Policy Title	**Prior Authorization Organization Determinations**
Policy Department	**Utilization Management**
Effective Date	**9/17/21**
Revision Date(s)	**6/24/2016, 9/6/2016, 10/28/2016, 10/11/2017, 5/15/19, 10/30/19, 7/13/20, 7/2/21**

Disclaimer:

Clover Utilization Management applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgement in rendering services. Providers are expected to provide care based on best practices and use their medical judgement for appropriate care.

Purpose:

The purpose of the Prior Authorization Organization Determinations policy is to:

- Establish a process for members or their authorized representative and providers to submit
  requests for medical services.
- Ensure the timely response to medical service requests that accommodates the clinical urgency of the situation and to minimize any disruption in the provision of healthcare.
- Comply with all State and Federal regulatory requirements.

Scope:

This Policy and Procedure applies to the timeliness and review process of Medicare Part C organization determinations within the Utilization Management (UM) Department. The UM Department is under the umbrella of the Medical Management Department (Clinical Operations).

Policy:

It is the policy of Clover Health (Clover) to ensure that members receive appropriate care and/or services and that utilization decisions are made in a timely manner in order to minimize disruption in the provision of care, and that decisions are made as expeditiously as the member's medical condition warrants. All Utilization Management (UM) decision making is based only on the appropriateness of care and services; appropriate setting and the existence of coverage. An authorization of services does not guarantee payment.

The Plan (Clover) does not reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives are not provided to UM decision makers nor are UM decision makers encouraged to render decisions that result in underutilization.

Definitions:

a. **Adverse Organization Determination** means that the Plan denies authorization or payment for services based on established, evidence based clinical review criteria. Denials may be based on fully or partially denied prospective (pre-service, i.e., requests from a practitioner or member before services are delivered) concurrent (i.e., review of services

currently being provided in a clinical setting), or retrospective (post service, i.e., submission of a request for authorization or payment after services are delivered).

b. **Effectuation** means compliance with a reversal of the Medicare health plan's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

c. **Independent Review Entity (IRE)** means an independent entity contracted by CMS to review Medicare health plans' adverse organization determinations.

d. **Inquiry** means any verbal or written request to a Medicare health plan, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee.

e. **Medical Exigency Standard** means the requirement that a Medicare health plan and related entities have to make decisions expeditiously as the enrollee's health condition requires.

f. **Medical Necessity** means covered services that are prescribed based on generally accepted medical practices in light of conditions at the time of treatment. Medically Necessary services are: appropriate and consistent with the diagnosis of the treating provider and the omission of such could adversely affect the member's medical condition; compatible with the standards of acceptable medical practice in the community; provided in a safe, appropriate, cost-effective setting given the nature of the diagnosis and severity of the symptoms not provided solely for the convenience of the member, the physician, or the facility providing the care those for which there are no other effective and more conservative or substantially less costly treatment, service or setting available.

g. **Organization Determination** means any determination (approval or denial) made by a Medicare health plan with respect to any of the following:

1. Payment for temporarily out of area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
2. Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;

3. The Medicare health plan'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 Medicare health plan;
4. Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
5. Failure of the Medicare health plan 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.

h. **Pre (Prior) Authorization** means authorization granted in advance of the rendering of a service after appropriate medical review. When related to an inpatient admission, this process may also be referred to as pre-certification.

i. **Reconsideration** means an enrollee's first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

j. **Successful Verbal Notification** is considered delivered on the date (and time, if applicable) a Clover representative speaks directly to or leaves a voicemail for an enrollee or enrollee's representative.

Procedure:

1. **Roles and Responsibility of the Customer Experience Department**
    a. Customer service representatives are trained to distinguish between coverage requests, appeals, and grievances pursuant to section 30.1 of the Medicare

Managed Care Manual Medicare Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

b. A Clover member may request care or services via telephone, mail or fax through the Customer Experience Department seven days a week, between 8:00 am and 8:00 pm, local time. Numbers are published in the Member Handbook.
c. The Customer Experience agents are responsible for documenting all requests for care/services received by the Customer Experience Department and document requests in the case file and immediately notify the Medical Management Department.

2. Roles and Responsibility of the Utilization Management Department

a. Medical Director
   i. In accordance with 42 CFR §422.562(a)(4) and 423.562(a)(5), the medical director is employed by Clover Health and assumes overall responsibility for clinical decision-making and is involved in aspects of related plan policies and operations including but not limited to: medical and utilization review, benefits and claims management, processing coverage decisions in accordance with adjudication timeframes and notice requirements, provider/prescriber outreach, staff training, and oversight of delegated entities.
   ii. The medical director is a physician, as defined in section 1861(r) of the Act, with a current, and unrestricted, license, to practice medicine in a state, territory, Commonwealth of the United States, or the District of Columbia.
b. Utilization Management
   i. Utilization Management is responsible for the operational compliance and performance of the department.
   ii. Utilization Management coordinates operations with UM and other departments within the health plan.
   iii. The Utilization Management is responsible for overseeing and coordinating the process of investigation and resolution of all pre-service requests submitted by the member, their authorized representative or providers.
   iv. Utilization Management prepares reports regarding Organization Determinations for review by the Plan's Medical Director and Chief Medical Officer and for submission to the Centers for Medicare & Medicaid Services (CMS)
c. Utilization Management Coordinator
   i. The UM Coordinator is responsible for:

1. The accurate and timely processing and creation of prior authorization requests received through telephone, mail, fax or online submission.
2. Establishes the member's eligibility (i.e. active enrollment with Clover Health) and confirms benefit coverage (i.e. that the requested service is billable to Medicare).
3. Sends all requests that require medical necessity review to the appropriate Utilization Management staff.
4. Adheres to adjudication timeframes as established by CMS for standard and expedited prior authorization organization determinations pursuant to section 40.10 of the Medicare Managed Care Manual Medicare Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
5. Ensures that all correspondence, including extensions and resolution notices are sent to the member, authorized representative and/or provider within the regulatory timeframes.
6. In accordance with section 40.9 of the Medicare Managed Care Manual Medicare Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective January 1, 2020), and only in the application of a clear statutory or contract exclusion set forth in Clover Health's Evidence of Coverage, the UM coordinator may issue an adverse decision. Determinations based on application of clear statutory or contract exclusions set forth in the Evidence of Coverage do not constitute a decision based on lack of medical necessity.
7. UM Coordinators do not issue organization determination based on medical necessity or the lack thereof.

d. Mailroom Correspondence Clerk
   i. The Mailroom Correspondence Clerk ensures that all correspondence, including extensions and resolution notices are sent to the member, authorized representative and/or provider within the regulatory timeframes.
e. Utilization Management Nurse
   i. The Utilization Management Nurse is responsible for initial and concurrent medical necessity review(s) for initial prior authorization requests.
   ii. The Utilization Management Nurse applies medical management guidelines including but not limited to CMS's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs),

Clover medical policies and MCG guidelines to each initial organization determination to determine if the service or item can be approved.

iii. If the request does not meet medical necessity or benefit criteria, the Utilization Management Nurse forwards the Organization Determination to the Medical Director for review and final determination.

3. Processing Initial Organization Determinations

a. Acceptance and Determination Notification

i. Clover Health maintains processes to accept coverage requests 24 hours a day, 7 days a week (including holidays). Pre-Service organization determination requests may be submitted to Clover Health by phone, fax, mail or online submission through Clover Health's public website.

ii. Clover Health has established processes to notify Clover Health members of pre-service decisions within the applicable timeframes as stated in section 40.10 of the Medicare Managed Care Manual Medicare Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

b. Processing Timeframes

i. Standard Organization Determinations will be processed within 14 calendar days. If an extension is applied then the auth will be processed within 28 days.

1. Standard pre-service determination requests for Part B Drug will be processed within 72 hours. An extension cannot be applied to determination requests for Part B drugs.

ii. Expedited Organization Determinations will be processed within 72 hours. If an extension is applied then the auth will be processed within 17 days.

1. Expedited pre-service determination request for Part B Drug will be processed within 24 hours. An extension cannot be applied to determination requests for Part B drugs.

4. Untimely Organization Determination

a. In the event that Clover does not render an Organization Determination within the regulatory timeframe for either a standard or expedited request, the failure itself constitutes an adverse Organization Determination and may be appealed.

5. Appeal Rights

a. The member, authorized representative or treating provider has the right to appeal the Organization Determination if it involves an adverse decision. Specific instructions on how to file a standard appeal and expedited (fast-track) appeal (Reconsideration) are included in the CMS-approved denial notices.

6. Withdrawal of a Request for an Initial Determination

a. Clover will allow the party that submits a request for an initial determination may make a verbal or written request to withdraw the request at any time before the decision is issued. For verbal withdrawal requests, Clover will clearly document the date and the reason why the party chose not to proceed with the initial determination procedures. Written requests will be attached to the case file.

7. Policy and Practice Guideline Review Frequency

a. The Clover Pre-Service Organization Determination policy and procedure along with any Medical Management practice guidelines are reviewed annually and presented to the Chief Medical Officer, Medical Management Committee, and Quality Improvement Committee with physician peers for consultation with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply in accordance to Chapter 6 Section 20 of the Medicare Managed Care Manual.

References
Medicare Managed Care Manual Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
42 CFR §422.568(b)(1) and (2)