Department: Health Services – Utilization Management	**Number:** HS-012
Title: Organization Determinations	
Original Effective Date: 10/1/2024	**Latest Revision Date:** 12/30/2024

Purpose:

Sonder Health Plans ("SHP", "the Plan", or the "MA Organization") Health Services Department ("HSD") ensures compliance with all applicable CMS regulations governing requests for organization determinations from enrollees, enrollee's authorized representative, legal representative of a deceased enrollee's estate, and/or providers for requested services and benefits. This policy aims to ensure decisions are made efficiently, using appropriate clinical guidelines, while maintaining compliance with applicable regulatory requirements. This policy applies to all HSD staff responsible for processing standard organization determination requests related to the provision of medical services, treatments, and benefits covered by SHP.

Definitions:

- **Adverse Determination**: A denial or limitation of a requested item, service, Part B Drug, or benefit based on medical necessity or coverage criteria. This includes the decision to deny a service or payment, in whole or in part, or discontinue/reduce a previously authorized or provided service.
- **Enrollee/Member/Beneficiary**: In this document, enrollee, member, and beneficiary may be used interchangeably and refers to a Medicare Advantage eligible individual who has elected Sonder Health Plans to receive coverage and benefits.
- **Emergency Services**: covered services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. SHP covers, without authorization, emergency services (based on the prudent layperson standard) necessary to screen and stabilize members. Prior authorization is not required for emergency transportation to an ER. Services provided by physicians to stabilize the member as part of the ER level of care are not subject to Utilization Review.
- Expedited Organization Determination: A decision (whether adverse or favorable) made by a Plan when a request for an item, service, or Part B drug must be made more quickly than a standard organization determination and when waiting for a standard timeframe could seriously jeopardize the member's health or life. A decision must be made as expeditiously as the member's health condition might require, but no later than 72 hours after receiving a request for items or services or within 24 hours after the request for Part B drugs.
- **Extension**: An additional 14 calendar days that the Plan may take to render a decision on an organization determination. This is permissible when (1) the enrollee requests the extension; (2) the extension is justified and in the interest of the enrollee due to the need for additional medical evidence from a noncontract provider that may alter the Plan's decision to deny an item or service; or (3) the extension is justified due to an extraordinary, exigent, or other non-routine circumstances and is in the interest of the enrollee. **Extensions may not be taken for expedited Part B drugs request – a decision must be made within 24 hours after receipt of the request.**
- **Initial Determination:** the first decision made by a Plan regarding whether to approve, partially approve, or deny a request for coverage of medical services, treatments, or supplies.
- **Notice of Denial of Medical Coverage (NDMCP – Integrated Denial Notice [IDN] – Form CMS-10003-NDMCP):** CMS Model letter used to notify enrollee, enrollee's representative, and provider

of any adverse organization determinations, including partial approvals. The notice includes the reasons for the denial, the clinical basis for the decision, and instructions on how to file an appeal.

- **Organization Determination ("OD"):** A decision made by the Plan, or its delegated entity, concerning whether the payment or provision of an item, service, or Part B drug is covered and medically necessary under the member's plan. Refer to extended criteria under the Procedures section below for the 5 categories of organization determinations per CMS guidelines.
- **Prior Authorization:** A request made to the Plan before a service, procedures, or treatment is performed to determine whether it will be covered. Services requiring prior authorization must be approved before the member can receive them. The Plan's decision is known as an Organization Determination. (*Consistent with CMS guidelines, SHP does not require prior authorization for emergency, urgently needed services, or stabilization services).*
- **Prudent Layperson:** any person who possesses an average knowledge of health and medicine who could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm to the individual.
- **Representative:** Means an individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in the grievance, organization determination, or appeal. Unless otherwise provided by law, the representative will have all the rights and responsibilities of an enrollee or other party, as applicable.
- **Retrospective Requests:** A retrospective request is any pre-service request for authorization that is submitted to SHP after services are rendered. If the request spans a time before and after it was received, the portion of the request prior to receipt is considered retrospective. For Inpatient services, a retrospective request is any request for authorization for a stay received more than one business day after the member discharges. In most circumstances, SHP does not authorize retrospective requests.
- **Standard Organization Determination**: A non-expedited decision (organization determination) made by the Plan regarding a request for medical services or benefits. The Plan must decide as expeditiously as the enrollee's health condition requires but no later than within 14 calendar days after the date the organization receives the request for a standard organization determination. Standard Organizations Determinations for Part B Drugs must be processed within 3 calendar days from the date the organization receives the request.
- **Transition of Care for New Enrollees:** If the previous Plan has approved a prescribed or ordered course of treatment or service for which the duration is 90 days, then the prior authorization approval must apply to the full 90 days and Plans may not subject this treatment or service to additional prior authorization requirements before the completion of the approved 90 days of treatment or service. SHP and the contracted provider will coordinate care to ensure that prior authorizations are approved for a period that ensures that care is delivered for as long as is medically necessary and that it minimizes disruptions in care for the enrollee.

Policy Statement:

SHP ensures the timely and accurate processing of Organization Determinations ("ODs") in accordance with the Centers for Medicare and Medicaid Services (CMS) regulations, and applicable state requirements. Standard ODs involve decisions regarding medical necessity, prior authorization, and coverage for healthcare services, supplies, and Part B drugs and are made, and notification provided, as quickly as the enrollee's health condition requires but no later than 14 calendar days after the date a request is received for a standard organization determination and no later than 72 hours from the date the organization receives a Part B Drug standard request or an expedited organization determination. The Plan will not systematically take the maximum time permitted for ODs or use extensions.

Procedures:

I. Actions Classified as Organization Determinations by CMS:

A. An organization determination is any determination made by an MA organization with respect to any of the following:
   i. Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
   ii. Payment for any other health services furnished by a provider other than the MA organization that the enrollee believes—
      a. Are covered under Medicare; or
      b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MA organization.
   iii. The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.
   iv. Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.
   v. Failure of the MA organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

II. Review of Benefit Coverage

A. SHP accepts requests for standard organization determinations in writing (via facsimile or email) or orally (via phone) from the enrollee, the enrollee's representative and/or the enrollee's provider.

B. To ensure that only requests for services covered by Medicare benefits or medically necessary proceed to the standard organization process, UM staff will perform the following procedures:
   i. Review of Benefit Coverage
      1. Upon receiving a standard organization determination request, UM staff will conduct an initial review to verify if the requested service is a covered benefit under the applicable SHP plan, including cost for DME items.
      2. The reviewer will consult the CMS-approved benefits summary and plan-specific Evidence of Coverage (EOC) document and, if applicable, CMS guidelines, to verify coverage.

C. Verification that an authorization request is required
   i. The UM staff will verify that the service requires authorization by utilizing the authorization requirements list.

D. Verification of Coverage Criteria
   i. The UM reviewer will refer to CMS guidelines, including but not limited to 42 CFR §422.101, CMS National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs) or SHP Internal Coverage Criteria. ***(Refer to HS-012: Application of Medical Criteria and Medical Necessity Reviews for additional guidance).***
   ii. In cases where coverage requirements are not straightforward, the reviewer should consult with SHP's Medical Director or other qualified HSD professional.

E. Determination of Coverage Status
   i. If Covered: If the requested service is confirmed to be a covered benefit under Medicare, UM staff will proceed with the standard organization determination process as outlined below in the policy.
   ii. If Not Covered: If the service is determined to be non-covered, issue a Notice of Denial of Medical Coverage/Payment (NDMCP), Form CMS-10003). This form is also called the Integrated Denial Notice (IDN).
      1. Ensure the notice includes: the specific reason for non-coverage with references to applicable regulations.
      2. Instructions for appealing the decision if the enrollee disagrees.
      3. ***Refer to HS-020: Adverse Determinations – Facilities for additional***

guidance.

F. Escalation Protocol: If the UM reviewer is uncertain about the coverage status, they may escalate the request to the Medical Director or HSD Clinical Leadership for further review before proceeding.

III. **Requests for Out of Network Providers**:

A. Upon receipt of a request for care from an out-of-net network provider, the Health Services Department staff may contact the requesting provider to identify the reason for the request and to collect information about the member's medical condition or special needs and about the out of network provider to whom the request pertains. If an in-Network Provider can be identified, and can provide the necessary services, it may be the recommendation of the Health Services staff to refer the member to the Contracted Provider.

B. Health Services Department staff may coordinate care through out of network providers if a network provider cannot provide the necessary services due to lack of availability or if the member has a unique medical need that cannot be met by a network provider. In these cases, the HSD staff in conjunction with the Provider Relations Department attempt to negotiate with a non-network provider prior to services rendered. In life threatening emergencies, when out of network providers are involved, Sonder Health Plan may facilitate the transfer of the member to the appropriate network physician as soon as it is medically appropriate.

C. If approved, a request for out of network negotiations may be made to Provider Relations. Upon completion of negotiations, the Health Services staff documents it in SHP's UM system.

D. If the Medical Director determines that the service should be obtained through a network provider, a denial is issued and the services are directed to the network provider, with authorization as necessary.

IV. **Procedures for Processing Organization Determinations**:

A. Initiation of Organization Determinations

i. Once a determination is made, according to the process flow above, that the requested organization determination is a covered benefit, UM staff will ensure that all requests are date and time stamped, documented in the Plan's UM system and forwarded, along with any supporting records, to the appropriate staff for a decision on prior authorization and medical necessity.

ii. If the request is for payment of services (not prior authorization or medical necessity), the request is routed to the Claims Department for processing.

B. Review and Determination Process

i. Requests for covered benefits that do not require medical necessity determination are processed by a UM staff member or auto approved by the Plan's authorization system.

ii. The request is reviewed for completeness. If clinical information is needed to make the request complete to review for medical necessity, the clinical information will be requested up to three times both verbally and by fax. These requests will be made within 24 hours for a Part B request or an expedited request. If the clinical information to determine medical necessity is not received, the request is considered incomplete and will be administratively denied.

iii. If the Utilization Review nurse is unable to make the determination, or if the Utilization Review nurse recommends that the request be denied, in whole or in part, it is forwarded to the Medical Director for final determination.

iv. All Part B requests are reviewed and determined by SHP's Pharmacy Staff.

1. A Pharmacist must review and make the final decision about any adverse determinations related to Part B and document the rationale accordingly in the member's record.

v. If SHP expects to issue a partial or full adverse medical necessity decision based on the initial review of the request, SHP ensures that the organization determination is reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before SHP issues the organization determination.

C. Dismissals

i. SHP may also dismiss a request for a standard organization determination either entirely or as to any stated issue as outlined in Policy HS-044: Processing Dismissals of Organization Determination Requests.

V. Medical Necessity Determinations

A. When making medical necessity determinations, HSD staff follows the specific guidelines in HSD policy HS-012 (Medical Necessity Review) and performs the tasks listed below to ensure fairness and compliance with federal regulations.

i. **Review of Coverage and Benefit Criteria:** SHP uses CMS approved, nationally recognized criteria as well as evidence-based, clinically developed sources for policy and standards of care when making organization determinations. Refer to HSD policy HS-012 (Medical Necessity Review) for specific guidance. SHP will not deny coverage for any basic benefits unless it aligns with these criteria.

ii. **Medical Necessity Assessment:**

1. HSD Staff will ensure that services or items provided are reasonable and necessary as required by CMS guidelines.
2. This means that services must be essential for diagnosing or treating a condition, injury, or illness; considered safe and effective; not experimental or investigation (unless approved by the Medical Director per policy HS-022); and considered appropriate, including the service's duration and frequency.

iii. **Review of Enrollee's Records:** The enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.

iv. **Solicit Input from the Medical Director:** Where appropriate, HSD staff will involve SHP's Medical Director to ensure the clinical accuracy of organization determinations and reconsiderations.

VI. Timeframes for Standard Organization Determinations

A. HSD staff must ensure that all standard organization determinations involving requests for items or services are made and notifications provided to enrollees as expeditiously as the enrollees' health conditions require, but no later than 14 calendar days from receipt of each request.

B. HSD staff must ensure that all standard organization determinations for Part B drugs are made as expeditiously as the enrollee's health condition requires, but no later than 72 hours from receipt of the request. Notifications will be provided to the enrollee and the prescribing physician or other involved prescriber, as appropriate.

C. The processing timeframe begins when SHP, any unit in SHP, or an SHP delegated entity (including a delegated entity that is not responsible for processing) receives a request.

D. Extensions:

i. SHP may extend the timeframe for standard organization requests up to 14 calendar days. This is permissible when (1) the enrollee requests the extension; (2) the extension is justified and in the interest of the enrollee due to the need for additional medical evidence from a noncontract provider that may alter the Plan's decision to deny an item or service; or (3) the extension is justified due to an extraordinary, exigent, or other non-routine circumstances and is in the interest of the enrollee. ***SHP may not extend Part B drug determination timeframes.***

ii. If SHP grants itself an extension, the enrollee must be notified in writing of the reason(s) for the delay. The enrollee must also be informed in the written notification about his/her right to file an expedited grievance if he/she disagrees with SHP's decision to grant an extension.

iii. In cases where an extension is applied, SHP must notify the enrollee or provider requesting the service, in writing, of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration time of the extension.

E. Refer to HS-039: Organization Determination Extension Policy for more detailed guidance on processing Extensions.

VII. <u>Timeframes for Expedited Organization Determinations</u>

A. The processing timeframe for expedited organization determinations begins when the appropriate SHP department receives a request.

B. The decision may be communicated to the provider and the member verbally as soon as the decision is made, and written notification is sent to the member within 72 hours (for item or service requests) or within 24 hours (for Part B drug requests) of the verbal notification.

C. All expedited service determinations are made within 72 hours from receipt of request and all expedited Part B drug determinations are made within 24 hours of receipt of request.

D. Regardless of how the member is notified (verbally and/or in writing), SHP provides the notification within the 72-hour timeframe (for items or services) or 24-hour timeframe (for Part B Drugs). When the determination is adverse, SHP mails written confirmation of its determination within 3 calendar days after providing verbal notification. SHP will make at least 2 attempts to notify the enrollee *verb*ally.

E. Extensions:

i. SHP may only extend the timeframe for an item or service request (not Part B drug request) up to 14 calendar days if: (1) The enrollee requests the extension; (2)the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change SHP's decision to deny an item or service; (3) The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest.

ii. **Extensions may not be taken for expedited Part B drugs** request **–** a decision must be made within 24 hours after receipt of the request.

iii. If SHP grants itself an extension, it must notify the enrollee in writing of the reason(s) for the delay. The enrollee must also be informed in the written notification about his/her rights to file an expedited grievance if he/she disagrees with SHP's decision to grant an extension.

iv. When an extension is applied, SHP must notify the enrollee or provider requesting the item or service in writing of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

v. Refer to HS-039: Organization Determination Extension Policy for more detailed guidance on processing extensions.

VIII. <u>Notification of Plan's Determination – Approvals:</u>

A. SHP must provide notices for initial organization determinations using the most efficient manner of delivery to ensure the enrollee receives the notice in time to act.

B. All Approvals:

i. Providers and enrollees may be notified of a favorable decision on a request for an item, service, or Part B drug either verbally (via telephone) or in writing (via fax and/or mail using a CMS approved letter) within the standard timeframe.

ii. SHP provides the notification to the requesting party, i.e., the provider, the enrollee or the enrollee's authorized representative, of its determination as expeditiously as the enrollee's condition requires and adheres to following additional guidelines:

1. If a provider submits the request on behalf of the enrollee, SHP must notify the enrollee as well as the provider of its determination.
2. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. SHP may provide notice to both the representative and enrollee but are not required to do so.
3. The enrollee's approval is required prior to sending written notification via fax or email.

C. For approvals of items or services (excluding Part B drugs), the notification must be provided as expeditiously as the enrollee's condition requires, but no later than 14 calendar days after the date SHP received the request. The approved service is described in a manner that the enrollee can understand and explains any conditions of the approval, such as the duration of the approval.

D. **For approvals of an expedited item or service request (excluding Part B drugs),** SHP notifies the provider, the enrollee, or the enrollee's authorized representative of its determination via verbal notification and/or in writing as expeditiously as the enrollee's condition requires but no later than 72 hours of receiving the request for an expedited organization determination, or no later than the expiration of the extension when an extension is granted. If SHP initially provides verbal notification of its decision, written notification is provided to the enrollee **within 3 calendar days of the verbal notification**.

E. For standard Part B drug requests, the notification must be provided as expeditiously as the enrollee's condition requires but no later than 72 hours from the date/time the Plan received the request. The approved service is described in a manner that the enrollee can understand.

   i. If SHP initially provides verbal notification of its decision, written notification is provided to the enrollee **within 3 calendar days of the verbal notification**.

IX. Notification of Adverse Determinations (Full or Partial):

A. Denial of services or items might include:

   i. Exhaustion of Benefits
   ii. Items, Services, Part B Drug Not Covered
   iii. Medical Necessity Not Met
   iv. Partial or Full Denial of an admission (to a hospital, SNF, or Rehabilitation facility) or observation stay.

B. **CMS Model Notice of Denial of Medical Coverage:** Enrollees, the enrollee's authorized representative, and providers are notified of any adverse organization determinations, including partial denials, in writing via the CMS Model Notice of Denial of Medical Coverage (Form CMS-10003-NDMCP). The NDMCP is written in a manner that is understandable to the enrollee and must:

   i. Be delivered in the most efficient manner to ensure the enrollee or the enrollee's authorized representative receives it in time to act. It must be translated if required.
   ii. A specific and detailed explanation of why the medical services, items or Part B drugs were denied, including a description of the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable.
   iii. For service denials, a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process.
   iv. Information regarding the enrollee's right to appeal and the right to appoint a representative to file an appeal on the enrollee's behalf.
   v. Include the enrollee's right to submit additional evidence in writing or in person.
   vi. An explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).
   vii. ***(Refer to HS-020: Adverse Determination – Facilities for required forms and processes for SNF and other facility denials)***

C. Form CMS-10003-NDMCP should also be used if an enrollee requests an MA organization to provide an explanation of a practitioner's denial of an item, service, or Part B drug, in whole or in part.

D. **For standard adverse organization determinations of item or service requests (other than Part B Drugs)**, including reducing or prematurely discontinuing the level of care for a previously authorized ongoing course of treatment, SHP notifies the provider, the enrollee, or the enrollee's authorized representative of its determination in writing as expeditiously

as the enrollee's condition requires but within 14 calendar days as follows:

i. Written notification of the adverse determination is mailed within 14 calendar days.
ii. If the 14 calendar days' timeframe was extended by up to an additional 14 calendar days, SHP notifies the enrollee as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

E. **For all standard adverse decisions for standard Part B drug requests**, SHP notifies the provider, enrollee, or the enrollee's representative of its determination via oral notification *and* in writing as expeditiously as the enrollee's condition requires, but no later than 72 hours from the date/time the Plan received the request. If SHP initially provides verbal notification of its decision, written notification is provided to the enrollee within 3 calendar days of the verbal notification.

F. **For partially favorable or fully adverse organization determinations of expedited item or service requests,** SHP notifies the enrollee, the enrollee's authorized representative (and the physician involved, as appropriate) of its determination via verbal *and* written notification as expeditiously as the enrollee's condition requires but no later than 72 hours after receiving a request for items or services as follows:

i. Written notification of the adverse determination is mailed within 72 hours after receiving a request for items or services.
ii. If SHP initially provides verbal notification of its decision within 72 hours of receiving the request, written notification **must** be provided to the enrollee within 3 calendar days of the verbal notification.

G. If the 72-hour time frame was extended by up to an additional 14 calendar days, SHP notifies the enrollee as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

H. **For all partially favorable or fully adverse organization determinations of expedited Part B drug requests,** SHP notifies the provider, enrollee, or the enrollee's representative of its determination via verbal notification *and* in writing as expeditiously as the enrollee's condition requires, but no later than 24 hours after SHP received the request.

i. If SHP initially provides verbal notification of its decision, written notification **must** be provided to the enrollee **within 3 calendar days of the verbal notification**.

X. Additional Guidelines for Ensuring Notification Timeliness

A. SHP adheres to CMS guidelines in determining timeliness of notifications. Specifically:

i. Written notification is considered delivered on the date (and time, if applicable) the notice has left the possession of SHP or SHP's delegated entity. This occurs when the notice has been deposited into the courier drop box or external outgoing mail receptacle (e.g., U.S. Postal Service or FedEx bin) or for electronic delivery of required materials, the date the plan sends the materials to the enrollee.

1. Placement into SHP's or SHP's delegated entity's internal outgoing mail receptacle is not considered delivered.

ii. Verbal notification is considered delivered on the date (and time, if applicable) an SHP staff speaks directly to or leaves a voicemail for an enrollee or enrollee's representative. SHP may initially provide verbal notification to enrollees prior to issuing written notification.

1. In circumstances when verbal notification is permitted per regulatory requirements and SHP staff successfully provides verbal notice (e.g., spoke with the person that submitted the request or was able to leave a voicemail message), the required written notification must be sent by the plan within 3 calendar days of the verbal notice.
2. If the plan is not able to successfully provide verbal notice (i.e., when a plan has an enrollee's telephone number on file but is unable to reach the enrollee at the number provided because, for example, it is either incorrect, out-of-service, or no person (or no voicemail system) answers), written notice must be sent within the applicable timeframe.

B. Effect of Failure to Provide Timely Notice:

i. If SHP fails to provide the enrollee with timely notice of a organization

determination as required by CMS and outlined in this policy, this failure itself constitutes an adverse organization determination and may be appealed.

IX. Change of Review Priority

A. After a request is initiated as a standard or expedited review, a provider may contact the plan to change the review priority.

B. If the provider indicates that the enrollee's health requires an expedited decision, the plan must begin the applicable expedited review period at the time they receive the physician's request to expedite the decision.

C. Note: A change of priority does not allow for extra review time. If the remaining standard review period is less than the applicable expedited review period, the original standard deadline still applies.

XI. Documentation:

A. The HSD Staff must document all Organization Determination requests and associated actions accurately and timely in the member's record and ensure that documentation supports compliance with applicable CMS regulations.

Attachment(s):

- **Attachment 1:** Actions Following Acceptance of a Request for Expedited Determination

Statutory Reference(s):

- **Federal:**
  - HPMS Memo dated 02-26-2024 - *Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)*
  - Medicare Managed Care Manual: Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
  - 42 CFR §422.101 – Requirements Relating to Basic Benefits
  - 42 CFR §422.561 – Definitions
  - 42 CFR §422.566 – Organization Determinations
  - 42 CFR §422.568 - Standard Timeframes and Notice Requirements for Organization Determinations
  - 42 CFR §422.570 - Expediting certain organization determinations
  - 42 CFR §422.572 – Timeframes and Notice Requirements for Expedited Organization Determinations

Contract Reference(s):

- Medicare Advantage D-SNP Health Plan Agreement Between Georgia Department of Community Health and Sonder Health Plans, Inc.

Document Reference(s):

- Form Notice of Denial of Medical Coverage CMS-10003-NDMCP

Related Policy(s):

- HS-012: Application of Medical Criteria and Medical Necessity Reviews
- HS-020: Adverse Determinations - Facilities
- HS-022: Experimental Treatment and New Technologies
- HS-039: Organization Determination Extension Process Policy
- HS-044: Processing Dismissals of Organization Determination Requests

ATTACHMENT 1
Actions Following Acceptance of a Request for Expedited Determination

Decision	Processing Requirements for Expedited Determinations
Favorable	• Provide verbal or written notification* of favorable decision to the enrollee (and the physician involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than:
	o 72 hours after receiving the request for items and services o 24 hours after receiving the request for Part B drugs.
	• If the MA plan initially provides verbal notification of its decision, it **may** deliver written confirmation of its decision within 3 calendar days of the verbal notification.
Partially Favorable or Adverse	• Provide written notification* to the enrollee of the decision (and the physician involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than:
	o 72 hours after receiving the request for items and services. o 24 hours after receiving the request for Part B drugs.
	• If the MA plan initially provides verbal notification of its decision, it **must** deliver written confirmation of its decision within 3 calendar days of the verbal notification.

Source: Medicare Managed Care Manual: Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 40.8