Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification may be oral and/or electronic)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Pre-Service Organization Determination	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request *Extensions* • May extend up to 14 calendar days. • If extended, the decision is required within a maximum of 28 calendar days after receipt of request • ***Note:*** Extension allowed ***only*** if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny)	Practitioner: Within 14 calendar days after receipt of request or no later than upon expiration of extension (for approvals and denials) *Extensions* Practitioner & Member: When the timeframe is extended, give notice **in writing** of the reasons for the delay, and the right to file a grievance if they disagree with the decision to grant an extension (within 14 calendar days of receipt of request)	Within 14 calendar days after receipt of request *Extensions* Maximum of 28 calendar days after receipt of request if an extension was warranted
Expedited Initial Organization Determination (*see footnote)	Within 72 hours after receipt of request (includes weekends & holidays) • Promptly decide whether to expedite – determine if applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function If submitted as expedited but determined not to be expedited, then pre-service organization determination timeframe applies	Practitioner & Member: Within 72 hours after receipt of request or no later than upon expiration of extension (for approvals and denials) Practitioner & Member: If request is not deemed to be expedited, give prompt oral notice of the	Within 72 hours after receipt of request ▪ ***Note:*** Oral notification to be followed by written notification within 3 calendar days of oral notification **(for approvals and denials)** If request is not deemed to be expedited, follow up written notification to be delivered to the member within 3 calendar

***Note: Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial organization determinations.**

ICE CMS UM TAT Final 12-02-02
Revised 6/5/03; 6/20/03; 5/17/04; 7/14/04

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification may be oral and/or electronic)**	**Written/Electronic Notification of Denial to Practitioner and Member**
	• Automatically transfer the request to the standard timeframe • The 14 day period begins with the day the request was received for an expedited determination	denial to expedite the request	days of oral notification
	Extensions • May extend up to 14 calendar days. • If extended, the decision is required within a maximum of 17 calendar days after receipt of request • ***Note:*** Extension allowed ***only*** if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny)	*Extensions* Practitioner & Member: When the timeframe is extended, give notice **in writing** of the reasons for the delay, and the right to file a grievance if they disagree with the decision to grant an extension (within 72 hours of receipt of request)	*Extensions* Maximum of 17 calendar days after receipt of request if an extension was warranted
Discontinuation of Acute Inpatient Services - Notice of Discharge & Medicare Appeal Rights (NODMAR) (Concurrent)	• Continue coverage of inpatient care until attending physician concurs with discharge	Attending Physician responsible for member's hospital care & must concur before issuance of NODMAR.	Required only if the member disagrees with the discharge decision; or the hospital is not discharging the member but the Health Plan or delegate will no longer continue coverage of the inpatient hospital stay. ▪ The notice must be issued no later than the day before hospital coverage ends. An enrollee is entitled to coverage until at least noon of the day after such notice is provided.

***Note: Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial organization determinations.**

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification may be oral and/or electronic)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
			• Obtain acknowledgement of receipt from member, member's representative, or witness of member's refusal to sign
Post-service Organization Determination (Retrospective) Note: Requests for payment that occur through claims follow separate claims processing timeframes.	Within 14 calendar days after receipt of request *<u>Extensions</u>* • May extend up to 14 calendar days • If extended, the decision is required within a maximum of 28 calendar days after receipt of request • ***<u>Note</u>:*** Extension allowed ***only*** if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny)	<u>Practitioner:</u> Within 14 calendar days after receipt of request or no later than upon expiration of extension (for approvals and denials) *<u>Extensions</u>* <u>Practitioner & Member:</u> When the timeframe is extended, give notice **in writing** of the reasons for the delay, and the right to file a grievance if they disagree with the decision to grant an extension (within 14 calendar days of receipt of request)	Within 14 calendar days after receipt of request *<u>Extensions</u>* Maximum of 28 calendar days after receipt of request if an extension was needed

***Note: Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial organization determinations.**

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

		Notification Timeframe	
Type of Request	**Decision**	**Notice of Medicare Non-Coverage (NOMNC) Notification**	**Detailed Explanation of Non-Coverage (DENC) Notification**
Termination of Provider Services: • Skilled Nursing Facility (SNF) • Home Health Agency (HHA) • Comprehensive Outpatient Rehabilitation Facility (CORF)	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: • Discharge from SNF, HHA or CORF services **OR** • A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative • The NOMNC must be delivered no later than two (2) calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date and date that coverage of services ends • The NOMNC may be delivered earlier if the date that coverage will end is known <u>*Note*</u>: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: • The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day before the QIO needs to make its decision

***Note: Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial organization determinations.**