NCQA Corrections, Clarifications and Policy Changes to the 2017 HP Standards and Guidelines

July 29, 2019

This document includes the corrections, clarifications and policy changes to the 2017 HP standards and guidelines. NCQA has identified the appropriate page number in the printed publication and the standard and head/subhead for each update. Updates have been incorporated into the Interactive Survey System (ISS). NCQA operational definitions for correction, clarification and policy changes are as follows:

- A ***correction (CO)*** is a change made to rectify an error in the standards and guidelines.
- A ***clarification (CL)*** is additional information that explains an existing requirement.
- A ***policy change (PC)*** is a modification of an existing requirement.

An organization undergoing a survey under the 2017 HP standards and guidelines must implement corrections and policy changes within 90 calendar days of the IRT release date, unless otherwise specified. The 90-calendar-day advance notice does not apply to clarifications or FAQs, because they are not changes to existing requirements.

Page	Standard	Head/Subhead	Update	Type of Update	IRT Release Date
	Policies and Procedures and applicable Appendices		NCQA improved the methodology to evaluate and communicate health plan accreditation and performance on clinical (HEDIS) and patient experience (CAHPS) measures. Beginning July 1, 2020, all Excellent and Commendable accreditation statuses will be replaced with Accredited along with the Health Plan Rating (for organizations required to report HEDIS/CAHPS); Provisional, Interim and Denied statuses will remain. ***Note:*** *NCQA will not change all references to the Excellent and Commendable statuses in the HPA 2017 publication.*	**PC**	**7/29/2019**
32	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Annual Reevaluation	Add the following subhead and text after the second paragraph under "Annual Reevaluation": **New Annual Reevaluation Using Health Plan Ratings beginning July 1, 2020** Beginning July 1, 2020, evaluation of HEDIS/CAHPS performance scoring will be replaced by Health Plan Ratings for all accredited organizations regardless of standards year. The 50/50 scoring method where accreditation standards are worth 50 points and HEDIS/CAHPS are worth 50 points will no longer exist. In addition, Excellent and Commendable accreditation statuses will be changed to Accredited; Provisional, Interim or Denied statuses will remain and will be displayed along with Health Plan Ratings on the NCQA Report Card. In addition to Accreditation status as noted above, the HPR result will be displayed on the NCQA Report Card as the indicator of HEDIS/CAHPS performance. Based on	**PC**	**7/29/2019**

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			the updated methodology, organizations earn a star rating of 0–5 stars (in half-star increments) for the HEDIS/CAHPS portion of Accreditation. The methodology includes a distinct set of measures for each product line. Each measure is classified in one of three categories: • Process measures, which have a weight of 1. • Outcome measures, which have a weight of 3. • Patient experience measures, which have a weight of 1.5. The overall rating is the weighted average of an organization's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the organization is Accredited by NCQA), rounded to the nearest half point. Overall performance is measured in three subcategories (displayed as stars and scored 0–5 in half point increments): 1. **Consumer Satisfaction:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Consumer Satisfaction category). 2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive service (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures). 3. **NCQA Accreditation Standards Score:** For an organization with an Accredited or Provisional status, 0.5 points (displayed as stars) are added to the overall rating. An organization with an Interim status receives one-third of the 0.5 bonus points (displayed as stars). ***Note:*** *If an organization chooses to publicly report performance data on the HEDIS Attestation, it is scored on the data submitted and receives the Accreditation bonus points (displayed as stars). If an organization Accredited on standards only chooses not to publicly report performance data, it will not be scored based on performance measurement results and will not be awarded the Accreditation bonus points.* Refer to the *Reports* section at https://www.ncqa.org/hedis/reports-and-research/ for the detailed HPR methodology and the list of required measures. Refer to the *General Guidelines* section of the *HEDIS Volume 2: Technical Specifications* for additional reporting requirements.		

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
NA	Policies and Procedures	Acknowledgments	Update the NCQA address on the page preceding the **Acknowledgments** page to read: 1100 13th Street NW, Third Floor Washington, DC 20005 Update the Policy Clarification Support link to read: http://my.ncqa.org	**CL**	**11/20/2017**
8	Overview	Other NCQA Programs	Add the following as the last bullet under "NCQA offers the following accreditation programs": • Utilization Management, Credentialing and Provider Network (UM-CR-PN). Delete the first bullet under "NCQA offers the following certification programs" that reads: • Certification in Utilization Management and Credentialing (UM-CR). Add the following as the last two bullets under "NCQA offers the following recognition programs": • Oncology Medical Home (PCMH-O). • School-Based Medical Home (SBMH). Delete the second bullet under "NCQA offers the following distinction programs" that reads: • Patient Experience Reporting (for NCQA-Recognized PCMHs). Add the following as the last section: *NCQA offers the following distinction programs for recognized PCMHs:* • Patient Experience Reporting. • Behavioral Health Integration. • Electronic Quality Measures (eCQM) Reporting.	**CL**	**11/20/2017**

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16	Policies and Procedures—Section 1: Eligibility and the Application Process	Applying for an NCQA Survey—Application request	Update the NCQA address to read: National Committee for Quality Assurance 1100 13th Street NW, Third Floor Washington, DC 20005	**CL**	**11/20/2017**
17	Policies and Procedures—Section 1	Organization Obligations	Revise the third bullet to read: • Bring forward an entire product line/product for accreditation. This includes administrative services only (ASO) and consumer-directed or high-deductible health plan products (e.g., CDHP, HDHP) that may be offered under an HMO, PPO or a EPO license. Organizations may exclude only ASO members, and in only two situations: – If the ASO contract prohibits the organization from contacting members for any reason. ▪ This "no-touch" contractual agreement is a contract or other written agreement between the organization (i.e., HMO, PPO, EPO) and the ASO, stating that the organization may not contact ASO members under any circumstances. – If the organization is not responsible for administering both in-network and out-of-network claims for ASO members (i.e., employer carve-out for both in-network and out-of-network claims). ▪ If claims are administered through a third party on behalf of an organization (i.e., a claims delegation arrangement), the organization is considered responsible for administering claims and members may not be excluded. If the organization excludes ASO members, it must exclude them from HEDIS/ CAHPS and from accreditation. An organization may not exclude members who cannot be reached (e.g., overseas military or Foreign Service members), unless one of these situations applies. Non-ASO members may not be excluded under this guideline. Federal government instructions and guidance supersede the requirements in this guideline.	**PC**	**11/21/2016**

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			An organization that has membership in a state that is not licensed to operate should include those members in the "home" state where it is licensed to operate and has its main membership.		
19	Policies and Procedures—Section 2	Add-On Survey (applies to First and Renewal Evaluation Options)	Remove the second bullet of the third paragraph, which reads: • Before the survey date, for the Interim Evaluation Option.	**CL**	**11/21/2016**
23	Policies and Procedures—Section 2	Calculating scores	Add the following as the first sentence of the first paragraph: NCQA calculates one standards score, even if multiple product lines are brought forward for accreditation.	**CL**	**11/21/2016**
24	Policies and Procedures—Section 2	Critical factor	Revise the fourth bullet to read: • UM 11, Element E. Revise the last bullet to read: • CR 7, Element B.	**CO**	**3/27/2017**
27	Policies and Procedures—Section 2	Scoring Guidelines—Conflict with regulatory requirements	Revise the second and third sentences of the second paragraph to read: For example, a state regulation might require the organization to give members no more than 60 calendar days to file an appeal, whereas NCQA requires the organization to give members no less than 180 calendar days to file an appeal. In this situation, the organization must allow the maximum amount of time (60 calendar days) to file an appeal.	**CL**	**11/21/2016**
39	Policies and Procedures—Section 4: Reporting Results	State Deeming Survey results	Replace the section with the following: For state Deeming Surveys, NCQA gives the appropriate state agency access to the organization's survey tool via "My.NCQA" (https://my.ncqa.org) to preview the final accreditation results and download the following documents: • The Medicaid Managed Care Results Summary Report. • The Standards score sheet. • The HEDIS score sheet.	**CL**	**3/26/2018**

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			• The QI program description. • The QI work plan (if not included in the QI program description). • The QI program evaluation. ***Note:*** *Per Federal Medicaid Rule: §438.332 – State review of the accreditation status, organizations must authorize NCQA as an independent accrediting entity to provide the State a copy of its most recent accreditation review. NCQA reserves the right to release to the State a copy of the accreditation review as required by the State, including recommended actions or improvements and corrective action plans required by NCQA for certain elements and standards where an organization's performance is determined to be noncompliant. This rule applies to all organizations seeking NCQA Accreditation for their Medicaid product line.*		
42	Policies and Procedures—Section 5: Additional Information	Reporting Hotline for Fraud and Misconduct—How to Report	Replace the "English-speaking USA and Canada" toll free telephone number with **844-440-0077**.	**CO**	**11/20/2017**
49	Policies and Procedures—Section 6: LTSS Distinction	Applying for an NCQA Survey—Request an application	Update the NCQA address to read: National Committee for Quality Assurance 1100 13th Street NW, Third Floor Washington, DC 20005	**CL**	**11/20/2017**
58	QI 1, Element A	Examples—Safety initiatives identified by element-level activities	Replace "CR 6, CR 7" in the last bullet with "CR 5, CR 6."	**CO**	**3/27/2017**
69	QI 4, Element A	Explanation—Data collection methods	Replace the second paragraph with the following: The organization may collect data across the entire member population or from a statistically valid sample.	**CO**	**11/21/2016**

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75	QI 4, Element E	Explanation—Factor 2: Member experience survey	Add the following as the second sentence of the second paragraph: The CAHPS 5.0H survey does not meet this factor. ***Updated issued on July 24, 2017.***	**CL**	**3/27/2017**
75	QI 4, Element E	Explanation—Factor 2: Member experience survey	Revise the second sentence of the second paragraph to read: The CAHPS 5.0H survey does not meet this factor; however, supplemental questions to the survey regarding behavioral healthcare may meet this factor if the organization has added a supplemental screening question to identify members who have accessed behavioral healthcare services.	**CL**	**7/24/2017**
124	QI 8, Element A	Scope of review/Look-back period	Revise the scope of review and look-back period to read: **Scope of review** *This element applies to First Surveys and Renewal Surveys.* NCQA reviews the organization's medical care coordination data, quantitative and qualitative analysis and opportunities for improvement. *For First Surveys*, NCQA also reviews the organization's most recent report regarding annual data collection, evaluation and identification of opportunities. *For Renewal Surveys*, NCQA also reviews the organization's most recent and the previous year's reports regarding annual data collection, evaluation and identification of opportunities. During the most recent year, the organization collected data across both settings and between practitioners for factors 1 and 2. During the previous year, the organization collected data across settings *or* between practitioners, but was not required to do both for factors 1 and 2 because of revisions to the factors. **Look-back period** *For First Surveys*: At least once during the prior year. *For Renewal Surveys*: 24 months.	**CL**	**11/21/2016**

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127	QI 8, Element B	Scope of review/ Look-back period	Revise the second paragraph of the scope of review and the look-back period to read: **Scope of review** NCQA reviews the organization's most recent and the previous year's reports or reviews dated materials showing actions taken. **Look-back period** *For Renewal Surveys:* 24 months.	**CL**	**11/21/2016**
128	QI 8, Element C	Scope of review/ Look-back period	Revise the second paragraph of the scope of review and the look-back period to read: **Scope of review** NCQA reviews the organization's most recent and the previous year's measurement of effectiveness. **Look-back period** *For Renewal Surveys:* 24 months.	**CL**	**11/21/2016**
129	QI 8, Element C	Related information—Collaborative activities	Add the following as the first sentence: The organization receives credit in Element C for use of a PCMH initiative, for the conditions for which it received credit in Elements A and B.	**CL**	**11/21/2016**
141, 196, 302, 491	QI 10, Element C, NET 7, Element C, UM 13, Element C, LTSS 4, Element B	Explanation—Factor 4: Access to PHI	Revise the text to read: The delegation agreement includes procedures to receive, analyze and resolve members' requests for access to their PHI.	**CL**	**11/21/2016**

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160	NET 2, Element B	Scope of review	Add the following as the fourth and fifth paragraphs: During the most recent year of the look-back period, the organization analyzes and stratifies data by behavioral healthcare practitioner prescribers versus nonprescribers for each factor. During the previous year of the look-back period, the organization analyzes data across all behavioral healthcare practitioners or by prescribers versus nonprescribers.	**CL**	**7/24/2017**
160	NET 2, Element B	Explanation	Add the following as the second paragraph: Factors 1 and 2 are **critical factors**; both must be met for the organization to score higher than 20% on this element.	**CL**	**7/24/2017**
161	NET 2, Element B	Examples—Factor 4: Follow-up of routine care	Revise the text to read: **Setting timeliness standards (step 1)** 1. 90% of sites have slots for routine follow-up appointments with prescribers within 30 days and with nonprescribers within 20 days. 2. 75% of members have a follow-up visit with a prescriber within 30 days of initial visit for a specific condition and with a nonprescriber within 20 days of initial visit for a specific condition. 3. 90% of members report that they "always" or "usually" get a follow-up appointment with a prescriber. 90% of members report that they "always" or "usually" get a follow-up appointment with a nonprescriber. **Data sources to assess reasonable access (step 2)** 1. Site surveys indicate that 80% of sites reported having slots for routine follow-up appointments with prescribers within 30 days. 85% of sites reported having slots for routine follow-up appointments with nonprescribers within 20 days. 2. Claims data analysis indicates that 50% of members had routine follow-up appointments with a prescriber within 30 days of an initial visit for a specific condition. 60% of members had routine follow-up appoints with nonprescribers within 20 days of initial visit for a specific condition.	**CL**	**11/21/2016**

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			3. Complaint data analysis indicates that 70% of members reported that they "always" or "usually" get a follow-up appointment with a prescriber. 80% of members reported that they "always" or "usually" get a follow-up appointment with a nonprescriber.		
163	NET 3, Element A	Element A: Access of Member Experience Accessing the Network	Revise the element stem to read: The organization annually:	**CO**	**3/27/2017**
165, 166	NET 3, Elements B, C	Data source	Add "materials" as a data source.	**CL**	**11/21/2016**
171	NET 4, Element C	Explanation	Revise the first sentence to read: Factors 1 and 2 are **critical factors;** both must be met for the organization to score higher than 20% on this element.	**CL**	**7/24/2017**
172	NET 4, Element C	Explanation—Factor 2: Requests for out-of-network services	Replace "factor 5" with "Element D" in the paragraph.	**CL**	**7/24/2017**
175	NET 4, Element D	Scope of review/ Look-back period	Revise the second and third paragraphs of the scope of review and the look-back period to read: **Scope of review** *For First Surveys and Renewal Surveys:* NCQA reviews the organization's most recently completed reports. **Look-back period** *For First Surveys and Renewal Surveys:* At least once during the prior year.	**CL**	**11/21/2016**

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182	NET 6, Element C	Explanation—Factor 4: Awareness of physician's participation in the organization's networks	Remove the second bullet, which reads: • Contracts match directory information.	**CL**	**11/21/2016**
189	NET 6, Element I	Explanation—Exception	Revise the exception to read: Factors marked "No" in Element G are scored NA in this element.	**CO**	**3/27/2017**
190	NET 6, Element J	Explanation	Revise the first bullet in the second paragraph to read: Allows searches by zip code.	**CO**	**11/21/2016**
197	NET 7, Element D	Look-back period	Revise the look-back period for Renewal Surveys to read: For Renewal Surveys: 12 months.	**CL**	**11/20/2017**
205	UM 1, Element A	Explanation	Add the following text after the first paragraph: **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. Denials resulting from medical necessity review are within the scope of review for the applicable elements in UM 4–UM 7. Decisions about the following require medical necessity review: • Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits. • Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.	**CL**	**3/27/2017**

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			• Care or services whose coverage depends on specific circumstances. • Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits. • Out-of-network services when they may be covered in clinically appropriate situations. • Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program. • "Experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in the organization's policies, medical necessity review is not required. 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 that does not depend on any circumstances. • Care or services whose coverage depends on specific circumstances. • Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits. • Out-of-network services when they may be covered in clinically appropriate situations. • Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program. • "Experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in the organization's policies, medical necessity review is not required.		

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206-207	UM 1, Element A	Explanation—Factors 5, 6: Processes and information sources used to make determinations	Delete the second and third paragraphs, which read**:** Medical necessity determinations include: • Decisions about covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits. • Decisions about preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services. • Decisions about care or services that could be considered either covered or not covered, depending on the circumstances. • Decisions about dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits. Benefit determinations are decisions on requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.	**CL**	**3/27/2017**
206	UM 1, Element A	Explanation	Add the following paragraphs directly above the subhead **Factor 1: Program Structure:** 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.	**CL**	**7/24/2017**
207	UM 1, Element A	Examples	Revise the second sub-bullet of the second bullet to read: Use of out-of-network practitioner if no in-network practitioner has the appropriate clinical expertise, because the organization is deciding if it is or is not medically necessary for the member to receive care out of network.	**CL**	**11/21/2016**

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207-208	UM 1, Element A	Examples	Delete the following examples: **Medical necessity determinations** • Decisions on defined covered medical benefits, such as: – Hospitalization. – Emergency services. – An admission for treatment or chemical dependency. • Decisions about care or services that could be considered either covered or not covered, depending on the circumstances; for example: – Breast reduction surgery for back pain. – Use of out-of-network practitioner if no in-network practitioner has the appropriate clinical expertise. – Denial of a request for continued inpatient behavioral healthcare treatment because of a determination that the member's treatment could be managed in an outpatient setting. – Denial of request for electroconvulsive therapy because the organization's clinical criteria specify that other methods of treatment must be attempted first. – An experimental or investigational procedure unless the requested service or procedure is specifically listed as an exclusion in the member's benefit plan. – Denial of request for electroconvulsive therapy because the organization's clinical criteria specify that other methods of treatment must be attempted first. – A pharmaceutical request requiring prerequisite drug of a step-therapy protocol.	**CL**	**3/27/2017**
221, 223, 224	UM 4, Elements C–E	Scope of review	Revise the second paragraph, as applicable to the type of files in each element, to read: NCQA reviews a random sample of up to 40 **nonbehavioral healthcare/behavioral healthcare/pharmaceutical** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence that the files were reviewed by an appropriate practitioner.	**PC**	**3/27/2017**

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222–224	UM 4, Elements C–E	Explanation	Revise the second paragraph to state: This element applies to **all nonbehavioral healthcare/behavioral healthcare/ pharmaceutical** denial determinations resulting from medical necessity review (as defined in UM 1, Element A).	**CL**	**7/24/2017**
222-224	UM 4, Elements C–E	Explanation	Revise the second paragraph for the following elements to read: **Element C:** This element applies to all nonbehavioral healthcare UM denials that are directly related to requests by members, or by their authorized representatives, for authorization or payment for health care services that are based on medical necessity. **Element D:** This element applies to all behavioral healthcare UM denials that are directly related to requests by members, or by their authorized representatives, for authorization or payment for health care services that are based on medical necessity. **Element E:** This element applies to all pharmacy UM denials that are directly related to requests by members, or by their authorized representatives, for authorization or payment for pharmaceuticals that are based on medical necessity.	**CL**	**11/21/2016**
~~222, 223, 224,~~ 230, 234, 235, 238, 240, 244	~~UM 4, Elements C–E~~ UM 5, Elements A–F	Explanation	Revise the second paragraph, as applicable to the type of files in each element, to read: Although NCQA only reviews denial files during the file review process, this element applies to all **nonbehavioral healthcare/behavioral healthcare/ pharmaceutical** determinations resulting from medical necessity review**,** whether they are approvals or denials. ***For UM 4, Elements C–E, updated the issue on July 24, 2017.***	**CL**	**3/27/2017**

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222, 224, 225, 232, 234, 236, 239, 241, 245, 256, 257, 259, 261, 262, 265, 266, 267, 269	UM 4, Elements C–E UM 5, Elements A–F UM 7, Elements A–I	Related information	Add the following as the first paragraph: Refer to UM 1, Element A for the medical necessity review definition.	**CL**	**3/27/2017**
228	UM 4, Element H	Scope of review	Because this element is being retired for the 2018 Standards Year, NCQA will score this element NA for the 2017 Standards Year for all product lines.	**PC**	**7/24/2017**
~~228~~	~~UM 4, Element H~~	~~Scope of review~~	~~Move the following sentence from the explanation to the scope of review as the last sentence:~~ ~~The organization provides the rationale for classifying the denial as a nonmedical necessity, and provides supporting materials (e.g., Certificate of Coverage, Summary of Benefits, member handbook).~~ ***UM 4, Element H is NA for 2017.***	~~**CL**~~	~~**11/21/2016**~~
~~228~~	~~UM 4, Element H~~	~~Explanation~~	~~Remove "UM" from the first sentence so that it reads:~~ ~~This element applies to requests for which the organization issued a non-medical necessity denial decision.~~ ***UM 4, Element H is NA for 2017.***	~~**CL**~~	~~**11/21/2016**~~
~~228~~, 232, 236, 242, 249	~~UM 4, Element H,~~ UM 5, Element A, UM 5, Element C, UM 5, Element E, UM 5, Element H	Related information—Postservice payment disputes	Revise the paragraph to read: 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 (i.e., the member is not at financial risk). Exclude denials from such requests from the list for file sample selection. ***UM 4, Element H is NA for 2017.***	**CL**	**11/21/2016**

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PREVIOUSLY POSTED UPDATES					
Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
230, 235	UM 5, Elements A, C	Scope of review	Revise the second paragraph, as applicable to the type of files in each element, to read: NCQA reviews a random sample of up to 40 **nonbehavioral healthcare/ behavioral healthcare** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of timeliness of decision making.	**PC**	**3/27/2017**
233, 238	UM 5, Elements B, D	Scope of review	Revise the second paragraph, as applicable to the type of files in each element, to read: NCQA reviews a random sample of up to 40 **nonbehavioral healthcare/ behavioral healthcare** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of timeliness of notification.	**PC**	**3/27/2017**
234, 239, 246	UM 5, Elements B, D, F	Related information—Oral notification	Revise the first paragraph to read: If the organization provides initial oral notification of a denial decision within 24 hours of an urgent concurrent request or within 72 hours of an urgent preservice request, it has an additional 3 calendar days following oral notification to provide written or electronic notification. The organization records the time and date of notification and the staff member who spoke with the practitioner or member. Oral notification must involve communication with a live person; the organization may not leave a voicemail.	**CL**	**11/20/2017**
235, 239, 246	UM 5, Elements B, D, F	Related information	Add the following as the last paragraphs: *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 7. The organization must have an alternative notification method for practitioners who do not have access to the web portal.	**CL**	**11/20/2017**

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
240	UM 5, Element E	Scope of review	Revise the third paragraph to read: NCQA reviews a random sample of up to 40 **pharmaceutical** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of timeliness of decision making.	**PC**	**3/27/2017**
244	UM 5, Element F	Scope of review	Revise the third paragraph to read: NCQA reviews a random sample of up to 40 **pharmaceutical** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of timeliness of notification.	**PC**	**3/27/2017**
247	UM 5, Element G	Explanation	Add the following immediately above **Exceptions** subhead: **Excluded from the timeliness report** For all product lines, the organization excludes decisions and notifications for nonemergency transportation approvals.	**CL**	**3/27/2017**
251, 252, 254	UM 6, Elements A–C	Scope of review	Revise the second paragraph, as applicable to the type of files in each element, to read: NCQA reviews a random sample of up to 40 **nonbehavioral healthcare/ behavioral healthcare/pharmaceutical** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of using relevant clinical information to support UM decision making.	**PC**	**3/27/2017**
251, 252, 254	UM 6, Elements A–C	Explanation	Revise the first paragraph, as applicable to the type of files in each element, to read: Although NCQA only reviews denial files during the file review process, this element applies to all **nonbehavioral healthcare/behavioral healthcare/pharmaceutical** determinations resulting from medical necessity review, whether they are approvals or denials.	**CL**	**3/27/2017**
252, 253, 254	UM 6, Elements A–C	Explanation	Add a **Related information** section after the **Exception(s)** section with the following text. Refer to UM 1, Element A for the medical necessity review definition.	**CL**	**3/27/2017**

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
255, 260, 265	UM 7, Elements A, D, G	Scope of review	Revise the second paragraph, as applicable to the type of files in each element, to read: NCQA reviews a random sample of up to 40 **nonbehavioral healthcare/behavioral healthcare/pharmaceutical** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of opportunity for a practitioner to discuss a denial with a reviewer.	**PC**	**3/27/2017**
255, 260	UM 7, Elements A, D	Explanation—Opportunity to discuss denial decisions	Revise the text to read: The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial: • In the denial notification, ***or*** • By telephone, ***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 denial notification, if the treating practitioner was notified by telephone. • 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.	**CL**	**11/21/2016**

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255, 260, 265,	UM 7, Elements A, D, G	Explanation	Revise the first paragraph, as applicable to the type of files in each element, to read: This element applies to all **nonbehavioral healthcare/behavioral healthcare/ pharmaceutical** denial determinations resulting from medical necessity review (as defined in UM 1, Element A).	**CL**	**3/27/2017**
256, 260, 266	UM 7, Elements A, D, G	Explanation—Opportunity to discuss denial decisions	Remove the word "denial" from the fifth bullet so that it reads: The time and date of the notification, if the treating practitioner was notified by telephone.	**CL**	**7/24/2017**
257, 262, 267	UM 7, Elements B, E, H	Explanation—Factor 1: Reason for denial Explanation—Factor 2: Reference to UM criterion	Add the following language as the last paragraph below each subhead: **Factor 1: Reason for denial** 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. For example, if the request is based on insufficient accessibility for the clinical urgency of the situation, the denial must address that the requested service may be obtained within the organization's accessibility standards. **Factor 2: Reference to UM criterion** For denials resulting from medical necessity review of out-of-network requests, the criteria referenced may be excerpts 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.	**CL**	**7/24/2017**
257, 262, 267	UM 7, Elements B, E, H	Explanation—Factor 2: Reference to UM criterion	Remove the following language: Referencing the Member Handbook or the Certificate of Coverage alone is not sufficient to meet the requirement.	**CL**	**7/24/2017**

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
257, 259, 262, 264, 267, 268	UM 7, Elements B, C, E, F, H, I	Explanation	Revise the second paragraph, as applicable to the type of files in each element, to read: This element applies to all **nonbehavioral healthcare/behavioral healthcare/ pharmaceutical** denial determinations resulting from medical necessity review (as defined in UM 1, Element A).	**CL**	**3/27/2017**
256, 261, 267	UM 7, Elements B, E, H	Scope of review	Revise the second paragraph, as applicable to the type of files in each element, to read: NCQA reviews a random sample of up to 40 **nonbehavioral healthcare/behavioral healthcare/pharmaceutical** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence that denial notices meet all three factors.	**PC**	**3/27/2017**
257, 262, 267	UM 7, Elements B, E, H	Explanation—Factor 2: Reference to UM criterion	Add as the second and third paragraphs: 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 CriteriaCompany 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). ~~Referencing the Member Handbook or the Certificate of Coverage alone is not sufficient to meet the requirement.~~ ***Updated the language regarding referencing the Member Handbook or Certificate of Coverage in a July 24, 2017 Policy Update.***	**CL**	**3/27/2017**
257, 267	UM 7, Elements B, H	Related information—Notification exception	Add the following as the first paragraph: NCQA does not require the organization to notify a member of an urgent preservice decision. The organization may notify only the attending or treating practitioner, because NCQA considers the attending or treating practitioner to be acting as the member's representative.	**CL**	**11/21/2016**

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258, 264, 268	UM 7, Elements C, F, I	Scope of review	Revise the second paragraph, as applicable to the type of files in each element, to read: NCQA reviews a random sample of up to 40 **nonbehavioral healthcare/behavioral healthcare/pharmaceutical** denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence that denial notices meet all four factors.	**PC**	**3/27/2017**
262	UM 7, Element E	Related information—Exceptions for notification	Add the following as the first paragraph: NCQA does not require the organization to notify a member of an urgent preservice decision. The organization may notify only the attending or treating practitioner, because NCQA considers the attending or treating practitioner to be acting as the member's representative.	**CL**	**11/21/2016**
263	UM 7, Element E	Examples—Factor 1: Acceptable language documenting the reason for the denial	Add the following subhead and factors 1 and 2 examples directly above **Factors 2, 3: Acceptable language referencing decision-making criteria.** ***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. "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."	**CL**	**7/24/2017**

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
266	UM 7, Element G	Explanation—Opportunity to discuss pharmaceutical denial decisions	Revise the text under the subhead to read: The organization notifies the treating practitioner about the opportunity to discuss a pharmaceutical medical necessity denial: • In the denial notification, ***or*** • By telephone, ***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 denial notification, if the treating practitioner was notified by telephone. • 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.	**CL**	**11/16/2015**
272	UM 8, Element A	Explanation—Factor 6: Same-or-similar-specialist review	Add the following text as the second paragraph: ***Note:*** *Pharmacists are not considered same-or-similar specialists because they do not treat patients.*	**CL**	**3/27/2017**
272	UM 8, Element A	Explanation—Factor 6: Same-or-similar-specialist review	Add "training" to the definition of "same specialty" in the third sentence to read: "Same specialty" refers to a practitioner with similar credentials, licensure and training as those who typically treat the condition or health problem in question in the appeal.	**CL**	**7/24/2017**

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273	UM 8, Element A	Explanation—Factor 13: Titles and qualifications	Revise the first sentence of the first paragraph to read: Appeal policies and procedures require the appeal notice to identify each reviewer who participated in the appeal, including:	**CL**	**11/20/2017**
273	UM 8, Element A	Explanation—Factor 13: Titles and qualifications	Revise the second paragraph to read: The organization is not required to include participant names in the written notification to members.	**PC**	**3/27/2017**
278	UM 9, Element B	Look-back period	Remove the following sentence from the look-back period: *For the Medicaid product line:* The 60-day appeal time frame will be scored for files processed on or after July 1, 2017.	**CO**	**11/21/2016**
281	UM 9, Element D	Explanation—Factor 5: Titles and qualifications	Delete the second paragraph, which reads: The organization provides reviewers' names to members upon request.	**PC**	**3/27/2017**
320	CR 3, Element A	Explanation—Factor 3: Education and training--*Completion of residency training*	Remove the sub-bullet under "FCVS for closed residency programs" and make the following text a separate paragraph: NCQA only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.	**CL**	**11/20/2017**
323	CR 3, Element B	Explanation—Factor 1: Scope of review for sanctions or limitations on licensure	Add as the first sentence in the first paragraph: The organization verifies state sanctions, restrictions on licensure or limitations on scope of practice in all states where the practitioner provides care to members.	**CL**	**11/20/2017**
329	CR 5, Element A	Data source	Add "materials" as a data source.	**CL**	**7/24/2017**

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341	CR 8, Element A	Explanation—Factor 3: Reporting	Replace the last sentence in the second paragraph with the following: NCQA scores this factor "yes" if the organization delegates CR activities to an NCQA-Certified CVO. NCQA-Certified CVOs must be certified to perform the activity being delegated by the organization.	**CL**	**3/27/2017**
377, 379 381, 386	MEM 1, Elements A–C MEM 2, Element A	Scope of review	Add as the last sentence of the third paragraph: If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.	**CL**	**11/20/2017**
378, 380, 381, 383, 384, 385	MEM 1, Elements A–G	Exceptions	Add the following exception to all elements in MEM 1: This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.	**CL**	**11/20/2017**
405	MEM 5, Element D	Scope of review	Replace the second paragraph with the following: NCQA reviews the organization's policies and procedures in place throughout the look-back period for factors 1 and 2. For First Surveys, NCQA reviews the organization's most recent annual evaluation report and actions completed within the look-back period for factors 3-6. For Renewal Surveys, NCQA reviews the organization's previous and most recent annual evaluation report and actions completed within the look-back period for factors 3-6.	**CO**	**3/27/2017**
405	MEM 5, Element D	Scope of review/ Look-back period	Revise the second paragraph of the scope of review and the look back period to read: **Scope of review:** NCQA reviews the organization's policies and procedures in place throughout the look-back period for factors 1 and 2 and reviews the organization's previous and most recent annual evaluation report and actions completed within the look-back period for factors 3-6. **Look-back period:** *For First Surveys:* 6 months.	CL	11/21/2016

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			For Renewal Surveys: 24 months. ***Updated the issue on March 27, 2017.***		
451	LTSS 1, Element A	Examples—Factor 3: Evidence and professional standards	Revise the 14th bullet to read: • Case Management Society of America Legal and Ethical Standards. Revise the last bullet to read: • American Case Management Association.	**CL**	**3/27/2017**
478	LTSS 2, Element E	Exceptions	Revise the first two paragraphs to read: Factors 1 and 3 are NA if the organization does not identify opportunities for improvement of effectiveness. NCQA evaluates whether this conclusion is reasonable, given the organization's analysis. Factors 2 and 4 are NA if the organization does not identify opportunities for improvement of experience. NCQA evaluates whether this conclusion is reasonable, given the organization's analysis.	**CO**	**11/21/2016**
479, 481	LTSS 2, Elements E, G	Explanation—Exceptions	Replace the last paragraph with the following: Element E: This element is NA for First Surveys. Element G: Factor 3 is NA for First Surveys.	**CO**	**3/27/2017**
480	LTSS 2, Element F	Examples	Revise the example to read: The organization is contracted to provide case management to 100 members (the denominator) identified as needing LTSS. • Of the 100 members identified, the organization is only able to contact 80 members (the organization is unable to find or reach 20 members). • Of the 80 members reached, the organization can schedule an initial assessment with 78 members (two members refused).	**CL**	**3/27/2017**

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			• The organization conducts an initial scheduled assessment of 75 members (one member dies, one is admitted to a skilled nursing facility, one refuses to meet the case manager on the day of the scheduled assessment). • Of the 75 assessments completed, case managers have interactive contact (in-person visits or telephone check-ins) with 60 members. In this scenario, the participation rate is 60/100.		
484	LTSS 3, Element A	Explanation—Factor 1: Identify members who transition	Revise the second paragraph to read: The organization has a process to identify members who transition between settings.	**CL**	**7/24/2017**
2-2	Appendix 2	CAHPS 5.0H Measures Required for 2017 HP Accreditation—Commercial HMO/POS/PPO	Revise the point value for Rating for Health Plan to: 2.6000.	**CL**	**11/21/2016**
4-8	Appendix 4	Table 4A: Medicare HMO/POS/PPO—HEDIS Point Allocation With a Reportable Rate on Comprehensive Diabetes Care	Make the following change to Table 4A: Revise the point value from "2.256" to "3.256" in the second-to-last row in the "Meets or Exceeds the 75th Percentile Threshold Regionally or Nationally" column.	**CL**	**11/20/2017**
4-9	Appendix 4	Table 4C: Medicare HMO/ POS/PPO—HEDIS/ CAHPS Point Allocation With a Reportable Rate on Rating of Health Plan	Revise the point value of the first row under the "Falls below 25th Percentile Threshold Regionally or Nationally" column from 0.578 to 0.325.	**CO**	**3/27/2017**

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
5-4	Appendix 5	How NCQA Evaluates Delegation	Add the following subhead and text immediately after the "Scoring delegation oversight" subsection: **Subdelegation** When a delegate subdelegates to a third entity, either the delegate or the organization oversees the subdelegate's work. The delegation agreement between the organization and the delegate specifies the entity responsible for overseeing subdelegates. If the delegate oversees the subdelegate, it must report to the organization regarding the subdelegate's performance. NCQA confirms that oversight of the subdelegate is performed according to its standards. The organization is responsible for oversight of all activities performed by the delegate and subdelegate on its behalf.	**CL**	**11/20/2017**
5-8	Appendix 5	Table 2: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited health plan—QI 4: Member Experience	Replace "Y" with "N" in the "Renewal" column under the third row as follows: D | Opportunities for Improvement | NA | NA | N	**CO**	**3/27/2017**
5-9	Appendix 5	Complex case management and UM files	Add the following as the last sentence in the first paragraph: Consequently, the organization does not need to include such files in the file universe but must complete the "100% AC" tab of the UM File Submissions Instructions workbook.	**CL**	**11/21/2016**

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<tr><th>Page</th><th>Standard</th><th>Head/Subhead</th><th>Update</th><th>Type of Update</th><th>IRT Release Date</th></tr>
<tr><td>5-11, 5-12</td><td>Appendix 5</td><td>Table 2: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited health plan—UTILIZATION MANAGEMENT</td><td>Revise the entries under UM 4, Element F and UM 12, Elements A & B as follows:
<table><tr><th>UM 4: Appropriate Professionals</th><th>Interim</th><th>First</th><th>Renewal</th></tr><tr><td>F Use of Board-Certified Consultants</td><td>Y</td><td>Y</td><td>Y</td></tr></table>
<table><tr><th colspan="4">UM 12: Triage and Referral for Behavioral Healthcare</th></tr><tr><td>A Triage and Referral Protocols</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td>B Supervision and Oversight</td><td>Y</td><td>Y</td><td>Y</td></tr></table></td><td>CO</td><td>3/27/2017</td></tr>
<tr><td>5-15</td><td>Appendix 5</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, NCQA-Certified UM/CR or CVO— QUALITY MANAGEMENT AND IMPROVEMENT</td><td>Add the following under QI 1, Element A as the third line:
Factor 5: Involvement of a behavioral healthcare practitioner</td><td>CO</td><td>3/27/2017</td></tr>
<tr><td>5-17</td><td>Appendix 5</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, NCQA-Certified UM/CR or CVO</td><td>Replace the second row under QI 5: Complex Case Management in the “Accredited MBHO” column with the following:
<table><tr><td>G</td><td>Initial Assessment</td><td>NA</td><td>Y</td><td>Y</td></tr><tr><td>H</td><td>Case Management-Ongoing Management</td><td>NA</td><td>Y</td><td>Y</td></tr></table></td><td>PC</td><td>11/21/2016</td></tr>
</table>

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<tr><td>5-18</td><td>Appendix 5</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, NCQA-Certified UM/CR or CVO</td><td>Add the following to the “Accredited MBHO” column, immediately above “UTILIZATION MANAGEMENT”:
<table>
<tr><th colspan="5">NET 3: Assessment of Network Adequacy</th></tr>
<tr><td>A</td><td>Assessment of Member Experience Accessing the Network
Factor 2: Analyzes data from complaints and appeals about network adequacy for behavioral healthcare services from QI 4, Element E</td><td>NA</td><td>Y</td><td>Y</td></tr>
<tr><td>C</td><td>Opportunities to Improve Access to Behavioral Healthcare Services</td><td>NA</td><td>Y</td><td>Y</td></tr>
</table></td><td>PC</td><td>11/21/2016</td></tr>
<tr><td>5-18</td><td>Appendix 5</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, NCQA-Certified UM/CR or CVO— UTILIZATION MANAGEMENT</td><td>Revise the entry under UM 12, Elements A & B as follows:
<table>
<tr><th></th><th colspan="3">Accredited MBHO</th><th colspan="3">Certified UM/CR</th></tr>
<tr><th></th><th>Interim</th><th>First</th><th>Renewal</th><th>Interim</th><th>First</th><th>Renewal</th></tr>
<tr><td colspan="7">UM 12: Triage and Referral for Behavioral Healthcare</td></tr>
<tr><td>A Triage and Referral Protocols</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr>
<tr><td>B Supervision and Oversight</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr>
</table></td><td>CO</td><td>3/27/2017</td></tr>
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<tr><td>5-23</td><td>Appendix 5</td><td>Table 7: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited CM organization</td><td>Add the following immediately above Element G:<table><tr><td>F</td><td>Case Management Process</td><td>Y</td><td>Y</td><td>Y</td></tr></table></td><td>PC</td><td>3/27/2017</td></tr>
<tr><td>9-2, 9-9</td><td>Appendix 9</td><td>Glossary</td><td>Delete the following definitions:<table><tr><td>benefit determination</td><td>A decision to provide coverage for a requested service that is specifically excluded from the organization's benefit or not covered beyond the stated limitations and restrictions imposed by the benefits plan.</td></tr><tr><td>benefit denial</td><td>A denial of a requested service that is excluded by the organization’s benefits plan or that is beyond the stated limitations and restrictions imposed by the benefits plan.</td></tr><tr><td>medical necessity determination</td><td>A decision about coverage for a requested service based on whether the service is needed, based on a member's circumstances, or clinically appropriate. NCQA requires a medical necessity review and appropriate practitioner review of “experimental” or “investigational” requests, unless the requested services or procedures are specifically excluded from the benefits plan.</td></tr></table></td><td>CL</td><td>3/27/2017</td></tr>
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9-3	Appendix 9	Glossary	Add the following definition: **clinical appropriateness**: Based on judgment of a health care practitioner, applicability of a requested service to a member's case in terms of type, frequency, extent, site and duration. For example, a request to receive out-of-network services, based on a member's assertion that appropriate services are not available in network, requires clinical judgment to assess the clinical circumstances and determine if network practitioners have the required expertise. That the services are medically necessary might not be in question.	**CL**	**3/27/2017**
9-4	Appendix 9	Glossary	Replace the definition of "concurrent review" with the following definition: **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.	**CL**	**7/24/2017**

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<tr><td>9-9</td><td>Appendix 9</td><td>Glossary</td><td>Add the following definition:<table><tr><td>medical necessity</td><td>Refers to services or supplies for diagnosing, evaluating, treating or preventing an injury, illness, condition or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria.
Note: This definition is based on the Centers for Medicare & Medicaid Services (CMS) and American College of Medical Quality (ACMQ) definitions.</td></tr></table></td><td>CL</td><td>3/27/2017</td></tr>
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