For Public Comment
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Proposed Standards Updates to 2025 Accreditation Programs:

UM Accreditation

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Utilization Management Accreditation 2025
Proposed Standards Updates

UM 5, Elements A, B | UM 12, Elements A–G | UM 13, Elements A–D

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UM 5: Timeliness of UM Decisions

The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation.

Intent

The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.

Element A: Notification of Nonbehavioral Healthcare Decisions

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

1. **For ~~commercial and Exchange~~ urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within ~~24~~ 72 hours of the request.**
2. ~~**For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**~~
3. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
4. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.**
5. **For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**
6. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**

Scoring

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

Data source Records or files

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

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

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

For Renewal Surveys: 12 months.

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

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

Dispute of file review results

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

Definitions used when classifying UM requests

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

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

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

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

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

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

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

Factors 1–~~5~~6: **Timeliness of notification**

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

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

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

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

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

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

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

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

Exceptions

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

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

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

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

~~Factors 1, 4 are~~ Factor 3 is NA for the Medicare and Medicaid product lines.

~~Factors 2, 5 are~~ Factor 4 is NA for the commercial and Exchange product lines.

Related information

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, the organization attempts to identify the practitioner. The organization documents its efforts to identify the practitioner.

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

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

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

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

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

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

Extension conditions

~~Factor 1: Urgent concurrent requests for commercial and Exchange product lines.~~

- ~~The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to, or any time after, the expiration of the previously approved period or number of treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.~~
- ~~The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.~~

~~Factors 2, 3:~~ Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.

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

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

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

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

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

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

~~Factor 3:~~ Factors 1, 2: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.

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

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

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***

The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

~~Factor 4:~~ Factor 3: Nonurgent preservice requests for commercial and Exchange product lines.

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

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

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

~~Factor 5:~~ Factor 4: Nonurgent preservice requests for Medicare and Medicaid product lines.

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

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

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

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

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

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

~~Factor 6:~~ Factor 5: Postservice requests for commercial, Exchange and Medicaid product lines.

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

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

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

Extension for other reasons.

In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

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

For Medicare, extensions are not allowed for postservice requests.

~~Factors 1–3:~~ Factors 1–2: Verbal notification of denials.

Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

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

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

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

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

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

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

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

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

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

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

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

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

Examples

Failure to follow filing procedures

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

Element B: Notification of Behavioral Healthcare Decisions

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

1. **For ~~commercial and Exchange~~ urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within ~~24~~ 72 hours of the request.**
2. ~~**For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**~~
3. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**
4. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.**
5. **For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**
6. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**

Scoring

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

Data source Records or files

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

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

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

For Renewal Surveys: 12 months.

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

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

Dispute of file review results

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

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

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

Factors 1–~~6~~5: **Timeliness of notification**

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

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

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

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

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

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

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

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

Exceptions

This element is NA if:

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

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

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

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

~~Factors 1, 4 are~~ Factor 3 is NA for the Medicare and Medicaid product lines.

~~Factors 2, 5 are~~ Factor 4 is NA for the commercial and Exchange product lines.

Related information

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, the organization attempts to identify the practitioner. The organization documents its efforts to identify the practitioner.

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

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

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

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

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

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

Extension conditions

~~Factor 1: Urgent concurrent requests for commercial and Exchange product lines.~~	• ~~The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to, or any time after, the expiration of the previously approved period or number of treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.~~ • ~~The organization may extend the decision notification time frame if the request to approve additional days for urgent~~

~~concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.~~

~~Factors 2, 3:~~
Factors 1, 2:
Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.

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

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

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

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

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

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

~~Factor 3:~~
Factors 1, 2:
Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.

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

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

- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, ***and***
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
  - The date when the organization receives the member's response (even if not all of the information is provided), ***or***

- The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

~~Factor 4:~~ Factor 3: Nonurgent preservice requests for commercial and Exchange product lines.

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

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

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

~~Factor 5:~~ Factor 4: Nonurgent preservice requests for Medicare and Medicaid product lines.

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

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

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

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

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

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

~~Factor 6:~~ Factor 5: Postservice requests for commercial, Exchange and Medicaid product lines.

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

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

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

Extension for other reasons.

In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

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

For Medicare, extensions are not allowed for postservice requests.

~~Factors 1–3:~~ Factors 1-2: Verbal notification of denials.

Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

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

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

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

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

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

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

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

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

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

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

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***

- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

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

Examples

Failure to follow filing procedures

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

UM 12: UM Information Integrity

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

Intent

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

Element A: Protecting the Integrity of UM Denial Information

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

1. **Scope of UM information.**
2. **Staff responsible for completing UM activities.**
3. **The process for documenting updates to UM information.**
4. **Inappropriate documentation and updates.**
5. **The process for documenting and reporting identified information integrity issues.**

Scoring

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

Data source Documented process

Scope of review

Product lines

This element applies to Interim Surveys for all product lines.

Documentation

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

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

Explanation This element may not be delegated.

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

UM denial information integrity refers to maintaining and safeguarding information used in UM denial decision process (UM 4–UM 7) against inappropriate documentation and updates.

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

Factor 1: **Scope of UM information**

The organization's policies and procedures specify that the organization protects the integrity of the following UM information:

- Requests from the member or the member's authorized representative.
- Documentation of UM request receipt date.
- Documentation of appropriate practitioner review.
- Documentation of use of board-certified consultants.
- Documentation of clinical information.
- UM decision
- Documentation of UM decision notification date.
- Denial notice.

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

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

The organization's policies and procedures:

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

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

The organization's policies and procedures:

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

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures:

- Specify that the following documentation and updates to UM information are inappropriate:
  - Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
  - Creating documents without performing the required activities.
  - Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
  - Attributing review to someone who did not perform the activity (appropriate practitioner review).

- Updates to information by unauthorized individuals.

Factor 5: Auditing, documenting and reporting information integrity issues

The organization's policies and procedures:

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

Exceptions

None.

Examples None.

Element B: Protecting the Integrity of UM Appeal Information

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

1. **The scope of UM information.**
2. **Staff responsible for performing UM activities.**
3. **The process for documenting updates to UM information.**
4. **Inappropriate documentation and updates.**
5. **The process for documenting and reporting information integrity issues, when identified.**

Scoring

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

Data source Documented process

Scope of review

Product lines

This element applies to Interim Surveys for all product lines.

Documentation

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

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

Explanation

This element may not be delegated.

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

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

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

Factor 1: **Scope of UM information**

The organization's policies and procedures specify that the organization protects the integrity of the following UM information:

- Request from the member or the member's authorized representative.
- Documentation of the appeal request receipt date.
- Documentation of the substance and investigation of the appeal.
- Documentation of appeal participants, as applicable.
  - Individual or group (e.g., panel) deciding the appeal.
  - Appropriate practitioner.
  - Same-or-similar-specialist review.
- Appeal notice.
- Documentation of the appeal decision notification date.

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

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

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

The organization's policies and procedures:

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

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

The organization's policies and procedures:

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

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures:

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

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

The organization's policies and procedures:

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

Exception

This element is NA for First Surveys and Renewal Surveys.

Examples None.

Element C: Information Integrity Training

The organization trains UM staff on the following, upon hire and annually thereafter:

1. **Inappropriate documentation and updates (Element A, factor 4).**
2. **Organization audits of staff, documenting and reporting information integrity issues (Element A, factor 5).**

Scoring

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

Data source Reports, Materials

Scope of review **Product lines**

This element applies to all surveys for all product lines.

Documentation

For All Surveys, NCQA reviews training materials and reports demonstrating that the organization conducted the required trainings for UM staff upon hire and annually .

Look-back period

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

Explanation

This element may not be delegated.

Factor 1: **Inappropriate documentation and updates**

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

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

The organization's training informs UM staff of:

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

Exceptions

None.

Examples

None.

Element D: Audit and Analysis—Denial Information

The organization annually:

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

Scoring

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

Data source

Reports

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys: NCQA reviews the organization's audit and analysis reports completed during the look-back period.

Look-back period

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

Explanation

THIS IS A MUST-PASS ELEMENT.

This element may not be delegated.

Factor 1: **Audit**

The organization annually audits for inappropriate documentation and updates to:

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

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

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

The organization provides an auditing and analysis report that includes:

- The report date.
- The title of individuals who conducted the audit.
- The auditing methodology.
  - Auditing period.
  - Audit universe size.
  - Audit sample size.
- The file identifier (case number).
- The type of dates audited (i.e., receipt date, notification date).
- Findings for each file.
  - A rationale for inappropriate documentation or inappropriate updates.
- The number or percentage and total number or percentage of inappropriate findings by date type.

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

Factor 2: Qualitative analysis

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

The organization's auditing and analysis report includes:

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

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

Exceptions

This element is NA for *Interim Surveys.*

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

Examples

Excerpt of an audit and analysis report

Factor 1: **Annual sampling**

Each January, the organization's UM director audits for inappropriate documentation and updates to UM denial receipt dates (UM 5) and notification dates (UM 7) for the previous calendar year.

The organization randomly samples and audits 5% or 50 files (whichever is less) for all UM denial decisions made in the previous year.

Identify the universe. The organization made 1,500 UM denial decisions based on medical necessity review in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 1,500 UM denial files.

Calculate the sample size. Multiply the total number of UM denials files in the universe by 5% (1,500 files x 0.05 = 75 files).

Randomly select the files for the sample: 50 files.

Audit the selected sample. Audit the files for inappropriate documentation and updates, and documents findings.

Factor 1: **Audit log**

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1235	No	None	NA
1245	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. 3/3/XX @ 2:59 PM
1255	No	NA	NA
1265	No	NA	NA
1275	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. 3/3/XX @ 3:40 PM
1285	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. on 3/3/XX @ 4:00 PM

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

Methodology

- Frequency: Annual (January).
- Audit sample: Sample UM denial files using NCQA "5% or 50 files" method.
- Universe: All UM denial files from January–December of the previous year.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

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

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

The UM director met with UM staff (UM assistant director, UM manager, UM analyst) to determine the cause inappropriate documentation and updates to UM denial receipt and notification dates.

Date Type	Description of Noncompliant Update	Reason
UM request receipt date	All 15 receipt dates were improperly updated in the UM denial file by the same staff on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.
UM denial notification date	All 15 notification dates were improperly updated by the same staff on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.

Element E: Improvement Actions—Denial System Information

The organization:

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

Scoring

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

Data source Documented process, Reports, Materials

Scope of review **Product lines**

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys:

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

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

Explanation This element may not be delegated.

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

Factor 1: **Implement corrective actions**

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

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

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

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

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

The organization draws conclusions about the actions' overall effectiveness.

Exceptions

This element is NA for *Interim Surveys.*

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

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

Examples

Excerpt from report on corrective actions and measures of effectiveness

***Factor 1:* Corrective actions**

The organization implemented immediate corrective actions to address noncompliant updates after sharing audit and analysis results with UM staff and organization leadership. Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

UM Information/ Noncompliant Update	Reason	Actions
UM request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Organization's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Update UM system to read only records for dates and other UM information. [Date] Establish process for two-step verification of system dates to records/information prepared for external review bodies.
UM denial notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	

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

The organization audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings, from the previous annual audit.

Methodology

- Audit staff: Names, titles.
- Frequency: Annual (January).
- Audit sample: Sample UM denial files using NCQA "5% or 50 files" method.
- Universe: All UM denial files from January–December of the previous year.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.

- Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 50 UM denial files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM request receipt date	50	0	0%
UM denial notification date	50	0	0%
Total	0	0	0%

Conclusions about the actions' overall effectiveness

UM Information/ Noncompliant Update	Actions	Conclusions
UM request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial files on 3/3/XX, after a decision had been sent.	Organization's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Update UM system to read only records for dates and other UM information. [Date]. Establish process for two-step verification of system dates to records/information prepared for external review bodies.	Leadership and UM staff to completed ethics training on [Date] and UM Information integrity training on [date] The UM system was updated to read only records on [date]. Implemented two-step verification process on [date] and ran a "real-world scenario" test for informational purposes on [date].
UM denial notification dates: UM staff member improperly updated decision notification dates in 15 UM denial files on 3/3/XX, after a decision had been sent.		

The correction implemented has been effective overall; the audit did not identify incidents of inappropriate documentation and update.

Element F: Audit and Analysis—Appeal Request Dates and Notification

The organization annually:

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

Scoring

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

Data source Reports

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys: NCQA reviews the organization's audit and analysis report(s) completed during the look-back period.

Look-back period

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

Explanation

THIS IS A MUST-PASS ELEMENT.

This element may not be delegated.

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

Factor 1: **Audit**

The organization annually audits for inappropriate documentation and updates to:

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

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

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

The organization provides an auditing and analysis report that includes:

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

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

Factor 2: **Qualitative analysis**

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

The organization's auditing and analysis report includes:

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

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

Exceptions

This element is NA for *Interim Surveys.*

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

Examples

Excerpt from an audit and analysis report

Factor 1: **Audit sampling**

Each January, the organization's UM director audits for inappropriate documentation and updates to UM 8–UM 9:

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

The organization randomly samples and audits 5% or 50 files (whichever is less) of all UM appeal decisions made in the previous year.

Identify the universe. The organization made 1,500 UM appeals decisions related to coverage or rescission of coverage in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 1,500 UM appeal files.

Calculate the sample size. Multiply the total number of UM appeal files in the universe by 5% (1,500 files x 0.05 = 75 files).

Randomly select the files for the sample: 50 files.
Audit the selected sample. Audit the files for inappropriate documentation and updates, and document findings.

Factor 1: **Audit log**

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1235	No	None	NA
1245	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because expedited appeal decision time frame had passed. 3/3/XX @ 2:59 PM
1255	No	NA	NA
1265	No	NA	NA

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1275	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because appeal decision notification time frame had passed. 3/3/XX @ 3:40 PM
1285	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent appeal decision notification time frame had passed. on 3/3/XX @ 4:00 PM

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

Methodology

- Frequency: Annual (January).
- Audit sample: Sample UM denial files using NCQA "5% or 50 files" method.
- Universe: All UM appeal files from January–December of the previous year.
- Auditor: UM director.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

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

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

The UM director met with UM staff (UM assistant director, UM manager, UM analyst) to determine the cause inappropriate documentation and updates to UM appeal receipt and notification dates.

Date Type	Description of Noncompliant Update	Reason
UM appeal request receipt date	All 15 appeal receipt dates were improperly updated in the UM appeal file by the same staff on 5/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 5/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.
UM appeal decision notification date	All 15 appeal decision notification dates were improperly updated by the same staff on 5/3/XX, after a decision had been sent.	Notification dates were improperly updated because the expedited appeal time frame had passed and an audit by the Department of Insurance was scheduled for 5/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.

Element G: Improvement Actions—Appeal Information

The organization:

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

Scoring

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

Data source Documented process, Reports, Materials

Scope of review **Product lines**

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys:

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

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

Explanation

This element may not be delegated.

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

Factor 1: **Implement corrective actions**

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

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

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

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

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

Exceptions

This element is NA for *Interim Surveys.*

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

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

Examples

Excerpt from report on corrective actions and measures of effectiveness

Factor 1: **Corrective actions**

The organization implemented immediate corrective actions to address noncompliant updates after sharing audit and analysis results with UM staff and organization leadership. Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

UM Information/ Noncompliant Update	Reason	Actions
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Organization's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Update UM system to read only records for dates and other UM information. [Date]. Establish process for two-step verification of system dates to records/information prepared for external review bodies.
UM appeal decision notification dates: UM staff member improperly updated decision notification dates in	Decision notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the	

UM Information/ Noncompliant Update	Reason	Actions
15 UM denial file on 3/3/XX, after a decision had been sent.	Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	

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

The organization audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings from the previous annual audit.

Methodology

- *Audit staff:* Names, titles.
- Frequency: Annual (January).
- Audit sample: Sample UM appeal files using NCQA "5% or 50 files" method.
- Universe: All UM appeals files from January–December of the previous year.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 50 UM denial files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM appeal request receipt date	50	0	0%
UM appeal decision notification date	50	0	0%
Total	**0**	**0**	**0%**

Conclusions about the actions' overall effectiveness

UM Information/ Noncompliant Update	Actions	Conclusions
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Organization's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Update UM system to read only records for dates and other UM information. [Date].	Leadership and UM staff to completed ethics training on [Date] and UM Information integrity training on [Date] The UM system was updated to read only records on [Date].

UM Information/ Noncompliant Update	Actions	Conclusions
UM appeal decision notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Establish process for two-step verification of system dates to records/information prepared for external review bodies.	Implemented two-step verification process on [Date] and ran a test real-world scenario for information purposes [Date]

The correction implemented has been effective overall; the audit did not identify incidents of inappropriate documentation and update.

UM 13: Delegation of UM

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

Intent

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

Element A: Delegation Agreement

The written delegation agreement:

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

Scoring

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

Data source Documented process, Materials

Scope of review

Product lines

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

Documentation

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

For factor 4:

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

- Delegation agreements in place prior to July 1, 2025, that do not address the system controls intent under the 2022–2024 standards must be updated to address UM information integrity requirements.

For factor 6: Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in the factor. For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon.

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

Look-back period

For Interim Surveys and First Surveys: 6 months for factors 1–6.

For Renewal Surveys: 24 months for factors 1–6.

Explanation

This element may not be delegated.

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

Factor 1: **Delegation agreement**

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

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

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

Factor 2: **Assigning responsibilities**

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

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

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

Factor 3: **Reporting**

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

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

The organization must receive regular reports from all delegates, even NCQA-Accredited or NCQA-Certified delegates.

Factor 4: **Performance monitoring**

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

UM denial and appeal information integrity refers to maintaining and safeguarding information from inappropriate documentation and updates as outlined in UM 12, Elements A and B, factor 4.

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

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

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

The organization's delegation agreement describes how the delegate obtains the following information upon request or on an ongoing basis:

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

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

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

Exceptions

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

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

Factor 5 is NA for mail service organization delegates.

Factor 7 is NA if the organization does not delegate UM medical necessity activities (UM 4–UM 7) and does not delegate UM appeal activities (UM 8, UM 9).

Related information

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

Examples

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

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

Element B: Predelegation Evaluation

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

Scoring

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

Data source Reports

Scope of review

Product lines

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

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

Documentation

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

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

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless delegated UM requirements were not in scope or were scored NA during the delegates' NCQA survey.

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

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

Predelegation evaluation

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

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

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

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

Exceptions

This element is NA if:

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

Related information

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

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

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

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of the UM Program

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

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

Scoring

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

Data source Reports

Scope of review

Product lines

Factor 1 applies to Interim Surveys for all product lines.

All factors in this element apply to First Surveys and Renewal Surveys for all product lines.

Documentation

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

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

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

For Renewal Surveys:

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

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

Look-back period

For Interim Surveys and First Surveys: Once during the prior year.

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

Explanation

This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless delegated UM requirements were not in scope or were scored NA during the delegates' NCQA survey.

Automatic credit is available for factors 5–7 if the organization all delegates are NCQA Accredited under the 2025 standards or later.

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

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

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

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

Factor 2: **Annual file audit**

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

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

- 5% or 50 of its files, whichever is less, *or*
- The NCQA "8/30 methodology," available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

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

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

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

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

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

- UM request receipt dates (UM 5).

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

For each delegate, the audit universe includes UM denial and appeal files processed by the delegate during the look-back period. Denial and appeal files are audited separately.

Because an organization may have several UM delegates processing UM requests and appeals, the organization annually audits each delegate using one of the following methods:

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

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

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

The organization provides an auditing and analysis report that includes:

- The date of the report.
- Title of staff who conducted the audit.
- The audit method:
  - Audit period.
  - Audit universe size.
  - Audit sample size.
- File identifier (case number).
- Type of dates audited (receipt date, notification date).
- Findings for each file.
  - Draw a conclusion if inappropriate documentation and updates occur.
- The number or percentage and total inappropriate documentation and updates by date type.

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

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

Factor 6: **Implement corrective actions**

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

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

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

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

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

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

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

The organization draws conclusions on the actions' overall effectiveness.

Exceptions

This element is NA if:

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

Factor 1 is NA for mail service delegates.

Factors 2–7 are NA for Interim Surveys.

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

Factors 5–7are NA if the delegate only provides cloud-based UM data storage functions and does not provide services that create, modify or use UM data.

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

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

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

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

Related information

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

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

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

Examples ***Excerpt of an audit and analysis report***

***Factor 5:* Annual audit**

Each January, the delegate's UM director audits for inappropriate documentation and updates to UM 8–UM 9:

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

The delegate randomly samples and audits 5% or 50 files (whichever is less) of all UM appeal decisions made in the previous year.

Identify the universe. The delegate made 1,500 UM appeal decisions regarding coverage in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 1,500 UM appeal files.

Calculate the sample size. Multiply the total number of UM appeal files in the universe by 5% (1,500 files x 0.05 = 75 files).

Randomly select the files for the sample, for a total of 50 files.

Audit the selected file sample. Audit the files for inappropriate documentation and updates, and document findings.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 50 UM denial files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM appeal request receipt date	50	0	0%
UM appeal decision notification date	50	0	0%
Total	0	0	0%

***Factor 1:* Audit log**

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1235	No	None	NA
1245	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. 3/3/XX @ 2:59 PM

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1255	No	NA	NA
1265	No	NA	NA
1275	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. 3/3/XX @ 3:40 PM
1285	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. on 3/3/XX @ 4:00 PM

Factor 5: **Audit report and analysis**

Methodology

- Delegate: [Delegate].
- Frequency: Annual (January).
- Audit sample: Sample UM denial files using NCQA "5% or 50 files" method.
- Universe: All UM appeal files from January–December of the previous year.
- Auditor: UM director.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

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

Qualitative analysis. The delegate's UM analyst provided the UM director with the audit log documenting when, how, why and by whom files were updated.

The UM director met with UM staff (UM assistant director, UM manager, UM analyst) to determine the cause inappropriate documentation and updates to UM appeal receipt and notification dates.

Date Type	Description of Noncompliant Update	Reason
UM appeal request receipt date	All 15 receipt dates were improperly updated in the UM appeal file by the same staff on 5/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 5/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.
UM appeal decision notification date	All 15 notification dates were improperly updated by the same staff on 5/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the appeal decision notification time frame had passed and an audit by the Department of Insurance was scheduled for 5/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.

Excerpt from reports of corrective actions and measures of effectiveness

***Factor 6:* Corrective actions**

The organization required the delegate to implement immediate corrective actions to address information integrity issues after sharing audit and analysis results with UM staff and organization leadership. Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

UM Information/ Noncompliant Update	Reason	Actions
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Require delegate's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Require delegate to update UM system to read only records for dates and other UM information. [Date]. Require delegate to establish process for two-step verification of system dates to records/information prepared for external review bodies.
UM appeal decision notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Decision notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	

Factor 7: **Effectiveness of corrective actions audit**

The delegate audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings, from the previous annual audit.

Methodology

- *Audit staff:* Names, titles.
- Frequency: Annual (January).
- Audit sample: Sample UM appeal files using NCQA "5% or 50 files" method.
- Universe: All UM appeals files from January–December of the previous year.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 50 UM denial files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM appeal request receipt date	50	0	0%
UM appeal decision notification date	50	0	0%
Total	0	0	0%

Conclusions on the actions' overall effectiveness

UM Information/ Noncompliant Update	Actions	Conclusions
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Delegate's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Delegate to update UM system to read only records for dates and other UM information. [Date]. Delegate to establish process for two-step verification of system dates to records/information prepared for external review bodies.	Delegate's leadership and UM staff to completed ethics training on [Date] and UM Information integrity training on [Date] Delegate updated its UM system to read only records on [Date]. Delegate implemented two-step verification process on [Date] and ran a test real-world scenario for information purposes [Date]
UM appeal decision notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.		

The correction implemented has been effective overall; the audit did not find incidents of inappropriate documentation and update.

Element D: Opportunities for Improvement

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

Scoring

100%	80%	50%	20%	0%
At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization took inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has not acted on identified problems

Data source

Documented process, Reports, Materials

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews reports for opportunities for improvement from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

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

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

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

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

This element does not apply to UM information integrity requirements, which are addressed in Element C, factors 5–7.

NCQA-Accredited delegates

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

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

- *NCQA-Accredited delegates are eligible for automatic credit.*

- *Non-Accredited delegates are reviewed and scored accordingly.*

Identify and follow-up on opportunities

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

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.

NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.