ATTACHMENT VII

Part C Organization Determinations, Appeals, and Grievances (ODAG)
Audit Process and Universe Request

Purpose: To evaluate a Medicare plan's performance in the four (4) areas outlined below related to organization determinations, appeals, and grievances. The Centers for Medicare & Medicaid Services will perform its audit activities using these instructions (unless otherwise noted).

Review Period: Three (3) month period preceding the date of the audit engagement letter (Month, Day, Year through Month, Day, Year) CMS reserves the right to expand the review period to ensure a sufficient universe size.

Note: The plan is expected to provide accurate and timely universe submissions. In addition, the plan is expected to present their supporting documentation during the audit and upload it to the secure site using the designated naming convention within the timeframe specified by the reviewers. If the plan fails to provide accurate and timely universe submissions or fails to submit the supporting documentation using the designated naming convention and within the timeframe specified by the reviewers, CMS will document this as an observation in the plan's program audit report.

I. Effectuation Timeliness - Organization Determinations and Appeals (ODA)

1. Select Universe and submit to CMS: In addition, they will pull a universe consisting of all pre-service and payment organization determinations and reconsiderations decisions which were approved (i.e., favorable to the enrollee) during the review period.
Submit Universes in Attachment VII-A (**Effectuation Timeliness Tabs: ET - Pre-Service, ET - Payment, ET – Recons, ET – IRE, ALJ, MAC**). The Plan should submit its universes in whole and not separately for each contract. If the file is too large for Excel, a CSV or a text file is acceptable.

Note: The dates of the favorable determinations and of the IRE, ALJ and MAC reversals (overturns) should fall within the review period specified above.

The universe should consist of the following:

1.1. Pre-service organization determinations consisting of decisions to approve medical care/services before the services are provided to enrollees.
1.1.1. Exclude concurrent review for inpatient hospital and SNF services, post-service reviews, notification of admission, and requests for extensions of previously approved services.
1.2. Payment organization determinations consisting of non-contracted provider paid claims. A claim consists of one or more service line items. This universe should only include one record for the entire claim. The entire claim must be paid.
1.2.1. Exclude duplicate claims and payment adjustments to claims.

1.3. Reconsiderations in which the original denial of an organization determination of either pre-service or payment was overturned in whole by the plan.
1.4. Reconsiderations overturned by the IRE, ALJ, or MAC. (**Note:** This universe is the same as the universe described in Section II, 1.4).

2. Select 30 Cases: CMS will select a targeted sample of 30 cases from the universe categories as follows:

- 10 favorable organization determination cases;
- 10 favorable reconsiderations cases; and
- 10 cases overturned by the IRE, ALJ or MAC.

If there are not enough reconsideration, IRE, ALJ or MAC cases, CMS will increase the number of organization determinations cases to obtain a total sample size of 30.

3. Obtain Evidence: CMS will review for timely notification and effectuation. For each case, the plan must produce all relevant documentation including, **but not limited to**:
    - Original pre-service or payment (i.e., claim) or reconsideration request.
    - Letters, emails or documentation confirming the plan's receipt of the request.
    - Notices, letters, or other documentation showing the plan requested additional information (if applicable) from the requesting provider/physician, including date, time, and type of communication.
    - All supplemental information submitted by the requesting provider/physician or enrollee, including documentation showing when information was received by the plan.
    - Notices/letters to enrollees or reports or other logs that show when enrollee or provider/physician was notified of the decision and effectuation was made in the plan's systems.
    - If applicable, all documentation to support the plan's decision to process an expedited request under the standard timeframe, including any pertinent medical documentation, and any associated notices provided to the enrollee and the requesting provider/physician.

4. Apply Compliance Standard: Apply the following test to each of the 30 cases. For a case to receive a score of "pass", the case must present evidence to favorably address both of the following questions:
    4.1. Was timely notification provided to the enrollee (or representative) and the provider/physician, if applicable (applies to plan level decisions only);and
    4.2. Was the decision effectuated in the plan's system timely?

5. Sample Case Results: CMS will test each of the 30 cases. If CMS requirements are not met, a sample case fails and a condition (finding) is documented. If CMS requirements are met, a sample case passes and no conditions (findings) are documented.

II. Appropriateness of Clinical Decision-Making & Compliance with ODA Processing Requirements

1. Select Universe and submit to CMS: Plan will pull a universe consisting of: all organization determinations and reconsiderations that were denied in whole or in part (i.e. unfavorable to the enrollee) during the review period, including those that were untimely and auto-forwarded to the IRE; and all IRE, ALJ, or MAC reconsiderations that reversed/overturned the plan's denial in whole or in part (favorable to the enrollee) during the review period.

    Note: The dates of the unfavorable determinations and of the IRE, ALJ and MAC reversals (overturns) should fall within the review period specified above.

    The universe should consist of the following:

    1.1. Pre-service organization determinations consisting of decisions to deny medical care/services before they are provided to enrollees.
    1.1.1. Exclude concurrent review for inpatient hospital and SNF services, post-service reviews, notification of admission, and requests for extensions of previously approved services.

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1.2. Payment organization determinations consisting of contracted or non-contracted provider denied claims. A claim consists of one or more service line items. If any line item is denied, the entire claim is considered adverse. This universe should only include one record for the entire claim.

1.2.1. Exclude claims that denied as duplicate; claims that denied for invalid billing codes; denied claims for beneficiaries who are not enrolled on the date of service; and denied due to recoupment of payment

1.3. Reconsiderations in which the original denial of an organization determination (pre-service or payment) was upheld in whole or in part by the plan.

1.4. Reconsiderations overturned by the IRE, ALJ, or MAC.

Submit Universe in Attachment VII-A (**Clin D-Mking&ODA Compliance Tabs: CDM – Pre-service, CDM – Payment, CDM – Recons, CDM – IRE ALJ MAC)**. The Plan should submit its universes in whole and not separately for each contract. If the file is too large for Excel, a CSV or a text file is acceptable.

2. Select 30 Cases: In sampling, CMS will ensure the 30 cases appear clinically significant. The sample will represent various medical services (ER services, outpatient hospital, inpatient hospital, urgent care). CMS will select a targeted sample of 30 cases from the universe categories as follows:
   - 10 adverse organization determination cases;
   - 10 adverse reconsideration cases; and
   - 10 cases overturned by the IRE, ALJ, or MAC.

   If there are not enough reconsideration, IRE, ALJ, or MAC cases, CMS will increase the number of organization determinations cases to obtain a total sample size of 30

3. Obtain Evidence (Case Files): CMS will review for timely and proper notification and clinical appropriateness of the decision and for timely effectuation by the plan of the IRE, ALJ or MAC overturns. For each case, the plan must produce all relevant documentation including, **but not limited to**:
   - Original pre-service or payment (i.e., claim) or reconsideration request.
   - All notices, letters, or other documentation showing the plan requested additional information (if necessary) from the provider/physician, including date, time and type of communication.
   - All supplemental information submitted by the provider/physician, including documentation showing when information was received by plan.
   - Documentation showing the plan's rationale for the decision, including any standard operating procedures or standard decision trees used by clinical personnel, internal communication(s); and reference to CMS Guidance, Federal Regulations, and plan documents (e.g., EOC, SB, NCDs, LCDs), as applicable.
   - All notices, letters, and communications to the enrollee (and provider/physician, if applicable) demonstrating when notification was made.
   - For cases that were auto-forwarded to the IRE, the case file should include documentation showing when the case was forwarded and when the enrollee was notified that the case was sent to the IRE.

4. Apply Applicable Compliance Standard: Apply the applicable test to the relevant 30 sampled cases. For an initial organization determination case to receive a score of "pass," the case must present evidence to favorably address questions 4.1.1 through 4.1.4. For a reconsideration case to receive a score of "pass" the case must present evidence to favorably address questions 4.2.1 through 4.2.4 and favorably address question 4.2.5 or 4.2.6.

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4.1. Initial organization determination requests that were partially or fully denied for lack of medical necessity:

- **4.1.1.** Was timely notification provided to the enrollee (or representative) and provider/physician, if applicable?
- **4.1.2.** Was appropriate notification provided to the enrollee (or representative) and provider/physician, if applicable?
- **4.1.3.** Was the request reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise including knowledge of Medicare coverage criteria?
- **4.1.4.** Did the plan appropriately consider clinical information and comply with CMS coverage requirements?
- **4.1.5.** If care or services were provided or referred by a contracted provider, was the member held harmless?

4.2. Reconsiderations where the initial organization determination was denied for lack of medical necessity:

- **4.2.1.** Was timely notification provided to the enrollee (or representative) and provider/physician, if applicable?
- **4.2.2.** Was appropriate notification provided to the enrollee (or representative) and provider/physician, if applicable?
- **4.2.3.** Was the reconsideration reviewed by a *different* physician with expertise in the field of medicine that is appropriate for the services at issue?
- **4.2.4.** Did the plan appropriately consider clinical information and comply with CMS coverage requirements?
- **4.2.5.** If care or services were provided or referred by a contracted provider, was the member held harmless? or
- **4.2.6.** If the plan made an adverse decision or did not meet the decision making timeframe, did the plan auto-forward to the IRE properly and within the required timeframe?

5. Sample Case Results: CMS will test each of the 30 cases. If CMS requirements are not met, a sample case fails and a condition (finding) is documented. If CMS requirements are met, a sample case passes and no conditions (findings) are documented.

III. Grievances

1. Select Universe and submit to CMS: Plan will pull a universe consisting of all grievances received (e.g., written correspondence, calls received by customer service representatives, etc.) during the review period.

Note: The date of receipt should fall within the review period specified above.

Submit Universe in Attachment VII-A (**Grievances Tab**). The Plan should submit its universes in whole and not separately for each contract. If the file is too large for Excel, a CSV or a text file is acceptable.

2. Select 15 Cases: CMS will select a targeted sample of 15 grievances from the universe. The sample will consist of oral and written grievances.

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3. Obtain Evidence: CMS will review to determine timeliness, appropriate classification, notification and outcome. For each case, plan must produce all relevant documentation including, but not limited to:
- Original grievance
- Documentation showing when grievance was received.
- Documentation explaining the issue.
- Documentation showing the Plan's investigation follow-up steps, and description of the final grievance outcome.

3.1. For quality of care grievances: provide documentation that supports that an investigation and appropriate follow up took place.

3.1.1. Include all notices, letters, and beneficiary communications demonstrating when notification of the final grievance outcome was made.

4. Apply Compliance Standard: Apply the following test to each of the 15 cases. For a case to receive a score of "pass", the case must present evidence to favorably address all of the following questions:

4.1. Was the case correctly categorized as a grievance, and if not, was it transferred to the appropriate process?

4.2. Was the enrollee notified of the disposition timely?; and

4.3. Did the grievance notification appropriately address all issues raised in the complaint?

5. Sample Case Results: CMS will test each of the 15 cases. If CMS requirements are not met, a sample case fails and a condition (finding) is documented. If CMS requirements are met, a sample case passes and no conditions (findings) are documented.

IV. Dismissals

1. Select Universe and submit to CMS: Plan will pull a universe consisting of all plan-level reconsideration requests (both pre-service and request for payment) that were sent to the IRE for dismissal due to missing Waiver of Liability (WoL) (non-contracted providers only) or CMS-1696 Appointment of Representative (AoR) (or other conforming instrument) during the review period.

Note: The date the case was forwarded to the IRE for dismissal should fall within the review period specified above.

Submit Universe in Attachment VII-A (**Dismissals Tabs: Dismissals – Pre-services, Dismissals - Payment**).The Plan should submit its universes in whole and not separately for each contract. If the file is too large for Excel, a CSV or a text file is acceptable.

2. Select 20 Cases: CMS will select a targeted sample of 20 plan-level requests for dismissal as follows:
- 10 pre-service dismissal requests
- 10 payment dismissal request

3. Obtain Evidence: CMS will review to determine if the plan made all reasonable efforts to obtain an Appointment of Representative (AOR) (or other conforming instrument) or Waiver of Liability (WoL) prior to sending the case to the IRE for dismissal, and to determine if the plan forwarded the case timely to the IRE for dismissal.
For each case, plan must produce all relevant documentation including, but not limited to:

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- Original pre-service or payment (i.e., claim) or reconsideration request.
- Initial organization determination.
- Letters, emails or documentation confirming the plan's receipt of the request.
- Notices, letters, or other documentation showing the plan requested additional information (i.e., the WoL or AOR (or other conforming instrument)) from the requesting provider/physician or purported representative, including date, time and type of communication.
- All supplemental information submitted by the requesting provider/physician or representative, including documentation showing when the information was received by the plan.
- Notices/letters to the IRE and proof of date the plan sent the case with a request for dismissal.

4. Apply Compliance Standard: Apply the following test to each applicable case:

4.1. Pre-service dismissal cases: For a case to receive a score of "pass," the case must present evidence to favorably address all of the following questions:

4.1.1. Did the plan make a reasonable effort to obtain the AOR (or other conforming instrument) and document those efforts in the case file?

4.1.2. Did the plan, upon failure to receive the AOR (or other conforming instrument) forward the case file to the IRE?

- within the required timeframe; and
- with a request for dismissal

4.2. Payment dismissal cases: For a case to receive a score of "pass", the case must present evidence to favorably address all of the following questions:

4.2.1. Did the plan make a reasonable effort to obtain the AOR (or other conforming instrument) or WoL and document those efforts in the case file?

4.2.2. Did the plan, upon the plan's failure to receive the AOR (or other conforming instrument) or WoL, forward the case file to the IRE?

- within the required timeframe; and
- with a request for dismissal; and

5. Sample Case Results: CMS will test each of the 20 cases. If CMS requirements are not met, a sample case fails and a condition (finding) is documented. If CMS requirements are met, a sample case passes and no conditions (findings) are documented.

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