement.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~No scoring option~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Reports

Scope of review NCQA reviews the organization's most recent and previous evaluation report.

Look-back period *For Renewal Surveys*: 24 months.

Explanation **THIS IS A CORE ELEMENT**. The organization must meet this requirement even if it does not have any clients or serve as a delegate.

This element may not be delegated.

The organization collects and analyzes data from its QI indicators, including client ~~(i.e., health plan, purchaser, employer or payer with which the organization contracts)~~ complaint data, to identify opportunities for improvement in UM operations. Analysis of quality information must go beyond a display of numeric results ~~data~~ to include narrative conclusions on results ~~display~~ to receive credit for this element.

Note: *Clients include health plans, purchasers, employers or payers with which the organization contracts.*

Factor 1: **Evaluation of aggregate data**

The organization conducts a quantitative analysis of data. This includes ~~that incorporates~~ aggregate ~~results~~ data and trends over time, and compares results against an established standard or goal in the QI plan (Element A). Tests of statistical significance are not required, but may be useful when analyzing trends.

Refer to ~~*Appendix 5: Glossary*~~ the glossary appendix for the full definition of and requirements for *quantitative analysis.*

Factor 2: **Performance**

The organization assess its performance against the goals and objectives defined in Element A (QI plan).

Factor 3: **Opportunities for improvement**

The organization assesses and chooses opportunities for improvement and describes its reasons for taking action (or not taking action).

Factor 4: **Barriers to improvement**

The organization conducts a root cause analysis or barrier analysis to identify the reasons for ~~the~~ results and draws conclusions about the results. ~~The a~~Analysis involves ~~includes~~ organization staff who ~~bring~~ understand~~ing about~~ the processes that may present barriers to improvement.

Refer to the glossary appendix for the full definition of and requirements for *qualitative analysis.*

Exceptions

This element is NA:

- If the organization is not seeking NCQA Accreditation in UM.
- For Initial Surveys.

Examples None.

Element C: Action and Follow-Up on Opportunities

~~For identified opportunities for improvement,~~ T~~t~~he organization implements interventions for identified opportunities for improvement and conducts follow-up evaluation ~~on~~ of actions~~. taken.~~

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review NCQA reviews the organization's most recent and previous implementation of interventions and follow-up of its actions on identified opportunities.

Look-back period *For Renewal Surveys*: 24 months.

Explanation **THIS IS A CORE ELEMENT**. The organization must meet this requirement even if it does not have any clients or serve as a delegate.

This element may not be delegated.

Interventions are of sufficient strength and specificity to show a likelihood that they contribute to measurable improvement and are linked to identified barriers.

The organization assesses the effectiveness of interventions to determine whether they improved performance. NCQA determines:

- Whether the measurement of effectiveness is commensurate with the interventions.
- Whether adequate time has elapsed since the organization implemented interventions to evaluate their effectiveness.

The organization's evaluation is in measurable terms and may include remeasurement against the original standard or a targeted, intermediate measurement of specific interventions.

Exceptions

This element is NA:

- If the organization does not have any opportunities for improvement.
  - NCQA evaluates whether this conclusion is reasonable, given evaluation results.
- If the organization is not seeking NCQA Accreditation in UM.
- For Initial Surveys.

Examples None.

UM 2: Privacy and Confidentiality

The organization protects the confidentiality of member information and records.

Intent

The organization sets standards for management of confidential information.

Element A: Confidentiality of Member Information

The organization's practitioner contracts address confidentiality of member information and records.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Materials

Scope of review NCQA reviews three active practitioner contracts executed within the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation **THIS IS A CORE ELEMENT.** The organization must meet this requirement even if it does not have any clients or serve as a delegate.

The organization's contracts require all contracted practitioners' offices have appropriate policies and procedures to maintain the confidentiality of member records and information.

Exceptions

This element is NA if:

- The organization is not seeking NCQA Accreditation in UM.
- The organization does not contract directly with practitioners.
- The organization does not maintain a practitioner network.

Examples None.

UM 3: UM Program Evaluation

The organization's UM program has clearly defined structures and ~~processes, and~~ assigns responsibility to appropriate individuals.

Intent

The organization has a well-structured UM program and makes utilization decisions affecting the health care of members ~~in a~~ fair<u>ly</u>, impartial<u>ly</u> and consistent<u>ly.</u> ~~manner~~

Element A: ~~Written~~ Program Description

The organization's <u>written</u> UM program description includes<u>:</u> ~~the following:~~

1. **A ~~written~~ description of the program structure.**
2. **The behavioral healthcare aspects of the program.**
3. **Involvement of a designated senior-level physician in UM program implementation.**
4. **Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program.**
5. **<u>Oversight of UM functions by a UM Committee.</u>**
6. **<u>A process for determining requests that require prior authorization.</u>**
7. **<u>7</u>~~5~~. The program scope and process used to determine benefit coverage and medical necessity.**
8. **<u>8</u>~~6~~. Information sources used to determine benefit coverage and medical necessity.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 6 factors~~	~~The organization meets 5 factors~~	~~The organization meets 3-4 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

<u>Met</u>	<u>Partially Met</u>	<u>Not Met</u>
<u>The organization meets 7-8 factors</u>	<u>The organization meets 5-6 factors</u>	<u>The organization meets 0-4 factors</u>

Data source

Documented process, ~~Reports~~

Scope of review

NCQA reviews the organization's <u>written</u> UM program description.

~~*For factors 3 and 4,* NCQA also reviews three UM Committee meeting minutes *or* other reports documenting active involvement of a senior-level physician and a designated behavioral healthcare practitioner in the UM program throughout the look-back period, or reviews all UM committee meeting minutes or other reports if the organization has fewer than three.~~

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months <u>for factors 1–4 and 7–8; prior to the survey date for factors 5–6.</u>

Explanation

THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate.

This element is a **structural requirement.** The organization must present its own documentation.

The UM program description is organized and written so that staff members and others can understand the program's structure, scope, processes and information sources used to make UM determinations.

Medical necessity review

Medical necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies.

NCQA's UM standards specify the steps in the medical necessity review. Medical necessity review requires that denial decisions be made only by an appropriate clinical professional as specified in NCQA standards.

Decisions about the following require medical necessity review:

- Any covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits, including, but not limited to:
    - Dental and vision services covered under medical benefits, including dental care or services associated with procedures that occur within or adjacent to the oral cavity or sinuses.
        - If medical and dental benefits are not differentiated in the benefits plan, the organization includes requests for care or services associated with dental procedures that occur within or adjacent to the oral cavity or sinuses for medical necessity review.
    - *Specialty dental and vision plans only:* All dental and vision services covered under the benefits plan.
    - Pharmaceuticals covered under medical or pharmacy benefits.
- Preexisting conditions, when the organization has a policy to deny coverage for care or services related to preexisting conditions.
- Care or services whose coverage depends on specific circumstances.
- Out-of-network services that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- "Experimental" or "investigational" requests covered by the organization.

Decisions about the following do not require medical necessity review:

- Services in the member's benefits plan that are limited by number, duration or frequency.
- Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
- Care or services whose coverage does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living.

- "Experimental" or "investigational" requests that are always excluded and are never covered under any circumstances. In these instances, the organization either:
    - Identifies the specific service or procedure excluded from the benefits plan, ***or***
    - If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures and that the organization maintains internal policies or criteria for these services or procedures.

If the services above, which do not require medical necessity review, are denied and subsequently appealed, they are within the scope of *Policies for Appeals* and *Appropriate Handling of Appeals*.

Dental and vision services not covered under a member's medical benefits are not within the scope of denial and appeal file review.

For specialty dental and vision plans only: All dental and vision services covered under a dental or vision benefits plan are within the scope of denial and appeal file review.

NCQA does not have any additional classifications of denials, such as administrative.

Medical necessity review of requests for out-of-network coverage

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

Denials ~~F~~file review universe

Although medical necessity review may result in approvals or denials, NCQA reviews only denials resulting from medical necessity review, as defined above, in UM 4–UM 7.

If an organization only makes medical necessity recommendations to its clients, and not medical necessity decisions, NCQA reviews the recommendation-only files against the requirements in UM 4–UM 7.

The UM medical necessity denial file-review universe is in three categories:

1. *Behavioral healthcare.* Includes denials of requests for evaluation or treatment of mental health conditions and psychological and substance abuse disorders.
2. *Pharmacy.* Includes denials of requests for pharmaceuticals covered under medical or pharmacy benefits and administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home), and does not include:

- Denials of requests for medical devices (e.g., insulin pumps and other types of durable medical equipment [DME]).
- Denials of requests for formulary exceptions (refer to UM 11, Element E).

3. *Nonbehavioral healthcare.* Includes denials of requests for coverage of medical, dental, vision or other nonbehavioral healthcare and nonpharmaceutical services, including, but not limited to, medical devices.

NCQA reviews denials, whether or not the member is at financial risk, excluding postservice payment disputes initiated by a practitioner or provider where the member is not at financial risk.

Members are considered to be at financial risk when:

- They have financial liability (i.e., co-insurance, deductibles, charges in excess of allowed amounts, differentials in cost between in-network care and out-of-network care, costs that vary within the formulary) for services beyond a flat copay that is always the same fixed dollar amount.
  - Copays may vary across a range of services, but must not be different within the same service category (e.g., $15 for primary care office visits and $25 for specialist office visits is acceptable), ***or***
- They may be balance-billed by a practitioner, provider or other party.

Classification of overturned denials. Although federal regulations may define an overturned denial based on the discussion between the member's treating practitioner and another physician or other appropriate reviewer (as described in UM 7~~: Denial Notices~~*)* as an appeal, such an approval does not fall under the scope of NCQA's appeal standards. The case is considered a denial if a denial notice was issued.

Appeal file-review universe

The member or their authorized representative may request an appeal of a previous decision (e.g., denials resulting from medical necessity review; benefit payment denial; rescission or reduction of coverage or provision of care; administrative action or quality-of-care or service issue). NCQA evaluates upheld appeals of an adverse decision for coverage of care or services under *Appropriate Handling of Appeals*.

NCQA does not divide the UM appeal file-review universe into separate categories. The file-review universe includes all appeals for coverage of health care services for nonbehavioral healthcare, behavioral healthcare and pharmacy in one file universe, unless an exception in UM 9 applies.

Organization employees and their dependents: The organization may exclude employees and their dependents from the denial and appeal file universe.

***Factor 1:* Description of ~~P~~program structure**

The ~~written~~ UM program description includes all of the following information about the ~~UM~~ program structure:

- UM staff~~'s~~ assigned activities.
- UM staff ~~who have~~ with the authority to deny coverage.
  - Involvement of a designated physician and a designated behavioral healthcare practitioner.

- The process for evaluating, approving and revising the UM program, and the staff responsible for each step.
- The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities.
- The organization's process for handling appeals and making appeal determinations.

Staff size. NCQA does not prescribe staff size or a method or criteria for determining staff size.

Factor 2: **Behavioral healthcare aspects of the program**

The program description specifies how the organization addresses sites of behavioral healthcare services (e.g., psychology groups) and levels of behavioral healthcare services (e.g., inpatient psychiatric care, outpatient psychiatrist visits). If the organization has a process for triage and referral to behavioral health services, the program description specifies the process.

Factor 3: **Senior-level physician involvement**

The program description specifies how a senior-level physician (a medical director, associate medical director or equivalent) is actively involved in the organization's UM Committee and UM activities, including implementation, supervision, oversight and evaluation of the UM program.

For specialty organizations: If the organization only provides UM for services not provided by physicians (e.g., dental care), a senior-level practitioner who represents the organization's specialty (e.g., a DDS) may substitute.

Factor 4: **Designated behavioral healthcare practitioner involvement**

The program description specifies how a designated behavioral healthcare physician or a doctoral-level behavioral healthcare practitioner is actively involved in the organization's UM Committee, including implementing and evaluating the behavioral health aspects of the UM program.

The behavioral healthcare practitioner must be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).

NEW Factor 5: **Oversight of UM functions by UM Committee**

The organization describes committee oversight of its UM functions. The committee may be a standing committee, the organization's QI committee or another committee. The committee includes participation of the senior-level physician (factor 3) and the designated behavioral healthcare practitioner (factor 4), as applicable.

The UM Committee:

- Annually reviews the UM program structure, scope, processes, process updates and information sources used to determine benefit coverage and medical necessity.
- Evaluates the findings from UM data analyses, including:

- Overall approval rates.
- The percentage of services requiring prior authorization that have an approval rate of 90% or more.
- Overall denial rates.
- Overturned appeal rate.
- Turnaround time frame compliance rate.
- Denial rate by reason category.
- Appeal upheld rate by reason category.

- Recommends improvements to the effectiveness of the UM program and rates.
- Evaluates the overall effectiveness of the UM program.

***NEW Factor 6:* Process for determining requests that require prior authorization**

The program description describes the organization's process for determining requests that require prior authorization, and for removing prior authorization requirements for requests.

***Factors ~~5~~7, ~~6~~8:* Processes and information sources used to make determinations**

The program description specifies:

- The organization's UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including:
  - How the organization develops and selects criteria.
  - How the organization reviews, updates and modifies criteria.
- How medical necessity and benefits coverage for inpatient and outpatient services are determined.
- The description of the data and information the organization uses to make determinations (e.g., patient records, conversations with appropriate physicians) and guide the UM decision-making process.
  - The description should not be burdensome for the member, the practitioner or the health delivery organization's staff.
- The triage and referral process for behavioral healthcare services (if applicable).
- How sites of service and levels of care are evaluated for behavioral healthcare services (if applicable).

The program description lists the information (e.g., patient records, conversations with appropriate physicians) the organization uses to make UM determinations.

Exceptions

Factors 2, 4 and behavioral healthcare aspects of factor 5 are NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Related information

Benefits plan exceptions. If the organization makes an exception to authorize a service, grants an extension of benefits or makes an exception to a limitation in the benefits plan (e.g., the organization covers up to 20 therapy visits but allows 21 visits), a subsequent

denial of the same service or a request for an extension or exception is not considered a medical necessity determination.

Examples

Factor 3: **Senior-level physician involvement**

The senior-level physician's responsibilities may include, but are not limited to:

- Setting UM policies.
- Supervising program operations.
- Reviewing UM cases.
- Participating on the UM Committee.
- Evaluating the overall effectiveness of the UM program.

Factor 4: **Behavioral healthcare practitioner involvement**

The designated behavioral healthcare practitioner's responsibilities may include, but are not limited to:

- Setting UM behavioral healthcare policies.
- Reviewing UM behavioral healthcare cases.
- Participating on the UM Committee.

NEW Element B: UM Data Collection

The organization annually reports:

1. **The overall approval rate.**
2. **The percentage of services requiring prior authorization that have an approval rate of 90% or more.**
3. **The overall denial rate.**
4. **Denial rates by reason.**
5. **The overall appeal rate.**
6. **The appeal overturn rate.**
7. **Timeliness of notification rate.**

Summary of Changes

- This is a new element.

Met	Partially Met	Not Met
The organization meets 7 factors	No scoring option	The organization meets 0-6 factors

Data source Reports

Scope of review

NCQA reviews the organization's completed UM report in IRT. The element applies to the organization's data and to all delegate data. Organizations earn credit for this element by completing the self-reported table in IRT.

NCQA reviews and scores this element separately for non-behavioral health, behavioral health and pharmacy.

Look-back period

For All Surveys: At least once during the prior year.

Explanation

The intent of this element is not to compare rates across organizations or non-behavioral health, behavioral health or pharmacy.

This element applies to urgent concurrent, urgent preservice and nonurgent preservice requests, and to preservice and expedited appeals.

Factors 1–6 do not apply to postservice requests and postservice appeals.

Factor 7 applies to urgent concurrent, urgent preservice, nonurgent preservice and postservice requests.

The organization calculates its UM rates according to the formulas in each factor. This element is not limited to medical necessity determinations. Partial denials count as denials. If any part of a request is approved, the organization may count it as part of the approval rate calculation.

***Factor 1:* Overall approval rate**

The overall approval rate measures the proportion of UM requests that were granted approval out of the total number of UM decisions made within a given reporting period.

The organization calculates the following according to the formula below:

- Overall approval rate = (Total number of approval decisions/Total number of UM decisions)*100.
    - Total number of approval decisions: Includes all UM requests that received an approval decision.
    - Total number of UM decisions: Includes all UM requests reviewed, encompassing both approvals and denials, excluding pending.

***Factor 2:* Percentage of services that require prior authorization**

To determine whether services and procedures are subject to prior authorization, the organization compiles a list of all nonbehavioral and behavioral services and procedures subject to prior authorization into a report. From the list of services and procedures subject to prior authorization, the organization evaluates one of the following:

- Services or procedures that are approved 90% or more of the time:
  - At the procedural level (e.g., spinal surgery).
  - At the individual code level within a procedure.
  - Across all codes subject to prior authorization.

***Factor 3*: Overall denial rate**

The overall denial rate measures the proportion of UM decisions that result in a denial rather than an approval.

The organization calculates the following according to the formula below:

- Overall denial rate = (Total number of denial decisions/Total number of UM decisions)*100.
    - Total number of denial decisions: Includes all UM requests that received a denial decision.
    - Total number of UM decisions: Includes all UM requests reviewed, encompassing both approvals and denials, excluding pending.

***Factor 4:* Denial rates by reasons**

The organization calculates its rate for each of the following reasons for denials and upheld appeals:

Lack of medical necessity rate =	(Total number of denial or upheld appeal decisions due to lack of medical necessity / Total number of denial or upheld appeal decisions) *100
Insufficient information rate =	(Total number of denial or upheld appeal decisions due to insufficient information / Total number of denial or upheld appeal decisions) *100
Out-of-network provider rate =	(Total number of denial or upheld appeal decisions due to an out of network provider / Total number of denial or upheld appeal decisions) *100
Benefit exclusion or limitation rate =	(Total number of denial or upheld appeal decisions due to benefit exclusions / Total number of denial or upheld appeal decisions) *100

***Factor 5:* Overall appeal rate**

The overall appeal rate is a metric used to evaluate how frequently denied UM requests are appealed. This provides insight into the volume of appeals, and whether initial denial decisions align with coverage and medical necessity standards.

The organization calculates the overall appeal rate according to the formula below:

- Overall appeal rate = (Total number of appeal requests/total number of denial decisions) *100.
    - Total number of appeal requests: The total count of UM denials that were appealed during the reporting period.
    - Total number of denial decisions: The total count of UM requests that were denied, regardless of reason, during the reporting period.

***Factor 6:* Appeal overturn rate**

The internal and external appeal overturn rate measures the proportion of denied UM decisions that were reversed through the appeals process, either through internal or external review.

The organization calculates its internal and external appeal overturn rate according to the formula below:

- Internal appeal overturned rate = (Total number of internal overturned decisions/Total number of internal appeal decisions) *100.
    - Total number of internal overturned decisions: The count of denials that were overturned during internal appeals process.
    - Total number of internal appeal decisions: The total number of appeals completed in the internal review process, whether upheld or overturned.
- External appeal overturned rate = (Total number of external overturned decisions/Total number of external appeal decisions) *100.
    - Total number of external overturned decisions: The count of denials that were overturned during external review process.
    - Total number of external appeal decisions: The total number of appeals reviewed in the external review process, whether upheld or overturned.

Factor 7: **Timeliness of notification rates**

This factor applies to all UM denial determinations. The organization applies the decision notification time frames in UM 5.

The organization calculates the rates of adherence to the time frames for each category of request:

- Urgent concurrent.
- Urgent preservice.
- Nonurgent preservice.
- Post-service.

For each category, the organization uses the following formula:

- (Total number of requests meeting the notification time frame/The total number of all requests) *100.

The organization's notification time frame begins from receipt of the request, and end when the decision is sent to the member and treating practitioner.

Note: *For organizations that do not communicate with members and practitioners, the notification time frame begins from the receipt of the request and ends when the decision or recommendation is sent to the client.*

Exceptions

None.

NEW Element C: Analysis of UM Data Collection

The organization annually performs analysis of the data from Element B.

Summary of Changes

- This is a new element.

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review NCQA reviews the organization's UM analysis reports completed during the look-back period.

NCQA reviews and scores this element separately for non-behavioral health, behavioral health and pharmacy.

Look-back period *For All Surveys*: At least once during the prior year.

Explanation

The organization uses the data it reported in Element B to complete a quantitative and qualitative analysis.

Quantitative and qualitative analysis

The organization conducts a quantitative analysis of results, and conducts a qualitative analysis of results that do not meet performance goals.

Refer to the glossary appendix for the full definition of and requirements for *quantitative analysis*.

Exceptions

None.

NEW Element D: UM Committee

The organization's UM Committee annually:

1. **Evaluates the UM program.**
2. **Identifies actions to address findings in factor 1.**
3. **Identifies actions to address the analysis of UM rates in Element C.**

Summary of Changes

- This is a new element.

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Materials, Reports

Scope of review *For All Surveys:* NCQA reviews the organization's most recent committee meeting minutes; reviews reports documenting active involvement of a senior-level physician and a designated behavioral healthcare practitioner; and reviews evidence that the organization provided the analysis report from Element C to its UM Committee.

NCQA reviews and scores this element separately for non-behavioral health, behavioral health and pharmacy.

Look-back period *For All Surveys:* At least once during the prior year.

Explanation The organization may use any standing committee, such as an existing UM committee its QI committee or another committee. The organization demonstrates active involvement of the senior-level physician (Element A, factor 3) and the designated behavioral healthcare practitioner (Element A, factor 4), as applicable, and provides evidence that it submitted its analysis report from Element C to the UM Committee.

Annual meetings and decisions may take place through video conference or web conference with audio, but may not be conducted only through email.

***Factor 1:* UM program**

The committee evaluates the organization's UM program to determine if it remains current and appropriate, including:

- The program structure.
- The program scope, processes and information sources used to determine benefit coverage and medical necessity.
- UM criteria.
- The process for determining requests that require prior authorization (Element A, factor 6).
- The overall effectiveness of the UM program.

***Factor 2:* Identify needed action to improve the UM program.**

The committee identifies actions to improve the organization's UM program based on the evaluation of factor 1, prioritizes them based on their significance and recommendations actions for the organization to pursue.

***Factor 3*: Identify needed action to address the analysis of UM rates.**

The committee identifies actions to address the root causes of the organization's UM rates that do not meet performance goals based on the evaluation of Element C, prioritizes them based on their significance and recommends actions for the organization to pursue.

Exceptions

None.

NEW Element E: Implementation of Improvement Actions

The organization annually implements interventions based on recommendations from the UM Committee (Element D) to:
1. Improve the effectiveness of the UM program.
2. Address the root causes of UM rates.

Summary of Changes

- This is a new element.

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factors	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review NCQA reviews the documentation of actions the organization planned to take, or has taken, to address UM Committee recommendations.

NCQA reviews and scores this element separately for non-behavioral health, behavioral health and pharmacy.

Look-back period *For All Surveys*: At least once during the prior year.

Explanation This element is a structural requirement. The organization must present its own documentation.

Factors 1, 2

The organization documents actions taken or planned, including dates of actions, to address UM Committee recommendations to improve the effectiveness of the UM program and address the root causes of UM rates. One action may address more than one finding, if appropriate. The organization identifies staff (by title) who are responsible for implementing actions. The organization considers member and practitioner experience data when making updates to improve the overall effectiveness of the UM program.

Exceptions

None.

NEW Element F: Measurement of the Effectiveness of Interventions

After the interventions in Element E have been implemented, the organization:
1. Evaluates improvement of UM program effectiveness.
2. Evaluates improvement of UM rates.
3. Reports findings from factors 1 and 2 to the UM Committee.

Summary of Changes

- This is a new element.

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Materials, Reports

Scope of review *For All Surveys:* NCQA reviews the organization's most recent evaluation of effectiveness. NCQA reviews meeting minutes that it reported the results of its audit to its UM committee.

NCQA reviews and scores this element separately for non-behavioral health, behavioral health and pharmacy.

For All Surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may submit a detailed implementation plan including a timeline in place of reports or materials.

Look-back period *For All Surveys:* At least once during the prior year.

Explanation **This element is a structural requirement.** The organization must present its own documentation.

***Factors 1–2:* Measure of effectiveness**

The organization evaluates the effectiveness of interventions in Element E within 3–6 months of implementing them to determine improvement in the UM program and UM rates, and draws conclusions about the overall effectiveness of implementations. The organization conducts a qualitative analysis if it identifies no improvement.

***Factor 3:* Report findings to the UM Committee**

The organization reports findings from factors 1 and 2 at the next scheduled UM Committee meeting.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may complete an implementation plan in place of reports or materials. The plan must include:

- A timeline for evaluating the effectiveness of interventions implemented to improve the UM program and rates.
- A timeline for reporting the findings to the UM committee.
- A description outlining roles and responsibilities.

UM 4: Clinical Criteria for UM Decisions

The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.

Intent

The organization applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

Element A: UM Criteria

The organization:

1. **Has written UM decision-making criteria that are objective and based on medical evidence.**
2. **Has written policies for applying the criteria based on individual needs.**
3. **Has written policies for applying the criteria based on an assessment of the local delivery system.**
4. **Involves appropriate practitioners in developing, adopting and reviewing criteria.**
5. **Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process, Reports, Materials

Scope of review NCQA reviews:

- *For factors 1–3:* The organization's policies and procedures in place throughout the look-back period. If the organization only uses its clients' criteria and does not have its own criteria, NCQA reviews the organization's policies and procedures for using and applying its clients' criteria.
- *For factor 4:* Three examples of meeting minutes or reports documenting the involvement of appropriate practitioners throughout the look-back period, or all UM committee meeting minutes or reports if the organization has fewer than three.

- *For factor 5:* The most recent annual review and update (for *Initial Surveys*) or most recent and previous year's annual reviews and updates (for *Renewal Surveys*).

Look-back period

For Initial Surveys: 6 months for factors 1–4; at least once during the prior year for factor 5.

For Renewal Surveys: 24 months.

Explanation

THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate. This element is a **structural requirement.** The organization must present its own documentation.

***Factor 1:* Written UM decision-making criteria**

The organization has specific criteria to determine the medical necessity and clinical appropriateness of medical, behavioral healthcare and pharmaceutical services requiring approval. The organization may address factors 2 and 3 as part of the UM criteria, or in separate, overriding documented processes for staff (e.g., standing instructions for staff to use when determining whether UM guidelines are appropriate for a specific situation).

***Factor 2:* Consideration of individual needs**

The organization considers at least the following characteristics when applying criteria to each individual:

- Age.
- Comorbidities.
- Complications.
- Progress of treatment.
- Psychosocial situation.
- Home environment, when applicable.

***Factor 3:* Assessment of the local delivery system**

The organization's UM policies and procedures require consideration of available services in the local delivery system and their ability to meet the member's specific health care needs, when UM criteria are applied.

***Factor 4:* Practitioner involvement**

Practitioners with clinical expertise in the area being reviewed <u>are provided</u> ~~have~~ the opportunity to advise or comment on development or adoption of UM criteria and on instructions for applying criteria. Although the organization may use practitioners that are its staff, non-staff network practitioners must also be involved in developing, adopting and reviewing criteria, because they are subject to application of the criteria. If an organization has been unable to involve network practitioners, it must document its attempts and provide the documentation to NCQA during the survey.

The organization may have practitioners review criteria if it does not develop its own UM criteria, and obtains criteria from external entities.

If an organization does not have its own practitioner network, it must involve the UM Committee. ~~use an advisory committee or staff practitioners~~.

Factor 5: **Reviewing and updating criteria**

The organization reviews its UM criteria and procedures against current clinical and medical evidence, and updates them~~,~~ when appropriate. If new scientific evidence is not available, the UM Committee ~~a designated group~~ may determine if further review of a criterion is necessary.

Exceptions

Factors 4 and 5 are NA if the organization does not have its own criteria and only uses client criteria.

Factor 5 is NA for UM criteria in use for less than 12 months.

Related information

Factors 2, 3: Applying criteria. Nationally developed procedures for applying criteria, particularly those for length of hospital stay, are often designed for "uncomplicated" patients and for a comprehensive delivery system; they may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to inpatient care. Written UM procedures direct decision makers to alternative procedures or approaches (e.g., a secondary set of UM criteria and individual case discussions) when assessment indicates that UM guidelines are not appropriate.

Examples

Factor 3: **Assessment of the local delivery system**

Assessment of available services in the local delivery system and their ability to meet a member's health care needs could include:

- Availability of inpatient, outpatient and transitional facilities.
- Availability of outpatient services in lieu of inpatient services (e.g., ~~such as~~ surgery centers vs. inpatient surgery).
- Availability of highly specialized services~~,~~ such as transplant facilities or cancer centers.
- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.
- Local hospitals' ability to provide all recommended services within the estimated length of stay.

Factor 4: **Practitioner involvement**

The organization solicits opinions about the UM criteria through either of the following:

- Practitioner participation on a committee.
- Distributing the UM criteria to applicable practitioners.

In large regional or national organizations, a central office may develop or adopt criteria if practitioners with clinical expertise are involved in their development or adoption.

Element B: Availability of UM Criteria

The organization makes UM criteria available to practitioners so they are available at the point of care.

~~**1. States in writing how practitioners can obtain UM criteria.**~~

~~**2. Makes the criteria available to its practitioners upon request.**~~

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports, Materials

Scope of review NCQA reviews the organization's communication of criteria availability to each practitioner at least once during the look-back period. ~~and that the criteria were made available upon request throughout the look-back period~~

Look-back period *For All Surveys:* Prior to the survey date.

~~*For Initial Surveys:* 24 months for factor 1 and 6 months for factor 2.~~

~~*For Renewal Surveys:* 24 months~~.

Explanation The organization distributes criteria by mail, fax or email, or on its website, if it informs practitioners that the information is available online. The organization mails the criteria to practitioners who do not have fax, email or internet access, upon request.

~~***Factor 1:* How to obtain criteria~~

~~No additional explanation required.~~

~~***Factor 2:* Availability of the UM criteria upon request~~

The organization makes criteria available at the point of care~~upon request~~, through any ~~of the~~ distribution method~~s~~ listed above or through ~~either~~ any of the following methods:

- ~~In person, at the organization.~~
- ~~By telephone.~~
- Through the EHR.
- On its website.
- By telephone.

If the organization does not have a practitioner network and is not delegated to communicate to client practitioners regarding criteria availability, then annual notification

is not required. The organization posts on its public website that criteria are available. ~~upon request.~~

Exceptions

This element is NA if the organization does not communicate with any practitioners (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with practitioners).

~~Factor 2 is NA if the organization demonstrates that it informed practitioners of the UM criteria's availability upon request, but no practitioners requested the criteria.~~

Examples None.

Element C: Consistency in Applying Criteria

At least annually, the organization:

1. **Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making.**
2. **Acts on opportunities to improve consistency, if applicable.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review NCQA reviews evaluation results or similar documentation, and evidence (e.g., minutes, policies, procedural updates) that the organization acted on opportunities.

Look-back period *For Initial Surveys:* At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation The evaluation of interrater reliability applies only to determinations made as part of a UM process.

Factor 1: **Evaluation of consistency**

The organization evaluates the consistency with which physician and nonphysician reviewers apply UM criteria:

- Using hypothetical UM test cases, ***or***
- Using a sample of UM determination files.
    - If the organization uses a sample of UM determination files, it uses one of the following auditing methods:
        - 5% or 50 ~~of its~~ UM determination files, whichever is fewer, ***or***

- NCQA "8/30 methodology" available at http://www.ncqa.org/programs/accreditation/policy-updates-supporting-documents, ***or***
- Another statistically valid method.

Factor 2: **Acting on opportunities**

No additional explanation required.

Exceptions

Factor 2 is NA if the organization has no opportunities to improve consistency. NCQA evaluates whether this conclusion is reasonable, given evaluation results.

Examples None.

UM 5: Communication Services

The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

Intent

Members and practitioners can access staff to discuss UM issues.

Element A: Access to Staff

The organization provides the following communication services for members and practitioners:

1. **Staff are available at least 8 hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.**
2. **Staff can receive inbound communication regarding UM issues after normal business hours.**
3. **Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.**
4. **TDD/TTY services for members who need them.**
5. **Language assistance for members to discuss UM issues.**
6. **Member navigation assistance with denials, appeals or other UM questions.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source Documented process, Materials

Scope of review *For factors 1–3:* NCQA reviews the organization's policies and procedures for providing communication services to members and practitioners that are in place throughout the look-back period.

For factors 4–6: 5: NCQA reviews materials or other evidence that demonstrate services provided to members at least once during the look-back period.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months for factors 1-5; prior to the survey date for factor 6.

Explanation

Member Services staff may triage communications to UM staff.

The organization is not required to offer TDD/TTY (factor 4) and language services (factor 5) to practitioners.

***Factor 1:* Communication during business hours**

No additional explanation required.

***Factor 2:* Communication after business hours**

The organization uses any of the following methods for after-hours communication, as appropriate:

- Telephone.
- Email.
- Fax.
- Electronic portal.

Communications received after normal business hours are returned on the next business day, and communications received after midnight on Monday–Friday are responded to on the same business day.

***Factor 3:* Staff identification**

The organization's policies and procedures state that when organization staff initiate or return calls to members or practitioners regarding UM issues, they identify themselves by name, title and organization.

***Factor 4:* TDD/TTY services**

TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) are electronic devices for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. The organization provides a separate phone number for receiving TDD/TTY messages, or uses the State/711 Relay Services.

***Factor 5:* Language assistance**

~~For all members who request language services, t~~The organization provides free language services~~, free of charge,~~ to all members who request them, ~~in the requested language~~ through bilingual staff or an interpreter.

Use of contracted translation services is not considered delegation.

This factor does not apply to after-hours communications.

***NEW Factor 6:* Member navigation assistance**

The organization provides assistance to members to help them understand UM decisions. The organization may refer members to staff or to resources that can help them interpret UM decisions.

Exception

This element is NA if the organization does not handle member or practitioner communication.

Examples

***Factors 4, 5:* TDD/TYY services and language assistance**

- Dated contracts.
- Dated call scripts.
- Notifications (e.g., newsletters, member letters) sent to members indicating TDD/TTY and language assistance services are available.

***NEW Factor 6:* Member navigation assistance**

- A member calls and requests assistance understanding their UM decision and a staff member provides additional information to resolve their questions.

UM 6: Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions.

Intent

UM decisions are made by qualified health professionals.

Element A: Licensed Health Professionals

The organization has written procedures:

1. Requiring appropriately licensed professionals to supervise all medical necessity decisions.

2. Specifying the type of personnel responsible for each level of UM decision making.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review

NCQA reviews the organization's policies and procedures.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate.

This element is a **structural requirement.** The organization must present its own documentation.

***Factor 1:* Supervision**

~~The p~~ Policies and procedures specify that the organization uses licensed health care professionals to supervise UM activities. These licensed health care professionals:

- Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

***Factor 2:* UM personnel and appropriate professionals**

~~The p~~ Policies and procedures specify that the organization uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:

- Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria and no clinical judgment is required.
- Licensed health care professionals.

Exceptions

None.

Related information

UM oversight. As specified in *UM 1: Program Structure*, Element A, a senior-level physician oversees the UM program and a designated behavioral healthcare practitioner is involved in the behavioral health aspects of the UM program. These individuals are not required to have day-to-day involvement in UM activities.

For doctoral-level clinical psychologists, such authority must be in the scope of their license to practice.

Examples

None.

Element B: Use of Practitioners for UM Decisions

The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:
1. Education, training or professional experience in medical or clinical practice.
2. A current clinical license to practice or an administrative license to review UM cases.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The description includes 2 factors for all appropriate practitioners~~	~~No scoring option~~	~~The description includes 1 factor for all appropriate practitioners~~	~~The description includes 1-2 factors for some appropriate practitioners~~	~~The description includes 0 factors~~

Met	Partially Met	Not Met
The description includes 2 factors for all appropriate practitioners	The description includes 1 factor for all appropriate practitioners	The description includes 0 factors

Data source Materials

Scope of review NCQA reviews the organization's practitioner job descriptions in place during the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation **THIS IS A CORE ELEMENT.** The organization must meet this requirement even if it does not have any clients or serve as a delegate.

This element is a **structural requirement.** The organization must present its own materials.

The written description applies to all types of practitioners who may review denials of care based on medical necessity for the organization. NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:

- *Physicians, all types*: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Doctoral-level clinical psychologists or certified addiction-medicine specialists*: Behavioral healthcare denials.
- *Pharmacists*: Pharmaceutical denials.
- *Dentists*: Dental denials.
- *Chiropractors*: Chiropractic denials.
- *Physical therapists*: Physical therapy denials.
- *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.

**In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license.*

For specialty organizations where the practitioner type is not listed above, (e.g., vision only or hearing only organizations), the organization must determine whether a practitioner (e.g., optometrist, audiologist) is appropriate for denials pertaining to a type of specialty service.

Factor 1: **Education, training or professional experience**

No additional explanation required.

Factor 2: **Current clinical or administrative license**

An **administrative license** is a limited license that allows practitioners to use clinical skills and knowledge to make judgment on the medical or clinical appropriateness of requested care or services but does not convey the authority to practice clinical medicine or to prescribe medications.

Exceptions

None.

Examples None.

Element C: Use of Board-Certified Consultants

The organization:

1. **Has written procedures for using board-certified consultants to assist in making medical necessity determinations.**
2. **Provides evidence that it uses board-certified consultants for medical necessity determinations.***

****Critical factors: Score cannot exceed 0% if one critical factor is scored "~~N~~no."***

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets factor 2 only~~	~~No scoring option~~	~~The organization meets factor 1 only, or meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets factor 2 only	The organization meets factor 1 only, or meets 0 factors

Data source Documented process, Reports, Materials, Records or files

Scope of review

For All Surveys:

- *For factor 1:* NCQA reviews the organization's written policies and procedures for using internal and external board-certified consultants, and reviews the list of board-certified consultants.

- *For factor 2:* NCQA also reviews three cases showing the use of external board-certified consultants during the look-back period. If there are not three cases showing the use of external consultants, NCQA also reviews internal cases, for a total of three cases. If the organization does not use external board-certified consultants, NCQA reviews three cases showing the use of internal consultants.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate.

Factor 2 is a critical factor; if this critical factor is scored "No," the organization's score cannot exceed "0%" for the element.

This element applies to medical necessity determinations.

***Factor 1:* Policies and procedures for using board-certified consultants**

The organization has written policies and procedures for using internal and external board-certified consultants. The organization maintains a list of board-certified consultants that includes contact information (e.g., phone numbers, names, specialties) and makes the list available to UM staff as a reference for contacting those consultants.

If external entities are unable to provide a list of all board-certified consultants for proprietary reasons, they may provide a list of the specialties of all board-certified consultants, with contact information; a name is not required. Listing an external entity's centralized contact information meets the intent if the entity does not provide direct contact information for individual specialists, but all available specialist types must be included on the organization's list.

***Factor 2:* Evidence of use of board-certified consultants**

NCQA reviews three cases showing the use of external board-certified consultants for medical necessity determinations. If the organization does not have three cases of using external board-certified consultants, NCQA also reviews cases of using internal consultants, for a total of three cases.

If the organization does not use external consultants for medical necessity determinations because all specialties are available in the organization, NCQA reviews three cases of the use of internal consultants. Network practitioners are not considered part of the organization.

Exceptions

None.

Related information

NCQA does not consider it delegation if a board-certified consultant reviews cases and makes a recommendation for medical necessity determinations, if the organization

makes the final decision. If the consultant makes the final decision, NCQA considers this to be delegation.

Examples

Factors 1, 2: **Use of board-certified consultant**

An attending physician believes a newborn is suffering from a neurological disorder. The physician requests approval for the infant to be treated by a pediatric neurologist. The organization does not have a pediatric neurologist on staff, but it does have access to a board-certified pediatric neurologist through a consulting firm. The organization collects the necessary clinical information and sends it to the consulting neurologist, who replies with a recommendation for authorization to an out-of-network pediatric neurologist within 24 hours.

UM 7: UM Information Integrity

The organization has UM information integrity policies and procedures, audits UM information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues.

Intent

The organization demonstrates its commitment to protecting the integrity of UM information used in in the processing of UM denials and UM appeals.

Element A: Protecting the Integrity of UM Denial Information

The organization has UM denial information integrity policies and procedures that specify:

1. **The scope of UM information.**
2. **The staff responsible for completing UM activities.**
3. **The process for documenting updates to UM information.**
4. **Inappropriate documentation and updates.**
5. **The organization audits UM staff and the process for documenting and reporting identified information integrity issues.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4-5 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 4-5 factors	No scoring option	The organization meets 0-3 factors

Data source Documented process

Scope of review

NCQA reviews the organization's policies and procedures for protecting the integrity of UM information.

Look-back period

For Initial Surveys and Renewal Surveys: Prior to the survey date.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element is a **structural requirement.** The organization must present its own documentation.

This element applies to UM information (both paper and electronic) used in the UM denial process (UM 4–UM 7).

UM denial information integrity refers to maintaining and safeguarding information used in UM denial decision process against inappropriate documentation and updates.

The organization's UM information integrity policies and procedures specifically address the integrity of information used in the UM denial process.

Factor 1: **Scope of UM information**

The organization's information integrity policies and procedures specify protection of each of the following types of information:

- UM requests from members or their authorized representatives.
- UM request receipt date.
- Appropriate practitioner review.
- Use of board-certified consultants.
- Clinical information collected and reviewed.
- UM decisions.
- UM decision notification dates.
- UM denial notices.

The organization defines the dates of receipt and written notification for UM denial determinations resulting from medical necessity review, consistent with requirements in UM 5.

Factor 2: **Staff responsible for performing UM activities**

The organization's policies and procedures specify the titles of staff who are:

- Responsible for documenting completion of UM activities.
- Authorized to modify (edit, update, delete) UM information.
    - Policies and procedures state if no staff are authorized to modify dates under any circumstances.
- Responsible for oversight of UM information integrity functions, including auditing.

Factor 3: **Process for documenting updates to UM information**

The organization's policies and procedures:

- Specify when updates to existing UM information is appropriate (e.g., the member sends an updated request or corrects a typographical error).
- Describe the organization's process for documenting the following when updates are made to UM information:
  - When (e.g., date and time) the information was updated.
  - What information was updated.
  - Why the information was updated.
  - Staff who updated the information.

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures specify that the following documentation and updates to UM information are inappropriate:

- Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
- Creating documents without performing the required activities.
- Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
- Attributing review to someone who did not perform the activity (e.g., appropriate practitioner review).
- Updates to information by unauthorized individuals.

Factor 5: **Auditing, documenting and reporting information integrity issues**

The organization's policies and procedures:

- Specify that the organization audits UM staff documentation and updates.
  - The organization does not have to include the audit methodology, but must indicate that an annual audit is performed.
- Describe the process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified.
  - NCQA, when the organization identifies fraud and misconduct.
    - Refer to *Notifying NCQA of Reportable Events* in Section 5 of the Policies and Procedures for details.
  - Specify consequences for inappropriate documentation and updates.

Exceptions

None.

Examples None.

Element B: Protecting the Integrity of UM Appeal Information

The organization has UM appeal information integrity policies and procedures for:

1. The scope of UM information.

2. The staff responsible for performing UM activities.

3. The process for documenting updates to UM information.

4. Inappropriate documentation and updates.

5. The organization audits UM staff and the process for documenting and reporting information integrity issues, when identified.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4-5 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 4-5 factors	No scoring option	The organization meets 0-3 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures for protecting the integrity of UM appeal information.

Look-back period *For Initial Surveys and Renewal Surveys:* Prior to the survey date.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element is a **structural requirement**. The organization must present its own documentation.

This element applies to UM information (both paper and electronic) used in the appeal process (UM 8–UM 9).

UM appeal information integrity refers to maintaining and safeguarding information used in the UM appeal process against inappropriate documentation and updates.

The organization's UM information integrity policies and procedures may be separate or may be incorporated in other organizational policies and procedures.

Factor 1: **Scope of UM information**

The organization's UM appeal information integrity policies and procedures specify protection of each of the following types of appeal information:

- UM appeal requests from members or their authorized representatives.
- UM appeal request receipt date.
- Substance and investigation of an appeal.
- UM appeal participants, as applicable.
  - Individual or group (e.g., panel) deciding the appeal.
  - Appropriate practitioner.
  - Same-or-similar-specialist review.
- UM appeal notice.
- UM appeal decision notification date.

The organization defines the dates of receipt and written notification for UM appeal decisions regarding coverage, whether or not a denial resulted from medical necessity review, consistent with the requirements in UM 8 and UM 9.

Factor 2: **Staff responsible for performing UM activities**

The organization's policies and procedures specify titles of staff who are:

- Responsible for documenting completion of UM activities.
- Authorized to modify (edit, update, delete) UM information.
    - Policies and procedures state if no staff are authorized to modify dates under any circumstances.
- Responsible for oversight of UM information integrity functions, including the audit.

Factor 3: **Process for documenting updates to UM information**

The organization's policies and procedures:

- Specify when updates to UM information are appropriate (e.g., the member sends an update request).
- Describe the organization's process for documenting the following when updates are made to UM information:
    - When (e.g., date and time) the information was updated.
    - What information was updated.
    - Why the information was updated.
    - Staff who updated the information.

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures:

- Specify that the following documentation and updates are inappropriate:
    - Falsifying UM dates (e.g., receipt date, appeal decision date, appeal notification date).
    - Creating documents without performing the required activities.
    - Fraudulently altering existing documents (e.g., investigation information, same-or-similar specialist review, appeal notices).
    - Attributing review to an individual who did not perform the activity.
    - Updates to information by unauthorized individuals.

Factor 5: **Auditing, documenting and reporting information integrity issues**

The organization's policies and procedures:

- Specify that the organization audits UM staff documentation and updates.
    - The policies and procedures do not have to include the audit methodology, but must indicate that an annual audit is performed.
- Describe the process for documenting and reporting inappropriate documentation and updates to:
    - The organization's designated individual(s) when identified.
    - NCQA, when the organization identifies fraud and misconduct.

  - Refer to *Notifying NCQA of Reportable Events* in Section 5 of the Policies and Procedures for details.
- Specify consequences for inappropriate documentation and updates.

Exception

None.

Examples None.

Element C: Information Integrity Training

The organization annually trains UM staff on:

1. Inappropriate documentation and updates (Elements A and B, factor 4).

2. Organization audits of staff, documenting and reporting information integrity issues (Elements A and B, factor 5).

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Reports, Materials

Scope of review NCQA reviews training materials and evidence that the organization conducted the required training.

Look-back period *For Initial and Renewal Surveys:* At least once during the prior year.

Explanation This element is a **structural requirement**. The organization must present its own documentation.

Factor 1: **Inappropriate documentation and updates**

The organization trains UM staff on inappropriate documentation and updates to UM information, as defined in Elements A and B, factor 4.

Factor 2: **Auditing, documenting and reporting information integrity issues**

The organization's training informs UM staff of:

- Organization audits of staff documentation and updates in UM files.

- The process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified.
  - NCQA, when the organization identifies fraud and misconduct.
- The consequences for inappropriate documentation and updates.

Exceptions

None.

Examples None.

Element D: Audit and Analysis—Denial Information

The organization annually:

1. **Audits for inappropriate documentation and updates to UM denial receipt and notification dates.**
2. **Conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Reports

Scope of review NCQA reviews the organization's audit and analysis reports completed during the look-back period.

Look-back period *For Initial Surveys and Renewal Surveys:* At least once during the prior year.

Explanation This element is a **structural requirement**. The organization must present its own documentation.

Factor 1: **Audit**

The organization annually audits for inappropriate documentation and updates to:

- UM request receipt dates (UM 5).
- UM denial decision notification dates (UM 5, UM 7).

The organization defines the dates of receipt and notification for UM denial determinations resulting from medical necessity review, consistent with the requirements in UM 5.

The audit universe includes files for UM denial decisions (based on the denial decision notification date) made during the look-back period. The organization randomly samples and audits 5% or 50 files, whichever is less, from the file universe. The organization may choose to audit more UM denial files than NCQA requires.

The organization provides an auditing and analysis report that includes:

- The report date.
- The title of individuals who conducted the audit.
- The 5% or 50 files auditing methodology.
    - Auditing period.
    - File audit universe size (described in the paragraph above).
    - Audit sample size.
- The audit log (as a referenced attachment)
    - The file identifier (case number).
    - The type of dates audited (i.e., receipt date, notification date).
- Findings for each file.
- A rationale for each instance of inappropriate documentation or update.
- The number or percentage and total number or percentage of inappropriate findings by date type.

The organization must provide a completed audit report even if no inappropriate documentation and updates were found.

Factor 2: **Qualitative analysis**

The organization annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause.

The organization's auditing and analysis report also includes:

- Titles of UM staff involved in the qualitative analysis.
- The cause of each finding.

Refer to the glossary appendix for the full definition of qualitative analysis.

Exception

Factor 2 is NA if the organization did not identify any inappropriate documentation and updates (factor 1). NCQA assesses whether this conclusion is reasonable, based on results of the organization's analysis.

Related information

If the organization audits more frequently, it must use the "5% or 50 files" methodology for each audit, and all audits must cumulatively cover the 12-month look-back period.

If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may, in lieu of completing a full audit and analysis report, generate, review and submit a complete system log showing there were no changes to dates during the look-back period. The organization may audit using the NCQA 5% or 50 files methodology. The organization audit and analysis report includes the following:

- Evidence that the organization's UM system automatically records receipt and decision notification dates, and does not permit changes under any circumstances.
- The report date.
- The title of the individual(s) who conducted the audit/review.
- Auditing/review period.
- File universe.
- Sampling methodology, if applicable.
- System generated log showing there were no changes to dates.

A separate analysis is not required if no dates were changed. If the audit reveals dates were changed, an analysis is required.

Examples

Factors 1, 2: **Audit and analysis report**

[Organization's Name]—Annual UM Information Integrity Assessment Report

Report date: February 10, [current year].

Auditor: [Individual's Name], UM director.

Auditing methodology: Each January, the UM director audits a random sample of UM denial files for inappropriate documentation and updates to UM request receipt dates (UM 5) and denial decision notification dates (UM 7) for the previous calendar year. The audit sample includes 5% or 50 files (whichever is less), randomly selected (based on the denial decision notification date) from all UM denial decisions made in the previous calendar year.

- Period reviewed: January 1 [previous year]–December 31 [previous year].
- File-review universe size: 1,500 UM denial decisions based on medical necessity review were made during the review period.
- Audit sample size calculation: 1,500 UM denial files x 0.05 = 75 files.
- Audit sample size: 50 files, which is less than 5% (75 files).

Audit date: January 6–9, [current year].

Audit log: Attachment 1. Partial illustration in the table below.

Case ID	Inappropriate Documentation/Updates?		Finding From Audit Period
	Receipt Date	Notification Date	
1235	No	No	NA
1245	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 2:59 PM after denial notice was sent.
1255	No	No	NA
1265	No	No	NA
1275	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 3:40 PM after denial notice was sent.
1285	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 4:00 PM after denial notice was sent.

Summary of findings:

Date Type	Compliant Denial Files	Noncompliant Denial Files	Total	Percentage of Noncompliant Denial Files
UM request receipt date	35	15	50	30%
UM denial notification date	35	15	50	30%

Qualitative analysis. The UM director provided UM staff with the audit log documenting how, when and by whom files were updated.

The UM director held a series of meetings (January 14–17, [current year]) with UM staff (UM assistant director, UM manager, UM analyst) to determine the causes of each inappropriate update to UM request receipt and denial notification dates~~,~~. The causes of the inappropriate updates are outlined in the table below.

Date Type	Description of Noncompliant Update	Reason
UM request receipt date	All 15 receipt dates were improperly updated in the UM denial file by the same staff on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.
UM denial notification date	All 15 notification dates were improperly updated by the same staff on 3/24/[previous year], after a decision had been sent.	Notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.

Element E: Improvement Actions—Denial Information

The organization:

1. **Implements corrective actions to address all inappropriate documentation and updates found in Element D.**
2. **Conducts an audit of the effectiveness of corrective actions (factor 1) on the findings 3–6 months after completion of the annual audit in Element D.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review

For Initial Surveys and Renewal Surveys:

- *For factor 1:* NCQA reviews the organization's documentation of corrective actions planned or taken to address inappropriate documentation and updates.
- *For factor 2:* NCQA reviews the organization's audit of the effectiveness of corrective actions.

Look-back period

For Initial Surveys and Renewal Surveys: At least once during the prior year.

Explanation

This element is a **structural requirement**. The organization must present its own documentation.

The organization addresses UM information integrity issues identified in Element D.

Factor 1: **Implement corrective actions**

The organization documents all actions taken or planned, including the time frame for actions, to address all inappropriate documentation and updates (findings) identified in Element D. One action may address more than one finding, if appropriate. Annual trainings (Element C) may not be the only corrective action.

The organization identifies the staff (by title) who are responsible for implementing corrective actions.

Factor 2: **Measure effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element D. The audit universe includes 3–6 months of UM denial files processed by the organization since the annual audit completed for Element D.

The organization conducts a qualitative analysis if it identifies integrity during the follow-up audit.

The organization draws conclusions about the actions' overall effectiveness.

Exceptions

This element is NA if the organization did not identify any inappropriate documentation and updates to UM denial receipt and decision notification dates. This must be evident in reports reviewed for Element D.

Factor 2 is NA if the annual audit is less than 3 months before the organization's NCQA Survey.

Related information

If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may use the specified methodology and submit a system log showing no changes were made to dates. A separate qualitative analysis is not required if the system log demonstrates that no dates were changed.

Examples

Factor 1: **Implement corrective actions**

[Organization's Name] UM director shared the audit analysis results and mitigation recommendations with the organization's leadership on January 31, [current year]. [Organization's Name] leadership required immediate implementation of actions and completion of all corrective actions in the table below, on or before the dates specified.

UM Information/ Noncompliant Update	**Reason**	**Correction Actions Planned**
UM request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial files on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	All UM staff must undergo ethics training, with emphasis on UM information integrity 4/15/[current year]. Owner: UM Director. Update UM system to read only records for dates and other UM information by 6/1/[current year]. Owner: UM Director.
UM denial notification dates: UM staff member	Receipt dates were improperly updated because the urgent concurrent	

improperly updated decision notification dates in 15 UM denial files on 3/4/[previous year], after a decision had been sent.	decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	Establish process for two-step verification of system dates to records/information prepared for external review bodies by 5/1/[current year]. Owner: IT Director.

Factor 2: **Effectiveness of corrective actions report**

*[Organization's Name]—*Annual UM Information Integrity Measure of Effectiveness

Report date: August 30, [current year].

Auditor: [Individual's Name], UM director.

Auditing methodology: [Organization Name] audits the effectiveness of corrective actions taken within 6 months of the annual audit completed on January 6–9, [current year], by randomly selecting a sample of 5% or 50 files from all UM denial decisions (based on the denial decision notification date) since the last annual audit.

- Period reviewed: February– [current year]– July [current year].
- File-review universe size: 750 UM denial decisions made during the review period.
- Audit sample size calculation: 750 UM denial files x 0.05 = 37.5 files (38 files).
- Audit sample size: 38 files, which is less than 5% (75 files).

Audit date: July 11–15, [current year].

Audit log: Attachment 1. Not shown in this example.

Summary of findings

Date Type	**Compliant Denial Files**	**Noncompliant Denial Files**	**Total**	**Percentage of Noncompliant Denial Files**
UM request receipt date	38	0	38	0%
UM denial notification date	38	0	38	0%

Qualitative analysis: Not required.

Actions effectiveness:

Noncompliant UM Updates **January [year] Audit**	**Corrective Actions Completed**	**Action Effectiveness** **July [year] Audit**
UM request receipt dates:	All UM staff completed ethics training, with emphasis on	There were no incidences of UM denial receipt or notification dates

UM staff improperly updated request receipt dates in 15 UM denial files on 3/4/[previous year], after a decision had been sent.	following UM information integrity policies and procedures on 4/15/[current year]. UM system updated to read only records for dates and all other UM information was completed 6/1/[current year]. Approved established process for two-step verification of system dates to records/information prepared for external review bodies on 5/1/[current year].	updates found in the audit sample. The implementation of read-only data in the UM system was tested during the audit and functioned properly. The two-process verification was tested for the upcoming Department of Insurance assessment which was scheduled for August [current year]. All records prepared for external review matched information in the UM system. No UM data were updated.
UM denial notification dates: UM staff improperly updated decision notification dates in 15 UM denial files on 3/4/[previous year], after a decision had been sent.		

Overall effectiveness—Conclusion

The corrective actions implemented were effective in preventing inappropriate documentation and updates, based on follow-up assessment, which showed that no incidences of inappropriate documentation and updates were made, and test results of the UM system read-only functionality and two-step verification proved the new features were working properly.

Element F: Audit and Analysis—Appeal Information

The organization annually:

1. **Audits for inappropriate documentation and updates to UM appeal receipt and notification dates.**
2. **Conducts qualitative analysis of inappropriate documentation and updates to UM appeal receipt and decision notification dates.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Reports

Scope of review NCQA reviews the organization's audit and analysis report(s) completed during the look-back period.

Look-back period

For Initial Surveys and Renewal Surveys: At least once during the prior year.

Explanation

This element is a **structural requirement**. The organization must present its own documentation.

This element applies to UM information (both paper and electronic) used in the UM appeal process (UM 8, UM 9).

Factor 1: **Audit**

The organization annually audits for inappropriate documentation and updates to:

- UM appeal request receipt dates.
- UM appeal decision notification dates.

The organization defines the dates of receipt and written notification for UM appeal decisions of coverage, whether or not an appeal resulted from medical necessity review, consistent with the requirements in UM 8 and UM 9.

The audit universe includes files for UM appeal decisions (based on the appeal decision notification date) during the look-back period. The organization randomly audits a sample of UM appeal files from the audit universe using 5% or 50 files, whichever is less. The organization may choose to audit more UM appeal files than NCQA specifies.

The organization provides an auditing and analysis report that includes:

- The date of the report.
- The title of staff who conducted the audit.
- The audit method:
    - Audit period.
    - Audit universe size (described in the paragraph above).
    - Audit sample size.
    - File identifier (case number).
    - Type of date audited (receipt date, notification date).
- Findings for each file.
- A rationale for each instance of inappropriate documentation or update.
- The number or percentage and total inappropriate documentation and updates.

The organization must provide a completed audit report even if no inappropriate documentation and updates were found.

Factor 2: **Qualitative analysis**

The organization annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause. Analysis involves staff responsible for executing the UM denial or appeal process.

The organization's auditing and analysis report includes:

- Titles of UM staff involved in the analysis.
- The cause of each finding.

Refer to *Appendix 5: Glossary* for the full definition of qualitative analysis.

Exception

Factor 2 is NA if the organization did not identify any inappropriate documentation and updates (factor 1). NCQA assesses whether this conclusion is reasonable, based on results of the organization's analysis.

Related information

If the organization audits more frequently, it must use the "5% or 50 files" methodology for each audit, and all audits must cumulatively cover the 12-month look-back period.

If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may, in lieu of completing a full audit and analysis report, generate, review and submit a complete system log showing there were no changes to dates during the look-back period. The organization may audit using the NCQA 5% or 50 files methodology. The organization audit and analysis report includes the following:

- Evidence that the organization's UM system automatically records receipt and decision notification dates, and does not permit changes under any circumstances.
- The report date.
- The title of the individual(s) who conducted the audit/review.
- Auditing/review period.
- File universe.
- Sampling methodology, if applicable.
- System generated log showing there were no changes to dates.

A separate analysis is not required if no dates were changed. If the audit reveals dates were changed, an analysis is required.

Examples

Factors 1, 2: **Audit and analysis report**

[Organization Name]—Annual UM Information Integrity Assessment

Report date: February 10, [current year].

Auditor: [Individual Name], UM director.

Auditing methodology: Each January, the UM director audits a random sample of UM appeal files for inappropriate documentation and updates to UM appeal receipt dates and UM appeal decision notification dates for the previous calendar year. The audit sample includes 5% or 50 files (whichever is less), randomly selected from all UM appeal decision notifications made in the previous year.

- Period reviewed: January 1 [previous year]–December 31 [previous year].
- File-review universe size: 1,500 UM appeal decisions made during the review period.
- Audit sample size calculation: 1,500 UM appeal files x 0.05 = 75 files.
- Audit sample size: 50 files, which is less than 5% (75 files).

Audit date: January 6–9, [current year].

Audit log: Attachment 1. Partial illustration in the table below.

Case ID	Inappropriate Documentation/ Updates?		Finding
	Receipt Date	Notification Date	
1235	No	No	NA
1245	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 2:59 PM after appeal notice was sent.
1255	No	No	NA
1265	No	No	NA
1275	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 3:40 PM after appeal notice was sent.
1285	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 4:00 PM after appeal notice was sent.

Summary of findings:

Date Type	Compliant Appeal Files	Noncompliant Appeal Files	Total	Percentage of Noncompliant Appeal Files
UM appeal request receipt date	35	15	50	30%
UM appeal notification date	35	15	50	30%

Qualitative analysis. The UM director provided staff with the audit log documenting how, when and by whom files were updated.

The UM director held meetings (January 14–17, [current year]) with UM staff (UM assistant director, UM manager, UM analyst) to determine the causes of each inappropriate update to UM appeal receipt and notification dates. The causes of the inappropriate updates are outlined in the table below.

Date Type	Description of Noncompliant Update	Reason
UM appeal request receipt date	All 15 appeal request receipt dates were improperly updated in the UM appeal file by the same staff on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year] Staff felt internal pressure to pass the state audit at any cost.
UM appeal notification date	All 15 appeal notification dates were improperly updated by the same staff on	Notification dates were improperly updated because the expedited appeal decision time frame had passed and an

	3/24/[previous year], after a decision had been sent.	audit by the Department of Insurance was scheduled for 3/11/[previous year] Staff felt internal pressure to pass the state audit at any cost.

Element G: Improvement Actions—Appeal Information

The organization:

1. **Implements corrective actions to address all inappropriate documentation and updates found in Element F.**
2. **Conducts an audit of the effectiveness of corrective actions (factor 1) on findings 3–6 months after completion of the annual audit for Element F.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review *For Initial Surveys and Renewal Surveys:*

- *For factor 1:* NCQA reviews the organization's documentation of corrective actions planned or taken to address inappropriate documentation and updates.
- *For factor 2:* NCQA reviews the organization's audit of the effectiveness of corrective actions.

Look-back period *For Initial Surveys and Renewal Surveys:* At least once during the prior year.

Explanation This element is a **structural requirement**. The organization must present its own documentation.

This element applies to UM information (both paper and electronic) used in the UM appeal process (UM 8, UM 9).

Factor 1: **Implement corrective actions**

The organization documents all actions taken or planned to address all inappropriate documentation and updates (findings) identified in Element F. One action may be address more than one finding, if appropriate. The organization may not use annual training (Element C) as the only action.

The organization identifies staff (by title) who are responsible for implementing corrective actions.

Factor 2: **Measure of effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element F, and draws conclusions about the actions' overall effectiveness. The audit universe includes 3–6 months of UM appeal files processed since the annual audit.

The organization conducts a qualitative analysis if it identifies noncompliance with integrity policies and procedures during the follow-up audit.

Exceptions

This element is NA if the organization did not identify any inappropriate documentation and updates. This must be evident in reports reviewed for Element F.

Factor 2 is NA if the annual audit is less than 3 months before the organization's NCQA Survey.

Related information

If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may use the specified methodology and submit a system log showing no changes were made to dates. A separate analysis is not required if no dates were changed.

Examples

Factor 1: Corrective actions

[Organization's Name] UM director shared audit analysis results and mitigation recommendations with the organization's leadership on January 31, [current year]. [Organization's Name] leadership required immediate implementation of actions and completion of all corrective actions on or before the dates outlined in the table below.

UM Information/ Noncompliant Update	**Reason**	**Correction Actions Planned**
UM appeal request receipt dates: UM staff improperly updated request receipt dates in 15 UM appeal file on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	All UM staff undergo ethics training, with emphasis on following UM information integrity policies and procedures by 4/15/[current year]. Owner: UM director. Update UM system to read only records for dates and other UM information by 6/1/[current year]. Owner: Information System director. Establish process for two-step verification of system dates to records/information prepared for external review bodies by
UM appeal notification dates: UM staff improperly updated decision notification dates in 15 UM appeal file	Notification dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year] Staff felt	

on 3/4/[previous year], after a decision had been sent.	internal pressure to pass the state audit at any cost.	5/1/[current year]. Owner UM director

Factor 2: **Measure effectiveness**

[Organization Name]—Annual UM Information Integrity Measure of Effectiveness

Report date: August 30, [current year].

Auditor: [Individual's Name], UM director.

Auditing methodology: [Organization Name] audits the effectiveness of corrective actions taken within 6 months of the annual audit completed on January [date, year]. The audit sample includes 5% or 50 files (whichever is less), randomly selected from all UM appeal decisions made by the organization since the last annual audit.

- Period reviewed: February [current year]–July [current year].
- File-review universe size: 750 UM appeal decisions made during the review period.
- Audit sample size calculation: 750 UM appeal files x 0.05 = 37.5 files (38 files).
- Audit sample size: 38 files, which is less than the 5% (75 files).

Audit date: July 11–15, [current year].

Audit *log*: Attachment 1. Not shown in this example.

Summary of findings

Date Type	**Compliant Appeal Files**	**Noncompliant Appeal Files**	Total	**Percentage of Noncompliant Appeal Files**
UM request receipt date	38	0	38	0%
UM appeal notification date	38	0	38	0%

Qualitative analysis: Not required.

Actions effectiveness

Noncompliant UM Updates **January [year} Audit**	**Corrective Actions Completed**	**Action Effectiveness** **July [year] Audit**
UM request receipt dates: UM staff improperly updated request receipt dates in 15 UM appeal file on	All UM staff completed ethics training, with emphasis on following UM information integrity	There were no incidences of UM appeal receipt or notification dates updates found in the audit sample.

3/4/[previous year], after a decision had been sent.	policies and procedures on 4/15/[current year]. UM system update to read only records for dates and all other UM information was completed 7/1/[current year]. Approved established process for two-step verification of system dates to records/information prepared for external review bodies on 6/1/[current year].	The implementation of read-only data in the UM system was tested during the audit and is functioning properly. The two-process verification was tested for the upcoming Department of Insurance was scheduled for August [current year]. All records prepared for external review matched information in the UM system. There was no inappropriate updating the UM data.
UM appeal notification dates: UM staff improperly updated decision notification dates in 15 UM appeal file on 3/4[previous year], after a decision had been sent.		

Overall effectiveness—Conclusion

The corrective actions implemented were effective in preventing inappropriate documentation and updates, based on follow-up assessment and that no incidences of inappropriate documentation and updates were made, and test results of the UM system read-only functionality and two-step verification proved the new features were working properly.

UM 8: Delegation of UM

If the organization delegates UM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated UM activities.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the process for providing member experience and clinical performance data to its delegates when requested.**
6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 6 factors~~	~~The organization meets 5 factors~~	~~The organization meets 3-4 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source Materials

Scope of review NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For factor 4:

- New delegation agreements implemented on or after July 1, 2025, must address the delegate's UM information integrity.
- Delegation agreements in place prior to July 1, 2025, that address the system controls requirements under the 2022–2024 standards do not need to be updated to address UM information integrity requirements. NCQA does not evaluate the agreement against prior system controls requirements.
- Delegation agreements in place prior to July 1, 2025, that do not address the system controls intent under the 2022–2024 standards must be updated prior to July 1, 2025, to address UM information integrity requirements.

For factor 5: Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in the factor. For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it

notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon.

The score for the element is the average of the scores for all delegates.

Look-back period

For Initial Surveys: 6 months for factors 1–6; prior to the survey date for the information integrity component under factor 4.

For Renewal Surveys: 24 months for factors 1–6; prior to the survey date for the information integrity component under factor 4.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period. The delegation agreement describes all delegated UM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Delegation agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of the last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the UM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
    - The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other UM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, including NCQA-Accredited delegates.

Factor 4: **Performance monitoring**

The delegation agreement states the organization's process for monitoring and evaluating the delegate's performance, as required in Element C, including UM information integrity.

UM information integrity refers to maintaining and safeguarding information used in the UM denial decision process (UM 4–UM 7) and UM appeal process (UM 8–UM 9) against inappropriate documentation and updates, as outlined in UM 12, Elements A and B, factor 4.

If the organization delegates processing of UM requests covered in UM 4–UM 7, or UM appeal requests covered in UM 8–UM 9, the delegate protects the integrity of UM information used in the denial and appeal processing, as applicable. The delegation agreement specifies that the following documentation and updates to UM information are inappropriate:

- Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
- Creating documents without completing the required activities.
- Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
- Attributing review to someone who did not complete the activity (e.g., appropriate practitioner review).
- Updates to information by unauthorized individuals.

Factor 5: **Providing member and clinical data**

The organization's delegation agreement describes what the delegate must do to obtain the following information when it is needed or on an ongoing basis.

- **Member experience data:** Complaints, CAHPS survey results or other data collected on members' experience with the delegate's services.
- **Clinical performance data:** HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or clinical performance measure results.

Factor 6: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exceptions

This element is NA if the organization does not delegate UM activities.

Factor 3 is NA for mail service organization delegates that only perform annual distribution (e.g., UM 11, Element B). Factor 3 is not NA for distribution that occurs more frequently than annually (e.g., denial and appeal notices).

Factor 5 is NA for mail service organization delegates.

Related information

Outsourcing UM data storage to a cloud-based entity. It is not considered delegation if the organization only outsources UM data storage to a cloud-based entity that does not provide services that create, modify or use the UM data.

Examples

Factor 3: **Reporting for delegation of UM denials and appeals**

- Number of UM cases handled by type (preservice, urgent concurrent or postservice) and by service (inpatient or outpatient).
- Number of denials issued.
- Number of denials appealed.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization evaluated delegate capacity before delegation began~~	~~No scoring option~~	~~The organization evaluated delegate capacity after delegation began~~	~~No scoring option~~	~~The organization did not evaluate delegate capacity~~

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

This element applies if delegation was implemented in the look-back period.

NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited delegates

For non-information integrity requirements, automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless the element is NA.

For information integrity requirements (UM 12, Elements A-G), automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM under the 2025 standards and beyond, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the delegate's structure, processes and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional UM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.

- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of the UM Program

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's UM program.**
2. **Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**
5. **Annually audits each delegate's UM denial and appeal files for inappropriate documentation and inappropriate updates to request receipt dates and decision notification dates.**
6. **Implements corrective actions for each delegate that addresses all inappropriate documentation and inappropriate updates found in factor 5.**
7. **Conducts an audit of the effectiveness of corrective actions (factor 6) on the findings for each delegate 3–6 months after completion of the annual audit for factor 5.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 6-7 factors~~	~~No scoring option~~	~~The organization meets 4-5 factors~~	~~No scoring option~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 6-7 factors	The organization meets 4-5 factors	The organization meets 0-3 factors

Data source Documented process, Reports, Materials

Scope of review NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's evaluation of the delegate's UM program (factor 1).

For *Initial Surveys:* NCQA also reviews the organization's most recent semiannual evaluation, annual review, audits, performance evaluation, corrective actions and measure of effectiveness (factors 2–7).

For Renewal Surveys:

- *Factors 2–4:* NCQA also reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.
- *Factors 5–7:* NCQA also reviews the organization's most recent annual audit, performance evaluation, corrective actions and measure of effectiveness.

The score for the element is the average of the scores for all delegates.

Look-back period

For Initial Surveys: Once during the prior year.

For Renewal Surveys: 24 months for factors 1–4; at least once during the prior year for factors 5–7.

Explanation

This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless the element is NA.

For factors 5–7, automatic credit is available if all delegates are NCQA Accredited under 2025 (or later) standards for Health Plan Accreditation, MBHO Accreditation or UM-CR-PN Accreditation, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Factor 1: **Review of the UM program**

The appropriate organization staff or committee review the delegate's UM program. At a minimum, the organization reviews parts of the UM program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates the denial and appeal processes, it audits denial and appeal files against NCQA standards.

Note: *The organization may use the same file sample for factors 2 and 5, if applicable.*

The organization uses one of the following to audit the delegate's files:

- 5% or 50 files, whichever is less, ***or***
- The NCQA "8/30 methodology," available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/.

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

For mail service delegates only, the organization may submit the delegate's timeliness report of mail distribution in lieu of an audit.

Factor 3: **Annual evaluation**

Annual evaluation is based on the delegation agreement and the appropriate NCQA standards.

Factor 4: **Evaluation of reports**

The organization receives regular reports from all delegates (including delegates with NCQA Accreditation).

Factor 5: **Annual audit of UM information integrity**

If the organization delegates processing of UM requests covered in UM 4–UM 7, or UM appeal requests covered in UM 8–UM 9, the organization or the delegate annually audits (as applicable) the delegate's UM denial and appeal files separately for inappropriate documentation and inappropriate updates to:

- UM request receipt dates (UM 5).
- UM denial decision notification dates (UM 5, UM 7).
- UM appeal request receipt dates (UM 8, UM 9).
- UM appeal decision notification dates (UM 8, UM 9).

Note: *The organization may use the same file sample for factors 2 and 5, if applicable.*

For each delegate, the audit universe includes UM denial and appeal files (based on the denial and appeal decision notification dates) processed by the delegate during the look-back period.

If the organization conducts the annual audit, it audits each delegate using one of the following methods:

- 5% or 50 files, whichever is less, ***or***
- The NCQA "8/30 methodology" available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

Either methodology is allowed, for consistency with other delegation oversight requirements for annual information integrity audits.

A delegate that conducts the annual audit has two audit options.

Option 1: Audit each client using one method:

- "5% or 50 files," ***or***
- The NCQA "8/30" method.

Option 2: Conduct one audit across all clients if the delegate uses the same staff, policies and procedures and UM system for all clients. In this case:

- The delegate must demonstrate that the same staff, policies and procedures and UM system are used for all clients.
- The audit universe includes UM denial and appeal files (based on the denial and appeal decision notification dates) processed by the delegate for all clients during the look-back period.

- The delegate must audit using the "5% or 50 files" method.

The organization or delegate may choose to audit more UM denial and appeal files than NCQA specifies.

The organization provides an auditing and analysis report that includes:

- The date of the report.
- Title of staff who conducted the audit.
- The audit methodology:
  - "5% or 50 files" or "8/30," as applicable.
  - Audit period.
  - Audit universe size.
  - Audit sample size.
- File identifier (case number).
- Type of dates audited (receipt date, notification date).
- Findings for each file.
- A rationale for each instance of inappropriate documentation or update.
- The number or percentage and total inappropriate documentation and updates by date type.

The delegate or organization must provide a completed audit report even if no inappropriate findings were found.

If the organization uses the delegate's audit results, it must provide evidence (e.g., report, meeting minutes) that it reviewed and evaluated the delegate's findings.

Factor 6: **Implement corrective actions**

The organization or the delegate may implement corrective actions.

For each delegate with inappropriate documentation and updates (findings) identified in factor 5, the organization documents corrective actions taken or planned, including the time frame for actions, to address all findings identified in factor 5. One action may be used to address more than one finding, if appropriate.

The organization or delegate's corrective action plan identifies staff (by title who are responsible for implementing corrective actions.

The organization reviews (e.g., report, meeting minutes) and approves a corrective action plan developed and implemented by a delegate.

Factor 7: **Measure effectiveness follow-up audit**

The organization or delegate audits the effectiveness of corrective actions (factor 6) on findings for each delegate within 3–6 months of the annual audit completed for factor 5.

For each delegate, the audit universe includes 3–6 months of UM denial and appeal files processed by the delegate since the annual audit. Denial and appeal files are audited separately.

The organization or delegate conducts a qualitative analysis if it identifies integrity issues during the follow-up audit.

If the organization uses the delegate's audit results, the organization must provide evidence (e.g., a report, meeting minutes, other evidence) that it reviewed and evaluated the delegate findings.

The organization draws conclusions on the actions' overall effectiveness.

Exceptions

The element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 1 is NA for mail service delegates.

Factors 3 and 4 are NA if a mail service delegate distributes information for an element with an annual frequency.

- Factors 3 and 4 are not NA for distribution that occurs more frequently than annually (e.g., denial and appeal notices).

Factors 5–7 are NA for mail service delegates that:

- Do not have access to the organization's UM system.
- Do not have a UM system of their own.
- Do not modify or store the UM data sent by the organization.

Factors 6 and 7 are NA if the organization's audit of all delegates' denial and appeal files did not identify any inappropriate documentation or updates to receipt dates and decision notification dates. This must be evident in reports reviewed for factor 5.

Factor 7 is NA if the timing of the organization's annual audit is less than three months before the organization's NCQA Survey.

Related information

Use of collaborative. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

For factor 5: If the delegate's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the delegate

may use the specified methodology and submit a system log showing no changes to dates. A separate analysis is not required if no dates were changed.

Examples

Factor 5: **Audit and analysis report**

[Delegate Name]—Annual UM Information Integrity Assessment

Report date: January [date, current year].

Auditor: [Delegate staff Name], UM director., [Delegate Name].

Auditing methodology: Each January, [Delegate's Name] UM director audits a random sample of UM denial files for inappropriate documentation and updates to UM denial receipt dates (UM 5) and notification dates (UM 7) for the previous calendar year. The audit sample includes 5% or 50 files (whichever is less), randomly selected from all UM denial decisions made in the previous year.

- Period reviewed: January 1–December 31 of the previous calendar year.
- File-review universe size: 1,500 UM denial decisions made during the review period.
- Audit sample size calculation: 1,500 UM denial files x 0.05 = 75 files.
- Audit sample size: 50 files, which is less than 5% (75 files).

Audit date: January 6–9, [current year].

Audit log: Attachment 1. Partial illustration in the table below.

Case ID	Inappropriate Documentation/ Updates?		Finding
	Receipt Date	Notification Date	
1235	No	No	NA
1245	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 2:59 PM after denial notice was sent.
1255	No	No	NA
1265	No	No	NA
1275	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 3:40 PM after denial notice was sent.
1285	Yes	Yes	Receipt and notification dates updated by [Staff Name] on 3/4/[previous year] @ 4:00 PM after denial notice was sent.

Summary of findings:

Date Type	Compliant Denial Files	Noncompliant Denial Files	Total	Percentage of Noncompliant Denial Files
UM request receipt date	35	15	50	30%
UM denial notification date	35	15	50	30%

Qualitative analysis. [Delegate's Name] UM director provided UM staff with the audit log documenting how, when and by whom files were updated.

[Delegate's Name] UM director held meetings (January 14–17, [current year]) with UM staff (UM assistant director, UM manager, UM analyst) to determine the causes of each inappropriate update to UM denial receipt and notification dates~~,~~. The causes of the inappropriate updates are outlined in the table below.

Date Type	Description of Noncompliant Update	Reason
UM request receipt date	All 15 receipt dates were improperly updated in the UM denial file by the same staff on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.
UM denial notification date	All 15 notification dates were improperly updated by the same staff on 3/24/[previous year], after a decision had been sent.	Notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.

Factor 6: **Corrective actions**

[Delegate's Name] UM director shared audit analysis results and mitigation recommendations with [Organization's name] UM director on January 31, [current year]. [Organization's name] UM director and leadership reviewed the report provided by [Delegate Name] (minutes attached), and required [Delegate] name] to implement immediate corrective actions and complete all corrective actions on or before the dates, outlined in the table below.

UM Information/ Noncompliant Update	Reason	Correction Actions Planned
UM request receipt dates: UM staff improperly updated request receipt dates in 15 UM denial file on 3/4/[previous year], after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	All [Delegate Name] UM staff undergo ethics training, with emphasis on following UM information integrity policies and procedures by 4/15/[current year]. Owner: UM director, [Delegate Name] [Delegate] to update UM system to read only records for dates and other UM information by 6/1/[current year]. Owner: IS director, [Delegate Name]
UM denial notification dates:	Notification dates were improperly updated	

UM staff improperly updated decision notification dates in 15 UM denial file on 3/4/[previous year], after a decision had been sent.	because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/11/[previous year]. Staff felt internal pressure to pass the state audit at any cost.	[Delegate Name] to establish process for two-step verification of system dates to records/information prepared for external review bodies by 5/1/[current year]. Owner: UM director, [Delegate Name]

Evidence of [Organization's] review: Minutes attached (not shown in example).

Factor 7: **Effectiveness of corrective actions**

[Delegate Name]—Annual UM Information Integrity Assessment

Report date: August 30, [current year].

Auditor: [Delegate staff Name], UM director., [Delegate Name].

Auditing methodology: [Delegate Name] audits the effectiveness of corrective actions taken within 6 months of the annual audit completed on January [date, year]. The audit sample includes 5% or 50 files (whichever is less), randomly selected from all UM denial decisions made by [Delegate] since the last annual audit.

- Period reviewed: February [current year]–July [current year].
- File-review universe size: 750 UM denial decisions made during the review period.
- Audit sample size calculation: 750 UM denial files x 0.05 = 37.5 files (38 files).
- Audit sample size: 38 files, which is less than 5% (75 files).

Audit date: July 11–15, [current year].

Audit log: Attachment 1. Not shown in the example.

Summary of findings

Date Type	Compliant Denial Files	Noncompliant Denial Files	Total	Percentage of Noncompliant Denial Files
UM request receipt date	38	0	38	0%
UM denial notification date	38	0	38	0%

Qualitative analysis: Not required.

Actions effectiveness:

Noncompliant UM Updates January [year] Audit	Corrective Actions Completed	Action Effectiveness July [year] Audit
UM request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/4/[previous year], after a decision had been sent. **UM denial notification dates:** UM staff member improperly updated decision notification dates in 15 UM denial file on 3/4/[previous year], after a decision had been sent.	All [Delegate Name] UM staff completed ethics training, with emphasis on following UM information integrity policies and procedures on 4/15/[current year]. [Delegate Name] UM system update to read only records for dates and all other UM information was completed 7/1/[current year]. [Delegate Name] established process for two-step verification of system dates to records/information prepared for external review bodies on 6/1/[current year].	There were no incidences of UM denial receipt or notification dates updates found in the audit sample. The implementation of read-only data in the UM system was tested during the audit and is functioning properly. The two-process verification was tested for the upcoming Department of Insurance was scheduled for August [current year]. All records prepared for external review matched information in the UM system. There was not updating the UM data.

Overall effectiveness—Conclusion

[Delegate's Name] UM director shared follow-up audit analysis results with [Organization's Name] UM director on August 1, [current year]. [Organization's Name] UM director and leadership reviewed the report provided by [Delegate Name] on August 15, [current year], which proved the new features were working properly (minutes attached), and concluded that the corrective actions implemented were effective in preventing inappropriate documentation and updates, based on test results of the UM system read-only functionality and two-step verification.

Evidence of [Organization's Name's] review: Minutes attached (not shown in the example).

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~At least once in each of the past 2 years that the delegation arrangement has been in effect, the~~	~~No scoring option~~	~~The organization has taken inappropriate or weak action, or has taken~~	~~No scoring option~~	~~The organization has taken no action on identified problems~~

~~organization has acted on identified problems, if any~~		~~action only in the past year~~		

Met	Partially Met	Not Met
At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	The organization has taken inappropriate or weak action, or has taken action only in the past year	The organization has taken no action on identified problems

Data source Documented process, Reports, Materials

Scope of review NCQA reviews reports for opportunities for improvement from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For *Initial Surveys:* NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For *Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period *For Initial Surveys*: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

This element does not apply to UM information integrity. Areas of improvement for information integrity are addressed in UM 13, Element C, factors 5-7.

NCQA-Accredited delegates

Automatic credit is available if all delegates are NCQA Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Identify and follow-up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
    - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

UMA 1: Approvals/Recommendations Evaluation Option

The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation. When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner.

Intent

The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care. The organization uses all information relevant to a member's care when it makes coverage decisions.

Applicable Elements

Element A: Notification of Nonbehavioral Healthcare Decisions

The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions:

1. **For urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
2. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
3. **For ~~commercial and Exchange~~ nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within ~~15~~ 7 calendar days of the request.**
4. ~~**For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**~~
4. **For postservice decisions, the organization gives electronic or written notification of the**
5. **decision to members and practitioners within 30 calendar days of the request.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

For organizations that do not communicate with members and practitioners, NCQA reviews the documentation the organization sends to its clients for evidence of timeliness.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all nonbehavioral healthcare denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure,* Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

Urgent request: A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, ***or***
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, ***or***
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Concurrent request: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Nonurgent request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Preservice request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

Postservice request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

Reclassification of nonbehavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–4 ~~5~~: **Timeliness of notification**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when the notice was provided to the member and the attending or treating practitioner, as applicable.

The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–4.

For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information*.

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

The organization may extend the decision notification time frame under certain circumstances. Refer to *Related information.*

Exceptions

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

This element is NA if the organization performs only UM pharmacy activities for clients.

Factor 3 is NA for the Medicare and Medicaid product lines.

Factor 4 is NA for the commercial and Exchange product lines.

Related information

An organization may have procedures for ongoing review of urgent concurrent care that was approved initially. For ongoing review, the notification period begins on the day of the review. The organization documents the date of the review and the decision notification in the UM denial file.

Addressing notices to the attention of the attending or treating practitioner.

For preservice and postservice decisions, if attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the request was from a provider (e.g., facility)~~,~~ and not ~~rather than~~ from a practitioner, the organization makes at least two attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner.

~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the time frame for urgent, preservice and postservice requests.

Extension conditions

Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***

- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.
    - Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factors 1, 2: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.

For commercial and Exchange, extensions are not allowed for urgent concurrent decisions.

For urgent preservice, the organization may extend the time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 3: Nonurgent preservice requests for commercial and Exchange product lines. If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:

- The date when the organization receives the member's response (even if not all of the information is provided), ***or***
- The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Factor 3 ~~4~~: Nonurgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
  - Documents that it made at least one attempt to obtain the necessary information.
  - Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 4 ~~5~~: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and

postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

For Medicare, extensions are not allowed for postservice requests.
Factors 1, 2: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)— if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

Failure to follow filing procedures

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

Element B: Notification of Behavioral Healthcare Decisions

The organization adheres to the following time frames for notification of behavioral healthcare UM decisions:

1. **For urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
2. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**

3. For ~~commercial and Exchange~~ nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 7 ~~15~~ calendar days of the request.
~~4. For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.~~
4. For postservice decisions, the organization gives electronic or written notification of the
~~5~~. decision to members and practitioners within 30 calendar days of the request.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

For organizations that do not communicate with members and practitioners, NCQA reviews the documentation the organization sends to its clients for evidence of timeliness.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all behavioral healthcare denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure*, Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

Reclassification of behavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a

new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–4 ~~5~~: **Timeliness of notification**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when it notifies the member and practitioner, as applicable.

The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–4.

For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information.*

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

The organization may extend the decision time frame under certain circumstances. Refer to *Related information.*

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude behavioral healthcare.
- The organization performs only UM pharmacy activities for clients.

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

Factor 3 is NA for the Medicare and Medicaid product lines.

Factors 4 is NA for the commercial and Exchange product lines.

Related information

An organization may have procedures for ongoing review of urgent concurrent care that was approved initially. For ongoing review, the notification period begins on the day of the review. The organization documents the date of the review and the decision notification in the UM denial file.

Addressing notices to the attention of the attending or treating practitioner.

For preservice and postservice decisions, if attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the request was from a provider (e.g., facility)~~,~~ and not ~~rather than~~ from a practitioner, the organization makes at least two attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, or the request was from a provider (e.g., facility) rather than a practitioner, the organization makes two or more attempts to identify the practitioner and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner." In this case, the attending or treating practitioner's name is not required.

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner.

~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested, and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative, and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the decision-making time frame for urgent, preservice and postservice requests.

Extension conditions

Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.
    - Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factors 1, 2: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.

For commercial and Exchange, extensions are not allowed for urgent concurrent decisions.

For urgent preservice, the organization may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 3: Nonurgent preservice requests for commercial and Exchange product lines.

If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Factor 3 4: Nonurgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.

- Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 4 ~~5~~: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

For Medicare, extensions are not allowed for postservice requests.

Factors 1, 2: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization must have an alternative method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples **Failure to follow filing procedures**

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

Element C: Notification of Pharmacy Decisions

The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions:

1. **For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
2. **For Medicare Part B and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
3. **For commercial and Exchange urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
4. **For Medicare Part B and Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
5. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 7 ~~15~~ calendar days of the request.**
6. **For Medicare Part B nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
7. **For Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**

8. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**
9. **For Medicare Part D urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of receipt of the request.**
10. **For Medicare Part D nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request.**
11. **For Medicare Part D postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of receipt of the request.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review Factors 1–8 apply to commercial, Medicaid and Exchange product lines and Medicare Part B drugs.

NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence of timeliness of notification.

For organizations that do not communicate with members and practitioners, NCQA reviews the documentation the organization sends to its clients for evidence of timeliness.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all pharmaceutical denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure,* Element A), whether the pharmaceutical is covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

Reclassification of pharmaceutical requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 2, 4, 7: **Timeliness of Medicaid pharmacy notification**

For the Medicaid product line, drugs that meet the federal definition of "covered outpatient drugs" as stated in SSA 1927(k)(2), the organization sends its decision notification within 24 hours.

For the Medicaid product line, drugs that are excluded from the federal definition of "covered outpatient drugs," as stated in SSA 1927(k)(3), the organization sends its decision notification within 72 hours for urgent concurrent requests and urgent preservice requests, and sends its decision notification within 14 calendar days for nonurgent preservice requests.

Factors 1–11: **Timeliness of pharmacy notification**

The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–5.

For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information.*

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when it notifies the member and practitioner, as applicable.

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request.

The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

The organization may extend the decision time frame under certain circumstances. Refer to *Related information.*

Exceptions

This element is NA:

- If all purchasers of the organization's services carve out or exclude pharmaceutical management.
- For pharmaceutical approvals made at the pharmacy.

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

Factors 1–8 are NA for Medicare Part D drugs.

Factors 1, 3 and 5 are NA for Medicare and Medicaid product lines.

Factors 2 and 4 are NA for commercial and Exchange product lines.

Factor 6 is NA for commercial, Medicaid and Exchange product lines.

Factor 7 is NA for commercial, Medicare and Exchange product lines.

Factors 9–11 are NA for commercial, Medicaid and Exchange product lines and Medicare Part B drugs.

Related information

Notifying the practitioner. If attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the request was from a

provider (e.g., facility) and not ~~rather than~~ from a practitioner, the organization makes two or more attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner. ~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Medicare Part B drugs (factors 2, 4, 6). For guidance on drugs covered under Medicare Part B, refer to the *Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, 10.8 – Drugs that are Covered Under Original Medicare Part B.*

Medicare Part D drugs (factors 9–11). For guidance on drugs covered under Medicare Part D, refer to the *Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, 10.2 - Covered Part D Drugs.*

Alignment with CMS time frames.

- Factor 9: Medicare Part D urgent preservice decisions. The time frame corresponds to the CMS "expedited coverage" determination time frame.
- Factor 10: Medicare Part D nonurgent preservice decisions. The time frame corresponds to the CMS "standard coverage" determination time frame.
- Factor 11: Medicare Part D postservice decisions. The time frame corresponds to the CMS "request for reimbursement" time frame.

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Medications dispensed at the pharmacy. Requests for coverage of medications dispensed at a pharmacy may only be classified as urgent concurrent, urgent preservice or nonurgent preservice, depending on whether the request meets NCQA's definition of "urgent." Medications dispensed at the pharmacy may not be classified as postservice requests.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative pharmaceuticals. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying

care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames for factors 1–8. Members or their authorized representatives may agree to extend the decision-making time frame for urgent, preservice and postservice requests.

Extension conditions

Factor 1: Urgent concurrent requests for commercial and Exchange product lines.

- The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to, or any time after, the expiration of the previously approved period or number of treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.
- The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.

Factors 2, 4: Urgent concurrent and urgent preservice requests for Medicaid product line. The organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 3: Urgent preservice requests for commercial and Exchange product lines. The organization may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***

- The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 5: Nonurgent preservice requests for commercial and Exchange product lines. If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to ~~15~~ 7 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Factor 7: Nonurgent preservice requests for Medicaid product line. The organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 8: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and

postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

Extending time frames for Medicare Part B and D for factors 2, 4, 6, 9–11—Alignment with CMS. In accordance with the Medicare Prescription Drug Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, extensions are not allowed.

For Medicare, extensions are not allowed for postservice requests.
Factors 1–4: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

For Medicare Part D drugs, initial verbal notification of a decision may be made within the specified time frames. Written notification must be made no later than 3 calendar days after verbal notification.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization must have an alternative method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

Failure to follow filing procedures

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

Element D: Relevant Information for Nonbehavioral Healthcare Decisions

There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review (as defined in *Program Description*) for evidence of using relevant clinical information to support UM decision making.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation Although NCQA only reviews denial files during the file review process, this element applies to all nonbehavioral healthcare determinations resulting from medical necessity review, whether they are approvals or denials.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Relevant clinical information

Denial files contain clinical information appropriate to each case.

The relevance of clinical information is considered in terms of the criteria used by the organization to make its decision (i.e., the clinical information must be related to criteria stated in the denial notice as not met). The organization must gather clinical information when determining medical necessity. If enough clinical information relevant to the criteria is not provided with the request, the organization must document in the denial file its attempts to gather the clinical information needed to make a decision.

Exception

This element is NA if the organization performs only UM pharmacy activities for clients.

Related information

Refer to UM 1, Element A for the definition of "medical necessity review."

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

Clinical information for determining coverage

Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.
- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Diagnosis codes.

Element E: Relevant Information for Behavioral Healthcare Decisions

There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review (as defined in Program Description) for evidence of using relevant clinical information to support UM decision making.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Although NCQA only reviews denial files during the file review process, this element applies to all behavioral healthcare determinations resulting from medical necessity review, whether they are approvals or denials.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Relevant clinical information

Denial files contain clinical information appropriate to each case.

The relevance of clinical information is considered in terms of the criteria used by the organization to make its decision (i.e., the clinical information must be related to the criteria the organization said were not met in its denial notice). The organization must gather clinical information when determining medical necessity. If enough clinical information relevant to the criteria is not provided with the request, the organization must document in the denial file its attempts to gather the clinical information needed to make a decision.

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude behavioral healthcare.
- The organization performs only UM pharmacy activities for clients.

Related information

Refer to UM 1, Element A for the definition of "medical necessity review."

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

Clinical information for determining coverage

Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.
- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.

- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Diagnosis codes.

Element F: Relevant Information for Pharmacy Decisions

The organization documents that it consistently gathers relevant information to support pharmacy UM decision making.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review (as defined in *Program Description)* for evidence of using relevant clinical information to support UM decision making.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation Although NCQA only reviews denial files during the file review process, this element applies to all pharmaceutical determinations resulting from medical necessity review, whether they are approvals or denials. This includes all pharmaceuticals covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Relevant clinical information

Pharmaceutical denial files contain clinical information appropriate to each case.

The relevance of clinical information is considered in terms of the criteria used by the organization to make its decision (i.e., the clinical information must be related to the criteria the organization said were not met in its denial notice). The organization must gather clinical information when determining medical necessity. If enough clinical information relevant to the criteria is not provided with the request, the organization must document in the denial file its attempts to gather the clinical information needed to make a decision.

Exception

This element is NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.

Related information

Refer to UM 1, Element A for the definition of "medical necessity review."

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

UMA 2: Behavioral Health Decisions Evaluation Option

Qualified licensed health professionals assess the clinical information used to support UM decisions. The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation. When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner. The organization documents and communicates the reasons for a denial.

Intent

UM decisions are made by qualified health professionals. The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care. The organization uses all information relevant to a member's care when it makes coverage decisions. Members and practitioners receive enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision.

Applicable Elements

Element A: Practitioner Review of Behavioral Healthcare Denials

The organization uses a physician or appropriate behavioral healthcare practitioner, as appropriate, to review any behavioral healthcare denial of care based on medical necessity.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review

NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence that the files were reviewed by an appropriate practitioner.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all behavioral healthcare denial determinations resulting from medical necessity review (as defined in UM 1, Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate practitioner review

Appropriate practitioners review all medical necessity denials for requested health care services offered under the organization's behavioral healthcare benefit. NCQA does not require practitioner review of requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

The UM denial file includes any of the following documentation of appropriate professional review:

- The reviewer's handwritten signature or initials.
- The reviewer's unique electronic signature or identifier on the denial letter or on the notation of denial in the file.
- A signed or initialed note from UM staff, attributing the denial decision to the professional who reviewed and decided the case.

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude behavioral healthcare.
- The organization performs only UM pharmacy activities for clients.

Related information

UM denial file exclusions. NCQA does not include UM decisions in the UM denial file sample that do not require medical necessity review.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element B: Notification of Behavioral Healthcare Decisions

The organization adheres to the following time frames for notification of behavioral healthcare UM decisions:

1. **For urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
2. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
3. **For ~~commercial and Exchange~~ nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 7 ~~15~~ calendar days of the request.**
4. ~~**For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**~~
4. **For postservice decisions, the organization gives electronic or written notification of the**
5. **decision to members and practitioners within 30 calendar days of the request.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

For organizations that do not communicate with members and practitioners, NCQA reviews the documentation the organization sends to its clients for evidence of timeliness.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all behavioral healthcare denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure*, Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

Reclassification of behavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as

preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–4 ~~5~~: **Timeliness of notification**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when it notifies the member and practitioner, as applicable.

The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–4.

For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information.*

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

The organization may extend the decision time frame under certain circumstances. Refer to *Related information.*

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude behavioral healthcare.
- The organization performs only UM pharmacy activities for clients.

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

Factor 3 is NA for the Medicare and Medicaid product lines.

Factors 4 is NA for the commercial and Exchange product lines.

Related information

An organization may have procedures for ongoing review of urgent concurrent care that was approved initially. For ongoing review, the notification period begins on the day of the review. The organization documents the date of the review and the decision notification in the UM denial file.

Addressing notices to the attention of the attending or treating practitioner.

For preservice and postservice decisions, if attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the request was from a provider (e.g., facility)~~,~~ and not ~~rather than~~ from a practitioner, the organization makes at least two attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, or the request was from a provider (e.g., facility) rather than a practitioner, the organization makes two or more attempts to identify the practitioner and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner." In this case, the attending or treating practitioner's name is not required.

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner.

~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested, and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative, and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the decision-making time frame for urgent, preservice and postservice requests.

Extension conditions

Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.
    - Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***

- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factors 1, 2: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.

For commercial and Exchange, extensions are not allowed for urgent concurrent decisions.

For urgent preservice, the organization may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 3: Nonurgent preservice requests for commercial and Exchange product lines.

If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Factor 3 4: Nonurgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***

- Documents that it made at least one attempt to obtain the necessary information.
- Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 4 ~~5~~: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

For Medicare, extensions are not allowed for postservice requests.

Factors 1, 2: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the

organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***

- The organization must have an alternative method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples **Failure to follow filing procedures**

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

Element C: Relevant Information for Behavioral Healthcare Decisions

There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data source Records or files

Scope of review

NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review (as defined in *Program Description*) for evidence of using relevant clinical information to support UM decision making.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Although NCQA only reviews denial files during the file review process, this element applies to all behavioral healthcare determinations resulting from medical necessity review, whether they are approvals or denials.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Relevant clinical information

Denial files contain clinical information appropriate to each case.

The relevance of clinical information is considered in terms of the criteria used by the organization to make its decision (i.e., the clinical information must be related to the criteria the organization said were not met in its denial notice). The organization must gather clinical information when determining medical necessity. If enough clinical information relevant to the criteria is not provided with the request, the organization must document in the denial file its attempts to gather the clinical information needed to make a decision.

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude behavioral healthcare.
- The organization performs only UM pharmacy activities for clients.

Related information

Refer to UM 1, Element A for the definition of "medical necessity review."

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

Clinical information for determining coverage

Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.

- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Diagnosis codes.

Element D: Discussing a Behavioral Healthcare Denial With a Reviewer

The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence of opportunity for a practitioner to discuss a denial with a reviewer.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation This element applies to all behavioral healthcare denial determinations resulting from medical necessity review (as defined in *Program Description*).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Opportunity to discuss denial decisions

The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:

- In the denial notification, ***or***
- By telephone, including leaving a voicemail, if the organization documents the name of the individual at the organization who notified the treating practitioner or left the voicemail and the date and time of the notification or voicemail, ***or***
- In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.

The organization includes the following information in the denial file:

- The denial notification, if the treating practitioner was notified in the denial notification.
- The time and date of the notification and the name of the individual at the organization, if the treating practitioner was notified by telephone.
    - If the treating practitioner was notified by voicemail, the name of the individual who left the voicemail and the date and time.
- Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

NCQA does not require evidence of discussion with an attending or treating practitioner, and does not consider the discussion to be an appeal.

For the Medicare product line, the organization may provide the treating practitioner with an opportunity to discuss a UM request with a physician or other appropriate reviewer prior to the decision to meet the intent of this element. The organization must provide documentation in the denial file.

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude behavioral healthcare.
- The organization performs only UM pharmacy activities for clients.
- The organization does not notify practitioners of the opportunity to discuss the denial with an appropriate reviewer (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with practitioners).

Related information

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element E: Written Notification of Behavioral Healthcare Denials

The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains:

1. The specific reasons for the denial, in easily understandable language.

2. **A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.**
3. **A statement that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 3 factors~~	~~High (90-100%) on file review for 2 factors; medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 3 factors~~	~~Low (0-59%) on file review for 1 factor~~	~~Low (0-59%) on file review for 2-3 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence that denial notices meet all three factors.

For factors 1, 2: If the organization does not communicate with members and practitioners, NCQA reviews the organization's documentation sent to its clients.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all behavioral healthcare denial determinations resulting from medical necessity review (as defined in *Program Description*).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **Reason for denial**

The denial notification states the reason for the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization denied the request and have enough information to file an appeal.

An appropriately written notification includes a complete explanation of the grounds for the denial (specific medical necessity criteria not met for the condition or requested service, based on review of relevant clinical information)~~for the denial~~, in language ~~that~~ a

layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language.

To illustrate, for the abbreviation DNA, spelling out is “DNA (deoxyribonucleic acid),” and explaining is “a DNA test looks at your genetic information.”

The organization may send a single notice to the member and practitioner that includes the specific reason for the denial, in language that would be easily understood by the member. The notice may also include, in a separate section, additional clinical or technical language directed toward a practitioner.

Denial notifications sent only to practitioners may include technical or clinical terms.

For denials resulting from medical necessity review of out-of-network requests, the reason for the denial must explicitly address the reason for the request (e.g., if the request is related to accessibility issues that may be impacted by the clinical urgency of the situation, the denial must address whether or not the requested service can be obtained within the organization’s accessibility standards).

Factor 2: **Reference to UM criterion**

The denial notification references the specific criterion used to make the denial decision. The criterion used and referenced is specific to the member's condition or to the requested services.

The criterion referenced must be identifiable by name and must be specific to an organization or source (e.g., ABC PBM’s Criteria for Treatment of Hypothyroidism with Synthroid or Criteria Company Inc.’s Guidelines for Wound Treatment).

If it is clear that the criterion is attributable to the organization, it is acceptable to state, “our Criteria for XXX” (e.g., our Criteria for Treating High Cholesterol with Lipitor).

If the organization uses a trademarked criterion name, it does not need to cite the organization that holds the trademark it does not need to cite the organization that holds the trademark (e.g., InterQual® Level of Care Criteria).

Because benefit documents are often large and complex, the organization must direct members to the information using the section title or page number.

For denials resulting from medical necessity review of out-of-network requests, criteria may be excerpted from benefit documents that govern out-of-network coverage, organization policies specifying circumstances where out-of-network coverage will be approved or clinical criteria used to evaluate the member’s clinical need relative to available network providers and services. The reference must specifically support the rationale for the decision and must relate to the reason for the request.

Factor 3: **Availability of criterion**

The denial notification informs the member, and the practitioner acting as the member’s authorized representative, that the criterion used to make the decision is available upon request. Providing the criterion, or an excerpt specific to the denial reason, with the

denial notification is also acceptable. NCQA scores this factor "Yes" if the criterion or excerpt is included in the decision notice or if the notification states that the criterion is included as an attachment.

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude behavioral healthcare.
- The organization performs only UM pharmacy activities for clients.

Factor 3 is NA:

- For Medicare denials and Fully Integrated Dual Eligible (FIDE) denials.
- If the organization does not communicate with members and practitioners (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with members or practitioners).

Related information

Refer to *Related information* in *UM 5,* Element B for "Member Notification Exceptions" and "Notifying the Practitioner."

Denials due to insufficient clinical information.

- If the organization denies a request due to lack of clinical information, the denial notice must meet factors 1–3.
- If the organization does not have enough clinical information to reference a specific criterion, the denial notice must state this and specify the information needed.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

***Factor 1:* Acceptable language documenting the reason for denial**

Unless it is not medically recommended, less intense treatments, such as a trial of different antidepressant medications, should be used prior to considering ECT. Your physician has not indicated that you have tried antidepressant medications; therefore, the requested ECT is denied at this time. We recommend that you discuss other treatment options with your physician.

Insufficient language documenting reason for denial

The treatment is determined to not be medically necessary.

***Factors 1, 2:* Denying an out-of-network exception request and referencing UM criteria**

A member's primary care practitioner requests out-of-network coverage for treatment of ADHD, explaining that only a specific pediatric psychiatrist can meet the member's

needs. Medical records demonstrate initial screening by the primary care practitioner; no other medical or behavioral diagnoses are noted.

The organization's denial notification states,

> "Our medical director has reviewed your child's primary care physician's request for coverage of treatment for attention deficit hyperactivity disorder (or "ADHD") with Dr. Jones, an out-of-network pediatric psychiatrist. As stated in your Certificate of Coverage under "Out of Network Coverage," your plan covers out-of-network practitioners only when your clinical needs cannot be met in-network. Your primary care physician did not provide evidence that your child has special needs related to the ADHD diagnosis or treatment. Several in-network pediatric psychiatrists are trained to diagnose and treat ADHD. Please work with your primary care physician to select an in-network practitioner."

Factors 2, 3: **Acceptable language referencing decision-making criteria**

After reviewing and discussing your current symptoms with your practitioner, we believe that your condition has improved to the point where you no longer pose a danger to yourself or to others and can be managed appropriately in an intensive outpatient program. Because your symptoms no longer meet our Criteria for Inpatient Detoxification Monitoring, your request for further days in the hospital is denied.

You can obtain a copy of the criteria on which this decision was based by sending a request to us at the following address or contacting us by telephone.

Element F: Written Notification of Behavioral Healthcare Appeal Rights/Process

The organization's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains the following information:

1. **A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.**
2. **An explanation of the appeal process, including members' right to representation and appeal time frames.**
3. **A description of the expedited appeal process for urgent preservice or urgent concurrent denials.**
4. **Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 4 factors~~	~~High (90-100%) on file review for 3 factors; medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 4 factors~~	~~Low (0-59%) on file review for 1-2 factors~~	~~Low (0-59%) on file review for 3-4 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review

NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence that denial notices meet all four factors.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all behavioral healthcare denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure,* Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **Description of appeal rights**

No additional explanation required.

Factor 2: **Right to representation and appeal time frames**

The denial notification:

- Includes a statement that members may be represented by anyone they choose, including an attorney.
- Provides contact information for a state office of health insurance consumer assistance or ombudsperson, if applicable.
  Note: *This is not required for members covered by the Federal Employee Health Benefits (FEHB) Program.*
- States the time frame for filing an appeal.
- States the organization's time frame for deciding the appeal.
- States the procedure for filing an appeal, including where to direct the appeal and information to include in the appeal.

The notification to the practitioner does not have to include the member's right to representation if the practitioner is not the member's authorized representative.

Factor 3: **Expedited appeal process**

The denial notification describes the expedited appeals process for urgent preservice or urgent concurrent denials. If the same process applies to standard and expedited appeals, there must be a description included in the letter that makes it clear that the process applies to both.

Factor 3 is met if the organization includes a description of the expedited appeals process in denial notices for every type of request.

The denial notification states:

- The time frame for filing an expedited appeal.
- The organization's time frame for deciding the appeal.
- The procedure for filing an expedited appeal, including where to direct the appeal and information to be included in the appeal.

Factor 4: **Concurrent expedited external review**

The denial notification states that for urgent care situations, expedited external review may occur at the same time as the internal appeal process.

The organization may discontinue the internal appeal for all member requests that were addressed by the external review if it is not required to continue the internal appeal process under state law. (The organization continues the internal appeal process for components of the request that are not addressed in the external review.)

The organization may include the information about concurrent expedited external review to member notifications only.

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude behavioral healthcare.
- The organization performs only UM pharmacy activities for clients.
- The organization does not communicate with members and practitioners (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with members or practitioners).

Factor 4 is NA for:

- Members covered by Medicare, Medicaid or the FEHB Program and for members in self-funded accounts.
- Nonurgent preservice and postservice denial decisions.

Related information

Refer to *Related information* in UM 5, Element B for "Member Notification Exceptions" and "Notifying the Practitioner."

Medicare denials and FIDE denials. CMS requires organizations to issue an Integrated Denial Notice (IDN) for non-inpatient medical service denials for Medicare and FIDE members. The IDN meets factors 1–3 for these members.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

UMA 3: Non-Behavioral Health Decisions Evaluation Option

Qualified licensed health professionals assess the clinical information used to support UM decisions. The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation. When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner. The organization documents and communicates the reasons for a denial.

Intent

UM decisions are made by qualified health professionals. The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care. The organization uses all information relevant to a member's care when it makes coverage decisions. Members and practitioners receive enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision.

Applicable Elements

Element A: Practitioner Review of Nonbehavioral Healthcare Denials

The organization uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence that the files were reviewed by an appropriate practitioner.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all nonbehavioral healthcare denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure*, Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the

onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate practitioner review

Appropriate practitioners review all medical necessity denials for requested health care services offered under the organization's medical benefit. NCQA does not require practitioner review of requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

The UM denial file includes any of the following documentation of appropriate professional review:

- The reviewer's handwritten signature or initials.
- The reviewer's unique electronic signature or identifier on the denial letter or on the notation of denial in the file.
- A signed or initialed note from UM staff, attributing the denial decision to the professional who reviewed and decided the case.

Exception

This element is NA if the organization performs only UM pharmacy activities for clients.

Related information

UM denial file exclusions. NCQA does not include UM decisions that do not require medical necessity review within the UM denial file sample.

Dental benefits. If medical and dental benefits are not differentiated in the benefits plan, the organization identifies dental care or services associated with procedures that occur within or adjacent to the oral cavity or sinuses. NCQA requires medical necessity review of requests for these services.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element B: Notification of Nonbehavioral Healthcare Decisions

The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions:

1. **For urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
2. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
3. **For ~~commercial and Exchange~~ nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within ~~15~~ 7 calendar days of the request.**
4. **~~For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.~~**
4. **For postservice decisions, the organization gives electronic or written notification of the**
5. **decision to members and practitioners within 30 calendar days of the request.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

For organizations that do not communicate with members and practitioners, NCQA reviews the documentation the organization sends to its clients for evidence of timeliness.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all nonbehavioral healthcare denial determinations resulting from medical necessity review (as defined in *UM 1: Program Structure,* Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

Urgent request: A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, ***or***
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, ***or***
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Concurrent request: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Nonurgent request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Preservice request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

Postservice request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

Reclassification of nonbehavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–4 ~~5~~: **Timeliness of notification**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when the notice was provided to the member and the attending or treating practitioner, as applicable.

The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–4.

For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information.*

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

The organization may extend the decision notification time frame under certain circumstances. Refer to *Related information.*

Exceptions

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

This element is NA if the organization performs only UM pharmacy activities for clients.

Factor 3 is NA for the Medicare and Medicaid product lines.

Factor 4 is NA for the commercial and Exchange product lines.

Related information

An organization may have procedures for ongoing review of urgent concurrent care that was approved initially. For ongoing review, the notification period begins on the day of the review. The organization documents the date of the review and the decision notification in the UM denial file.

Addressing notices to the attention of the attending or treating practitioner.

For preservice and postservice decisions, if attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the

request was from a provider (e.g., facility)~~,~~ and not ~~rather than~~ from a practitioner, the organization makes at least two attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner.

~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the time frame for urgent, preservice and postservice requests.

Extension conditions

Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
    - Documents that it made at least one attempt to obtain the necessary information.

- Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factors 1, 2: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.

For commercial and Exchange, extensions are not allowed for urgent concurrent decisions.

For urgent preservice, the organization may extend the time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 3: Nonurgent preservice requests for commercial and Exchange product lines.

If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***

- The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.
Factor 3 ~~4~~: Nonurgent preservice requests for Medicare and Medicaid product lines.

For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, ***and***
  - Documents that it made at least one attempt to obtain the necessary information.
  - Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 4 ~~5~~: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.
Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and

postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

For Medicare, extensions are not allowed for postservice requests.
Factors 1, 2: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)— if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

Failure to follow filing procedures

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

Element C: Relevant Information for Nonbehavioral Healthcare Decisions

There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~

~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review (as defined in *Program Description*) for evidence of using relevant clinical information to support UM decision making.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation Although NCQA only reviews denial files during the file review process, this element applies to all nonbehavioral healthcare determinations resulting from medical necessity review, whether they are approvals or denials.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Relevant clinical information

Denial files contain clinical information appropriate to each case.

The relevance of clinical information is considered in terms of the criteria used by the organization to make its decision (i.e., the clinical information must be related to criteria stated in the denial notice as not met). The organization must gather clinical information when determining medical necessity. If enough clinical information relevant to the criteria is not provided with the request, the organization must document in the denial file its attempts to gather the clinical information needed to make a decision.

Exception

This element is NA if the organization performs only UM pharmacy activities for clients.

Related information

Refer to UM 1, Element A for the definition of "medical necessity review."

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples **Clinical information for determining coverage**

Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.
- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Diagnosis codes.

Element D: Discussing a Denial With a Nonbehavioral Healthcare Reviewer

The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence that a practitioner has the opportunity to discuss a denial with a reviewer.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation This element applies to all nonbehavioral healthcare denial determinations resulting from medical necessity review (as defined in *Program Description*).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Opportunity to discuss denial decisions

The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:

- In the denial notification, ***or***
- By telephone, including leaving a voicemail, if the organization documents the name of the individual at the organization who notified the treating practitioner or left the voicemail and the date and time of the notification or voicemail, ***or***
- In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.

The organization includes the following information in the denial file:

- The denial notification, if the treating practitioner was notified in the denial notification.
- The time and date of the notification and the name of the individual at the organization, if the treating practitioner was notified by telephone.
    - If the treating practitioner was notified by voicemail, the name of the individual who left the voicemail and the date and time.
- Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

NCQA does not require evidence of discussion with an attending or treating practitioner, and does not consider the discussion to be an appeal.

For the Medicare product line, the organization may provide the treating practitioner with an opportunity to discuss a UM request with a physician or other appropriate reviewer prior to the decision to meet the intent of this element. The organization must provide documentation in the denial file.

Exception

This element is NA if the organization does not notify practitioners of the opportunity to discuss the denial with an appropriate reviewer (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with practitioners).

Related information

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element E: Written Notification of Nonbehavioral Healthcare Denials

The organization's written notification of nonbehavioral healthcare denials provided to members and their treating practitioners contains the following information:

1. **The specific reasons for the denial, in easily understandable language.**
2. **A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.**

3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 3 factors~~	~~High (90-100%) on file review for 2 factors; medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 3 factors~~	~~Low (0-59%) on file review for 1-2 factors~~	~~Low (0-59%) on file review for 3 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence that denial notices meet all three factors.

For factors 1, 2: If the organization does not communicate with members and practitioners, NCQA reviews the organization's documentation sent to its clients.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all nonbehavioral healthcare denial determinations resulting from medical necessity review (as defined in *Program Description).*

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **Reason for denial**

The denial notification states the reason for the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization denied the request and have enough information to file an appeal.

An appropriately written notification includes a complete explanation of the grounds for the denial (specific medical necessity criteria not met for the condition or requested service, based on review of relevant clinical information) ~~for the denial~~, in language ~~that~~

a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language.

To illustrate, for the abbreviation DNA, spelling out is “DNA (deoxyribonucleic acid),” and explaining is “a DNA test looks at your genetic information.”

Denial notifications sent only to practitioners may include technical or clinical terms.

The organization may send a single notice to the member and practitioner that includes the specific reason for the denial in language that would be easily understood by the member. The notice may also include, in a separate section, additional clinical or technical language directed toward a practitioner.

For denials resulting from medical necessity review of out-of-network requests, the reason for the denial must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the denial must address whether or not the requested service can be obtained within the organization’s accessibility standards).

Factor 2: **Reference to UM criterion**

The denial notification references the specific criterion used to make the denial decision. The criterion used and referenced is specific to the member's condition or to the requested services.

The criterion referenced must be identifiable by name and must be specific to an organization or source (e.g., ABC PBM’s Criteria for Treatment of Hypothyroidism with Synthroid or Criteria Company Inc.’s Guidelines for Wound Treatment). If it is clear that the criterion is attributable to the organization, it is acceptable to state “our Criteria for XXX” (e.g., our Criteria for Treating High Cholesterol with Lipitor).

If the organization uses a trademarked criterion name, it does not need to cite the organization that holds the trademark (e.g., InterQual® Level of Care Criteria).

Because benefit documents are often large and complex, the organization must direct members to the information using the section title or page number.

For denials resulting from medical necessity review of out-of-network requests, criteria may be excerpted from benefit documents that govern out-of-network coverage, organization policies specifying circumstances where out-of-network coverage will be approved or clinical criteria used to evaluate the member’s clinical need relative to available network providers and services. The reference must specifically support the rationale for the decision and must relate to the reason for the request.

Factor 3: **Availability of criterion**

The denial notification informs the member, and the practitioner acting as the member’s authorized representative, that the criterion used to make the decision is available upon request. Providing the criterion, or an excerpt specific to the denial reason, with the denial notification is also acceptable. NCQA scores this factor “Yes” if the criterion or

excerpt is included in the decision notice or if the notification states that the criterion or excerpt is included as an attachment.

Exceptions

This element is NA if the organization performs only UM pharmacy activities for clients.

Factor 3 is NA:

- For Medicare denials and Fully Integrated Dual Eligible (FIDE) denials.
- If the organization does not communicate with members and practitioners (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with members or practitioners).

Related information

Refer to *Related information* in *UM 5,* Element A for "Member Notification Exceptions" and "Notifying the Practitioner."

Denials due to insufficient clinical information.

- If the organization denies a request due to lack of clinical information, the denial notice must meet factors 1–3.
- If the organization does not have enough clinical information to reference a specific criterion, the denial notice must state this and specify the information needed.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

***Factor 1:* Acceptable language documenting the reason for a denial**

After speaking with your physician, Dr. Jones, and reviewing your medical record, we have concluded that the requested rhinoplasty procedure (a surgery to change the shape of your nose) is not associated with a medical condition; it is for cosmetic purposes only. We cover this procedure when it is done to correct a deviated septum (where the wall between the nasal passage is crooked). The information provided by your doctor does not indicate that this is the case. As indicated in XYZ Plan's Summary of Covered Benefits, in "Exclusions and Limitations on Covered Benefits," rhinoplasty for cosmetic purpose is excluded; therefore, we cannot approve your request for this procedure.

Insufficient language documenting the reason for a denial

- The treatment is determined not to be medically necessary.
- The treatment is not a covered benefit.

***Factors 2, 3:* Acceptable language referencing decision-making criteria**

After reviewing our UM Criteria for Wound Treatment, which considers age, progress of treatment and assessment of your home environment, we have determined your treatment of IV antibiotics and dressing changes can be provided at home.

You can obtain a copy of the criteria on which this decision was based by sending a request to us at the following address or contacting us by telephone.

Element F: Written Notification of Nonbehavioral Healthcare Appeal Rights/Process

The organization's written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information:

1. **A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.**
2. **An explanation of the appeal process, including members' rights to representation and appeal time frames.**
3. **A description of the expedited appeal process for urgent preservice or urgent concurrent denials.**
4. **Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 4 factors~~	~~High (90-100%) on file review for at least 3 factors and medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 4 factors~~	~~Low (0-59%) on file review for 1-2 factors~~	~~Low (0-59%) on file review for 3-4 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence that denial notices meet all four factors.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all nonbehavioral healthcare denial determinations resulting from medical necessity review (as defined in *Program Description*).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **Description of appeal rights**

No additional explanation required.

Factor 2: **Right to representation and appeal time frames**

The denial notification:

- Includes a statement that members may be represented by anyone they choose, including an attorney.
- Provides contact information for a state office of health insurance consumer assistance or ombudsperson, if applicable.
  Note: *This is not required for members covered by the Federal Employee Health Benefits (FEHB) Program.*
- States the time frame for filing an appeal.
- States the organization's time frame for deciding the appeal.
- States the procedures for filing an appeal, including where to direct the appeal and information to include in the appeal.

The notification to the practitioner is not required to include the member's right to representation if the practitioner is not acting as an authorized representative.

Factor 3: **Expedited appeal process**

The denial notification describes the expedited appeals process for urgent preservice or urgent concurrent denials. If the same process applies to standard and expedited appeals, there must be a description included in the letter that makes it clear that the process applies to both. Factor 3 is met if the organization includes a description of the expedited appeals process in denial notices for every type of request.

The denial notification states:

- The time frame for filing an expedited appeal.
- The organization's time frame for deciding the expedited appeal.
- The procedure for filing an expedited appeal, including where to direct the appeal and information to include in the appeal.

Factor 4: **Concurrent expedited external review**

The denial notification states that for urgent care situations, expedited external review may occur at the same time as the internal appeal process.

The organization may discontinue the internal appeal for all member requests addressed by the external review if it is not required to continue the internal appeal process under state law. The organization continues the internal appeal process for components of the request that are not addressed in the external review.

The organization may include the information about concurrent expedited external review to member notifications only.

Exceptions

This element is NA if:

- The organization performs only UM pharmacy activities for clients.
- The organization does not communicate with members and practitioners (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with members or practitioners).

Factor 4 is NA for:

- Members covered by Medicare, Medicaid or the FEHB Program and for members in self-funded accounts.
- Nonurgent preservice and postservice denial decisions.

Related information

Medicare denials and Fully Integrated Dual Eligible (FIDE) denials. CMS requires organizations to issue an Integrated Denial Notice (IDN) for non-inpatient medical service denials for Medicare and FIDE members. The IDN meets factors 1–3 for these members.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

UMA 4: Pharmacy Decisions & Pharmaceutical Management Evaluation Option

Qualified licensed health professionals assess the clinical information used to support UM decisions. The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation. When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner. The organization documents and communicates the reasons for a denial.

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

Intent

UM decisions are made by qualified health professionals. The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care. The organization uses all information relevant to a member's care when it makes coverage decisions. Members and practitioners receive enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision.

The organization develops, regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence, if applicable.

Applicable Elements

Element A: Practitioner Review of Pharmacy Denials

The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence that the files were reviewed by an appropriate practitioner.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to all pharmaceutical denial determinations resulting from medical necessity review (as defined in *Program Description*), whether the pharmaceutical is covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate practitioner review

Appropriate practitioners review all medical necessity denials for requested pharmaceuticals offered under the organization's benefit. NCQA does not require practitioner review of requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

The UM denial file includes any of the following as documentation of appropriate professional review:

- The reviewer's handwritten signature or initials.
- The reviewer's unique electronic signature or identifier on the denial letter or on the notation of denial in the file.
- A signed or initialed note from UM staff, attributing the denial decision to the professional who reviewed and decided the case.

Exception

This element is NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.

Related information

UM denial file exclusions. NCQA does not include the following UM decisions in the UM denial file sample:

- UM decisions that do not require medical necessity review.
- UM approvals, including substitution of a generic pharmaceutical for a name-brand pharmaceutical.
- Pharmacy benefit denials resulting from closed formularies and related to tiered formularies, copayments, generic substitution and therapeutic interchange.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element B: Notification of Pharmacy Decisions

The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions:

1. **For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
2. **For Medicare Part B and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
3. **For commercial and Exchange urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
4. **For Medicare Part B and Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
5. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 7 ~~15~~ calendar days of the request.**
6. **For Medicare Part B nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
7. **For Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**
8. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**
9. **For Medicare Part D urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of receipt of the request.**
10. **For Medicare Part D nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request.**
11. **For Medicare Part D postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of receipt of the request.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review

Factors 1–8 apply to commercial, Medicaid and Exchange product lines and Medicare Part B drugs.

NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence of timeliness of notification.

For organizations that do not communicate with members and practitioners, NCQA reviews the documentation the organization sends to its clients for evidence of timeliness.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all pharmaceutical denial determinations resulting from medical necessity review (as defined in *Program Description*), whether the pharmaceutical is covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

Reclassification of pharmaceutical requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

***Factors 2, 4, 7:* Timeliness of Medicaid pharmacy notification**

For the Medicaid product line, drugs that meet the federal definition of "covered outpatient drugs" as stated in SSA 1927(k)(2), the organization sends its decision notification within 24 hours.

For the Medicaid product line, drugs that are excluded from the federal definition of "covered outpatient drugs," as stated in SSA 1927(k)(3), the organization sends its decision notification within 72 hours for urgent concurrent requests and urgent preservice requests, and sends its decision notification within 14 calendar days for nonurgent preservice requests.

***Factors 1–11:* Timeliness of pharmacy notification**

<u>The organization notifies the member (or their authorized representative) and the member's attending or treating practitioner of the UM decision within the time frames specified in factors 1–5.</u>

<u>For urgent concurrent decisions, the organization may notify the provider (e.g., hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that staff will inform the attending or treating practitioner.</u>

The organization may address the notification to the attention of the attending or treating practitioner under certain circumstances. Refer to *Related information.*

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when it notifies the member and practitioner, as applicable.

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

The organization may extend the decision time frame under certain circumstances. Refer to *Related information.*

Exceptions

This element is NA:

- If all purchasers of the organization's services carve out or exclude pharmaceutical management.
- For pharmaceutical approvals made at the pharmacy.

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

Factors 1–8 are NA for Medicare Part D drugs.

Factors 1, 3 and 5 are NA for Medicare and Medicaid product lines.

Factors 2 and 4 are NA for commercial and Exchange product lines.

Factor 6 is NA for commercial, Medicaid and Exchange product lines.

Factor 7 is NA for commercial, Medicare and Exchange product lines.

Factors 9–11 are NA for commercial, Medicaid and Exchange product lines and Medicare Part B drugs.

Related information

Notifying the practitioner. If attending or treating practitioner information ~~on the attending or treating practitioner~~ was not provided with the request, or if the request was from a provider (e.g., facility) and not ~~rather than~~ from a practitioner, the organization makes two or more attempts to identify the practitioner, and documents its attempts in the UM file. Leaving a voicemail counts as one attempt. If the organization cannot identify the attending or treating practitioner, it addresses the notification "to the attention of the attending or treating practitioner" (in this case, the attending or treating practitioner's name is not required).

For urgent concurrent decisions, the organization may inform the provider's Utilization Review department staff without attempting to identify the attending or treating practitioner. ~~For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.~~

~~In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.~~

Medicare Part B drugs (factors 2, 4, 6). For guidance on drugs covered under Medicare Part B, refer to the *Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, 10.8 – Drugs that are Covered Under Original Medicare Part B.*

Medicare Part D drugs (factors 9–11). For guidance on drugs covered under Medicare Part D, refer to the *Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements, 10.2 - Covered Part D Drugs.*

Alignment with CMS time frames.

- Factor 9: Medicare Part D urgent preservice decisions. The time frame corresponds to the CMS "expedited coverage" determination time frame.
- Factor 10: Medicare Part D nonurgent preservice decisions. The time frame corresponds to the CMS "standard coverage" determination time frame.

- Factor 11: Medicare Part D postservice decisions. The time frame corresponds to the CMS "request for reimbursement" time frame.

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Medications dispensed at the pharmacy. Requests for coverage of medications dispensed at a pharmacy may only be classified as urgent concurrent, urgent preservice or nonurgent preservice, depending on whether the request meets NCQA's definition of "urgent." Medications dispensed at the pharmacy may not be classified as postservice requests.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative pharmaceuticals. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames for factors 1–8. Members or their authorized representatives may agree to extend the decision-making time frame for urgent, preservice and postservice requests.

Extension conditions

Factor 1: Urgent concurrent requests for commercial and Exchange product lines.

- The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to, or any time after, the expiration of the previously approved period or number of treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.
- The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.

Factors 2, 4: Urgent concurrent and urgent preservice requests for Medicaid product line. The organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 3: Urgent preservice requests for commercial and Exchange product lines. The organization may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 5: Nonurgent preservice requests for commercial and Exchange product lines. If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to ~~15~~ 7 calendar days, under the following conditions:

- Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Factor 7: Nonurgent preservice requests for Medicaid product line. The organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, ***or***
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 8: Postservice requests for commercial, Exchange and Medicaid product lines. If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
    - The date when the organization receives the member's response (even if not all of the information is provided), ***or***
    - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.
Extension for other reasons. In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

Extending time frames for Medicare Part B and D for factors 2, 4, 6, 9–11—Alignment with CMS. In accordance with the Medicare Prescription Drug Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, extensions are not allowed.

For Medicare, extensions are not allowed for postservice requests.
Factors 1–4: Verbal notification of denials. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

For Medicare Part D drugs, initial verbal notification of a decision may be made within the specified time frames. Written notification must be made no later than 3 calendar days after verbal notification.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization must have an alternative method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***

- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples **Failure to follow filing procedures**

- An organization's procedure is that members or practitioners submit UM requests in writing, but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame, but the member or practitioner submits the request outside the time frame.

Element C: Relevant Information for Pharmacy Decisions

The organization documents that it consistently gathers relevant information to support pharmacy UM decision making.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review (as defined in *Program Description*) for evidence of using relevant clinical information to support UM decision making.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation

Although NCQA only reviews denial files during the file review process, this element applies to all pharmaceutical determinations resulting from medical necessity review, whether they are approvals or denials. This includes all pharmaceuticals covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Relevant clinical information

Pharmaceutical denial files contain clinical information appropriate to each case.

The relevance of clinical information is considered in terms of the criteria used by the organization to make its decision (i.e., the clinical information must be related to the criteria the organization said were not met in its denial notice). The organization must gather clinical information when determining medical necessity. If enough clinical information relevant to the criteria is not provided with the request, the organization must document in the denial file its attempts to gather the clinical information needed to make a decision.

Exception

This element is NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.

Related information

Refer to UM 1, Element A for the definition of "medical necessity review."

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples

None.

Element D: Discussing a Pharmacy Denial With a Reviewer

The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence of opportunity for a practitioner to discuss a denial with a reviewer.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation This element applies to all pharmaceutical denial determinations resulting from medical necessity review (as defined in *Program Description*), whether the pharmaceutical is covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Opportunity to discuss pharmaceutical denial decisions

The organization notifies the treating practitioner about the opportunity to discuss a pharmaceutical medical necessity denial:

- In the denial notification, ***or***
- By telephone, including leaving a voicemail, if the organization documents the name of the individual at the organization who notified the treating practitioner or left the voicemail and the date and time of the notification or voicemail, ***or***
- In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.

The organization includes the following information in the denial file:

- The denial notification, if the treating practitioner was notified in the denial notification.
- The time and date of the notification and the name of the individual at the organization, if the treating practitioner was notified by telephone.
    - If the treating practitioner was notified by voicemail, the name of the individual who left the voicemail and the date and time.
- Evidence that the treating practitioner was notified that a physician or pharmacist reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

NCQA does not require evidence of discussion with an attending or treating practitioner and does not consider the discussion to be an appeal.

For the Medicare product line, the organization may provide the treating practitioner with an opportunity to discuss a UM request with a physician or other appropriate reviewer

prior to the decision to meet the intent of this element. The organization must provide documentation in the denial file.

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude pharmaceutical management.
- The organization does not notify practitioners of the opportunity to discuss the denial with an appropriate reviewer (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with practitioners).

Related information

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element E: Written Notification of Pharmacy Denials

The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information:

1. **The specific reasons for the denial, in language that is easy to understand.**
2. **A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based.**
3. **A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 3 factors~~	~~High (90-100%) on file review for 2 factors and medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 3 factors~~	~~Low (0-59%) on file review for 1 factor~~	~~Low (0-59%) on file review for 2-3 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence that denial notices meet all three factors.

For factors 1, 2: If the organization does not communicate with members and practitioners, NCQA reviews the organization's documentation sent to its clients.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all pharmaceutical denial determinations resulting from medical necessity review (as defined in *Program Description*), whether the pharmaceutical is covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **Reason for denial**

The denial notification states the reason for the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization denied the request and have enough information to file an appeal.

An appropriately written notification includes a complete explanation of the grounds for the denial (specific medical necessity criteria not met for the condition or requested service, based on review of relevant clinical information) ~~for the denial~~, in language ~~that~~ a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language.

To illustrate, for the abbreviation DNA, spelling out is "DNA (deoxyribonucleic acid)," and explaining is "a DNA test looks at your genetic information."

Denial notifications sent only to practitioners may include technical or clinical terms.

The organization may send a single notice to the member and practitioner that includes the specific reason for the denial, in language that would be easily understood by the member. The notice may also include, in a separate section, additional clinical or technical language directed toward a practitioner.

For denials resulting from medical necessity review of out-of-network requests, the reason for the denial must explicitly address the reason for the request (e.g., if the request is related to accessibility issues that may be impacted by the clinical urgency of the situation, the denial must address whether or not the requested service can be obtained within the organization's accessibility standards).

Factor 2: **Reference to UM criterion**

The denial notification references the specific criterion used to make the denial decision. The criterion used and referenced is specific to the member's condition or to the requested services.

The criterion referenced must be identifiable by name and must be specific to an organization or source (e.g., ABC PBM's Criteria for Treatment of Hypothyroidism with Synthroid or Criteria Company Inc.'s Guidelines for Wound Treatment).

If it is clear that the criterion is attributable to the organization, it is acceptable to state, "our Criteria for XXX" (e.g., our Criteria for Treating High Cholesterol with Lipitor).

If the organization uses a trademarked criterion name, it does not need to cite the organization that holds the trademark it does not need to cite the organization that holds the trademark (e.g., InterQual® Level of Care Criteria).

Because benefit documents are often large and complex, the organization must direct members to the information using the section title or page number.

For denials resulting from medical necessity review of out-of-network requests, criteria may be excerpted from benefit documents that govern out-of-network coverage, organization policies specifying circumstances where out-of-network coverage will be approved or clinical criteria used to evaluate the member's clinical need relative to available network providers and services. The reference must specifically support the rationale for the decision and must relate to the reason for the request.

Factor 3: **Availability of criterion**

The denial notification informs the member, and the practitioner acting as the member's authorized representative, that the criterion used to make the decision is available upon request. Providing the criterion, or an excerpt specific to the denial reason, with the denial notification is also acceptable. NCQA scores this factor "Yes" if the criterion or excerpt is included in the decision notice or if the notification states that the criterion is included as an attachment.

Exceptions

This element is NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.

Factor 3 is NA:

- For Medicare denials and Fully Integrated Dual Eligible (FIDE) denials.
- If the organization does not communicate with members and practitioners (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with members or practitioners).

Related information

Refer to *Related information* in UM 5, Element C for "Member Notification Exceptions" and "Notifying the Practitioner."

Denials due to insufficient clinical information.

- If the organization denies a request due to lack of clinical information, the denial notice must meet factors 1–3.
- If the organization does not have enough clinical information to reference a specific criterion, the denial notice must state this and specify the information needed.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element F: Written Notification of Pharmacy Appeals Rights/Process

The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information:

1. **A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.**
2. **An explanation of the appeal process, including the members' right to representation and the appeal time frames.**
3. **A description of the expedited appeal process for urgent preservice or urgent concurrent denials.**
4. **Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 4 factors~~	~~High (90-100%) on file review for 3 factors and medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 4 factors~~	~~Low (0-59%) on file review for 1-2 factors~~	~~Low (0-59%) on file review for 3-4 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence that denial notices meet all four factors.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to all pharmaceutical denial determinations resulting from medical necessity review (as defined in *Program Description*), whether the pharmaceutical is covered under an organization's medical benefit or its pharmacy benefit.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **Description of appeal rights**

No additional explanation required.

Factor 2: **Right to representation and appeal time frames**

The denial notification:

- Includes a statement that members may be represented by anyone they choose, including an attorney.
- Provides contact information for a state office of health insurance consumer assistance or ombudsman, if applicable.
  Note: *This is not required for members covered by the Federal Employee Health Benefits (FEHB) Program.*
- States the time frame for filing an appeal.
- States the organization's time frame for deciding the appeal.
- States the procedure for filing an appeal, including where to direct the appeal and information to include in the appeal.

The notification to the practitioner is not required to include the member's right to representation if the practitioner is not acting as an authorized representative.

Factor 3: **Expedited appeal process**

The denial notification describes the expedited appeals process for urgent preservice or urgent concurrent denials. If the same process applies to standard and expedited appeals, there must be a description included in the letter that makes it clear that the process applies to both. Factor 3 is met if the organization includes a description of the expedited appeals process in denial notices for every type of request.

The denial notification states:

- The time frame for filing an expedited appeal.
- The organization's time frame for deciding the appeal.

- The procedure for filing an expedited appeal, including where to direct the appeal and information to include in the appeal.

Factor 4: **Concurrent expedited external review**

The denial notification states that for urgent care situations, expedited external review may occur at the same time as the internal appeal process. The organization may discontinue the internal appeal for all member requests addressed by the external review if it is not required to continue the internal appeal process under state law. The organization continues the internal appeal process for components of the request that are not addressed in the external review.

The organization may include the information about concurrent expedited external review to member notifications only.

Exceptions

This element is NA if:

- All purchasers of the organization's services carve out or exclude pharmaceutical management.
- The organization does not communicate with members and practitioners (e.g., organization does not maintain a practitioner network, organization does not serve as a delegate to communicate with members or practitioners).

Factor 4 is NA for:

- Members covered by Medicare, Medicaid or the FEHB Program and for members in self-funded accounts.
- Nonurgent preservice and postservice denial decisions.

Related information

Medicare denials and FIDE denials. CMS requires organizations to:

- Issue an IDN for non-inpatient medical service denials for Medicare and FIDE members.
    - The IDN meets factors 1–3 for these members.
- Issue a Notice of Denial of Medicare Prescription Drug Coverage for Medicare Part D members.
    - The notice meets factors 1–3 for these members.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element G: Pharmaceutical Management Procedures

The organization's policies and procedures for pharmaceutical management include the following:

1. The criteria used to adopt pharmaceutical management procedures.

2. A process to use clinical evidence from appropriate external organizations.

3. A process to include pharmacists and appropriate practitioners in the development of procedures.
4. A process to provide procedures to practitioners annually and when it makes changes.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This element applies to pharmaceuticals managed by the organization, whether they are covered under the organization's medical benefit or under its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, ~~whether or~~ even those not ~~they are~~ listed in the organization's formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

If the organization does not manage certain aspects of this element (i.e., generic substitution, therapeutic interchange, step-therapy protocols), its policies and procedures specify the aspects that do not apply.

Factor 1: **Criteria for adoption**

Criteria for adopting pharmaceutical procedures are different from the clinical criteria used in medical necessity review and required in *UM 2: Clinical Criteria for UM Decisions*. In this element, NCQA reviews the organization's decision criteria for developing pharmaceutical management procedures as a whole.

The organization's policies and procedures specify that the criteria used when adopting the pharmaceutical management procedures includes:

- Pharmaceutical classes.
- Classes preferred or covered at any level.
- Lists of preferred pharmaceuticals or formularies.
- Considerations for limiting access to drugs in certain classes.
- Prior authorization criteria.
- Generic substitution, therapeutic interchange, step therapy or other management methods to which the practitioner's prescribing decisions are subject.
- Within each class of pharmaceuticals:
    - Pharmaceuticals preferred or covered at any level.
    - An exceptions process available to members.
    - Substitutions made automatically or with permission of the prescribing practitioner.
    - Evidence that preferred-status pharmaceuticals can produce similar or better results for a majority of the population than other pharmaceuticals in the same class.
    - Other requirements, restrictions, limitations or incentives that apply to the use of certain pharmaceuticals.

Factor 2: **Use of clinical evidence**

The organization's policies and procedures specify that to make pharmaceutical decisions, the organization uses clinical evidence from the following sources, as appropriate:

- Government agencies.
- Medical associations.
- National commissions.
- Peer-reviewed journals.
- Authoritative compendia.

Factor 3: **Involvement of pharmacists and appropriate practitioners**

When reviewing and making periodic updates to the pharmaceutical management policies and procedures, the organization's pharmaceutical management committee involves:

- Clinical pharmacists.
- Appropriate practitioners.

The committee may be local, regional or national. If the committee is national, involvement of local practitioners is not required.

Factor 4: **Distributing pharmaceutical management procedures**

The organization's policies and procedures specify that it distributes pharmaceutical management procedures to practitioners by mail, fax, email, or on its website, if it informs practitioners that the information is available online. The notice must include a description specific enough to give readers a clear idea of the topic and the general content and must include a link or direction to the specific information. The organization may group or summarize the information by theme. The organization has a process to mail pharmaceutical management procedures to practitioners who do not have fax, email or internet access.

If the organization does not have members and a practitioner network and is not delegated to communicate to its client members and practitioners regarding pharmaceutical restrictions/preferences, then the organization has a process to post on its public website where client members and practitioners can find the information.

Exception

This element is NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.

Examples None.

Element H: Pharmaceutical Restrictions/Preferences

Annually, and within 30 calendar days after updates, the organization communicates to members and prescribing practitioners:

1. **A list of pharmaceuticals, including restrictions and preferences.**
2. **How to use the pharmaceutical management procedures.**
3. **An explanation of limits or quotas.**
4. **How prescribing practitioners must provide information to support an exception request.**
5. **The organization's process for generic substitution, therapeutic interchange and step-therapy protocols.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review NCQA reviews the organization's pharmaceutical procedures and lists.

NCQA also reviews materials distributed to members and prescribing practitioners. The organization may also provide reports to show evidence of distribution to members and practitioners.

Look-back period *For Initial Surveys:* At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation This element applies to all pharmaceuticals, whether they are covered under an organization's medical benefit or its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, ~~whether or not they are~~ even those not listed in the organization's formularies.

    - Including open and closed formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

Pharmaceutical and pharmaceutical management procedures communicated to members and prescribers include information on, as applicable:

- Covered pharmaceuticals.
- Copayment information, including tiers.
- Pharmaceuticals that require prior authorization.
- Limits on refills, doses or prescriptions.
- Use of generic substitution, therapeutic interchange or step-therapy protocols.
- How formulary updates are communicated, and how often, if the organization has scheduled formulary updates.

Distribution of pharmaceutical procedures and updates

The organization distributes pharmaceutical procedures to all members and practitioners.

The organization may limit communication of updates to "negative" formulary changes (i.e., changes that result in restrictions or replacements) and may limit such communications to affected members and their practitioners.

The organization distributes pharmaceutical management procedures and updates by mail, fax or email, or on its website if it informs members and prescribing practitioners that the information is available online. The notice must include a description specific enough to give readers a clear idea of the topic and the general content and must include a link or direction to the specific information. The organization may group or summarize the information by theme. The organization mails pharmaceutical management procedures and updates to prescribing practitioners and affected members who do not have fax, email or internet access.

If the organization does not have members and a practitioner network and is not delegated to communicate to its client members and practitioners regarding pharmaceutical restrictions/preferences, then the organization posts on its public website where client members and practitioners can find the information.

Factors 1–3

No additional explanation required.

***Factor 4:* Exception request**

If the organization administers a closed formulary, there is an exception process for circumstances where the formulary does not adequately accommodate members' clinical

needs, and a process for prescribing practitioners to submit information that supports exception requests.

Factor 5: **Process for generic substitution, therapeutic interchange and step-therapy protocols**

The organization's procedures regarding generic substitution, therapeutic interchange and step-therapy are outlined and communicated to members and prescribers. The organization is not required to communicate procedures that are not in use within its benefit.

Exceptions

This element is NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.

Factor 4 is NA for organizations that do not administer a closed formulary for their members.

Examples

Pharmaceutical management procedures

Member and practitioner newsletters or handbooks describe changes to generic substitution, therapeutic interchange or step-therapy protocols.

Element I: Pharmaceutical Patient Safety Issues

The organization's pharmaceutical procedures include:

1. **Identifying and notifying members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification.**
2. **An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review NCQA reviews the organization's policies and procedures in place throughout the look-back period.

NCQA also reviews three communications to members and three communications to prescribing practitioners, as applicable, or reviews all communications if the organization has fewer than three each for members and prescribing practitioners.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

This element applies to all pharmaceuticals, whether the pharmaceutical is covered under an organization's medical benefit or under its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, ~~whether or not they are~~ even those not listed in the organization's formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

Factors 1, 2: **Class II recalls, Class I recalls and market withdrawal**

- *Class II recall:* Removal of a distributed product where use of or exposure to the product may cause temporary or medically reversible adverse health consequences or where the probability of serious, adverse health consequences is remote.
- *Class I recall:* Removal of a distributed product due to reasonable probability that use of or exposure to the product will cause serious, adverse health consequences or death.
- *Market withdrawal:* Removal or correction of a distributed product which involves a minor violation that would not be subject to legal action by the FDA.

Factor 1: **Withdrawals for safety reason or Class II recalls**

The organization is not required to communicate to members and practitioners about wholesale-only withdrawals.

The organization is only required to notify affected members that it can identify. The organization identifies affected members using batch or lot numbers or NDC codes of the withdrawn or recalled pharmaceuticals.

Exception

This element is NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.

Related information

Information regarding drug recalls and withdrawals. Definitions and safety alerts of Class I, Class II and market withdrawals are posted on the FDA website: http://www.fda.gov/.

Explanation

Examples

Content of notification

Communication to affected members regarding recalled or withdrawn pharmaceuticals may include:

- The name of the drug/pharmaceutical.

- The date of the withdrawal/recall.
- The reason for the withdrawal/recall.
- Instructions such as:
  - Return the pharmaceutical to the pharmacy.
  - See the prescribing practitioner for directions or a new prescription.

Communication to affected practitioners may include:

- The name of the pharmaceutical.
- The date of the withdrawal/recall.
- Patients affected (if known).

Element J: Reviewing and Updating Procedures

With the participation of physicians and pharmacists, the organization annually:

1. Reviews the procedures.

2. Reviews the list of pharmaceuticals.

3. Updates the procedures as appropriate.

4. Updates the list of pharmaceuticals as appropriate.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source

Scope of review

NCQA reviews the organization's policies and procedures.

NCQA also reviews pharmaceutical management committee minutes or similar documentation, and updates to the pharmaceutical procedures, if applicable.

Look-back period

For Initial Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

This element applies to all pharmaceuticals, whether they are covered under an organization's medical benefit or under its pharmacy benefit, including, but not limited to:

- All pharmaceuticals, ~~whether or not they are~~ even those not listed in the organization's formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

This element applies to pharmaceutical management procedures described in Elements A–C.

The organization may space its review and updates of pharmaceutical management procedures and list of approved pharmaceuticals over the course of the year.

Involvement of physicians and pharmacists

When reviewing and making periodic updates to the pharmaceutical management policies and procedures, the organization's pharmaceutical management committee involves:

- Clinical pharmacists.
- Appropriate physicians.

The committee may be local, regional or national. If the committee is national, involvement of local physicians or pharmacists is not required.

Factors 1–4

No additional explanation required.

Exception

This element is NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.

Examples None.

Element K: Considering Exceptions

The organization has exceptions policies and procedures that describe the process for:

1. **Making an exception request based on medical necessity.***
2. **Obtaining medical necessity information from prescribing practitioners.***
3. **Using appropriate pharmacists and practitioners to consider exception requests.**
4. **Timely handling of exception requests.**
5. **Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.**

Critical factors: Score cannot exceed 20% if one critical factor is scored "no." Score cannot exceed 0% if two or more critical factors are scored "no."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 5 factors~~	~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met

The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation This element applies to all pharmaceuticals, whether they are covered under an organization's medical benefit or under its pharmacy benefit, including but not limited to:

- All pharmaceuticals, ~~whether or not they are~~ even those not listed in the organization's formularies.
- Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home).
- Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.

The organization has pharmaceutical management procedures that promote the clinically appropriate use of pharmaceuticals, unless otherwise carved out by all purchasers of the organization's services.

Factors 1 and 2 are critical factors; if one critical factor is scored "No," the organization's score cannot exceed 20% for the element. If both critical factors are scored "No," the organization's score cannot exceed 0% for the element.

Formulary exceptions are requests by members of their authorized representatives to obtain a pharmaceutical that is not included as part of the organization's closed formulary.

Factor 1: **Exception for medical necessity**

The organization's policies and procedures allow members to request exceptions based on medical necessity if needed pharmaceuticals are not on the list of approved pharmaceuticals.

Factor 2: **Obtaining information from prescribing practitioners**

The organization's policies and procedures detail the clinical information needed from prescribing practitioners in order to determine medical necessity.

Factor 3: **Review by appropriate practitioner**

No additional explanation required.

Factor 4: **Timely handling of exception requests**

The organization's policies and procedures provide time frames for exception requests. Time frames are not required to be the same as those stated in *UM 5: Timeliness of UM Decisions*, but must consider clinical urgency.

Factor 5: **Denial notification and appeal rights**

The organization's policies and procedures specify that if the organization denies a request for an exception based on medical necessity, internal and external appeal processes are available on the same basis as for denials of other services.

Exceptions

This element is NA if:

- The organization does not administer a closed formulary for its clients' members.
- All purchasers of the organization's services carve out or exclude pharmaceutical management.

Related information

Formulary exception appeals. A denial of a formulary exception request is a coverage decision subject to appeal under the policies and procedures required under *UM 8: Policies for Appeals.* Upheld appeals of formulary exception denials are included in the file universe in *UM 9: Appropriate Handling of Appeals.*

Existing exception policies. Many organizations and PBMs have exception policies in place; some use online or telephone systems to communicate with pharmacists and consider coverage for the prescribed pharmaceutical based on medical necessity. It is not the intent of this element to interfere with these processes; they meet the requirements of Element E if the organization's formal appeal process is available to members whose exception request was denied.

Examples

Factor 1: **Reasons for exception requests**

- Intolerance or allergy to pharmaceuticals on the organization's list of approved drugs.
- Inadequate or inappropriate response to pharmaceuticals on the organization's list of approved drugs.

UMA 5: Appeal Decisions

The organization has written policies and procedures for thorough, appropriate and timely resolution of member appeals. The organization adjudicates member appeals in a thorough, appropriate and timely manner.

Intent

There is an established, impartial process for resolving member disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service. The organization has a full and fair process for resolving member disputes and responding to members' requests to reconsider a decision they find unacceptable regarding their care and service.

Applicable Elements

Element A: Internal Appeals

The organization's written policies and procedures for registering and responding to written internal appeals include the following:

1. **For commercial and Exchange, allowing at least 180 calendar days after notification of the denial for the member to file an appeal.**
2. **For Medicare and Medicaid, allowing at least 60 calendar days after notification of the denial for the member to file an appeal.**
3. **Documenting the substance of the appeal and any actions taken.**
4. **Full investigation of the substance of the appeal, including any aspects of clinical care involved.**
5. **The opportunity for the member to submit written comments, documents or other information relating to the appeal.**
6. **Appointment of a new person to review an appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.**
7. **Appointment of at least one person to review an appeal who is a practitioner in the same or a similar specialty.**
8. **The decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request.**
9. **The commercial, Exchange and Medicare decision for a postservice appeal and notification to the member within 60 calendar days of receipt of the request.**
10. **For Medicaid, the decision for a postservice appeal and notification to the member within 30 calendar days of receipt of the request.**
11. **The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request.**
12. **Notification to the member about further appeal rights.**
13. **Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based.**
14. **Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.**
15. **Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review.**
16. **Allowing an authorized representative to act on behalf of the member.**

17. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner.
18. Continued coverage pending the outcome of an appeal.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 18 factors~~	~~The organization meets 14-17 factors~~	~~The organization meets 9-13 factors~~	~~The organization meets 4-8 factors~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 14-18 factors	The organization meets 9-13 factors	The organization meets 0-8 factors

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation **THIS IS A CORE ELEMENT.** The organization must meet this requirement even if it does not have any clients or serve as a delegate.

This element is a **structural requirement**. The organization must present its own documentation.

This element applies to appeal decisions related to coverage or rescission of coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services).

A member may appeal any adverse medical necessity or benefit decision.

With a member's permission, the organization may refer an appeal directly to an IRO without conducting an internal review.

Definition of appeal requests

Preservice appeal: An appeal of an adverse decision for coverage of care or services in advance of the member obtaining care or services.

Postservice appeal: A request to change an adverse determination for care or services that have been received by the member.

Expedited appeal: An appeal on an adverse decision for coverage for urgent care.

Factors 1, 2: **Appeal filing time frames**

Appeal policies and procedures include the following time frames for members (or their authorized representatives) to file an appeal, as applicable:

- *For commercial and Exchange appeals:* 180 calendar days or more.
- *For Medicare and Medicaid appeals:* 60 calendar days.

Factor 3: **Documenting the substance of an appeal and actions taken**

Appeal policies and procedures specify that documentation of the substance of the appeal includes, but is not limited to:

- The member's reason for appealing the previous decision.
- Additional clinical or other information provided with the appeal request.

Appeal policies and procedures specify that documentation of actions taken includes, but is not limited to:

- Previous denial or appeal history.
- Follow-up activities associated with the denial and conducted before the current appeal, if applicable.

The organization determines the extent of documentation in the appeal file.

Factor 4: **Investigating the substance of an appeal**

Appeal policies and procedures specify that the organization fully investigates the content of the appeal and documents its findings. The organization's appeal review does not give deference to the denial decision.

Factor 5: **Right to submit comments and other information**

Appeal policies and procedures specify that members have the opportunity to submit information relevant to the appeal. The organization documents when members fail to submit relevant information by the specified deadline.

Factor 6: **Person or people deciding the appeal**

Appeal policies and procedures specify who in the organization decides appeals.

The organization may designate any individual or group (e.g., a panel) in its policies and procedures to overturn appeals and to uphold appeals that do not require medical necessity review.

For appeals that require medical necessity review, the final decision to uphold an appeal must be made by an appropriate practitioner or a group (e.g., a panel) that includes an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision.

NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:

- *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.

- *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials.
- *Pharmacists:* Pharmaceutical denials.
- *Dentists:* Dental denials.
- *Chiropractors:* Chiropractic denials.
- *Physical therapists:* Physical therapy denials.
- *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.

*In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license.

Factor 7: **Same-or-similar-specialist review**

Appeal policies and procedures require same-or-similar specialist review as part of the process to uphold the initial decision in an appeal that requires medical necessity review.

The purpose of same-or-similar specialist review of appeals is to apply specific clinical knowledge and experience when determining if an appeal meets criteria for medical necessity and clinical appropriateness.

The same-or-similar specialist may be the same individual designated to make the appeal decision or may be a separate reviewer who provides a recommendation to the individual making the decision. The same or similar specialist may be any of the practitioner types specified in factor 6, with the exception of pharmacists, because pharmacists generally treat patients only in limited situations and therefore are not considered same-or-similar specialists for the purposes of deciding appeals.

To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:

- Includes treating the condition.
- Includes treating complications that may result from the service or procedure.
- Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.

"Training and experience" refers to the practitioner's clinical training and experience.

When reviewing appeal files, NCQA reviews whether the specialist's training and experience aligns with the condition, service or procedure in question, as opposed to requiring an exact match to the referring or treating practitioner type or specialty.

The intent is that the specialist reviewing the appeal would have encountered a patient with this condition who is considering or has received the service or procedure in a clinical setting. Because of this, more complex services and procedures require review by practitioners with more specialized training and experience. For example, while a decision to uphold a denial of hospital admission for arrhythmia might be reviewed by any number of practitioners, including, but not limited to, a cardiologist, cardiothoracic surgeon, internist, family practitioner, geriatrician or emergency medicine physician, a decision to uphold a denial of surgery to repair an atrial septal defect in a newborn would require review by a cardiothoracic surgeon with pediatric experience.

NCQA accepts board certification in a specialty as a proxy for clinical training and experience. A specialist who maintains board certification in a general and specialty area (e.g., internal medicine and pulmonology) is considered to have training and experience in both areas. NCQA does not require that the same-or-similar specialist reviewer be actively practicing.

Experience with the condition, service or procedure that is limited to UM decision making in cases similar to the appeal in question is not considered sufficient experience, nor do UM decision-making criteria supersede the requirement for same-or-similar specialist review.

If the organization's clinical criteria limits who can perform a service or procedure, or who can prescribe a pharmaceutical to specific practitioner types or specialties, then only those practitioner types or specialties may be considered same-or-similar specialist reviewers.

Factors 8–11: **Appeal decisions**

Appeal policies and procedures specify that appeal decisions and notification are timely. The appeal decision notification states the reason for upholding the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization upheld the appeal decision and have enough information to file the next level of appeal.

An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language.

To illustrate, for the abbreviation DNA, spelling out is "DNA (deoxyribonucleic acid)," and explaining is "a DNA test looks at your genetic information."

Upheld appeal notifications sent only to practitioners may include technical or clinical terms.

The organization may send a single notice to the member and practitioner that includes the specific reason for the upheld appeal, in language that would be easily understood by the member. The notice may also include, in a separate section, additional clinical or technical language directed toward a practitioner.

For expedited appeals (factor 11), appeal policies and procedures specify that the organization grants an expedited review for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility. Organizations that do not handle admissions, continued stays or emergency services (e.g., PBMs) may instead outline services for which they grant expedited review.

Factor 12: **Notification of further appeal rights**

Appeal policies and procedures include a description of the next level of appeal, either within the organization or to an external organization, as applicable, and relevant written procedures.

Factor 13: **Reference to and excerpt from criteria**

Appeal policies and procedures specify that the appeal notification references the specific criterion used to make the appeal decision.

Appeal policies and procedures specify that the organization informs the member or the member's authorized representative that the criterion used to make the decision is available upon request. The criterion availability component of factor 13 is met if the policies and procedures specify that the criterion, or an excerpt of the criterion, is included in the decision notice or as an attachment.

Factor 14: **Access to and copies of documents**

No additional explanation required.

Factor 15: **Titles and qualifications**

Appeal policies and procedures require the appeal notice to identify all reviewers who participated in making the appeal decision, including the same-or-similar specialist reviewer, when applicable, as they provide specific clinical knowledge and experience that affects the decision.

For each individual, the notice includes:

- *For a benefit appeal:* The title (position or role in the organization).
- *For a medical necessity appeal:* The title (position or role in the organization), qualifications (clinical credentials such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist).

The organization is not required to include individuals' names in the written notification.

Factor 16: **Authorized representative**

Appeal policies and procedures specify that the organization processes appeals from the member and their authorized representative (i.e., an individual who acts on behalf of another individual through consent or under applicable law). For urgent care decisions, an organization allows a health care practitioner with knowledge of the member's medical condition (e.g., a treating practitioner) to act as the authorized representative. The organization may establish procedures for determining if an individual is authorized to act on behalf of a member. The member's authorized representative is documented in the appeal file. ~~No additional explanation required~~.

Factor 17: **Culturally and linguistically appropriate notification**

Appeal policies and procedures specify that appeal notices are based on members' cultural and linguistic needs.

Factor 18: **Continued coverage pending outcome of appeal**

Note: *This factor applies to appeals of denials, reduction or termination of coverage for an ongoing course of treatment for which coverage was previously approved. It does not apply to requests for extensions.*

Appeal policies and procedures allow continued coverage, pending the outcome of an internal appeal of a concurrent care decision until:

- The end of the approved treatment period, ***or***
- Determination of the appeal, subject to regulatory and contractual obligations.

If the outcome of the appeal is in the organization's favor, NCQA standards do not prohibit the organization from seeking reimbursement from the member for payments made.

Medicare appeals for factors 8, 9, 11–15. The organization's policies and procedures describe its process for sending an upheld denial to MAXIMUS.

Medicare Part D appeals for factors 8, 9, 11–13. The organization describes its process for notifying members that an upheld denial should be sent to MAXIMUS.

Exceptions

Factor 1 is NA for Medicare and Medicaid product lines.

Factor 2 is NA for commercial and Exchange product lines.

Factor 9 is NA for Medicaid product lines.

Factor 10 is NA for commercial, Medicare and Exchange product lines.

Factors 14 and 15 are NA for Medicare Part D appeals.

For factor 14, the "free of charge" component is NA for Medicare appeals.

Factor 18 is NA if the organization does not provide or administer coverage for members.

Related information

Discussion with the practitioner. NCQA does not consider a request by a treating practitioner to discuss the decision with an appropriate practitioner reviewer in *UM 7: Denial Notices,* Elements A and D to be an initiation of the appeal process.

Extending the time frame to obtain additional information. Although there are allowable extensions for initial UM decisions, the organization may only extend the appeal time frame to obtain additional information when:

- The member agrees to extend the appeal time frame, ***or***
- Federal program regulations allow the organization to request additional information from the member.

Allowable extensions for the Medicare and Medicaid product line only. For Medicare and Medicaid, the organization may allow a 14-day extension if the member requests the

extension or the organization demonstrates that more information is needed and the delay is in the member's interest.

Verbal notification. Verbal notification does not replace electronic or written notification of expedited appeal decisions, but when provided, the organization may extend the time frame for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within 72 hours.

For commercial, Medicare and Exchange appeals, if the organization provides verbal notification for an expedited appeal, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid appeals, verbal notification is appropriate for nonurgent preservice, postservice and expedited appeals. Verbal notification of a decision does not extend the electronic or written notification time frame. Organizations may verbally inform members if there is a delay and must resolve appeals as expeditiously as the member's health requires.

Expedited appeals. The organization may inform the hospital Utilization Review (UR) department staff of its decision, with the understanding that staff will inform the attending/treating practitioner. Notifications may be addressed to the hospital UR department, but must be to the attention of the attending or treating practitioner.

FEHB member appeals. For FEHB Program member appeals for which the organization requested additional information, NCQA gives the organization credit for factor 8 if its policies state that it makes appeal decisions within 30 calendar days after the date when the information was received.

Note: *This may extend the normal 30-calendar-day preservice time frame.*

Other levels of internal appeal. An organization may have two levels of internal appeal, and may also have voluntary levels of appeal beyond the internal appeal process. The organization informs members of the process. Policies and procedures specify the time frames allocated for each level of internal appeal; however, the total of both time frames must be the same or less than the time frame specified for the type of appeal under review. For example, for a preservice appeal where NCQA allows 30 calendar days, the organization may allocate 10 calendar days to complete first-level appeals and 20 calendar days to complete second-level appeals.

The 180-calendar-day allowance for filing an appeal applies to first-level appeals.

NCQA standards do not specify a minimum time frame for members to file a second level appeal following the decision on a first-level appeal.

Policies and procedures specify the level of review that includes same-or-similar-specialist review.

The organization suspends the statute of limitations or other legal or equitable basis for denial of the claim based on timeliness while a voluntary appeal is pending.

Use of practitioner web portals. The organization may provide electronic upheld appeal decision notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirement in UM 8 and UM 9. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic upheld appeal decision notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 8 and UM 9. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Examples None.

Element B: Notice of External Review Rights

The organization provides annual written notification to members of the availability of independent, external review of final internal UM determinations.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports, Materials

Scope of review NCQA reviews the organization's notice of external appeal rights.

For Initial Surveys: NCQA reviews the most recent distribution of external review rights to members.

For Renewal Surveys: NCQA reviews the most recent and previous annual distribution of external review rights to members.

Look-back period *For Initial Surveys*: At least once during the prior year.

Renewal Surveys: 24 months.

Explanation This element is a **structural requirement**. The organization must present its own documentation.

Distribution of external review rights

The organization distributes information on the availability of final, external review to members by mail, fax or email, or on its website if it informs members that the information is available online. The organization mails the information to members who do not have fax, email or internet access.

Exceptions

This element is NA for organizations that do not:

- ~~that do not c~~Conduct any aspect of appeal review.
- ~~This element is NA for organizations that do not c~~Communicate UM determinations to members (e.g., the organization does not serve as a delegate to communicate UM determinations to members for any ~~of its~~ clients).

This element is NA for appeals:

- By members covered by Medicare, Medicaid or the FEHB Program.
- By members in self-funded accounts.
- By members whose employer has arranged for employees to have access to employer-mandated independent review.

Examples None.

Element C: Preservice and Postservice Appeals

An NCQA review of the organization's appeal files indicates that they contain the following information:

1. Documentation of the substance of appeals.

2. Investigation of appeals.

3. Appropriate response to the substance of appeals.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 3 factors~~	~~High (90-100%) on file review for 2 factors; medium (60-89%) on file review for 1 factor~~	~~At least medium (60-89%) on file review for 3 factors~~	~~Low (0-59%) on file review for 1 factor~~	~~Low (0-59%) on file review for 2-3 factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 upheld appeal files for evidence the appeal file contains all three factors.

Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

If the organization does not communicate with members and practitioners, NCQA reviews the organization's documentation sent to its clients.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation This element evaluates handling of appeals according to the policies required by *UM 8: Policies for Appeals*. This element applies to all medical necessity and benefit decision appeals.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **Documentation of the substance**

The organization's documentation for the appeal includes:

- The member's reason for appealing the previous decision.
- Actions taken, including, but are not limited to:
  - Previous denial or appeal history.
  - Follow-up activities associated with the denial and conducted before the current appeal, if applicable.

Factor 2: **Documentation of the investigation of appeals**

The organization investigates the content of the appeal, including all aspects of clinical care involved, and documents its findings. The investigation does not defer to the denial decision.

Factor 3: **Appropriate response to the substance of appeals**

The organization's response is commensurate with the seriousness and urgency of the appeal. It directly responds to the reasons given by the member when appealing and addresses new information provided by the member or practitioner as part of the appeal

Exception

This element is NA if the organization does not conduct any aspect of appeal review.

Related information

Personal care services. Benefit appeal files include appeals for personal care services such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element D: Timeliness of the Appeal Process

The organization adheres to the following time frames for notification of preservice, postservice and expedited appeal decisions:

1. **For preservice appeals, the organization gives electronic or written notification within 30 calendar days of receipt of the request.**
2. **For commercial, Exchange and Medicare postservice appeals, the organization gives electronic or written notification within 60 calendar days of receipt of the request.**
3. **For Medicaid postservice appeals, the organization gives electronic or written notification within 30 calendar days of the request.**
4. **For expedited appeals, the organization gives electronic or written notification within 72 hours of receipt of the request.**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA selects a random sample of up to 40 upheld appeal files for evidence of timeliness of resolution, including decision making and notification.

Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

If the organization does not communicate with members and practitioners, NCQA reviews the organization's documentation sent to its clients.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element evaluates handling of appeals according to the policies required by *Policies for Appeals*. This element applies to all medical necessity and benefit decision appeals.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factors 1–4: **Timeliness of appeal process**

NCQA considers 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when the notice was provided to the member or member's authorized representative, as applicable.

The organization documents the date when it receives the request, and the date it resolves the appeal, in the appeal file. The request is received when it arrives at the organization, even if it is not received by the appeals department.

For organizations that do not communicate with members and practitioners, NCQA measures timeliness from when the request is received from the client.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request.

The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

Exceptions

This element is NA if the organization does not conduct any aspect of appeal review.

Factor 2 is NA for the Medicaid product line.

Factor 3 is NA for commercial, Medicare and Exchange product lines.

Related information

Extending the decision time frame. The organization may extend the appeal time frame to obtain additional information if:

- The member agrees to extend the appeal time frame, ***or***
- Federal program regulations allow the organization to request additional information from the member.

The organization may deny the appeal and notify the member if it does not receive the information within the time frames.

The organization documents the extension in the appeal file.

Allowable extensions for the Medicare and Medicaid product lines only. For Medicare and Medicaid, the organization may allow a 14-day extension if the member requests the extension or the organization demonstrates that more information is needed and the delay is in the member's interest.

Verbal notification. Verbal notification does not replace electronic or written notification of expedited appeal decisions, but when provided, the organization may extend the time frame for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within 72 hours.

For commercial, Medicare and Exchange appeals, if the organization provides verbal notification for an expedited appeal, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicare Part C appeals, the date when the upheld denial is sent to MAXIMUS is the date of notification.

For Medicaid appeals, verbal notification is appropriate for nonurgent preservice, postservice and expedited appeals. Verbal notification of a decision does not extend the electronic or written notification time frame. Organizations may verbally inform members if there is a delay and must resolve appeals as expeditiously as the member's health requires.

Expedited appeals. The organization may inform the hospital Utilization Review (UR) department staff of its decision, with the understanding that staff will inform the attending/treating practitioner. Notifications may be addressed to the hospital UR department, but must be to the attention of the attending or treating practitioner.

FEHB member appeals. For FEHB Program member appeals for which the organization requested additional information, preservice and postservice appeal files meet factors 1 and 2 if the decision was made within 30 calendar days after the date when the information was received.

Note: *This may extend the preservice and postservice appeal time frames.*

Other levels of internal appeal. An organization may have two levels of internal appeal and may also have voluntary levels of appeal beyond the internal appeal process. The organization informs members of the process. Policies and procedures specify the time frames allocated for each level of internal appeal; however, the total of both time frames must equal or be less than the time frame specified for the type of appeal under review. For example, for a preservice appeal where NCQA allows 30 calendar days, the organization may allocate 10 calendar days to complete first-level appeals and 20 calendar days to complete second-level appeals.

The 180-calendar-day allowance for filing an appeal applies to first-level appeals.

NCQA standards do not specify a minimum time frame for members to file a second level appeal following the decision on a first-level appeal.

Policies and procedures specify the level of review that includes same-or-similar-specialist review.

The organization suspends the statute of limitations or other legal or equitable basis for denial of the claim based on timeliness while a voluntary appeal is pending.

Use of practitioner web portals. The organization may provide electronic upheld appeal decision notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirement in UM 8 and UM 9. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic upheld appeal decision notifications to members through a web portal if:

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***
- The information posted in the portal meets the requirements in UM 8 and UM 9. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element E: Appeal Reviewers

The organization provides nonsubordinate reviewers who were not involved in the previous determination and same-or-similar-specialist review, as appropriate.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~Medium (60-89%) on file review~~	~~No scoring option~~	~~Low (0-59%) on file review~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 upheld appeal files for evidence of involvement of nonsubordinate and same-or-similar specialist reviewers.

Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element evaluates handling of appeals according to the policies required by *Policies for Appeals*. This element applies to all medical necessity and benefit decision appeals.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Person or people deciding the appeal

The organization may designate any individual or group (e.g., a panel) to overturn appeals and to uphold appeals that do not require medical necessity review.

However, for appeals that require medical necessity review, the final decision to uphold an appeal must be made by an appropriate practitioner or a group (e.g., a panel) that includes an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision.

NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:

- *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
- *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials.
- *Pharmacists:* Pharmaceutical denials.
- *Dentists:* Dental denials.
- *Chiropractors:* Chiropractic denials.
- *Physical therapists:* Physical therapy denials.
- *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.

*In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license.

Same-or-similar specialist review

Same-or-similar specialist review is a required part of the process to uphold the initial decision in an appeal that requires medical necessity review.

The purpose of same-or-similar specialist review of appeals is to apply specific clinical knowledge and experience when determining if an appeal meets criteria for medical necessity and clinical appropriateness.

The same-or-similar specialist may be the same individual designated to make the appeal decision or may be a separate reviewer who provides a recommendation to the individual making the decision. The same-or-similar specialist may be any of the practitioner types specified above, with the exception of pharmacists, because pharmacists generally treat patients only in limited situations and therefore are not considered same-or-similar specialists for the purposes of deciding appeals.

To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:

- Includes treating the condition.
- Includes treating complications that may result from the service or procedure.
- Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.

"Training and experience" refers to the practitioner's clinical training and experience.

When reviewing appeal files, NCQA reviews whether the specialist's training and experience aligns with the condition, service or procedure in question, as opposed to requiring an exact match to the referring or treating practitioner type or specialty.

The intent is that the specialist reviewing the appeal would have encountered a patient with this condition who is considering or has received the service or procedure in a clinical setting. Because of this, more complex services and procedures require review by practitioners with more specialized training and experience. For example, while a decision to uphold a denial of hospital admission for arrhythmia might be reviewed by any number of practitioners, including, but not limited to, a cardiologist, cardiothoracic surgeon, internist, family practitioner, geriatrician or emergency medicine physician, a decision to uphold a denial of surgery to repair an atrial septal defect in a newborn would require review by a cardiothoracic surgeon with pediatric experience.

NCQA accepts board certification in a specialty as a proxy for clinical training and experience. A specialist who maintains board certification in a general and specialty area (e.g., internal medicine and pulmonology) is considered to have training and experience in both areas. NCQA does not require that the same-or-similar specialist reviewer be actively practicing.

Experience with the condition, service or procedure that is limited to UM decision making in cases similar to the appeal in question is not considered sufficient experience, nor do UM decision-making criteria supersede the requirement for same-or-similar specialist review.

If the organization's clinical criteria limits who can perform a service or procedure, or who can prescribe a pharmaceutical to specific practitioner types or specialties, then only those practitioner types or specialties may be considered same-or-similar specialist reviewers.

Exception

This element is NA if the organization does not conduct any aspect of appeal review.

Related information

Same-or-similar specialist review with multiple levels of appeal. If a second-level appeal file is chosen for review, NCQA reviews the file for all requirements, including same-or-similar specialist, even if same-or-similar specialist review occurs at the first level of appeal. If a first-level appeal file is chosen, and the specialist review occurs at the second level:

- NCQA scores the same-or-similar specialist review NA if the second-level appeal has not taken place.
- NCQA scores all requirements, including same-or-similar specialist, if the second-level appeal has taken place.

Nonsubordinate reviewers with multiple levels of appeal. Nonsubordinate reviewers are required at each level of the appeal process for appeals that require medical necessity review.

Automated systems. If the initial denial decision was made by an automated system (e.g., claims system), any reviewer is considered new and nonsubordinate.

Contracting with a board-certified consultant. NCQA does not consider it delegation if the organization contracts with board-certified consultants who make recommendations and provide same-or-similar specialty review. If the consultant makes the appeal decision NCQA considers this to be delegation.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.

Element F: Notification of Appeal Decision/Rights

An NCQA review of the organization's internal appeal files indicates notification to members of the following:

1. **Specific reasons for the appeal decision, in easily understandable language.**
2. **A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.**
3. **Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.**
4. **Notification that the member is entitled to receive reasonable access to and copies of all documents, free of charge, upon request.**
5. **A list of titles and qualifications, including specialties, of individuals participating in the appeal review.**
6. **A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.**
7. **<u>For final internal appeal notices, members are not required to bear costs of the IRO, including filing fees.</u>**

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file~~	~~High (90-100%) on file review for 4 or 5~~	~~At least medium on file~~	~~Low (0-59%) on file review for 1-3 factors~~	~~Low (0-59%) on file review~~

~~review for 6 factors~~	~~factors and medium (60-89%) on file review for the remaining 1-2 factors~~	~~review for 6 factors~~		~~for 4 or more factors~~

Met	Partially Met	Not Met
TBD	TBD	TBD

Data source Records or files

Scope of review NCQA reviews a random sample of up to 40 upheld appeal files for evidence that appeal notices meet all 6 factors. Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

If the organization does not communicate with members and practitioners, NCQA reviews the organization's documentation sent to its clients for applicable factors.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element evaluates handling of appeals according to the policies required by *UM 8: Policies for Appeals.* This element applies to all medical necessity and benefit decision appeals.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **The appeal decision**

The appeal decision notification states the reason for upholding the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization upheld the appeal decision and have enough information to file the next level of appeal.

An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language.

To illustrate, for the abbreviation DNA, spelling out is “DNA (deoxyribonucleic acid),” and explaining is “a DNA test looks at your genetic information.”

Upheld appeal notifications sent only to practitioners may include technical or clinical terms.

The organization may send a single notice to the member and practitioner that includes the specific reason for upholding the denial, in language that would be easily understood by the member. The notice may also include, in a separate section, additional clinical or technical language directed toward a practitioner.

For appeals resulting from medical necessity review of out-of-network requests, the reason for upheld appeal decision must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the appeal decision must address whether or not the requested service can be obtained within the organization’s accessibility standards).

Factor 2: **Reference to UM criterion**

The appeal notification references the specific criterion used to make the denial decision. The criterion used and referenced is specific to the member's condition or to the requested services.

The criterion must be identifiable by name and must be specific to an organization or source (e.g., ABC PBM’s Criteria for Treatment of Hypothyroidism with Synthroid or Criteria Company Inc.’s Guidelines for Wound Treatment).

If it is clear that the criterion is attributable to the organization, it is acceptable to state, “our Criteria for XXX” (e.g., our Criteria for Treating High Cholesterol with Lipitor).

If the organization uses a trademarked criterion name, it does not need to cite the organization that holds the trademark (e.g., InterQual® Level of Care Criteria).

Because benefit documents are often large and complex, the organization must direct members to the information using the section title or page number.

For appeals of denials resulting from medical necessity review of out-of-network requests, criteria may be excerpted from benefit documents that govern out-of-network coverage, organization policies specifying circumstances where out-of-network coverage will be approved or clinical criteria used to evaluate the member’s clinical need relative to available network providers and services. The reference must specifically support the rationale for the decision and must relate to the reason for the request.

Factor 3: **Availability of criterion**

The appeal notification informs the member or the member’s authorized representative, that the criterion used to make the decision is available upon request. Providing the criterion, or an excerpt specific to the denial reason, with the appeal decision notification is also acceptable. NCQA scores this factor “Yes” if the criterion or excerpt is included in

the decision notice or if the notification states that the criterion or excerpt is included as an attachment.

Factor 4: **Access to and copies of documents**

No additional explanation required.

Factor 5: **Titles and qualifications**

The upheld appeal decision notification identifies all reviewers who participated in making the appeal decision, including the same-or-similar specialist reviewer, when applicable, as they provide specific clinical knowledge and experience that affects the decision.

For each individual, the notice includes:

- *For a benefit appeal:* The title (position or role in the organization).
- *For a medical necessity appeal:* The title (position or role in the organization), qualifications (clinical credentials such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist).

The organization is not required to include individuals' names in the written notification.

Factor 6: **Additional appeal rights**

The notification describes members' additional appeal rights if their appeal is denied.

If the next level of appeal is independent external review, the notification includes a statement that members are not required to bear costs of the IRO, including any filing fees, unless state law mandates that members pay an IRO filing fee.

If the organization instructs the member to send an appeal directly to an IRO, including MAXIMUS, factor 6 requirements are met if members are told where to send the appeal and the relevant time frames, if applicable.

NEW Factor 7: **Cost of review**

If state law mandates that members pay an IRO filing fee, the organization receives credit for this factor if it provides the state's language. This factor applies to final-level appeals.

Exceptions

This element is NA if the organization does not conduct any aspect of appeal review.

Factors 3, 4 and 5 are NA for Medicare Part D appeals.

For factor 4, the "free of charge" component is NA for Medicare appeals.

Factor 7 is NA:

- For appeal notifications before July 1, 2025.
- If the organization had no final internal appeals during the look-back period.

- For appeals by members covered by Medicare, Medicaid or the Federal Employees Health Benefit (FEHB) Program.
- For appeals by members in self-funded accounts.
- If the employer mandates that its employees go through its external appeal process.

Related information

Identification of appeal reviewers. The appeal decision notification sent to the member does not need to include the names of the individuals who participated in the appeal decision. The organization is not required to provide a signature on the appeal decision notice sent to the member.

Medicare appeals. For Medicare appeal files, factors 1–6 are met if there is evidence that the organization sent the upheld denial to MAXIMUS.

Organizations that make both decisions and recommendations. Further instructions for file review are specified in the policies and procedures and the file review worksheet.

Examples None.