NCQA Corrections, Clarifications and Policy Changes to the 2019 UM-CR-PN Standards and Guidelines

November 25, 2019

This document includes the corrections, clarifications and policy changes to the 2019 UM-CR-PN 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 Review Tool (IRT). 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 2019 UM-CR-PN 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/Element	Head/Subhead	Update	Type of Update	IRT Release Date
20	Policies and Procedures—Section 2: The Accreditation Process	Must-pass elements	Update the second paragraph as follows: ***Note:*** *All must-pass elements are file-review elements. The must-pass threshold for all UM elements is 80%; the must-pass threshold for CR 3, Element A is 50%.* • *If an organization does not meet the must-pass threshold for any UM must-pass element:* – *It must submit a Corrective Action Plan to NCQA within 30 calendar days.* – *It must undergo a CAP Review on the affected elements to confirm completion of the Corrective Action Plan.* – *A status modifier of "Under Corrective Action" will be displayed after the applicable accreditation status (e.g., Accredited—Under Corrective Action) until NCQA confirms that the organization has completed the CAP.* • *If an organization fails three or more UM must-pass timeliness elements (UM 5, Elements A–F and UM 9, Elements B), the ROC may issue a Denied Accreditation status.* • *If an organization does not meet the must-pass threshold for CR 3, Element A the ROC may issue a Denied Accreditation status.*	**CL**	**11/25/2019**

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53	UM 1, Element A	Explanation—The scope of medical necessity review	Add the following as the last paragraph: *Organization employees and their dependents:* The organization may exclude employees and their dependents from the denial and appeal file universe.	**CL**	**11/25/2019**
108, 115,121	UM 7, Elements C, F, I	Explanation—Factor 2: Right to representation and appeal time frames	Revise the second bullet to read: • Provides contact information for the 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.*	**CL**	**11/25/2019**
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	Multiple		Refer to the memo to review requirements that were eliminated for the 2020 Standards Year and will be scored NA for the 2019 Standards Year.	**PC**	**7/29/2019**
13	Policies and Procedures—Section 2: Accreditation	Introductory Follow-Up Survey	Add the following as the last sentence in the second paragraph: The effective date of the accreditation status is the same date specified in the Introductory Initial Survey decision that precipitated the Introductory Follow-Up Survey.	**CL**	**7/29/2019**
14	Policies and Procedures: Section 2—The Accreditation Process	Accreditation Survey Types	Add the following subhead and text under the "Introductory Survey" section: **Expedited Survey** Although generally an organization with Denied Accreditation status may not reapply for accreditation until one year from the date of the Denied status, there are certain circumstances under which an organization may apply for a new Accreditation Survey in less than a year—an **Expedited Survey.**	**CL**	**3/25/2019**

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			An Expedited Survey is a full-scope survey. The look-back period for an expedited survey is six months. The organization is reviewed against current standards. It may provide documentation that was submitted previously or new documentation and may bring forward new products/product lines that were not included in the original submission. To qualify for an Expedited Survey, the organization must submit a written request stating how it corrected the substantive issues that led to its Denied Accreditation status. At its sole discretion, NCQA may grant a request for an Expedited Survey in less than one year, if: • The organization was denied accreditation under the Interim Evaluation Option, ***or*** • The organization demonstrates to NCQA's satisfaction that the issues identified in the original survey can be corrected in less than one year as a result of the organization's activity and correction of the issues could raise the organization's accreditation status.		
14	Policies and Procedures—Section 2: The Accreditation Process	Accreditation Status	Revise the third paragraph to read: ***Note:*** *An organization that is seeking accreditation in Credentialing and Provider Network does not need to purchase two survey tools; however, it should select both Provider Network and Credentialing Evaluation products.*	**CL**	**12/3/2018**
16	Policies and Procedures: Section 2—The Accreditation Process	Accreditation Status—Corrective Action	Revise the text to read: In certain circumstances, NCQA may require corrective action by the organization. Corrective action are steps taken to improve performance when an organization does not meet specific NCQA accreditation requirements. Failure to comply timely with requested corrective action may result in a lower score or reduction or loss of accreditation status.	**CL**	**7/29/2019**
19	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan (CAP)	Revise the second bullet under the *Note* to read: • If an organization does not meet the must-pass threshold for any must-pass element, a status modifier of "Under Corrective Action" will be displayed after the applicable accreditation status (e.g.,	**CL**	**12/3/2018**

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			Accredited—Under Corrective Action) until NCQA confirms that the organization has completed the CAP.		
28	Policies and Procedures: Section 4—Reporting Results	Reporting Accreditation Status to the Public—Accreditation Status List	Revise the subhead and text **Under Corrective Action** to read: **Under corrective action** NCQA requires the organization to complete corrective actions. Failure to comply timely with requested corrective action may result in a lower score or reduction or loss of accreditation status.	**CL**	**7/29/2019**
29	Policies and Procedures: Section 4—Reporting Results	Reporting Accreditation Status to the Public—Accreditation Status List	Revise the last paragraph under **Right to release and publish** to read: NCQA publicly reports Denied Accreditation status for one year (unless the organization declines its status under the Introductory Survey option) or until the status is replaced as the result of another survey. An organization that dissolves or ceases to exist is removed from public reporting.	**CL**	**7/29/2019**
47	UMA 2, Element D	Scope of review	Revise the first paragraph to read: NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected clients, or from all clients, if there are fewer than four, *and* reviews other evidence that the organization cooperates with the client's efforts to implement QI and other activities.	**CL**	**12/3/2018**
67	UM 4, Element B	Explanation	Add a new 8th bullet in the explanation that reads: Doctoral-level Board-Certified Behavioral Analysts: Applied behavioral analysis denials.	**CL**	**3/25/2019**
78, 84, 91	UM 5, Elements A, C, E	Related information—Extending time frames	Incorporate the sentence regarding the organization choosing to extend the decision time frame, under the "Extending time frames" subhead to the first sentence under the subhead "Factor 1: Urgent concurrent requests for commercial and Marketplace" to read: The organization may extend the decision notification time frame if the request to extend urgent concurrent care was not made prior to 24 hours before the expiration of the prescribed period of time or number of treatments.	**CL**	**7/29/2019**

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95	UM 5, Element G	Explanation—Factors 1-6	Add the following as a second paragraph to the factors 1-6 explanation: Approval decisions must adhere to the timeliness requirements in UM 5 and must be included in factors 1, 3, 5. However, the timeliness of notifications sent for approvals is not required to be included in factors 2, 4 and 6.	**CL**	**3/25/2019**
95	UM 5, Element G	Exceptions	Add the following as the first exception: Factors 2, 4 and 6 are NA for notification of approval decisions.	**CL**	**3/25/2019**
104, 111, 118	UM 7, Elements B, E, H	Explanation—Factor 1: Reason for denial	Replace the first paragraph with the following text: 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, 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 acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Denial notifications sent only to practitioners may include technical or clinical terms.	**CL**	**12/3/2018**
107, 114, 120	UM 7, Elements C, F and I	Scope of review	Add the following as the second paragraph in the scope of review: Organizations must implement the changes in factors 2 and 3 for files processed on or after 11/1/18.	**PC**	**12/3/2018**

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109, 116, 122	UM 7, Elements C, F, I	Related information—Medicare denials	Revise the subhead and text to read: **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.	**PC**	**12/3/2018**
124	UM 8, Element A	Look-back period	Revise the look-back period to read: *For Initial Surveys:* 6 months. *For Renewal Surveys*: 6 months for factor 16; 24 months for all other factors.	**CL**	**12/3/2018**
125-126	UM 8, Element A	Explanation—Factors 7-9: Appeal decisions	Replace the first paragraph with the following text: 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 acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Upheld appeal notifications sent only to practitioners may include technical or clinical terms.	**CL**	**12/3/2018**
127	UM 8, Element A	Exceptions	Add the following as the last exception: Factor 16 is NA if the organization does not provide or administer coverage for members.	**CL**	**12/3/2018**

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127	UM 8, Element A	Related information—Extending the time frame to obtain additional information	Add "or" to the first bullet so that it reads: • The member agrees to extend the appeal time frame, ***or***	**CL**	**12/3/2018**
128	UM 8, Element B	Scope of review	Replace the second paragraph with the following two paragraphs: *For First 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.	**CL**	**12/3/2018**
135-136	UM 9, Element D	Explanation—Factor 1: The appeal decision	Replace the explanation with the following text: 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 acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Upheld appeal notifications sent only to practitioners may include technical or clinical terms.	**CL**	**12/3/2018**
137	UM 9, Element D	Related information—Medicare appeals	Revise the first sentence to read: For Medicare appeal files, factors 1–6 are met if there is evidence that the organization sent the upheld denial to MAXIMUS.	**PC**	**7/29/2019**

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140	UM 10, Element A	Exceptions	Add the following as the first paragraph under the Exceptions subhead: This element is NA if the organization is not responsible for designing and administering the benefit structure.	**CL**	**3/25/2019**
154	UM 13, Element A	Explanation—Factor 1: Delegation agreement	Add the following after the first paragraph: 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 (meaning the date of 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 date 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.	**CL**	**3/25/2019**
155	UM 13, Element A	Explanation—Factor 5: Providing member and clinical data	Revise the first sentence to read: The organization's delegation agreement specifies that the organization will provide the following data when requested: Add the following as the last paragraph: The organization may provide the delegate with the data upon request or on an ongoing basis.	**CL**	**3/25/2019**
198	CR 3, Element C	Explanation—Factor 5: Current malpractice coverage	Revise the Explanation to read: The application states the amount of a practitioner's current malpractice insurance coverage (even if the amount is $0) and the date when coverage expires. If the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of	**CL**	**7/29/2019**

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			coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. Documentation of malpractice insurance coverage may also be a face sheet or a federal tort letter as an addendum to the application. In this case, the practitioner is not required to attest to malpractice coverage on the application. The face sheet or federal tort letter must include the insurance effective and expiration dates (the future effective date is acceptable).		
208-212	CR 7, Elements A-E	Exceptions	Add the following exception as the first paragraph: The element is NA for organizations that do not contract with organizational providers.	**CL**	**7/29/2019**
211, 212	CR 7, Elements D, E	Exceptions	Add the following subhead under the Exceptions section: **Examples** ***Note: This issue is specific to the printed version of the publication. It is correct in the IRT.***	**CO**	**3/25/2019**
214	CR 8, Element A	Explanation—Factor 1: Mutual agreement	Add the following after the first paragraph: 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 (meaning the date of 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 date of delegated activities.	**CL**	**3/25/2019**

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			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.		
223	NET 1, Element A	Data source	Add "documented process" as a data source.	**CL**	**7/29/2019**
223	NET 1, Element A	Scope of review	Revise the text to read: NCQA reviews the organization's data collection methodology (presented as a documented process or within the report), assessment of unmet member needs, characteristics of the practitioner network and documentation of any adjustments made in the network to meet identified needs at least once within the look-back period.	**CL**	**7/29/2019**
223	NET 1, Element A	Explanation—Factor 1: Assessing members' needs	Revise the text to read: *Data collection* To assess the cultural, ethnic, racial and linguistic needs of its members relative to its network, the organization must first collect data on ethnic, racial and linguistic characteristics of its members. A separate source of data specific to cultural characteristics (e.g., employer demographics, member surveys or focus groups) is not required. *Assessment* The organization assesses the unmet needs of its members relative to its network. To meet the factor, the organization must address all four needs – cultural, ethnic, racial and linguistic. Cultural preferences and beliefs may be assessed from members (e.g. member surveys or focus groups) or other sources. If using other sources, aspects of culture can be initially inferred from ethnic, racial and linguistic characteristics but must also be supplemented with information about the cultural needs and preferences (e.g. religion, family traditions, customs) of its population or populations with similar characteristics. The organization may use existing health services research.	**CL**	**7/29/2019**

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224	NET 1, Element A	Explanation—Factor 2: Practitioner Availability	Revise the text to read: In order to meet member needs, the organization assesses the applicable characteristics (i.e., culture, ethnicity, race, spoken language) of the network practitioners related to the needs identified in factor 1. The organization adjusts the practitioner network to provide the types and number of practitioners necessary to meet the cultural, ethnic, racial and linguistic needs of its members within defined geographical areas. Adjustment of the practitioner network may include requiring existing practitioners to complete cultural competency training, providing practitioners with culturally and linguistically appropriate health education materials, or recruiting practitioners whose cultural and ethnic backgrounds are similar to the underrepresented member population. The organization determines what adjustments are appropriate based on identified needs. The organization receives credit for factor 2 if it demonstrates that, based on its assessment of members' unmet needs and the applicable characteristics of the network, it is not necessary to adjust the practitioner network.	**CL**	**7/29/2019**
224	NET 1, Element A	Examples	Revise the text to read: **Five-step process for meeting the intent of this element** 1. Collect data on ethnic, racial and linguistic needs of members from U.S. Census and enrollment data. 2. Conduct research or review literature on cultural needs and preferences based on the characteristics of the organization's members. 3. Correlate data with members' preferences based on member feedback or complaint data. 4. Assess the cultural, ethnic, racial and linguistic characteristics of network practitioners to evaluate whether network practitioners meet members' needs. 5. Take action to adjust the practitioner network if it does not meet members' cultural, ethnic, racial and linguistic needs.	**CL**	**7/29/2019**

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			Data sources • Data from survey questions or focus groups that identify the health-related preferences or beliefs from specific ethnic groups. • U.S. Census data on the racial/ethnic composition of the population within a service area or region. • Practitioner race, ethnicity and language data collected during the credentialing process. • Published health statistics, health services research, data provided by plan sponsors or government agencies. **Actions resulting from assessment** • Recruit, credential and contract with practitioners who speak a language that reflects members' linguistic needs. • Recruit, credential and contract with practitioners whose cultural and ethnic backgrounds are similar to the underrepresented member population. Require practitioners to complete cultural competency training courses based on the racial/ethnic composition of the member population.		
234	NET 2, Element A	Explanation—Quantitative and qualitative analyses	Revise the second paragraph to read: The analysis may be conducted at the organizational level (i.e., primary care practitioners and practices may be grouped together), but if the analysis reveals issues, the organization conducts a practitioner-level analysis (by individual primary care practitioner) across all primary care practitioners and practices or from a statistically valid sample of them to determine if members are able to get an appointment to see a practitioner.	**CL**	**12/3/2018**
235	NET 2, Element B	Explanation—Quantitative and qualitative analyses	Revise the second paragraph to read: The analysis may be conducted at the organizational level (i.e., behavioral healthcare practitioners and practices may be grouped together), but if the analysis reveals issues, the organization conducts a practitioner-level analysis (by individual behavioral healthcare practitioner) across all behavioral healthcare practitioners and practices or from a statistically valid sample of them to	**CL**	**12/3/2018**

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			determine if members are able to get an appointment to see a practitioner.		
237	NET 2, Element C	Explanation—Quantitative and qualitative analyses	Revise the second paragraph to read: The analysis may be conducted at the organizational level (i.e., specialists and specialty practices may be grouped together), but if the analysis reveals issues, the organization conducts a practitioner-level analysis (by individual specialist) across all affected high-volume and high-impact specialty practitioners and practices or from a statistically valid sample of them to determine if members are able to get an appointment to see a practitioner.	**CL**	**12/3/2018**
261	NET 6, Element G	Explanation	Add the following as the third and fourth paragraphs above the factor 1 subhead in the Explanation: A hospital is an institution that primarily provides diagnostic and therapeutic services to patients admitted for medical diagnosis, treatment and care of injured, disabled, or ill individuals by or under the supervision of a physician. This element is limited to acute care hospitals including specialty acute care such as children's hospitals or Veteran Affairs hospitals.	**CL**	**7/29/2019**
268	NET 7, Element A	Explanation—Factor 1: Mutual agreement	Add the following after the first paragraph: 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 (meaning the date of 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 date 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.	**CL**	**3/25/2019**

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<tr><td>269</td><td>NET 7, Element A</td><td>Explanation—Factor 5: Providing member and clinical data</td><td>Revise the first sentence to read:
The organization's delegation agreement specifies that the organization will provide the following data when requested:

Add the following as the last paragraph:
The organization may provide the delegate with the data upon request or on an ongoing basis.</td><td>CL</td><td>3/25/2019</td></tr>
<tr><td>3-7</td><td>Appendix 3</td><td>Delegating to NCQA-Accredited/Certified Organizations—
General requirements</td><td>Add the following as the last sentence in the fifth bullet:
If there are two or more delegates, "70 percent" is cumulative.</td><td>CL</td><td>12/3/2018</td></tr>
<tr><td>3-15</td><td>Appendix 3—Delegation and Automatic Credit Guidelines</td><td>Table 3: Automatic credit for delegating to an organization with NCQA Accreditation in UM, CR or PN</td><td>Add UM 4, Element G as follows:
<table><tr><th></th><th></th><th colspan="2">ACCREDITED in UM</th></tr><tr><th></th><th></th><th>Initial Survey</th><th>Renewal Survey</th></tr><tr><td>G</td><td>Affirmative Statement About Incentives</td><td>Y</td><td>Y</td></tr></table></td><td>CL</td><td>3/25/2019</td></tr>
</table>