

NCQA Corrections, Clarifications and Policy Changes to the 2020 UM-CR-PN Standards and Guidelines

March 30, 2020

This document includes the corrections, clarifications and policy changes to the 2020 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 2020 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
13	Policies and Procedures— Section 1: Eligibility and the Application Process	Organization Obligations	Add the following as the fourth bullet: <ul style="list-style-type: none"> • Bring through all lines of business for which it performs UM functions. 	CL	3/30/2020
22	Policies and Procedures— Section 2: The Accreditation Process	Must-Pass Elements and Corrective Action Plan	Replace “UM 5: Timeliness of UM Decisions, Elements A–F” in the second bullet with “UM 5: Timeliness of UM Decisions, Elements A–C.”	CL	3/30/2020
81, 86, 93	UM 5, Elements A-C	Related information— Extension conditions	Revise the bullets under “factor 1: Urgent concurrent requests for commercial and Exchange product lines” to read: <ul style="list-style-type: none"> • 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 	CL	3/30/2020

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			coverage of additional days. In this case, the organization has up to 72 hours to make the decision.		
81, 86, 93	UM 5, Elements A-C	Related information— Extension conditions	Revise the second bullet under the factors 2, 3 subhead in Elements A, B and the factors 1, 2 subhead in Element C to read: <ul style="list-style-type: none"> • 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
126	UM 8, Element A	Explanation	Revise the text that follows " <i>Medicare appeals for factors 7–13</i> " to read: The organization's policies and procedures describe its process for sending an upheld denial to MAXIMUS.	CL	3/30/2020
127, 132	UM 8, Element A UM 9, Element B	Related information— Verbal notification	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
131	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
135	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	CL	3/30/2020

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			or not the requested service can be obtained within the organization's accessibility standards).		
189	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
3-10	Appendix 3	Table 1: Automatic credit for health plans delegating to an organization with NCQA Accreditation in UM, CR or PN	Revise footnote 12 to read: For UM 5, Element D, automatic credit is available if the delegate is accredited under the 2016 standards and beyond.	CL	3/30/2020