NCQA Corrections, Clarifications and Policy Changes to the 2020 MBHO Standards and Guidelines

March 30, 2020

This document includes the corrections, clarifications and policy changes to the 2020 MBHO 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 2020 MBHO 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
25	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan	Add the following bullet immediately above the last bullet in the "Note": • *If an organization scores lower than 80% in three or more must-pass elements, it receives Provisional Accreditation status and must undergo a Resurvey within 6-9 months to confirm completion of the CAP.*	**CO**	**3/30/2020**
103, 110	QI 8, Elements G, H	Explanation—Factor 2: Documentation of clinical history	Add the following text as the last paragraph: Factor 2 does not require assessment or evaluation.	**CL**	**3/30/2020**
203	UM 5, Element A	Related information	Revise the bullets under "Factor 1: Urgent concurrent requests for commercial and Exchange product lines" to read: • 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 the expiration of the previously approved period of time or number of treatments. The organization may treat the request 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.	**CL**	**3/30/2020**

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203	UM 5, Element A	Related information	Revise the second bullet under the factors 2, 3 subhead to read: The organization may extend the time frame by up to 14 calendar days if it needs additional information and 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.	**CL**	**3/30/2020**
221	UM 8, Element A	Explanation	Revise the text that follows *"Medicare appeals for factors 7–13"* to read: The organization's policies and procedures describe its process for sending an upheld denial to MAXIMUS.	**CL**	**3/30/2020**
222, 226	UM 8, Element A UM 9, Element B	Related information	Revise the third paragraph regarding Medicaid appeals to read: 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.	**CL**	**3/30/2020**
225	UM 9, Element B	Explanation—Factors 1-3: Timeliness of appeal process	Revise the third paragraph to read: 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.	**CL**	**3/30/2020**
229	UM 9, Element D	Explanation—Factor 1: The appeal decision	Add the following text as the last paragraph: 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).	**CL**	**3/30/2020**

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256	CR 1, Element A	Related information	Add the following text as the second sentence after the "Automated credentialing system" subhead: The organization provides its security and login policies and procedures to confirm the unique identifier and the signature can only be entered by the signatory.	**CL**	**3/30/2020**
277	CR 5, Element A	Factor 2	Revise the factor 2 language to read: 2. Collecting and reviewing sanctions and limitations on licensure.	**CL**	**3/30/2020**
312	RR 4, Element C	Scope of review	Revise the scope of review to read: *For Initial Surveys and Renewal Surveys:* NCQA reviews the organization's most recent annual data collection, assessment and analysis report.	**CL**	**3/30/2020**
314	RR 4, Element D	Scope of review	Replace the first and second paragraph of the scope of review with the following: *For Initial Surveys and Renewal Surveys:* NCQA reviews the organization's most recent annual report or dated policy and procedure showing actions taken.	**CL**	**3/30/2020**
336, 343	LTSS 1, Elements B, D	Explanation—Factor 2: Documentation of clinical history	Add the following text as the last paragraph: Factor 2 does not require assessment or evaluation.	**CL**	**3/30/2020**
355	LTSS 1, Element G	Explanation—Factor 12: Documentation of services received	Revise the explanation to read: The file or case record documents whether the individual received the services specified in the case management plan.	**PC**	**3/30/2020**
358	LTSS 1, Element I	Explanation—Factors 2, 3: Background checks and additional screening tool for paid LTSS providers	Add the following as the last sentence of the first paragraph: NCQA does not consider it delegation if the organization uses another entity to conduct background checks.	**CL**	**3/30/2020**
3-18	Appendix 3	Automatic Credit for Delegating to an NCQA-PHM Prevalidated Health IT Solutions	Rename the section to the following: Automatic Credit for Delegating to an NCQA-PHM Prevalidated Vendor for Health IT Solutions	**CL**	**3/30/2020**

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3-18	Appendix 3	Automatic Credit for Delegating to an NCQA-PHM Prevalidated Vendor for Health IT Solutions	Revise the first paragraph to read: Organizations that delegate CCM functions to an NCQA-Prevalidated Vendor for health IT solutions that receive the designation "eligible for automatic credit" present the Letter of Eligibility for documentation. The organization is responsible for providing documentation that states the name and the version of the health IT solution the organization is using and the date when it was licensed or implemented by the organization. Documentation may include a contract, agreement, purchase order or other document that states the name and version of the health IT solution and the date when it was licensed or implemented.	**CL**	**3/30/2020**