ORGANIZATION POLICY AND PROCEDURE	
 	**Product Line:** **✠Medicare** **X Medi-Cal** **X Commercial** **OTHER**
Title: 08-01-16-51-00007- Expedited Initial Organization Determination (EIOD)	
Division(s): Health Services	
Department(s): Utilization Management	

	CMS	
	DMHC	
	NCQA-HP	
	NCQA-WHP	
	OTHER	

Approved by: President/Chief Medical Officer/Medical Director	**Approval date: 08/01/2016** 08/11/2022 **Reviewed 01/15/2020** **01/10/2022** **08/08/2022**

SCOPE

The Elite Care Health Organization (ECHO) Staff, Contracted Providers and Practitioners shall follow the procedures set forth in this policy.

PURPOSE

To ensure that the ECHO Utilization Management Employees comply with the CMS requirements for Expedited Initial Organization Determination process that includes the member's notification requirements.

POLICY

Elite Care Health Organization complies with the Balanced Budget Act of 1997, section 422.562 & 422.572 that requires that the UM Department employees review any request for a service or treatment within specific time frames. Should a provider believe that a member has a condition that is "Time Sensitive" and requires urgent attention, an "expedited (72 hour) review is to be initiated 24 hours for Part B drugs.

PROCEDURE

1. ECHO has adopted the ICE Utilization Management Timeline Standards for The Centers for Medicare and Medicaid Services (CMS). (ICE UM TAT CMS Standards), Medi-Cal and Commercial Timeliness Standards.
2. ECHO accepts oral request for Expedited Organization Determination. The member or a physician must submit either an oral or written request directly through the UM department. The physician may also provide oral or written support for a members' own request for an expediated determination. ECHO will automatically provide an expedited organization determination in the following cases:

   2.11. If a member or physician indicates either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the member or

   2.12. The member's ability to regain maximum function. ECHO does not require the member's physician to be the members representative in order to make the request.
3. If Expedited Criteria are not met

   3.1. Promptly decide whether to expedite – determine if:

   3.1.1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or

   3.1.2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision

   3.1.3. Ensure the Turnaround Timeframes (TAT) are met

   3.1.4. If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice.

   3.1.5. Use the specific Health Plan Expedited Criteria Not Met template to provide written notice.

   3.1.5.1. The written notice must include:

   3.1.5.1.1. Explain that the UM Department will automatically transfer and process the request using the 14-day timeframe (Medicare) or 5 business days (Medi-Cal/Commercial) for standard determinations.

   3.1.5.1.2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination.

   3.1.5.1.3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function

   3.2. Once the above is completed, the standard initial organization determination timeframe applies:

   3.2.1. Automatically transfer the request to the standard timeframe.

   3.2.2. The 14day period begins with the day the request was received for an expediteddetermination. 5 Business days for Medi-Cal or Commercial LOB.

4. Favorable Determinations

4.1. ECHO will give a verbal or written approval notification to the member and the provider within 72 hours after the receipt of the request which includes weekends and holidays. Written notification must be mailed to the member as well within 3 calendar days of the oral notification. ECHO will give a verbal or write approval notification to the member and the provider with 24hrs after the receipt of their request which includes weekends and holidays.

4.2. Part B Drug Request verbal or written approval notification to the member and the provider within24 hours after the receipt of the request which includes weekends and holidays. Written notification must be mailed to the member as well within 24 hours days of the oral notification. ECHO will give a verbal or write approval notification to the member and the provider with 24hrs after the receipt of their request which includes weekends and holidays

4.3. In cases where request is directly from the member and a decision was rendered as expedited due to members health condition a verbal or written notification will be provided no later than 72 hours after receiving the member's request.

4.4 The date and time of the oral notification must be documented in the member's medical record. Verbal notification as successfully delivered i.e.: HIPPA compliant voice message for a member ormember representative will be documented in the member's medical record.

- For urgent pre-service, oral notice will be given within 24 hours of the request if it is follow up in writing within 3 calendar days. Oral notification will include date/time of notification.
- For urgent pre-service, if written notice is only given; it must be received by the member and the provider within 72hours of the receipt of the request. Notification may be mailed via overnight to ensure thatnotification is received within 72 hours of receipt of request.

Urgent Concurrent Review:

- For urgent concurrent, oral notice will be given within 24 hours of the request provided follow up in writing within 3 calendar days. Oral notification will include date/time of notification.
- For urgent concurrent review, lf written notice is only given; it must be received by the member and the provider within 72hours of the receipt of the request. Notification may be mailed via overnight to ensure thatnotification is received within 72 hours of receipt of request.

- Health Plan Specific Approval Letter template is to be used for written notification

4.4. If Medical Director/reviewing physician approves a request to expedite the determination. Medical director/Physician reviewer must make the medical (excluding Pharmacy Part B Drugs) determination and notify the enrollee and the physician involved, as appropriate, of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. UM Staff may notify the enrollee orally or in writing, the enrollee must be notified within the 72-hour time frame. Pharmacy Part B Drugs expedited requests must make the determination and notify the enrollee and physicians involved within 24 Hours from the receipt request. (NOTE: Part B Drug timeframes cannot be extended)

a. The processing timeframe begins when the appropriate department receives the request.
b. Timeframes measured in hours must be met within the number of hours indicated.
c. Unless otherwise specified, written notification is considered delivered on the date and time the organization deposited the notice in the courier drop box or external outgoing mail receptacle (e.g., U.S. Postal Service or FedEx). Mailroom policy will dictate mail

drop-off/pickup.

4.5. Excluding Pharmacy Part B Drugs, the organization may extend the 72-hour time frame by up to 14 calendar days if the enrollee requests the extension. The organization also may extend the time frame by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee or if the organization determines that the extension is justified and in the enrollee's best interest due to the need for additional medical evidence from a noncontract provider that may change an organization's decision to deny an item or service; or the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest.

4.6. When the organization extends the time frame, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the organization's decision to grant an extension. The organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

4.7. For denials, 'if' verbal notification is provided to the member within 72 hours of receipt of the request, written confirmation of the denial must be mailed to the member within 3 calendar days of the verbal notification. If no verbal notification was provided, must be able to show the date and time the organization deposited the notice in the courier drop box. Favorable, Partially Favorable or Adverse Decisions (Expedited Requests):

4.8. If the organization initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 3 calendar days of the verbal notification.

4.9. 5). Policy

4.10. Outreach for information to support coverage decision

a. Outreach will be done within 24 hours of receipt.
b. All request for information will be documented and maintained within the case file.
c. Specific description of the required information will be documented
d. The name, phone number, fax number, email and/or mailing address, as applicable for the point of contact.
e. The date and time of each request, document by date and time stamps on copies of written request, call record, facsimile transmission, email and/or overnight mail with certified return receipt.
f. Call records shall include specific information abut who was contacted, what was discussed/requested and what information was obtained.

5. Adverse Determination

5.1. A verbal denial notice must be given within 72 hours of the receipt of request and 24hrs for Part B Drugs

5.1.1. The date and time of the oral notification must be documented in the member's medicalrecord.

5.2. A written notice must follow the verbal notification within three (3) calendar days.

5.3. If written notice is only given, it must be received by the member and the provider within 72 hours of the receipt of the request.

5.4. Health Plan denial template for written notification of a denial decision is to be issued to the member and the provider.

5.5. Verbal notification of its decision, it must deliver written confirmation of its decision

within 3 calendar days of the verbal notification.

5.6. Written notice of denials of requests for expedited determinations and instructions on how to file an expedited grievance when enrollees dispute the managed care denial or extension decision.

5.7. Skilled therapy service requests (PT, OT, ST) are not denied based on the absence of potential for improvement or restoration.

5.8. If medical information from non-contract providers to make a decision, necessary information must be requested from the non-contract provider within 24 hours of the initial request. Non-contract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the organization in meeting the required time frame. Regardless of whether the organization must request information from non-contract providers, the organization is responsible for meeting the same time frame and notice requirements as it does with contracting providers.
If no verbal notification was provided, organization must be able to show evidence of the date/time the organization deposited the notice in the courier drop box.
******Policy needs to address tracking timely notification by documenting the date/time the letter deposited in the courier drop box, e.g. USPC, UPS, FedEx, etc.
Must review the date of the envelope or evidence of tracked mailing date/time.
Reviewing a mailroom policy is not acceptable.

6. After Hours request

6.1 ECHO accepts after hours Expedited request via portal. The member or a physician must submit request via portal directly through the UM department.Voicemail can be left on the UM general mailbox. The physician may also provide oral or written support for a members' own request for an expediated determination. ECHO will automatically provide an expedited organization determination the next business day. If request submitted via portal, system automatically stamps date and time request was submitted. Request via phone or fax will be submitted with date and time request was received. Determination and notification will be provided within the allotted TAT requirement. If request requires determination on the weekend physician reviewer is on standby for review. UM Manager will provider oral notification to the member. Provider notification is sent via fax through EZCAP system once determination has been made.

Reference(s)

Attachment(s)
ICE UM TAT CMS Standards

ICE_UM_TAT_CMS_S
tandards_6-10-11.doc

08-01-16-51-00007-A- Request for Clinical Information Fax Cover Sheet