



Medicare Enrollment & Appeals Group

DATE: February 22, 2017

TO: All Medicare Advantage Organizations and Prescription Drug Plan Sponsors

FROM: Jerry Mulcahy
Director

SUBJECT: Updated Guidance on Outreach for Information to Support Coverage Decisions

This memorandum provides clarifying guidance related to Medicare Advantage organizations (MAOs) and Part D sponsors requesting information (e.g., clinical documentation) from providers and prescribers when adjudicating coverage decisions.

The draft 2016 Call Letter solicited feedback from stakeholders on the value of CMS developing guidance on what constitutes reasonable outreach by plans. As a result, the final 2016 Call Letter noted that CMS would develop sub-regulatory guidance on what constitutes appropriate outreach; this was reiterated in the final 2017 Call Letter. Until the CMS Manual guidance in Chapter 13 of the Medicare Managed Care Manual and Chapter 18 of the Prescription Drug Benefit Manual is updated later this year, this memorandum is meant to identify best practices that, if implemented, will result in more timely and accurate coverage decisions for beneficiaries. This memorandum replaces the October 18, 2016 HPMS memorandum, "Guidance on Outreach for Information to Support Coverage Decisions." The guidance included in this memorandum will be posted and publicly available on the MA and Part D appeals web pages on CMS.gov.

Pursuant to the existing regulatory requirements at 42 CFR §422.566(a) and §423.566(a), MA and Part D plans must have processes in place for making coverage decisions, which includes soliciting necessary clinical documentation. This guidance outlines best practices for MAOs and Part D sponsors for conducting outreach for both standard and expedited requests on (1) the number and timing of the attempts made to contact a provider, (2) documentation of the plan's efforts to contact a provider, (3) potential method(s) of contact and (4) the content of messaging to the provider when information is requested. This memo also discusses MAOs' and Part D sponsors' responsibilities in documenting requests for information. Best practices are intended to provide plans with actionable information to enhance compliance with existing CMS regulations and policy. CMS strongly encourages plans to implement the best practices described in this memo to help them achieve improved outcomes. The guidance in this memo does not change the standards or requirements against which sponsors will be audited.

Best Practice Recommendations for Conducting Outreach

Unless otherwise noted, this guidance applies to situations that involve both contracted and non-contracted providers.

When an MAO or Part D sponsor does not have all of the information it needs to make a coverage decision, the plan must make reasonable and diligent efforts to obtain all necessary information, including medical records and other pertinent documentation, from the enrollee's provider. MAOs and Part D sponsors are required to conduct outreach within the applicable adjudication timeframe and to document their efforts in accordance with the procedures set forth below. Operational policies and procedures for communicating with providers and requesting information should be designed to satisfy the requirement that pre-service decisions must be issued as expeditiously as the enrollee's health condition requires. See §50.2.1 of Chapter 13 of the Medicare Managed Care Manual and §50.2.1 of Chapter 18 of the Medicare Prescription Drug Benefit Manual for additional information on the medical exigency standard.

While the tables below (*Best Practice Recommendations for Medicare Advantage Organizations* and *Best Practice Recommendations for Part D Sponsors*) set forth guidelines for requesting information to support coverage decisions, the sufficiency of the plan's outreach efforts are contingent upon the facts and circumstances of each case. As part of its required organization determination and appeals procedures, MAOs and Part D sponsors must have procedures in place for requesting and obtaining information necessary for making timely and appropriate decisions. Based on the contractual relationship between a plan and its contracted providers, CMS expects that plans will be able to obtain requested documentation from contracted providers in a reliable and timely manner. Pursuant to 42 CFR §422.562(a)(4) and §423.562(a)(5), the plan's medical director should be involved in the development and oversight of such policies and procedures to ensure the appropriateness of the plan's clinical decision-making. Additionally, 42 CFR §422.562(a)(3) and §423.562(a)(4) states that if an MAO or Part D sponsor delegates any of its responsibilities for making or reviewing organization determinations, the plan is responsible for ensuring that delegated entities adhere to appropriate procedures.

Note regarding MA-PD enrollees: When adjudicating requests for Part D coverage for beneficiaries who are enrolled in MA-PD plans, CMS expects the plan to leverage its contractual relationship when the request involves the need for information from a contracted provider. Contract terms between MAOs and their contract providers are expected to properly incentivize contract providers to produce requested clinical records and other needed information in a timely manner. This expectation extends to all Medicare benefits offered under the plan's contract, including Part D benefits. As a best practice, if the contracted provider does not respond to requests for information and/or the request is made by a contracted provider on behalf of the enrollee, the contracted provider may be more responsive if a plan physician contacts the provider and requests the needed information.

Best Practice Recommendations for Medicare Advantage Organizations

	Adjudication Timeframe	Number of Outreach Attempts	Timing of Outreach Attempts
Standard Organization Determinations - Payment	30 days	3	During business hours in the provider's time zone
Standard Organization Determinations – Pre-Service	14 days	3	<ul style="list-style-type: none"> • Initial attempt within 2 calendar days of receipt of request • When possible, during business hours in the provider's time zone
Expedited Organization Determinations	72 hours	3	<ul style="list-style-type: none"> • Initial attempt upon receipt of request • When possible, during business hours in the provider's time zone
Standard Reconsiderations	30 days (pre-service) 60 days (payment)	3	<ul style="list-style-type: none"> • Initial attempt within 4 calendar days of receipt of request • When possible, during business hours in the provider's time zone
Expedited Reconsiderations	72 hours	3	<ul style="list-style-type: none"> • Initial attempt upon receipt of request • When possible, during business hours in the provider's time zone

Best Practice Recommendations for Part D Sponsors

	Adjudication Timeframe	Number of Outreach Attempts	Timing of Outreach Attempts
Coverage Determinations – Payment	14 days	3	During business hours in the provider's time zone
Standard Coverage Determinations – Benefits	72 hours	3	<ul style="list-style-type: none"> • Initial attempt within 24 hours of receipt of request • When possible, during business hours in the provider's time zone
Expedited Coverage Determinations	24 hours	3	<ul style="list-style-type: none"> • Initial attempt upon receipt of request • When possible, during business hours in the provider's time zone • Given the limited timeframe, outreach must not be limited to business hours
Standard Redeterminations	7 days	3	<ul style="list-style-type: none"> • Initial attempt within 2 calendar days of receipt of request • When possible, during business hours in the provider's time zone
Expedited Redeterminations	72 hours	3	<ul style="list-style-type: none"> • Initial attempt upon receipt of request • When possible, during business hours in the provider's time zone

Outreach Methods and Involvement of Plan Physicians

Methods for requesting information should vary depending on the type of request and the adjudication timeframe. Outreach methods can include:

- Telephone;
- Fax;
- E-mail; and/or
- Standard or overnight mail with certified return receipt.

CMS recommends varying the means of contact and timing the requests in a manner that increases the likelihood of making contact with the provider and receiving the information.

CMS expects MAOs and Part D sponsors, with their medical directors, to design their outreach policies for expedited requests to reflect the immediate need for access to critically needed items or services and drug therapy, including consideration of how the outreach is conducted and who is making the outreach attempts.

When adjudicating reconsiderations and redeterminations, if the plan expects to uphold its initial adverse decision based on lack of medical necessity because the plan needs information from the provider or prescriber to approve coverage, the physician making the decision should attempt to communicate with the provider or prescriber about the request before issuing the decision.

Documenting Requests for Information

An MAO or Part D sponsor must conduct a full and meaningful review of organization and coverage determinations and reconsideration and redetermination requests. The plan or sponsor is expected to make reasonable efforts to gather all of the information needed to make substantive and accurate decisions as early in the coverage process as possible. MAOs and Part D sponsors must document all requests for information and maintain that documentation within the case file. The plan must clearly identify the records, information, and documents it needs when requesting information from the provider. Recordkeeping is essential for demonstrating compliance with procedures for making coverage decisions. Documentation should include the following:

- A specific description of the required information;
- The name, phone number, fax number, e-mail and/or mailing address, as applicable, for the point of contact at the plan; and
- The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission or e-mail. Call records should include the date and time of the call, specific information about who was contacted, what was discussed/requested, and what information was obtained by the plan.

MAOs

If the MAO does not obtain the requested information, it must make a decision within the applicable timeframe based on the available clinical information. Extensions to the applicable adjudication timeframe are permitted, as long as the extension meets the requirements at 42 CFR §§422.568(b)(1), 422.572(b)(1), and 422.590(e)(1), as appropriate. Unless the extension has been requested by the enrollee, the extension must be in the enrollee's interest and either for purposes of requesting information from a non-contract provider that is necessary to approve the request, or because of extraordinary or exigent circumstances. If the plan issues an adverse decision due to the inability to obtain the information needed to approve coverage, the plan should clearly identify that basis and the necessary information in the written denial notice.

Part D Sponsors

If the Part D sponsor does not obtain the information, it must make a decision within the applicable timeframe based on the available information. If the plan issues an adverse decision due to the inability to obtain medical information needed to approve coverage, the plan should clearly identify that basis and the necessary information in the written denial notice.

Questions about this guidance should be directed to the following resource mailboxes:

- Medicare Advantage: Part_C_Appeals@cms.hhs.gov
- Part D: PartD_Appeals@cms.hhs.gov
- CMS audits: part_c_part_d_audit@cms.hhs.gov