UM Initial Determination Timeframes - Medicare Products

These timeframes take into consideration CMS requirements.

Type of Review	If You Have All Necessary Information To Make A Decision:	If You Still Need Information To Make A Decision:
Standard Requests for Services (Any Non-Urgent Request) – All except Pharmacy (Medicare Part D)	Decision, verbal notification and written notification to the member and provider must be completed as expeditiously as the enrollee's health requires but no later than 14 calendar days of the date of the request. All decisions involving participating providers must be made within this timeframe. **Behavioral Health Exception:** As of 01/01/17 per NYS Substance Use Mandate: For prospective /pre-service (first review) for inpatient levels of treatment for addiction, if an in –network OASAS certified facility notifies the insurer of an admission within 48 business hours of the admission, the Plan will automatically approve the admission . NYS out of network providers who are licensed in NYS and the identified member has a contract that has OON benefit; the approval rule also should apply. The approval should be done as follows: 14 days for inpatient substance	The Plan is expected to make every effort to obtain additional information within the required timeframe. The Plan should request the information (and document such requests) in a timely manner in order to make the decision within 14 calendar days and follow up on such requests. All decisions involving participating providers must be made within 14 days. If the information is not received from a non-participating provider within 14 calendar days of the original request, and it is in the member's best interest to have an extension, or if the member requests it, an extension of an additional 14 calendar days may be granted. Send a written request to the member/provider for the specific information needed. We must notify the member or the member's authorized representative of the reason for an extension, the date by which it expects to make a decision, and the member's right to grieve the extension. Once the requested information is received, the decision, verbal and written notification must be made as expeditiously as the member's health condition requires but no later than the expiration of the extension. If no information or incomplete information is received, the decision, verbal and written notification must be made before the expiration of the extension.

Type of Review	If You Have All Necessary Information To Make A Decision:	If You Still Need Information To Make A Decision:
	use disorder (SUD) detoxification; 14 days for inpatient SUD rehabilitation; and 14 days for SUD residential treatment. Per the Assurance of Discontinuance (AOD), auto-approval will apply to all New York-licensed facilities. Also, per the Opiate Mandate, the Plan's UM staff must communicate an approval to the facility the same day if authorization is requested by 2 p.m. and the member has an opiate diagnosis otherwise must give an approval within 24 hours. **Behavioral Health Substance Use Exception** For New York State licensed substance use providers; for initial requests, if the member is already admitted, for inpatient detoxification and rehabilitation and residential treatment: · For opioid diagnoses received prior to 2:00 PM decision, verbal and written notification to the member and provider must be completed by the end of the day the request is received. Request may not be pended. · For opioid diagnoses, if the request is received after 2:00 PM decision,	

Type of Review	If You Have All Necessary Information To Make A Decision:	If You Still Need Information To Make A Decision:
	verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. · For substance use diagnoses other than opioid decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. **Behavioral Health Exception:** Substance Use Mandate: All inpatient concurrent substance use reviews will have an outcome within 24 hours. (urgent and nonurgent). If a request for inpatient substance use disorder treatment is submitted at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, the Plan will make a determination within 24 hours of receipt of the request.	
Standard Requests for Drugs (Any Non-Urgent Request) –Pharmacy	Decision, verbal notification and written notification to the member and provider must be completed as expeditiously as the enrollee's health condition requires but no later than 72 hours after the receipt of the request.	In accordance with the Medicare Prescription Drug Manual, Chapter 18: Part D Enrollee Grievances, Coverage Determinations, and Appeals, extensions are not allowed.

Type of Review	If You Have All Necessary Information To Make A Decision:	If You Still Need Information To Make A Decision:
Only (Medicare Part D)	For exception requests - Decision, verbal notification and written notification to the member and provider must be completed as expeditiously as the enrollee's health condition requires but no later than 72 hours from the receipt of the supporting statement. A Health Plan may make its initial notification orally so long as it also mails a written follow-up decision within 3 calendar days of the oral notification.	
Expedited Requests for Services * (Any Urgent Request) – All except Pharmacy (Medicare Part D)	Decision, verbal notification and written notification to the member and provider must be completed as expeditiously as the enrollee's health condition requires but no later than 72 hours from the receipt of the request. All decisions involving participating providers must be made within this timeframe. **Behavioral Health Exception:** As of 01/01/17 per NYS Substance Use Mandate: For prospective /pre-service (first review) for inpatient levels of treatment for addiction, if an in –network OASAS	The Plan is expected to make every effort to obtain additional information within the required timeframe. The Plan should request the information (and document such requests) in a timely manner in order to make the decision within 72 hours and follow up on such requests. All decisions involving participating providers must be made within 72 hours. If the information is not received from a non-participating provider within 72 hours of the original request, and it is in the member's best interest to have an extension, or if the member requests it, an extension of an additional 14 calendar days may be granted. Send a written request to the member/provider for the specific information needed. We must notify the member or the member's authorized representative of the reason for an extension, the date by which it expects to make a decision, and the member's right to file an expedited grievance of our

Type of Review	If You Have All Necessary Information To Make A Decision:	If You Still Need Information To Make A Decision:
	certified facility notifies the insurer of an admission within 48 business hours of the admission, the Plan will automatically approve the admission . NYS out of network providers who are licensed in NYS and the identified member has a contract that has OON benefit; the approval rule also should apply. The approval should be done as follows: 14 days for inpatient substance use disorder (SUD) detoxification; 14 days for inpatient SUD rehabilitation; and 14 days for SUD residential treatment. Per the Assurance of Discontinuance (AOD), auto-approval will apply to all New York-licensed facilities. Also, per the Opiate Mandate, the Plan's UM staff must communicate an approval to the facility the same day if authorization is requested by 2 p.m. and the member has an opiate diagnosis otherwise must give an approval within 24 hours. **Behavioral Health Substance Use Exception** For New York State licensed substance use providers; for initial requests, if the member is already admitted, for inpatient detoxification and rehabilitation and residential treatment:	decision to grant an extension. Once the requested information is received, the decision, verbal and written notification must be made as expeditiously as the member's health condition requires but no later than the expiration of the extension. If no information or incomplete information is received, the decision, verbal and written notification must be made before the expiration of the extension.

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	· For opioid diagnoses received prior to 2:00 PM decision, verbal and written notification to the member and provider must be completed by the end of the day the request is received. Request may not be pended. · For opioid diagnoses, if the request is received after 2:00 PM decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. · For substance use diagnoses other than opioid decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. **Substance Use Mandate:** All inpatient concurrent substance use reviews will have an outcome within 24 hours. (urgent and nonurgent). If a request for inpatient substance use disorder treatment is submitted at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission,	

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	the Plan will make a determination within 24 hours of receipt of the request.	
Expedited Requests for Drugs * (Any Urgent Request) – Pharmacy Only (Medicare Part D)	Decision, verbal notification and written notification to the member and provider must be completed as expeditiously as the enrollee's health condition requires, but no later than 24 hours after the receipt of the request. For exception requests - Decision, verbal notification and written notification to the member and provider must be completed as expeditiously as the enrollee's health condition requires but no later than 24 hours after the receipt of the supporting statement. A Health Plan may make its initial notification orally so long as it also mails a written follow-up decision within 3 calendar days of the oral notification. **Behavioral Health Exception:** As of 01/01/17 per NYS Substance Use Mandate: For prospective /pre-service (first review) for inpatient levels of treatment for addiction, if an in –network OASAS certified facility notifies the insurer of an admission within 48 business hours of the	In accordance with the Medicare Prescription Drug Manual, Chapter 18: Part D Enrollee Grievances, Coverage Determinations, and Appeals, extensions are not allowed.

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	admission, the Plan will automatically approve the admission . NYS out of network providers who are licensed in NYS and the identified member has a contract that has OON benefit; the approval rule also should apply. The approval should be done as follows: 14 days for inpatient substance use disorder (SUD) detoxification; 14 days for inpatient SUD rehabilitation; and 14 days for SUD residential treatment. Per the Assurance of Discontinuance (AOD), auto-approval will apply to all New York-licensed facilities. Also, per the Opiate Mandate, the Plan's UM staff must communicate an approval to the facility the same day if authorization is requested by 2 p.m. and the member has an opiate diagnosis otherwise must give an approval within 24 hours. **Behavioral Health Substance Use Exception** For New York State licensed substance use providers; for initial requests, if the member is already admitted, for inpatient detoxification and rehabilitation and residential treatment: · For opioid diagnoses received prior to 2:00 PM decision, verbal and	

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	written notification to the member and provider must be completed by the end of the day the request is received. Request may not be pended. · For opioid diagnoses, if the request is received after 2:00 PM decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. · For substance use diagnoses other than opioid decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. **Substance Use Mandate:** All inpatient concurrent substance use reviews will have an outcome within 24 hours. (urgent and nonurgent). If a request for inpatient substance use disorder treatment is submitted at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, the Plan will make a determination within 24 hours of receipt of the request.	

Post-Service – All except Pharmacy (Medicare Part D)	Decision and written notification to the member and provider must be completed within 30 calendar days of receipt of the request. No verbal notification is required on post-service decisions. All decisions involving participating providers must be made within this timeframe.	Applies only to non-participating providers: Within 30 calendar days of the original request, send a written request to the member/provider for the specific information needed. Once the requested information is received, the decision and written notification must be made within 60 calendar days of the receipt of the request. No verbal notification is required on post-service decisions. If no information or incomplete information is received by the end of the specified time period given, the decision and written notification must be made within 60 calendar days or the receipt of the request using whatever information has already been received.
Post-Service – Phamacy Only (Medicare Part D)	Decision and written notification to the member and provider must be completed within 14 calendar days of receipt of the request. No verbal notification is required on post-service decisions.	In accordance with the Medicare Prescription Drug Manual, Chapter 18: Part D Enrollee Grievances, Coverage Determinations, and Appeals, extensions are not allowed.

* Medicare allows requests for expedited decisions. Any member or any physician may request that the Health Plan expedite a decision when:

- The member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy; and
- The member believes that the Health Plan should furnish directly or arrange for services to be provided (when the enrollee has not already received the services outside of the Health Plan).

The Health Plan must automatically provide an expedited organization determination to any request made or supported by a physician. For a request made by the member, the Health Plan must decide whether or not to expedite the request.