



Utilization Management Microcredential Program Handbook



Overview

About CMSA

The Case Management Society of America (CMSA) is a professional association dedicated to improving patient outcomes. With diverse membership, CMSA fosters interdisciplinary collaboration and evidence-based practices. Through its efforts, CMSA aims to improve care coordination and healthcare delivery across various settings. CMSA is the authority for the professional practice of case management to improve the health of individuals, families, caregivers, and support systems within their communities by:

- Setting standards and best practices for case management across the healthcare continuum
- Impacting policy to improve health outcomes
- Providing evidence-based tools and resources to case managers

CMSA facilitates the growth and development of professional case managers across the full health care continuum, promoting high quality, ethical practice benefiting patients and their families. As an organization, CMSA strives for improved health outcomes through evidence-based resources, health care policy and the Standards of Practice for Case Management.

About the Microcredential

The Utilization Management (UM) Microcredential is a focused, competency-based professional credential designed to recognize foundational knowledge and practical skills specific to utilization management. It provides a streamlined pathway for healthcare professionals to validate their understanding of UM principles, regulatory frameworks, and reviewer responsibilities without the scope or time commitment of a full professional certification.

The microcredential emphasizes applied skills, scenario-based decision making, and demonstrated competence in core UM functions. Participants who earn the microcredential receive a digital badge that verifies their achievement and can be displayed on résumés, professional profiles, and employer platforms.

The microcredential is designed for healthcare professionals seeking to develop or validate foundational knowledge and applied skills in utilization management. It is appropriate for:

- Early- to mid-career case managers working in acute care, post-acute, or payer settings
- Professionals transitioning into utilization management, revenue cycle, or care coordination roles
- Nurses, social workers, and allied health professionals involved in medical necessity review, care coordination, or discharge planning
- Individuals seeking to strengthen core competencies prior to pursuing a comprehensive certification

This microcredential is not intended to replace advanced professional certifications or licensure, nor does it represent mastery across the full spectrum of case management practice.

Overview

Why a Micro-Credential Matters

The UM Microcredential allows professionals to:

- Demonstrate validated UM expertise to current or prospective employers
- Strengthen foundational knowledge before pursuing a full certification
- Expand scope of practice within care management, quality, or revenue cycle roles
- Support organizational goals related to utilization management quality and accuracy

Difference Between Microcredential and Certification

While both microcredentials and certifications validate professional competency, they differ in scope, depth, and intended purpose:

Microcredential

- Targeted Scope: Focuses on a single domain or skill area (e.g., Utilization Management).
- Shorter Duration: Training and assessment are narrower and designed for rapid upskilling.
- Competency-Based: Measures specific skills or applied knowledge tied to practical UM tasks.
- Not a Comprehensive Certification: Does not require multi-year experience or broad-domain mastery.

Certification

- Broad, Multi-Domain Scope: Validates comprehensive competency across an entire profession or field (e.g. case management).
- High-Stakes Examination: Assessments are typically longer, psychometrically rigorous, and cover wide-ranging competencies.
- Professional Credential with Post-Nominals: May grant designation letters (e.g., CCM®).
- Ongoing Recertification Obligations: Requires continuing education, renewal cycles, and adherence to professional standards.
- Widely Recognized Benchmark of Expertise: Serves as a formal validation of advanced, full-scope professional proficiency.

Program Governance and Oversight

The Utilization Management (UM) Microcredential Program is administered by the Case Management Society of America (CMSA). CMSA is responsible for all aspects of application review, examination administration, credential awarding, and policy enforcement to ensure fairness, consistency, and credential integrity.

Day-to-day program administration is managed by designated CMSA staff. In situations where eligibility determinations or administrative decisions are unclear, complex, or exceptional, matters may be escalated to the CMSA Credentialing Task Force for review and final determination.

Eligibility Requirements

A. Education Requirements

To be eligible, applicants must have either:

- A current, active, unrestricted healthcare license or certification (e.g., RN, LPN, Social Worker, Case Manager), valid through the exam date
- OR**
- A bachelor's or graduate degree in a health or human services field with a supervised field experience in case management, health, or behavioral health, from an accredited institution.

B. Work Experience

To be eligible, applicants must have either:

- Applicants must meet one of the following pathways before submitting an application:
 - Category 1: Supervised Case Management
 - At least 12 months of full-time case management or utilization review experience
 - Supervised by a certified case manager (CCM or equivalent)
 - The supervisor must have held their certification for at least 12 months before supervising the applicant
- OR**
- Category 2: Independent Case Management
 - At least 24 months of full-time case management or utilization review experience
 - No supervision requirement
- OR**
- Category 3: Supervisory
 - At least 12 months of full-time experience supervising staff who perform case management or utilization review.

C. Skills and Competencies

All applicants must ensure the following:


- Familiarity with clinical review tools (e.g., MCG, InterQual)
- Understanding of insurance principles and healthcare legislation
- Ability to assess medical necessity and care appropriateness

D. Moral Character Requirements

Applicants must attest to the following in terms of moral character:

- No history of license/certification revocation, suspension, or probation, unless resolved.
- No history of disciplinary actions for dishonesty or related professional conduct.
- No felony convictions, recent arrests, or legal violations related to drug, alcohol, or sexual misconduct.
- Applicants must truthfully disclose any criminal, legal, or professional discipline history during the last seven years.

E. International Considerations

- Education and licensure/certification from Puerto Rico or U.S. Territories must be validated by U.S.-recognized accrediting bodies.
 - Licenses or certifications earned outside the U.S. or its Territories are not accepted, unless the applicant is currently practicing in a U.S. government facility.
 - Applicants from U.S. Territories must have passed the appropriate U.S. licensure exams (e.g., NCLEX for nursing).
- 



Application Process

Step 1: Review Eligibility Requirements

- **A. Educational Requirements**
 - If applying through the Licensure/Certification pathway, applicants will need submit one of the following:
 - Copy of current, active, unrestricted healthcare license
 - Official online verification
 - Copy of certification card or certificate showing active status
 - **If applying through the Degree pathway, applicants will need submit one of the following:**
 - Copy of current, active, unrestricted healthcare license
 - Official online verification
 - Copy of certification card or certificate showing active status
- **B. Work Experience**
 - Applicants must submit an employer or HR letter confirming their required work experience. They must also Job title(s), dates of employment, employer name(s), and supervisor name(s) with email addresses
 - Valid supervisor contact information so duties can be verified
 - Notifying provide accurate, verifiable information, including:
 - supervisors in advance that they may be contacted
- **C. Letter of Intent**
 - Applicants must submit a Letter of Intent affirming their commitment to ethical practice and verifying their moral character.

Step 2: Complete the Online Application

Applications can be submitted via the Submission Portal. Ensure all documents are in PDF format and labeled appropriately. Submission portal: <https://www.pathlms.com/cmsa/courses/184622>

Step 3: Pay Applicable Fees (Non-refundable)

- Member Fees: \$75
- Nonmember Fees: \$200

Step 4: Application Review

Applications are reviewed within 2-3 weeks. Qualified applicants will receive an acceptance email with next steps for enrollment.



Exam Blueprint

This microcredential assessment is designed through a structured, evidence-based exam development process to ensure fairness, validity, and relevance to real-world practice. This process aligns with professional standards used across credentialing, adult learning, and competency-based education.

This blueprint ensures balanced coverage of all critical content and appropriate difficulty levels.

Domain	Weight
A. Foundations of Utilization Management	15%
B. Tools, Guidelines & Regulatory Frameworks	20%
C. Documentation and Communication in UM	15%
D. Denials, Appeals, and Revenue Integrity	20%
E. Data-Driven Utilization Management	15%
F. Collaboration and Interdisciplinary Practice	15%

Detailed Content Outline

Domain A: Foundations of Utilization Management

- Definition, purpose, and evolution of UM
- Case manager's role in cost control, advocacy, and utilization oversight
- Key UM concepts: medical necessity, appropriateness, efficiency
- Managed care origins and influence on UM practices

Domain B: Tools, Guidelines, and Regulatory Frameworks

- Clinical decision support tools: InterQual, MCG
- Application of CMS Conditions of Participation (CoPs)
- Understanding MOON, HINN, ABN notifications
- Determining level of care: inpatient, observation, SNF, home health
- Payer policies, prior authorizations, and regulatory compliance

Domain C: Documentation and Communication in UM

- Essential components of accurate UM documentation
- Types of reviews: admission, concurrent, retrospective
- Scripting techniques for provider interaction
- Clear documentation to support medical necessity

Domain D: Denials, Appeals, and Revenue Integrity

- Types and causes of denials (technical, clinical, administrative)
- Strategies to prevent denials and reduce financial risk
- Writing and supporting successful appeal letters
- Role and value of the Physician Advisor in UM processes



Exam Blueprint

Domain E: Data-Driven Utilization Management

- Key performance indicators (KPIs): LOS, avoidable days, readmission
- Using analytics to identify trends and gaps
- Reporting metrics and performance outcomes
- Applying LEAN, Six Sigma, and PDSA in UM practice

Domain F: Collaboration and Interdisciplinary Practice

- Interdisciplinary collaboration for effective UM
- Case manager's interface with payers, providers, and ancillary teams
- Communicating denials, delays, and needs across disciplines
- Building a culture of shared accountability in UM efforts

Question Types

Format:

- Multiple choice
- Scenario-based questions

Number of Questions:

- 100

Time Allotted:

- 120 minutes





Exam Development Process

Item Writing

Assessment items (questions) were created by subject matter experts (SMEs) using standardized item-writing guidelines that promote:

- Clarity and precision
- Realistic, practice-based scenarios
- Avoidance of bias or ambiguity
- Alignment with the exam blueprint
- Appropriateness for adult and professional learners

Review and Validation

Each question underwent peer review by additional SMEs to ensure:

- Content accuracy
- Relevance to the field
- Alignment with competency expectations
- Cultural and language appropriateness
- Elimination of unintended bias

Validation steps also included pilot testing with learner samples. Revisions were made based on performance data.

Scoring and Standard Setting

- Candidate performance is based on the total number of correctly answered items. No partial credit is awarded for any question type.
- The exam result is reported as a binary outcome (pass or fail), communicated immediately upon completion.
- Experienced subject matter experts (SMEs) participated in a structured standard-setting process to estimate the level of knowledge and skill expected from a minimally competent practitioner.

Passing Standard and Reporting

- Candidates must achieve a minimum passing score of 80% to earn the micro-credential. The score requirement reflects the performance expected of a minimally competent practitioner.
- Results are issued as a pass/fail determination only. No numerical scores, subscores, or percentiles are disclosed.
- Candidates receive their examination outcome immediately following completion of the test.



Exam Administration

Testing Platform

The Utilization Management Micro-Credential exam is administered through secure, professionally proctored environments to ensure fairness, integrity, and consistency for all candidates.

Examinees may choose between:

- remote proctoring through ExamRoom.AI

OR

- in-person proctoring coordinated through an employer's HR, Training Department, or other designated organizational contact (per organization policy).

Scheduling the Exam

Once a candidate is approved and receives their acceptance email, they may schedule their exam through the designated scheduling portal.

- Remote Proctoring through ExamRoom.AI
 - Candidates will receive a link directing them to ExamRoom.AI's scheduling platform. Exam dates and times are offered on a flexible, first-come basis.
- In-Person Proctoring (Employer-Based)
 - Candidates who choose in-person testing must coordinate directly with their organization's HR department, training department, or other designated organizational contact (per organization policy) to arrange an approved testing session.
 - Candidates must provide the designated proctor's contact information on their application to ensure proper communication and verification.
 - Once the application is approved, CMSA will send the proctor a secure PIN required to unlock the exam. The candidate will then schedule the exam date and time directly with their proctor.

Identification Requirements

All candidates must present valid identification prior to beginning the exam.

- Accepted Forms of ID
 - Government-issued photo ID (driver's license passport, state ID)
 - Must be current (not expired)
 - Must match the candidate's name on record
- Remote testers will complete additional digital verification steps as required by ExamRoom.AI



Exam Administration

Exam Accommodations

- Reasonable accommodations are available for candidates with documented disabilities or qualifying conditions.
- To request accommodations:
 - Submit the [accommodation request form](#).
 - Provide supporting documentation
 - Submit requests at least 30 days prior to the intended testing date
- Accommodations may include:
 - Extended time
 - Separate testing room
 - Assistive technology (when allowed)
 - Additional breaks (as medically required)
- All accommodations must be approved by CMSA prior to scheduling the exam.

Retake Policy

- Candidates who do not achieve the passing standard may retake the exam following a mandatory 14-day waiting period. This interval helps maintain exam integrity and prevents overexposure to test content.
- A maximum of three (3) total exam attempts is permitted. Candidates who wish to pursue additional attempts beyond the maximum must submit a written request to CMSA for review. Approval of additional attempts is at CMSA's discretion and is not guaranteed.
- Each retake requires payment of the applicable retake fee. Candidates must adhere to the waiting interval and satisfy all scheduling and procedural requirements prior to registering for a subsequent attempt.
- All retake administrations use newly randomized exam forms drawn from the secure item bank to minimize item exposure and ensure fairness across administrations.



Exam Administration

Testing Rules and Requirements

- The following apply to both remote and in-person testing:
 - No use of messaging tools, additional browsers, or external applications
 - No assistance from other individuals
 - Testing areas must be clear of personal items
 - Candidates must remain visible to the proctor throughout the exam
 - Breaks are not permitted unless required and approved as an accommodation
- **Remote testers may also be required to:**
 - Perform a room scan
 - Close background applications
 - Remove secondary monitors
- **Violation of these rules may result in termination of the exam session and potential invalidation of the candidate's score.**

Candidate Code of Conduct

All applicants and candidates for the Utilization Management (UM) Microcredential are expected to uphold the highest standards of professional and ethical conduct throughout the application and examination process. By applying for and participating in the program, candidates agree to:

- Provide accurate, complete, and truthful information in all application materials and communications
- Comply with all examination rules, policies, and security requirements
- Maintain the confidentiality of all exam content and materials
- Refrain from any form of cheating, misconduct, or unauthorized assistance during the examination
- Respect the integrity of the credentialing process and the professional standards established by CMSA

Violation of these expectations may result in disciplinary actions, including but not limited to denial of eligibility, invalidation of exam results, revocation of the credential, and restriction from future participation.



Exam Administration

Exam Misconduct and Disciplinary Actions

CMSA maintains strict policies to preserve the integrity and security of the Utilization Management Microcredential program. Exam misconduct includes, but is not limited to:

- Use of unauthorized materials, devices, or external assistance during the exam
- Copying, recording, or attempting to reproduce exam content
- Sharing or distributing exam content in any format
- Impersonation or allowing another individual to test on one's behalf
- Providing false or misleading information during the application or examination process

All suspected misconduct will be reviewed through a formal evaluation process. This review may include analysis of proctor reports, system data, video recordings, and other relevant evidence. If misconduct is confirmed, CMSA may take one or more of the following actions:

- Invalidate exam results
- Deny or revoke the credential
- Restrict future participation in CMSA credentialing programs
- Notify relevant stakeholders, such as employers or regulatory bodies, when appropriate

Candidates will be notified of any findings and actions taken. Individuals may request a review of disciplinary decisions in accordance with CMSA's established appeals procedures.



Appeals Process

Scope of Appeal

Appeals may be submitted for review when a candidate believes that:

- A testing irregularity occurred (e.g., environmental disruption, proctoring error).
- A technical or system malfunction affected exam performance.
- A scoring or administrative error may have occurred.

Appeals will not be considered for:

- Disagreement with exam content or perceived item difficulty.
- Requests to challenge or review individual test questions.
- Attempts to obtain exam content, rationales, or scoring keys.

Submission Requirements

All appeals must be submitted in writing to education@cmsa.org

The written appeal must include:

- Candidate's full legal name
- Date of exam and testing modality (online/in person)
- Detailed description of the issue being appealed
- Any supporting evidence (screenshots, proctor communications, incident numbers, etc.)
- Preferred contact information for follow up

Only complete submissions are eligible for review. Incomplete or unverifiable claims cannot be processed.

Submission Timeline

- Appeals must be filed within 14 calendar days of the exam administration.
- Appeals submitted after this period may not be reviewed unless documentation shows compelling cause (e.g., system outage, delayed reporting).

Review Process

- Upon receipt, appeals undergo an initial administrative completeness check.
- Valid appeals are then forwarded to CMSA's credentialing taskforce which will convene a review team to evaluate the submission.
- Reviewers may examine:
 - Proctor logs
 - System performance data
 - Video/audio recordings (if applicable)
 - Statistical indicators of scoring anomalies
 - Any relevant administrative records



Appeals Process

Outcome Determination

- **Possible determinations include:**
 - Score affirmation (no change)
 - Authorization for a retest at no additional cost
 - Score invalidation accompanied by corrective action
 - Other remedies consistent with program policy
- The decision of CMSA's credentialing review team is final.

Notification of Results

- Candidates will receive a written response via email, typically within 10–15 business days of appeal submission.
- Additional time may be required if:
 - Proctoring vendors, testing platforms, or third-party verification tools must be consulted
 - The case involves alleged misconduct or complex technical investigation

Confidentiality and Records

- All appeal materials are treated as confidential and stored securely.
- Appeal outcomes do not affect eligibility for future exams unless tie to verified misconduct.





Security Policies

The program maintains a multi-layered security framework designed to safeguard all exam materials, including secure item banks, delivery systems, and candidate data. Protocols are engineered to prevent unauthorized access, reproduction, or dissemination of exam content.

Item Bank and Form Generation Controls

- **Use of Secure Item Pools:** All exam questions are stored in a controlled, access-restricted item bank. Only authorized psychometric and exam administration personnel may interact with the item repository.
- **Randomized Exam Forms:** Each candidate receives a unique exam form assembled from the larger question pool. Exam forms are generated using algorithmic item selection to ensure comparable difficulty, blueprint alignment, and psychometric balance across all delivered versions.
- **Content Exposure Minimization:** Because each form is unique, the likelihood of repeated exposure of the same items is reduced, strengthening exam integrity and reducing the risk of item harvesting or reverse engineering.
- **Rotation and Refresh Cycles:** Items are periodically retired, revised, or replaced based on statistical performance, security risk indicators, and SME review to maintain a secure and up-to-date item pool.

Candidate Identity Verification

- **Multi-Factor Identification:** Candidates must present verified government-issued identification. Remote testing may incorporate biometric matching, AI-supported facial recognition, or real-time ID validation.
- **Testing Environment Validation:** For online proctoring, candidates may be required to complete room scans and equipment checks to confirm the absence of prohibited resources.

Testing Environment Controls

- **Proctoring and Monitoring:** Exams are administered in controlled environments via in-person or live remote proctoring. Continuous monitoring includes audio, video, screen activity, and behavior analytics.
- **Secure Browser Technology:** Online delivery systems may employ lockdown browsers to disable external applications, screen captures, printing, or internet navigation.



Security Policies

Prohibited Behaviors

- **Unauthorized Content Access or Sharing:** Copying, capturing, recording, or distributing exam items—including attempts to harvest content from randomized forms—is strictly prohibited.
- **External Assistance:** Use of notes, devices, messaging tools, coaching, or generative AI during the exam is forbidden.
- **Impersonation:** Attempting to substitute or act as another candidate constitutes exam misconduct.

Monitoring & Statistical Surveillance

- **Behavioral Anomaly Monitoring:** Proctors and automated systems flag irregular test-taking behaviors or environmental anomalies for review.
- **Statistical Security Analysis:** Post-exam reviews include checks for suspicious response patterns, rapid-response anomalies, unusually similar answer strings between candidates, or score distributions inconsistent with expected norms—particularly across different randomized forms.

Incident Handling & Enforcement

- **Formal Reporting Process:** All suspected incidents of misconduct are documented and escalated to exam administrators for investigation.
- **Sanctions:** Violations may result in score invalidation, suspension of testing privileges, credential revocation, or referral to regulatory or employer entities.
- **Candidate Appeal Rights:** Candidates may request a review of security-related determinations in accordance with established exam policy.



Earning and Maintaining Your Credential

Individuals who successfully earn the Utilization Management (UM) Microcredential may use the credential to demonstrate their achievement and professional development in utilization management.

Upon earning the UM Microcredential, candidates are encouraged to:

- Display the digital badge on professional profiles, including LinkedIn and online portfolios
- Include the credential on résumés, email signatures, and professional materials
- Share credential verification links provided through Accredible

The credential may not be used to imply:

- Professional licensure
- Certification beyond the defined scope of the microcredential
- Authorization to perform clinical or regulatory functions outside an individual's professional qualifications

Credential use must be accurate and not misleading. Misrepresentation of the credential, including falsification or unauthorized use, may result in revocation and further disciplinary action. Only individuals who have successfully earned and maintain the credential may represent themselves as holders of the UM Microcredential.

Receiving Your Digital Badge

Candidates who pass the exam will receive a CMSA Utilization Management Microcredential Digital Badge, issued through Accredible, CMSA's digital credentialing platform provider.

How Accredible Works

Accredible provides a secure, user-friendly platform for managing and sharing digital credentials. Candidates will receive an automated email from Accredible containing:

- A link to view and claim their badge
- Instructions for creating or accessing their Accredible account
- Options for downloading, sharing, or embedding the credential

Accredible credentials include:

- Tamper-proof blockchain-backed validation
- Unique URLs for secure employer verification
- Long-term cloud storage so recipients never lose their credentials



Earning and Maintaining Your Credential

Renewal and Credential Maintenance

The Utilization Management (UM) Microcredential is valid for a period of three (3) years from the date of issuance.

To maintain the credential, individuals must complete fifteen (15) continuing education units (CEUs) within the three-year credential cycle. These CEUs must:

- Be accredited by a recognized continuing education provider
- Be directly relevant to utilization management, including topics such as medical necessity review, regulatory compliance, care coordination, reimbursement, or related areas of practice

Acceptable CE activities may include accredited courses, professional education programs, or other learning experiences that align with utilization management competencies.

Credential holders are responsible for:

- Tracking and maintaining documentation of completed CEUs
- Ensuring CE activities meet the program's relevance and accreditation requirements
- Submitting proof of completion during the renewal process

At the end of the three-year period, individuals must complete the renewal process as outlined by CMSA to maintain active credential status. CMSA reserves the right to audit CEU submissions to verify compliance with renewal requirements.

Individuals who do not meet the renewal requirements within the specified timeframe may no longer represent themselves as holding the UM Microcredential.

Renewal Process

The renewal process includes the following components:

- **Renewal Application**
 - Credential holders must submit a completed renewal application through the designated CMSA platform.
 - The application will require confirmation of continued professional activity and adherence to program standards.
 - A non-refundable renewal fee is required at the time of application submission.
 - Members: \$25 | Nonmembers: \$75



Earning and Maintaining Your Credential

Renewal Process

- **Continuing Education Documentation**
 - Applicants must provide documentation demonstrating completion of the required fifteen (15) continuing education units (CEUs) earned during the current credential cycle.
 - Documentation must:
 - Verify that CEUs were completed within the three-year credential period
 - Identify the accrediting body or provider
 - Include sufficient detail to confirm relevance to utilization management practice CMSA reserves the right to request additional documentation or clarification to verify compliance with renewal requirements.
- **Review and Approval**
 - Submitted renewal applications will be reviewed by CMSA to confirm that all requirements have been met.
 - Incomplete applications or insufficient documentation may result in delays or denial of renewal.

Lapse of Credential

Credential holders who do not complete the renewal process prior to the expiration date may be required to reapply and successfully complete the current version of the microcredential examination to regain the credential.

CMSA will make reasonable efforts to notify credential holders of upcoming renewal deadlines; however, it is the responsibility of the individual to ensure timely completion of all renewal requirements.



Policies and Administrative Procedures

Refund Policies

- All exam fees are non-refundable, including application fees, examination fees, and retake fees.
- Candidates are encouraged to carefully review eligibility requirements and scheduling obligations before completing registration to avoid unnecessary charges.
- Exceptions are not provided for scheduling conflicts, failure to appear, or technical issues caused by the candidate's equipment or environment.

Transfers & Deferrals

- Candidates may request to transfer or defer an exam appointment under limited circumstances consistent with CMSA's guidelines.
- A transfer or deferral may be approved when:
 - The request is submitted prior to the scheduled exam time.
 - The candidate experiences a documented medical condition, emergency, or extenuating work or personal circumstance.
- Requests must be submitted in writing to CMSA.
- Only one transfer or deferral is permitted per paid exam fee.
- A new exam date must be scheduled within the timeframe identified by CMSA.

Non-Discrimination Statement

- All applicants, candidates, and credential holders are treated with respect and evaluated solely based on their qualifications and adherence to program standards.
- CMSA is committed to providing a fair, equitable and inclusive credentialing process. **The program strictly prohibits discrimination based on:**
 - Race
 - Ethnicity
 - Gender or gender identity
 - Disability
 - Age
 - Religion
 - Sexual orientation
 - National origin
 - Any other protected characteristics



Policies and Administrative Procedures

Privacy and Data Protection

- CMSA applies the same privacy, security, and data-use standards to all exam candidates, regardless of CMSA membership status.
- Membership does not alter how exam-related information is collected, stored, or used.
- CMSA does not use exam application data to modify or update a candidate's CMSA membership record unless the candidate explicitly requests it.
- Exam-related information is never shared for membership marketing, promotional outreach, or benefits distribution unless the candidate has already opted into those communications as part of their CMSA profile.
- **Candidate information is:**
 - Collected only for eligibility verification, exam administration, credentialing, and program operations.
 - Stored securely within CMSA's protected database.
 - Not shared with third parties except for essential exam administration partners, such as ExamRoom.AI and Accredible.
- **CMSA and its approved vendors use:**
 - Secure, encrypted systems
 - Access-restricted systems
 - Compliance with relevance privacy standards and regulations
- Exam content, candidate records, and scoring data are all confidential. CMSA staff, proctors, and vendors follow strict confidentiality protocols and may not disclose exam materials or candidate information under any circumstances.

Administrative Guidelines

- CMSA aims to respond to administrative requests, such as deferrals, accommodations, and verifications, within 5-7 business days.
- Submitted applications will be reviewed within 14 business days to determine eligibility and confirm required documentation.
- Processing times may vary depending on request complexity, volume, or the need for additional verification.
- Candidates should monitor email communications closely, as all exam-related notifications are delivered electronically.
- CMSA reserves the right to modify policies, procedures, or administrative requirements at any time.
 - Updated policies will be posted on the official CMSA website and communicated to candidates when applicable.
 - Changes do not apply retroactively to completed exam attempts or previously rendered decisions.



Customer Service and Support

Program Support Contact

Michelle Whitfield, CMSA Education Manager
education@cmsa.org | mwhitfield@parthenonmgmt.com

Technical Help Desk

- ExamRoom.AI
Email: Support@examroom.ai
Phone: +1 877-848-3926
Chat bot on [Examroom.ai](https://examroom.ai)
- Accredible: https://help.accreditable.com/s/article/accreditable-partner-customer-support-faqs?language=en_US

Resources & Appendices

- Glossary of Terms
- Resources
- Accommodation Request Form: <https://www.surveymonkey.com/r/MJ7Q9H6>

Glossary of Terms

Accreditation Standards

Externally developed requirements (for example, The Joint Commission, NCQA, URAC) that establish expectations for patient safety, quality, and utilization management processes, and are often used to validate or exceed minimum CMS Conditions of Participation and payer standards.

Admission Review

A structured, criteria-based assessment performed at or near the time of hospital entry to determine whether a patient meets medical necessity requirements for inpatient admission versus observation or outpatient care, incorporating CMS rules (such as the Two-Midnight Rule) and payer policies.

Affected/Impacted Payers

Health plans and programs subject to the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), including Medicare Advantage organizations, Medicaid and CHIP FFS and managed care programs, and Qualified Health Plan issuers on Federally-Facilitated Exchanges (FfEs).

Appeals and Grievances

Formal, time-bound procedures that allow patients and providers to contest adverse utilization management decisions (appeals) or raise concerns about service quality or plan conduct (grievances), governed by federal and state regulations and accreditation standards.

Appeals Process

A defined, multi-level sequence that may include internal plan review, external independent review, and regulatory escalation, designed to re-evaluate adverse determinations using complete clinical information and applicable coverage criteria.

Application Programming Interface (API)

A set of technical rules and standards that enable different software systems to connect and exchange data electronically; under CMS-0057-F, affected payers must implement FHIR-based APIs to support prior authorization, patient access, and payer-to-payer data exchange.

Attending Physician

The physician of record with primary responsibility for directing the patient's care during an encounter, collaborating with UR staff and physician advisors on medical necessity, documentation, and level-of-care determinations in accordance with hospital policy and payer rules.

Glossary of Terms

Audit

A retrospective, systematic review of clinical and billing records by internal staff, payers, or regulators to assess the appropriateness of utilization, compliance with laws and accreditation standards, and the accuracy of coding and reimbursement.

Avoidable Days

Hospital days beyond what is medically necessary, frequently driven by delays in clinical decision-making, discharge planning, post-acute placement, or administrative processes, and monitored as a key throughput and utilization metric.

Behavioral Health UM

The application of utilization management principles to mental health and substance use disorder services, ensuring that care is clinically appropriate, timely, and compliant with parity and access requirements.

Case Mix Index (CMI)

A numeric value reflecting the average clinical severity and expected resource use of a hospital's inpatient population, typically based on MS-DRG or APR-DRG weights, and used for benchmarking, reimbursement, and utilization analysis.

Clinical Documentation Integrity (CDI)

A coordinated process to ensure that provider documentation fully and accurately represents the patient's diagnoses, treatments, and risk profile, thereby supporting compliant coding, quality reporting, and defensible medical necessity determinations.

CMS Two-Midnight Rule

A Medicare policy stating that inpatient admission is generally appropriate when the admitting physician expects the patient to require hospital care spanning at least two midnights and this expectation is supported by clinical documentation.

Community-Based UM Programs

Regionally focused utilization management initiatives, often operated by payers or provider networks, that apply UM principles to a specific community or population to improve access, quality, and cost effectiveness.

Comprehensive Care Programs

Multi-disciplinary, longitudinal care models (often for chronic or high-risk patients) that coordinate medical, behavioral, and social services to reduce avoidable utilization, improve outcomes, and support value-based reimbursement.

Glossary of Terms

Concurrent Review

A real-time or near real-time evaluation of a patient's ongoing hospital stay to confirm continued medical necessity, appropriate level of care, and progression toward discharge, using standardized criteria and collaboration with the care team.

Condition Code 44

A Medicare billing code used when a UR committee, with physician concurrence, changes a patient's status from inpatient to outpatient/observation prior to discharge, in accordance with CMS guidelines.

Conditions of Participation (CoPs)

Regulatory requirements issued by CMS that hospitals must meet to participate in Medicare and Medicaid, including specific provisions for utilization review at 42 CFR § 482.30 and discharge planning at 42 CFR § 482.43.

Continued Stay Review (Concurrent Review)

The portion of concurrent review focused on whether additional hospital days remain medically necessary, and whether barriers to timely progression of care or discharge exist, as defined in the UR plan.

Denial Management

An organized set of activities to prevent, track, analyze, and appeal payer denials, with the goal of reducing revenue loss, correcting process gaps, and ensuring medically necessary care is reimbursed appropriately.

Denial Reason / Specific Reason for Denial

A clear, clinically and contractually grounded explanation issued by a payer for an adverse decision; under CMS-0057-F, impacted payers must provide a specific reason for all prior authorization denials beginning in 2026.

Discharge Planning

A coordinated, patient-centered process that begins early in the hospital stay to assess post-acute needs, engage patients and caregivers, arrange follow-up services, and ensure safe, timely transition to the next level of care in compliance with 42 CFR § 482.43.

Documentation of Medical Necessity

The clinical narrative, objective findings, and supporting data recorded in the medical record that demonstrate why the services, level of care, and length of stay are reasonable, necessary, and consistent with accepted standards and payer criteria.

Glossary of Terms

Electronic Prior Authorization (ePA) Measure

A Promoting Interoperability/MIPS measure requiring clinicians to attest to the use of electronic, standards-based prior authorization workflows, leveraging payer APIs as they are implemented under CMS-0057-F.

Exception to UR Plan Requirement

Two circumstances in which a separate hospital UR plan under 42 CFR § 482.30 is not required: when a QIO assumes binding review responsibility or when CMS mandates the use of state Medicaid UR procedures judged superior to federal requirements.

Expedited (Urgent) Prior Authorization Request

A prior authorization request for services where applying the standard review timeframe could seriously jeopardize the patient's life, health, or ability to regain function; CMS-0057-F requires impacted payers to respond to expedited requests within 72 hours.

Fast Healthcare Interoperability Resources (FHIR®)

An HL7® interoperability standard that structures health data into modular "resources," enabling modern APIs such as Patient Access, Provider Access, Payer-to-Payer, and Prior Authorization APIs required under CMS-0057-F.

Interoperability

The capacity of different health information systems, organizations, and applications to securely exchange and use electronic health data in a standardized way that supports coordinated care, patient engagement, and regulatory requirements.

Key Performance Indicators (KPIs)

Quantitative measures used to monitor and improve UR and UM performance (for example, admission appropriateness, average length of stay, denial rates, timeliness of prior authorization and concurrent review).

Length of Stay (LOS)

The number of days between hospital admission and discharge, often compared with expected or benchmark LOS for similar diagnoses to assess efficiency, resource use, and case management effectiveness.

Level of Care (LOC)

The most appropriate care setting and intensity of services for a patient at a given time (for example, inpatient, observation, outpatient, skilled nursing), determined by clinical criteria, physician judgment, and payer policies.

Glossary of Terms

MACPAC

The Medicaid and CHIP Payment and Access Commission, an independent agency that advises Congress and HHS on Medicaid and CHIP payment, access, and prior authorization policies.

MedPAC

The Medicare Payment Advisory Commission, an independent congressional agency that analyzes Medicare payment, access, and quality issues and makes policy recommendations to Congress.

Medical Necessity

A standard used by payers and regulators to determine whether a service, admission, or continued stay is reasonable, clinically appropriate, and consistent with generally accepted standards of medical practice for the diagnosis or treatment of the patient's condition.

Medical Necessity of Admission

The determination that a patient's clinical status, risk, and expected course of treatment justify a particular level of care (for example, inpatient versus observation), as documented by the physician and evaluated through UR criteria and payer rules.

Observation Status

A hospital outpatient designation for patients who require short-term monitoring, diagnostic testing, or treatment while a decision is made regarding inpatient admission or discharge, subject to specific payment and coverage rules.

OIG Oversight

Monitoring and enforcement activities by the HHS Office of Inspector General to ensure that utilization management practices, including denials, do not improperly restrict beneficiary access to medically necessary services.

Outlier Case Review

Focused review of inpatient cases with unusually high cost or extended LOS that may qualify for outlier payments under IPPS, assessing both clinical appropriateness and documentation.

Patient Access API

A FHIR-based API required of impacted payers that allows patients, through third-party applications, to access claims, encounter, and specified clinical and prior authorization information.

Glossary of Terms

Patient Access Barriers

Obstacles—such as delays, denials, narrow networks, or administrative complexity—that limit patients’ timely access to necessary services, often scrutinized by CMS, OIG, and advocacy organizations.

Payer Policy Compliance

The degree to which providers and hospitals follow each payer’s coverage, prior authorization, documentation, and billing rules while also meeting overarching federal and state requirements.

Peer-to-Peer Review

A discussion between the treating provider and a payer’s clinical reviewer (often a physician) to clarify clinical facts and advocate for coverage when an initial UM determination is unfavorable or uncertain.

Periodic Review of Extended Stay Cases

A UR plan requirement—especially for non-IPPS hospitals—to review inpatients with extended or high-cost stays at defined intervals to determine ongoing medical necessity and appropriate level of care.

Physician Advisor (PA)

A licensed physician who supports the UR and revenue cycle processes by interpreting payer rules, advising on level-of-care and medical necessity questions, assisting with peer-to-peer reviews, and educating clinicians.

Physician Burnout

A work-related syndrome characterized by emotional exhaustion, depersonalization, and reduced sense of accomplishment, to which administrative tasks such as prior authorization and UM requirements substantially contribute.

Prior Authorization API

A FHIR-based interface that impacted payers must implement to expose prior authorization requirements, allow electronic submission of requests, return decisions (including specific denial reasons), and update status within required timeframes.

Prior Authorization Final Rule (CMS-0057-F)

A 2024 CMS regulation that strengthens requirements for electronic prior authorization, establishes API mandates (Patient Access, Provider Access, Payer-to-Payer, Prior Authorization APIs), and sets decision timeframes and transparency metrics for impacted payers.

Glossary of Terms

Professional Services Review

UR committee evaluation of services furnished by physicians and other practitioners, including drugs and biologicals, to determine medical necessity and promote efficient use of hospital resources as required by 42 CFR § 482.30.

Prospective Review / Prior Authorization

Utilization management activities performed before services are delivered to determine whether requested services meet clinical and coverage criteria and may proceed, often as a condition of payment.

Provider Access API

A FHIR-based API required for impacted payers that enables in-network providers to access patient claims, encounter, USCDI clinical data, and prior authorization information to support clinical decision-making and care coordination.

Payer-to-Payer API

An API that impacted payers must implement to enable secure electronic exchange of clinical, claims, and prior authorization data with other payers when a patient changes or holds multiple plans, supporting continuity of care.

Retrospective Review

A post-service evaluation of medical necessity, appropriateness, and coding of care already delivered, used for compliance, quality assessment, and appeals.

Revenue Cycle Team

Interdisciplinary staff (coding, billing, patient access, UR, CDI) responsible for converting clinical encounters into accurate claims and payments while maintaining compliance with payer and regulatory requirements.

Screening Criteria

Evidence-based clinical guidelines or tools (for example, InterQual, MCG) used to compare a patient's documented condition to standardized benchmarks when determining the appropriate level of care or need for continued stay.

Social Determinants of Health (SDOH)

Non-medical factors—such as housing, food security, transportation, income, and social support—that influence health risks, utilization patterns, and outcomes, and that should be considered in discharge planning and UM.

Glossary of Terms

Standard Prior Authorization Request

A non-urgent prior authorization request for which CMS-0057-F requires impacted payers to provide a decision within seven calendar days after receipt, with status updates reflected promptly in their APIs.

Throughput Optimization

Coordinated efforts to improve patient flow from entry to discharge by addressing process bottlenecks, reducing avoidable days, aligning bed capacity, and streamlining handoffs.

Utilization Review (UR)

A CMS-mandated hospital process under 42 CFR § 482.30 that evaluates the medical necessity, appropriateness, and efficiency of admissions, continued stays, and professional services for Medicare and Medicaid patients.

Utilization Management (UM)

An overarching function that integrates utilization review, case management, discharge planning, and prior authorization activities to ensure that health care services are necessary, high-quality, and delivered in the most appropriate setting.

UR Coordinator / Case Manager

A nurse, social worker, or similarly trained professional who performs day-to-day UR activities, including admission and concurrent reviews, documentation support, communication with payers, and collaboration with the care team to resolve barriers to appropriate utilization.

URAC

An independent accrediting body that establishes and evaluates standards for health utilization management and other programs, emphasizing evidence-based decisions, consumer protection, and regulatory compliance.

Utilization Review Committee (UR Committee)

The hospital committee required by 42 CFR § 482.30 to oversee UR activities, review medical necessity of admissions, continued stays, and professional services, and ensure the UR plan is implemented without conflicts of interest.

VHA Directive 1117

The U.S. Department of Veterans Affairs directive that outlines UM expectations and processes across VA health care systems, aligning with federal standards while addressing VA-specific operational needs.

Glossary of Terms

Written Notification of Non-Medically Necessary Stay

Formal notice, typically generated after UR committee review, informing the responsible practitioner and revenue cycle team that some or all hospital days or services do not meet medical necessity criteria, prompting status changes, billing adjustments, or appeals as appropriate.



References

American Journal of Managed Care. (2024). Utilization management and physician burnout: Results from a national survey. *American Journal of Managed Care*, 30(5), SP213–SP220. <https://www.ajmc.com>

American Medical Association. (2024). AMA prior authorization physician survey: 2024 results. Author. <https://www.ama-assn.org>

Alliance Health. (2023). Utilization management program description: FY 2023–2024. Alliance Health. <https://www.alliancehealthplan.org>

Arizona Priority Care. (2021). Utilization management program description. Arizona Priority Care. <https://www.azprioritycare.com>

Centers for Medicare & Medicaid Services. (2024, January 17). Interoperability and Prior Authorization final rule (CMS-0057-F). *Federal Register*, 89(12), 3065–3162. <https://www.federalregister.gov/d/2024-00518>

Centers for Medicare & Medicaid Services. (2025). CMS interoperability and prior authorization final rule: Frequently asked questions. <https://www.cms.gov>

Centers for Medicare & Medicaid Services. (2025). CMS Interoperability and Prior Authorization final rule: Overview and resources. <https://www.cms.gov/prior-authorization-interoperability>

Centers for Medicare & Medicaid Services. (2025). Medicare and Medicaid programs: Conditions of participation (CoPs) for hospitals – Utilization review requirements (42 CFR §482.30). U.S. Department of Health and Human Services. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.30>

Cubanski, J., Neuman, T., Freed, M., & Damico, A. (2023, February 2). Prior authorization in Medicare Advantage plans: How often is it used? Kaiser Family Foundation. <https://www.kff.org>

Daniels, C. E., & Hirsch, R. L. (2021). *The hospital guide to contemporary utilization review* (3rd ed.). HCPro.

Dean, E. B., French, M. T., & Mortensen, K. (2020). Food insecurity, health care utilization, and health care expenditures. *Health Services Research*, 55, 883–893.

References

Doshmangir, L., Farzadfar, F., Abolhassani, N., Mahdavi, M., Rahbari, R., Rezapour, A., & Arab-Zozani, M. (2022). Strategies for utilisation management of hospital services: A scoping review. *BMC Health Services Research*, 22(1), 655. <https://doi.org/10.1186/s12913-022-08030-2>

Freed, M., & Cubanski, J. (2025, January 29). Nearly 50 million prior authorization determinations were made for Medicare Advantage enrollees in 2023. Kaiser Family Foundation. <https://www.kff.org>.

Gaines, M. E., Auleta, A. D., & Berwick, D. M. (2020). Changing the game of prior authorization: The patient perspective. *JAMA*, 323(8), 705–706.

Giardino, A. P., Giardino, E. R., & Ahmed, R. A. (2023). Utilization management. In *StatPearls*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK560822/>

Hoagland, A., Yu, O., & Horný, M. (2024). Social determinants of health and insurance claim denials for preventive care. *JAMA Network Open*, 7(9), e2433316.

Humana Inc. (2025). Humana commitment to reduce prior authorization burden. Humana Newsroom.

Jennings, L. A., Laffan, A. M., Schlissel, A. C., Colligan, E., Tan, Z., Wenger, N. S., & Reuben, D. B. (2019). Health care utilization and cost outcomes of a comprehensive dementia care program for Medicare beneficiaries. *JAMA Internal Medicine*, 179(2), 161–166.

Maddukuri, N. (2024). Optimizing appeals and grievances workflows in healthcare. *International Journal of Computer Engineering and Technology*, 15(6), 1827–1839.

Medicaid and CHIP Payment and Access Commission. (2024, August). Prior authorization in Medicaid. <https://www.macpac.gov/publication/prior-authorization-in-medicaid/>

Medicare Payment Advisory Commission. (2023, November). Evaluating access in Medicare Advantage: Provider networks and prior authorization. MedPAC Public Meeting. <https://www.medpac.gov>

Medicare Payment Advisory Commission. (2024, June). Provider networks and prior authorization in Medicare Advantage. In *Report to the Congress: Medicare and the health care delivery system* (Chapter 10). <https://www.medpac.gov/document/june-2024-report-to-the-congress-medicare-and-the-health-care-delivery-system/>

References

National Committee for Quality Assurance. (2024). Utilization management standards and guidelines, 2024–2025. NCQA. <https://www.ncqa.org>

Office of Inspector General, U.S. Department of Health and Human Services. (2022, April). Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care (OEI-09-18-00260). <https://oig.hhs.gov/reports/2022/oei-09-18-00260.pdf>

Schwartz, A. L., Chen, Y., Jagmin, C. L., Verbrugge, D. J., Brennan, T. A., Groeneveld, P. W., & Newhouse, J. P. (2022). Coverage denials: Government and private insurer policies for medical necessity in Medicare: Study examines medical necessity coverage denials in Medicare and private insurers. *Health Affairs*, 41(1), 120–128.

URAC. (2022). Health Utilization Management Accreditation, version 8.1. URAC. <https://www.urac.org>

U.S. Department of Veterans Affairs. (2020, October 15). VHA Directive 1117: Utilization Management. Veterans Health Administration. <https://www.va.gov>

