FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

UTILIZATION MANAGEMENT	ASPIRE HEALTH PLAN	Effective Date: 01/01/2021	
		Policy #: AHP-OP002	
	Standard and Expedited Medical Utilization Review Determination	Review Date: 11/26/2024	Applicable to: ☑ Medicare Advantage ☑ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Kellie Verdugo, Director Utilization Management	

1.0 PURPOSE

1.1 The purpose of this policy is to describe Aspire Health Plan's (AHP) and first tier, downstream and related entities ("delegates") processes and notification timeframe requirements for standard and expedited requests for determination in accordance with regulatory requirements.

2.0 POLICY

2.1 AHP will uphold member's rights regarding organization determinations including:

2.1.1 The organization will adhere to the time frames set for timeliness of UM decision making pursuant to the CA Health and Safety Code section 1367.01(h)(1) and (5) (Commercial) and CMS regulations (Medicare Advantage).

2.1.2 Decisions to approve, modify, or deny health care services based on medical necessity made by AHP are made in a timely fashion appropriate for the nature of the member's condition.

2.1.3 The right to request an expedited organization determination and, if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance.

2.1.4 The right to a written notice from AHP of its own decision to take an extension on a request for an organization determination that explains the reasons for the delay and explains the member's right to file an expedited grievance if the member disagrees with the extension.

2.2 AHP applies the required timeframes (refer to Tables below), with consideration of the member's health condition for the following as referenced in:

2.2.1 Making determinations on requests received for review.

2.2.2 Providing notice of the determination to the provider and the member for approvals and denials.

2.3 Approval and denial notices of determination to the member must include the following elements:

2.3.1 A statement that Members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.

2.3.2 A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.

2.3.3 An explanation of the appeal process, including the right to member representation and time frames.

2.3.4 A description of the expedited appeal process for urgent preservice or urgent concurrent denials.

3.0 APPLICABILITY

3.1 This policy and procedure applies to both Medicare and Commercial lines of business.

4.0 DEFINITIONS

4.1 Refer to the AHP Definitions Manual

5.0 PROCEDURE

5.1 Authorization Request Receipt

5.1.1 Providers submit requests for authorization via the provider portal, or by mail, fax, and telephone.

5.1.2 AHP will date and time stamp mailed requests upon arrival.

5.1.3 AHP will create an authorization request file in the source system if not already done so by online (provider portal) submission.

5.1.4 AHP will document all oral requests in writing in the authorization request file.

5.1.5 AHP will verify member eligibility and benefits and document any exclusions or limitations in the authorization request file.

5.2 Timeframes and Determination of Urgent or Standard Review

5.2.1 AHP will classify the request as an urgent request provided or supported by a physician, if the physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

5.2.2 For an urgent determination request made by a member, AHP will decide whether to expedite the determination based on whether applying the standard time frame for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

5.2.3 AHP will only consider requests for an expedited review if the member or a physician submitted either an oral or written request directly to Aspire or if applicable, to the entity responsible for making the determination.

5.2.4 AHP will follow the notification and determination timeframes as referenced in 2.2 and tables below.

5.3 When the request is approved:

5.3.1 Notification to providers will include an authorization number for the specific services authorized.

5.4 Notification Format (Denials)

5.4.1 The denial notification:

5.4.1.1 Includes a statement that members may be represented by anyone they choose, including an attorney

5.4.1.2 Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsperson, if applicable

5.4.1.3 States the time frame for filing an appeal

5.4.1.4 States the organization's time frame for deciding the appeal

5.4.1.5 States the procedure for filing an appeal, including where to direct the appeal and information to include in the appeal

5.4.2 The denial notification states the reason for the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization denied the request and have enough information to file an appeal.

5.4.3 An appropriately written notification includes a complete explanation of the grounds for the denial, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

5.4.4 For denials resulting from medical necessity review of out-of-network requests, the reason for the denial must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the denial must address whether or not the requested service can be obtained within the organization's accessibility standards).

5.4.5 The denial notification references the specific criterion used to make the denial decision. The criterion used and referenced is specific to the member's condition or to the requested services.

5.4.6 The denial notification informs the member, and the practitioner acting as the member's authorized representative, that the criterion used to make the decision is available upon request.

5.4.7 AHP notifies treating practitioners about the opportunity to discuss a medical necessity denial, or a denial of a medical pharmacy determination when delegated to AHP by one of its commercial plan partners (e.g. peer-to-peer discussion) in the following ways:

5.4.7.1 By notification of denial (e.g. denial letter faxed to provider); or,

5.4.7.2 Via other materials sent to the treating practitioner when requested.

5.5 When the determination is completely or partially adverse, or the member's Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehab Facility (CORF) or Home Health Agency (HCA) services are ending, the reviewer will follow the appropriate procedure for notifying the member and provider as referenced in 2.2.

5.6 AHP identifies potential catastrophic and chronic conditions and refers them to case management and/or disease management.

5.7 AHP updates the case documentation to reflect all activities, interactions, determinations, and notifications.

6.0 TRAINING

6.1 Training for employees will occur within 90 days of hire, and upon updates to the policy.

7.0 REVIEW PERIOD

7.1 Annually

8.0 REGULATORY REQUIREMENTS AND REFERENCES

8.1 CA Health and Safety Code sections 1367.01(h)(1) and (2)

8.2 CA Health and Safety Code section 1367.01(h)(3)

8.3 CA Health and Safety Code sections 1367.01(e) and (g)

8.4 NCQA UM-4, UM-7

8.5 Health Industry Collaboration Effort (HICE) (2016). Utilization Management Timeline Standards (Commercial HMO - California). https://www.iceforhealth.org/library.asp.

8.6 Health Industry Collaboration Effort (HICE) (2023). *Utilization Management Timeline Standards (CMS)*. https://www.iceforhealth.org/library.asp

8.7 Centers for Medicare and Medicaid Services (2022). *Parts C & D Grievances, Organization/Coverage Determinations, and Appeals Guidance*. https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

8.8 Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance – Sections 40, 100

9.0 POLICY VIOLATION

9.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.

Utilization Management Commercial Timeliness Standards					
Urgency/Type of Request	**Status**	**Decision Timeframes**	**Notification Timeframes**	**Notification Method**	**Citation**
Urgent Pre-Service	**Approval**	Not to exceed 72 hours after the receipt of the request.	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request. Member: Within 72 hours of receipt of the request.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written. Document date and time of oral notifications. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	**California Health and Safety Code §1367.01(h)(2) §1367.01(h)(3) §1367.01(h)(4)**
	Denial			Written/electronic notification of denial to practitioner and member. If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 business days after the initial oral notification. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	
Urgent Pre-Service **Extension Needed**	**Approval**	Notify Member and Practitioner within 24 hours of receipt of request and provide 48 hours for submission of requested information. If additional information is received, complete or not, decision must be made in a timely fashion appropriate for the member's condition, not to exceed 48 hours after receipt of information.	Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information. Member: Within 48 hours after receipt of information.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written. Document date and time of oral notifications. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	
	Denial			Written/electronic notification of denial to practitioner and member. If oral notification is given with 72 hours of receipt of the request, written or electronic notification must be given no later than 3 business days after the initial oral notification. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	

Utilization Management Commercial Timeliness Standards					
Urgency/Type of Request	**Status**	**Decision Timeframes**	**Notification Timeframes**	**Notification Method**	**Citation**
Non-Urgent Pre-Service	**Approval**	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision. Member: Within 2 business days of receipt of the request.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	**California Health and Safety Code §1367.01(h)(1) §1367.01(h)(3) §1367.01(h)(4)**
	Denial			Written/electronic notification of denial to practitioner and member. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	
Non-Urgent Pre-Service Extension Needed	**Approval**	Notify Member and Practitioner within 5 business days of receipt of request and provide at least 45 calendar days for submission of requested information. If additional information **is received**, complete or not, decision must be made in a timely fashion as appropriate for the member's condition, not to exceed 5 business days of receipt of information. If additional information **is not received**, decision must be made with the information available in a timely fashion as appropriate for the member's condition, not to exceed an additional 5 business days.	Practitioner: Within 24 hours of the decision. Member: Within 2 business days of the decision.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	
	Denial			Written/electronic notification of denial to practitioner and member. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	
Non-Urgent Pre-Service Extension Needed **Expert Reviewer Consult Required**	**Approval**	Upon expiration of the 5 business days or as soon as you become aware that you will not meet the 5-business day timeframe, whichever occurs first, notify practitioner and member of the type of expert review required and the anticipated date on which a decision will be rendered.	Practitioner: Within 24 hours of the decision. Member: Within 2 business days of the decision.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	
	Denial	Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.		Written/electronic notification of denial to practitioner and member. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	

Utilization Management Commercial Timeliness Standards

Urgency/Type of Request	Status	Decision Timeframes	Notification Timeframes	Notification Method	Citation
Post-Service	**Approval**	Within 30 calendar days of receipt of request.	Practitioner and Member: Within 30 calendar days of receipt of the request.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written.	**California Health and Safety Code §1367.01(h)(1) §1367.01(h)(3) §1367.01(h)(4)**
	Denial			Written/electronic notification of denial to practitioner and member.	
Post-Service Extension Needed	**Approval**	Notify Member and Practitioner within 30 calendar days of receipt of request and provide at least 45 calendar days for submission of requested information. If additional information **is received**, complete or not, decision must be made within 15 calendar days of receipt of information.	**Information Received** Practitioner and Member: Within 15 calendar days of receipt of information. **Information NOT Received** Practitioner and Member: Within 15 calendar days after the timeframe given to the practitioner and Member to supply the information.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written.	
	Denial	If additional information **is not received**, decision must be made with the information available within an additional 15 calendar days.		Written/electronic notification of denial to practitioner and member.	
Post-Service Extension Needed **Expert Reviewer Consult Required**	**Approval**	Upon expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert review required and the anticipated date on which a decision will be rendered. Decision must be made within 15 calendar days from the date of the delay notice.	Practitioner and Member: Within 15 calendar days from the date of the delay notice.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written.	
	Denial			Written/electronic notification of denial to practitioner and member.	

Utilization Management Commercial Timeliness Standards

Urgency/Type of Request	Status	Decision Timeframes	Notification Timeframes	Notification Method	Citation
Urgent (Exigent circumstances) Prescription Drugs	**Approval**	Within 24 hours of receipt of request. *"Exigent Circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function OR when an insured is undergoing a current course of treatment using a non-formulary drug.*	Practitioner: Within 24 hours of receipt of request. Member: Within 72 hours of receipt of the request.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	**California Health and Safety Code §1367.241 (CA SB 282: 2015-2016)** ***Note***: *CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes*
	Denial			Written/electronic notification of denial to practitioner and member. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	
Non-Urgent Prescription Drugs	**Approval**	Within 72 hours of receipt of request. **Note:** No extensions allowed for pharmacy requests	Practitioner: Within 72 hours of receipt of request. Member: Within 2 business days of receipt of the request.	Practitioner initial notification and member notification of approvals may be oral and/or electronic/written. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only).	
	Denial			Written/electronic notification of denial to practitioner and member. AHP- Decision must be faxed to the provider. Fax confirmation must be uploaded to auth request (Anthem and BSC only)	
Standing Referrals to Specialists / Specialty Care Centers	All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	**Note**: Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	**California Health and Safety Code §1374.16**
Urgent Translation Requests	LAP Services Are Not Delegated	Request forwarded within one (1) business day of member's request.			Refer to Plan-to-Plan Agreement
Non-Urgent Translation Requests		Request forwarded within two (2) business days of member's request.			

Medicare Advantage Part B Initial Organization Determination					
Urgency	**Status**	**Decision Timeframe**	**Notification Timeframes**	**Notification Method**	**Citation**
Standard	**Approval**	Within 72 hours after receipt of request. Part B timeframes cannot be extended.	Within 72 hours after receipt of request. Part B timeframes cannot be extended.	Notice may be provided **verbally or in writing** to the requesting party. Note: Written notice is not required if verbal notice is successfully provided	§ 422.568 (b)(3)
	Denial	Within 72 hours after receipt of request. Part B timeframes cannot be extended.	Within 72 hours after receipt of request. Part B timeframes cannot be extended.	A **written** denial notice is **required** to be sent to the enrollee (and physician involved, as appropriate) whenever an MA plan's determination is partially or fully adverse to the enrollee. MA plans must use approved notice language when issuing written denial notices to enrollees.	§ 422.568 (b)(3) § 422.568 (d) § 422.568 (e)
Expedited	**Approval**	Within 24 hours after receipt of request. Part B timeframes cannot be extended.	Within 24 hours after receipt of request. Part B timeframes cannot be extended.	Provide **verbal or written** notification of favorable decision to the enrollee no later than 24 hours after receipt of request. If the MA plan initially provides **verbal** notification of its decision, it **may** deliver written confirmation of its decision within 3 calendar days of the verbal notification. Note: Written notice is not required if verbal notice is successfully provided.	§ 422.572 (a)(2)
	Denial	Within 24 hours after receipt of request. Part B timeframes cannot be extended.	Within 24 hours after receipt of request. Part B timeframes cannot be extended.	Provide **written** notification to the enrollee of the decision no later than 24 hours after receipt of request. If the MA plan initially provides verbal notification of its decision, it **must** deliver written confirmation of its decision within 3 calendar days of the verbal notification.	§ 422.572 (a)(2) § 422.572 (c) § 422.572 (e)

Medicare Advantage Part C Initial Organization Determination					
Urgency	**Status**	**Decision Timeframe**	**Notification Timeframes**	**Notification Method**	**Citation**
Standard	**Approval**	Within 14 calendar days after receipt of request. The MA organization may extend the timeframe by up to 14 calendar days.	Within 14 calendar days after receipt of request. The MA organization may extend the timeframe by up to 14 calendar days.	Notice may be provided **verbally or in writing** to the requesting party. Note: Written notice is not required if verbal notice is successfully provided.	§ 422.568 (b)
	Denial	Within 14 calendar days after receipt of request. The MA organization may extend the timeframe by up to 14 calendar days.	Within 14 calendar days after receipt of request. The MA organization may extend the timeframe by up to 14 calendar days.	A **written** denial notice is **required** to be sent to the enrollee (and physician involved, as appropriate) whenever an MA plan's determination is partially or fully adverse to the enrollee. MA plans must use approved notice language when issuing written denial notices to enrollees.	§ 422.568 (b) § 422.568 (d) § 422.568 (e)
Expedited	**Approval**	Within 72 hours after receipt of request. The MA organization may extend the timeframe by up to 14 calendar days.	Within 72 hours after receipt of request. The MA organization may extend the timeframe by up to 14 calendar days.	Provide **verbal or written** notification of favorable decision to the enrollee no later than 72 hours after receipt of request. If the MA plan initially provides verbal notification of its decision, it **may** deliver written confirmation of its decision within 3 calendar days of the verbal notification. Note: Written notice is not required if verbal notice is successfully provided	§ 422.572 (a)
	Denial	Within 72 hours after receipt of request. The MA organization may extend the timeframe by up to 14 calendar days.	Within 72 hours after receipt of request. The MA organization may extend the timeframe by up to 14 calendar days.	Provide **written** notification to the enrollee of the decision no later than 72 hours after receipt of request. If the MA plan initially provides verbal notification of its decision, it **must** deliver written confirmation of its decision within 3 calendar days of the verbal notification.	§ 422.572 (a) § 422.572 (c) § 422.572 (e)
Standard **Expedited**	**Extension**	Decision Notification After an Extension must occur no later than expiration of extension.	**Standard** Notification of Extension must be given within 14 calendar days of receipt of request. **Expedited** Notification of Extension must be given within 72 hours of receipt of request.	Written notice must include: The reasons for the delay The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension.	§ 422.568 (b) § 422.572 (b)

Medicare Advantage Part D Initial Coverage Determination					
Urgency	**Status**	**Decision Timeframe**	**Notification Timeframes**	**Notification Method**	**Citation**
Standard	**Approval**	Within 72 hours after receipt of request. Or no later than 72 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. Part D timeframes cannot be extended.	Within 72 hours after receipt of request. Or no later than 72 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. If a supporting statement is not received by the end of 14 calendar days from receipt of the exceptions request, the enrollee must be notified (and the prescribing physician or other prescriber involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the end of 14 calendar days from receipt of the exceptions request. Part D timeframes cannot be extended.	Enrollee notification must be in **writing**. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may provide notice to both the representative and enrollee but are not required. Verbal notice may initially be provided to the enrollee as long as written notice is mailed within 3 calendar days of verbal notification. If requested by an enrollee's prescribing physician or other prescriber on behalf of the enrollee, the plan sponsor must provide notice to the prescriber and written notice to the enrollee. If a plan sponsor successfully notifies the physician or prescriber verbally, the plan sponsor does not need to send a written follow-up.	§ 423.568(b) § 423.568(d) § 423.568(e)
	Denial	Within 72 hours after receipt of request. Or no later than 72 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. Part D timeframes cannot be extended.	Within 72 hours after receipt of request. Or no later than 72 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. If a supporting statement is not received by the end of 14 calendar days from receipt of the exceptions request, the enrollee must be notified (and the prescribing physician or other prescriber involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the end of 14 calendar days from receipt of the exceptions request. Part D timeframes cannot be extended.	Enrollee notification must be in writing. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may provide notice to both the representative and enrollee but are not required. If notice is delivered within required timeframe, enrollee receives Notice of Denial of Medicare Prescription Drug Coverage, Form CMS-10146 (see §40.12.3 for specific CMS requirements). Verbal notice may initially be provided to the enrollee as long as written notice is mailed within 3 calendar days of verbal notification. If the request was made by an enrollee's prescribing physician or other prescriber on behalf of the enrollee, the plan sponsor must provide notice to the prescriber and written notice to the enrollee. If a plan sponsor successfully notifies the physician or prescriber verbally, the plan sponsor does not need to send a written follow-up to the physician or prescriber but must still send written notice to the enrollee.	§ 423.568(b) § 423.568(f) § 423.568(g)

Medicare Advantage Part D Initial Coverage Determination

Urgency	Status	Decision Timeframe	Notification Timeframes	Notification Method	Citation
Expedited	**Approval**	Within 24 hours after receipt of request. Or no later than 24 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. Part D timeframes cannot be extended.	Within 24 hours after receipt of request. Or no later than 24 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. If a supporting statement is not received by the end of 14 calendar days from receipt of the exceptions request, the enrollee must be notified (and the prescribing physician or other prescriber involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours from the end of 14 calendar days from receipt of the exceptions request. Part D timeframes cannot be extended.	Enrollee notification must be in **writing**. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may provide notice to both the representative and enrollee but are not required. Verbal notice may initially be provided to the enrollee as long as written notice is mailed within 3 calendar days of verbal notification. If requested by an enrollee's prescribing physician or other prescriber on behalf of the enrollee, the plan sponsor must provide notice to the prescriber and written notice to the enrollee. If a plan sponsor successfully notifies the physician or prescriber verbally, the plan sponsor does not need to send a written follow-up.	§ 423.572
	Denial	Within 24 hours after receipt of request. Or no later than 24 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. Part D timeframes cannot be extended.	Within 24 hours after receipt of request. Or no later than 24 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. If a supporting statement is not received by the end of 14 calendar days from receipt of the exceptions request, the enrollee must be notified (and the prescribing physician or other prescriber involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours from the end of 14 calendar days from receipt of the exceptions request. Part D timeframes cannot be extended.	Enrollee notification must be in writing. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may provide notice to both the representative and enrollee but are not required. If notice is delivered within required timeframe, enrollee receives Notice of Denial of Medicare Prescription Drug Coverage, Form CMS-10146 (see §40.12.3 for specific CMS requirements) Verbal notice may initially be provided to the enrollee as long as written notice is mailed within 3 calendar days of verbal notification. If the request was made by an enrollee's prescribing physician or other prescriber on behalf of the enrollee, the plan sponsor must provide notice to the prescriber and written notice to the enrollee. If a plan sponsor successfully notifies the physician or prescriber verbally, the plan sponsor does not need to send a written follow-up to the physician or prescriber but must still send written notice to the enrollee.	§ 423.572