blue california
Promise Health Plan

Policy Title: CMS Part C Reporting: Service-Related Organization Determination		POLICY #: 50.2.32 Line of business: Medicare Adv	
Department Name: Utilization Management	**Original Date** 2/11	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable)		**Date: 3/21**	

PURPOSE

To establish procedures for accurate and timely submission of CMS' Part C Reporting requirements for service-related organization determination.

DEFINITIONS:
An **Organization Determination** is a plan's response to a request for coverage (payment or provision) of an item or service- including auto adjudicated claims, prior authorizations requests, and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.

A **Fully Favorable** decision means an item or service was covered in whole.

A **Partially Favorable** decision means an item or services was partially covered.

An **Adverse** decision means an item or service was denied in whole, or fully unfavorable.

Service-Related Authorizations include all service-related decisions, including pre-authorizations, concurrent authorizations and post-authorizations.

Dismissal – defined as when an independent review entity (IRE) may dismiss a case forwarded by the plan if the case lacks required information or otherwise does not meet CMS requirements for a valid reconsideration request.

Withdrawal – defined as a situation where the party who flies a request for reconsideration may withdraw the request at any time before a decision is mailed by writing to the Medicare health plan.

POLICY

It is Blue Shield Promise policy to ensure that the Part C Reporting Requirements are accurate and submitted in a timely manner (refer to Medicare Ops P&P 50.23.5)

1. Data will be based on the reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30 and 10/1 through 12/31
2. Data will correspond to the applicable CMS Contract
3. Blue Shield of California Promise will meet the CMS Deadline for annual reporting of this measure. The reports for all quarters are due to CMS on 2/28 of each year.
4. Care defines the term "Organization Determination" in accordance with 42 CFR §422.566 and the Medicare Managed Care Manual Chapter 13, Sections 10.1 and 20.2

5. Organization determination reporting inclusions are:
    a. All fully favorable service-related organization determinations for contract and non-contract providers/suppliers
    b. All partially favorable service-related organization determination for contract and non-contract providers/suppliers
    c. All adverse service-related organization determinations for contract and non-contract providers/suppliers
    d. Completed organization determinations during the reporting period, regardless of when the request was received.
    e. Withdrawals and dismissals
6. Organization determination reporting exclusions are:
    a. Independent Review Entity (IRE) decisions
    b. A Quality Improvement Organization (QIO) review of an individual's request to continue to Medicare covered services (e.g., SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.

ORGANIZATION DETERMINATION:

1. Calculation of the total number of organization determinations includes:
    a. All organization determinations (Part C only) with a date of member notification of the final decision that occurs during the reporting period, regardless of when the request for organization determination was received.
    b. Decisions made on behalf of the organization by a delegated entity
    c. Only organization determinations that are filed directly with the organization or its delegated entities.
    d. All methods of organization determination request receipt (e.g., telephone, letter, fax, in-person)
    e. All organization determinations regardless of who filed the request
    f. Dismissals or withdrawals
2. Calculation of the total number of organization determinations <u>excludes</u>:
    a. All organization determinations that involve services provided to Medicaid-only members
    b. Quality Improvement Organization (QIO) reviews of a member's request to continue Medicare-covered services (e.g., a SNF stay)
    c. All organization determinations that are forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity.
3. Calculation of the number of <u>fully favorable</u> organization determination includes:
    a. All fully favorable pre-service organization determinations for contract and non-contract providers/suppliers
4. Calculation of the member of <u>fully favorable</u> organization determination excludes:
    a. All organizations determine that involve services provided to Medicaid-only members
    b. Dismissals or withdrawals
    c. Quality Improvement Organization (QIO) reviews of a member's request to continue Medicare-covered services (e.g., a SNF stay)
5. Calculation of the number of <u>partially favorable</u> organization determinations includes:
    a. All partially favorable pre-service organization determination for contract and non-contract providers/suppliers
6. Calculation of the number of <u>adverse</u> organization determinations, <u>includes</u>:
    a. All adverse pre-service organization determinations for contract and non-contract providers/suppliers

PROCEDURE

Data Preparation, Review, and Submission

1. The Utilization Management Department is the business owner for Part C Organization Determinations CMS Reporting. It is responsible for ensuring that the data submitted is accurate. This includes a comparison to prior reporting periods.
2. The Utilization Management receives the data from the MIS Department
    a. The data are reviewed using established source code. Source code is based on corresponding Part C Technical Specifications. Source Code is logic is documented by the MIS team and updated as necessary based on changes to the reporting requirements.
3. The Utilization Management reviews the data produced by MIS Department (in collaboration with Medicare Operations Department) and confirms the accuracy of the data by email notification to Medicare Operations.

Responding to Potential Data Discrepancy Notifications

1. If there are notices received from Medicare Ops related to the accuracy of the data submitted, the Utilization Management Department performs another quality review and addresses any discrepancies or corrections to the Medicare Operations Department.
2. The Utilization Management provides the Medicare Operations Department the final data/statistics to be submitted to CMS.
    a. An e-mail confirmation showing the final data to be submitted is received from the Medicare Operations Department.

REFERENCES

42 CFR §422.516(a)

- CMS Data Validation Procedure Manual Appendix B: Data Validation Standard
- Part C Reporting Requirements Technical Specifications

ATTACHMENETS:

H0148 and H5928 Part C Organization Determinations Source Codes (internal)