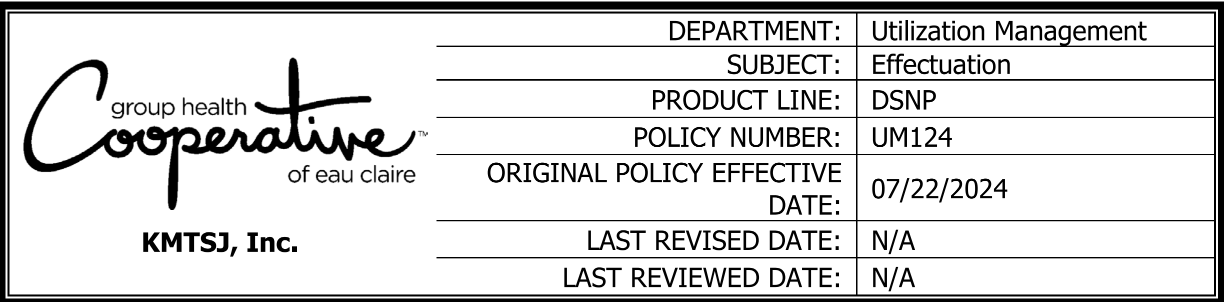


group health Cooperative of eau claire	DEPARTMENT:	Utilization Management
	SUBJECT:	Effectuation
	PRODUCT LINE:	DSNP
	POLICY NUMBER:	UM124
	ORIGINAL POLICY EFFECTIVE DATE:	07/22/2024
KMTSJ, Inc.	LAST REVISED DATE:	N/A
	LAST REVIEWED DATE:	N/A

SCOPE:

To ensure Group Health Cooperative of Eau Claire (the Cooperative) has processes to address decision reversals and notify members in a timely manner to avoid delays in services.

POLICY:

When a plan's decision is reversed in whole or in part by any other appeal entity, the Cooperative will authorize or provide the service or benefits as expeditiously as the member's health condition requires, however, no later than the required timeframes (based on when notice was received).

PROCEDURE:

Effectuation Timeframes

Type of Request	IRE Reconsiderations	Other Entity Reconsiderations
Standard Service	• Provide as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days. • If it is not appropriate to provide within 14 calendar days, authorize within 72 hours.	Authorize or provide no later than 60 calendar days
Standard Part B Drug	Authorize or provide within 72 hours	Authorize or provide no later than 60 calendar days
Standard Payment	No later than 30 calendar days	No later than 60 calendar days
Expedited Items or Services	Authorize or provide no later than 72 hours	Authorize or provide no later than 60 calendar days
Expedited Part B Drug	Authorize or provide no later than 24 hours	Authorize or provide no later than 24 hours

In general, when the plan sponsor or other appeal entity issues a favorable coverage determination or appeal decision, the decision is retroactive to the date of the earliest request or prescription purchase approved in a coverage determination or appeal decision. Appeal entity

means the IRE, an ALJ, the Medicare Appeals Council or a federal court with jurisdiction over the matter.

Approved exceptions are valid for the remainder of the plan year; therefore, all prescriptions purchased between the dates of the earliest prescription approved as an exception request and the end of the plan year are reimbursable.

Independent Review Entity Monitoring of Effectuation Requirements

CMS requires the IRE to monitor a plan's compliance with effectuating decisions that fully or partially reverse an original plan determination (denial). The process is as follows:

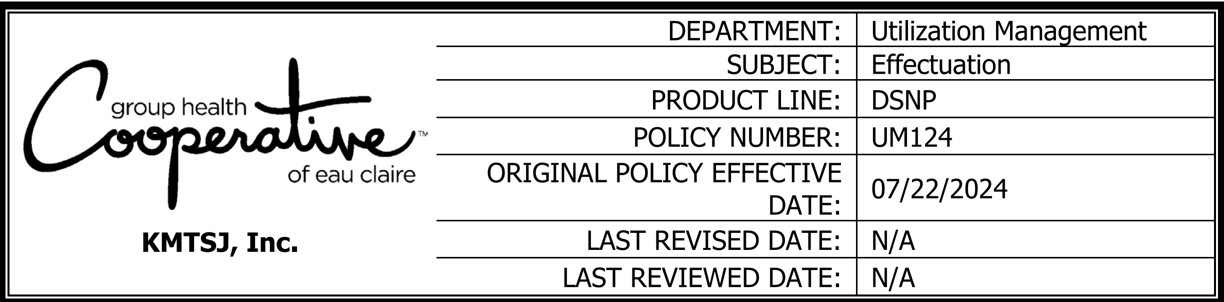
- The IRE issues a copy of the reconsidered determination to the plan. Included with this copy is a Notice of Requirement to Comply;

- Pursuant to the compliance notice and §§422.618, 422.619, 423.636(b), and 423.638(b), the plan is required to submit to the IRE a statement attesting the plan has effectuated the decision in compliance with the IRE's decision. This documentation is to confirm when and how compliance occurred (e.g., service authorization, payment made, etc.). Notification to the IRE that the plan "intends to pay for" or "intends to provide" the service is not sufficient. The plan must provide the IRE with affirmative notice that the IRE's decision has been effectuated by payment or provision of the service. The plan's notice of compliance should be forwarded to the IRE concurrent with the plan's effectuation;

- If the IRE does not obtain the compliance notice within 2 weeks, it will mail the plan a reminder notice; and if the IRE does not receive the plan's compliance report within 30 days of the reminder notice, the IRE reports the plan's failure to comply with CMS. The plan is not copied on the notice to CMS.

Effectuation Requirements for Former Plans

A plan is legally responsible under its contract and the regulations to authorize, provide, or pay for all Medicare covered services or prescription drugs that are denied and upon appeal are found to be services the plan should have authorized, provided, or paid for its members. CMS policy is that a member is entitled to receive a service and/or payment of a service or prescription drug from a plan from which the member either voluntarily or involuntarily disenrolled prior to a final decision on appeal. The plan must follow the requirements found at 42 CFR §§422.100, 423.104 422.504, and 423.505 as they relate to individual disenrollment or contract termination/service area reduction.



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Reference Sources:

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
July 16, 2024

APPROVED: Michele Bauer MD. DATE: 07/22/2024

Formal policies and procedures require department manager review, approval, and signature. Executive and/or administrative policies and procedures require CEO/General Manager review, approval, and signature.

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision