



## Troy Medicare Policy and Procedure

<b>Title:</b> Prior Authorization Organization Determinations			<b>Policy Number:</b> UM - 006
<b>Primary Department:</b> Utilization Management	<b>LOB:</b> Medicare Advantage		<b>Author:</b> J Murphy
<b>Effective Date:</b> 11/1/2022	<b>Original Date:</b> 11/1/2022	<b>Review Date(s):</b> 4/26/2023; 12/7/2023	<b>Archive Date:</b>
<b>Interactive Related Department(s)</b>			
<input type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input checked="" type="checkbox"/> Medical Management <input type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing	<input type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Pharmacy <input type="checkbox"/> Member Services <input type="checkbox"/> Quality Management <input checked="" type="checkbox"/> Utilization Management	<input type="checkbox"/> Care Management <input type="checkbox"/> Enrollment <input type="checkbox"/> Plan Administration <input type="checkbox"/> Claims <input type="checkbox"/> Other _____	

Disclaimer: Troy Utilization Management applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Troy Policies, and MCG for determining medical necessity. Troy Health Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

### POLICY PURPOSE

The purpose of the Prior Authorization Organization Determinations policy is to:

- Establish a process for members or their authorized representative and providers to submit requests for medical services.
- Ensure the timely response to medical service requests that accommodates the clinical urgency of the situation and to minimize any disruption in the provision of healthcare.
- Comply with all State and Federal regulatory requirements.

Troy Health, Inc. is committed to complying with all regulations and requirements for Medicare Advantage Plans, and applicable federal and state laws.

### SCOPE

This Policy and Procedure applies to the timeliness and review process of Medicare Part C organization determinations within the Utilization Management (UM) Department. The UM Department is under the umbrella of the Medical Management Department (Health Services).

### REFERENCES

- [Medicare Managed Care Manual Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#)
- 42 CFR Part 422 Subpart M

## RESPONSIBLE PARTIES

- Vice President of Health Services
- Chief Medical Officer

## DEFINITIONS

- **Adverse Organization Determination** means that Troy denies authorization or payment for services based on established, evidence based clinical review criteria. Denials may be based on fully or partially denied prospective (pre-service, i.e., requests from a practitioner or member before services are delivered) concurrent (i.e., review of services currently being provided in a clinical setting), or retrospective (post service, i.e., submission of a request for authorization or payment after services are delivered).
- **Effectuation** means compliance with a reversal of the Medicare health plan's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.
- **Independent Review Entity (IRE)** means an independent entity contracted by CMS to review Medicare health plans' adverse organization determinations.
- **Inquiry** means any verbal or written request for information to a plan or its delegated entity that does not express dissatisfaction or invoke a plan's grievance, coverage or appeals process, such as a routine question about a benefit.
- **Medical Exigency Standard** means the requirement that a Medicare health plan and related entities must make decisions as expeditiously as the enrollee's health condition requires.
- **Medical Necessity** means covered services that are prescribed based on generally accepted medical practices considering conditions at the time of treatment. Medically Necessary services are: appropriate and consistent with the diagnosis of the treating provider and the omission of such could adversely affect the member's medical condition; compatible with the standards of acceptable medical practice in the community; provided in a safe and appropriate setting given the nature of the diagnosis and severity of the symptoms not provided solely for the convenience of the member, the physician, or the facility providing the care those for which there are no other effective and more conservative treatment, service or setting available.
- **Organization Determination** means any determination (approval or denial) made by a Medicare health plan with respect to any of the following:

1. Payment for temporarily out of area renal dialysis services, emergency services, post-stabilization care, or urgently needed services
  2. Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan
  3. The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan
  4. Reduction, or premature discontinuation of a previously authorized ongoing course of treatment
  5. Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.
- **Pre (Prior) Authorization** means authorization granted in advance of the rendering of a service after appropriate medical review. When related to an inpatient admission, this process may also be referred to as pre-certification.
  - **Successful Verbal Notification** is considered delivered on the date (and time, applicable) a Troy representative speaks directly to or leaves a voicemail for an enrollee or enrollee's representative.

## POLICY

It is the policy of Troy Medicare to ensure members receive appropriate care and/or services and that utilization decisions are made in a timely manner in order to minimize disruption in the provision of care, and that decisions are made as expeditiously as the member's medical condition warrants. All Utilization Management (UM) decision making is based only on the appropriateness of care and services, appropriate setting and the existence of coverage. An authorization of services does not guarantee payment.

Troy Medicare does not reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives are not provided to UM decision makers nor are UM decision makers encouraged to render decisions that result in underutilization.

## PROCEDURE

### 1. Roles and Responsibility of the Utilization Management Department

- a. Medical Director
  - i. In accordance with 42 CFR §422.562(a)(4) and 423.562(a)(5), the medical director is employed by Troy Medicare and assumes overall responsibility for clinical decision-making and is involved in aspects of related plan policies and operations including but not limited to: medical and utilization review, benefits and claims management, processing coverage decisions in accordance with adjudication timeframes and

- notice requirements, provider/prescriber outreach, staff training, and oversight of delegated entities.
- ii. The medical director is a physician, as defined in section 1861(r) of the Act, with a current, and unrestricted, license, to practice medicine in North Carolina.
- b. Vice President, Health Services
  - i. Utilization Management is responsible for the operational compliance and performance of the department.
  - ii. Utilization Management coordinates operations with UM and other departments within the health plan.
  - iii. The Utilization Management department is responsible for overseeing and coordinating the process of investigation and resolution of all pre-service requests submitted by the member, their authorized representative or providers.
  - iv. Utilization Management prepares reports regarding Organization Determinations for review by the Plan's Medical Director and Chief Medical Officer and for submission to the Centers for Medicare & Medicaid Services (CMS)
- c. Utilization Management Coordinator:
  - i. The accurate and timely processing and creation of prior authorization requests received through telephone, mail, fax or online submission.
  - ii. Sends all requests that require medical necessity review to the appropriate Utilization Management staff.
  - iii. Adheres to adjudication timeframes as established by CMS for standard and expedited prior authorization organization determinations pursuant to section 40.10 of the Medicare Managed Care Manual Medicare Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
  - iv. Ensures that all correspondence, including extensions and resolution notices are sent to the member, authorized representative and/or provider within the regulatory timeframes.
  - v. UM Coordinators do not issue organization determination based on medical necessity or the lack thereof.
- d. Utilization Management Nurse
  - i. The Utilization Management Nurse is responsible for initial and concurrent medical necessity review(s) for initial prior authorization requests.
  - ii. The Utilization Management Nurse applies medical management guidelines based on the UM-026 Troy UM Medical Necessity Guidelines for Coverage determination policy to determine if the service or item meets medical necessity criteria.
  - iii. If the request does not meet medical necessity or benefit criteria, the Utilization Management Nurse forwards the Organization Determination to the Medical Director for review and final determination.

## **2. Processing Initial Organization Determination**

- a. Acceptance and Determination Notification
  - i. Pre-Service organization determination requests may be submitted to Troy by email, fax, mail, or member call-center.
  - ii. Troy Medicare has established processes to notify Troy members of pre-service decisions in a manner and format that is understandable to the member within the applicable timeframes
- b. Processing Timeframes
  - i. Standard request for coverage of items or services - Determination shall be made within 14 days from the receipt of the request. Standard request for coverage of Part B drugs - determination shall be made within 72 hours from the receipt of the request
  - ii. Expedited request for coverage of items or services - Determination shall be made within 72 hours of the receipt of the request, or as expeditiously as the enrollee's health condition requires. Expedited request for coverage of Part B drugs - determination shall be made within 24 hours
  - iii. Denial of expedited request -If the standard request process will not seriously jeopardize the life or health of the member or the member's ability to regain maximum function (the physician does not have to use these exact words), Troy may deny the member's request to expedite an initial determination and transfer the request to the standard initial determination process, give the enrollee prompt verbal notice of the denial, and deliver written notice of the denial within 3 days of the verbal notice.
- c. Extension – Troy Medicare may invoke an extension for up to 14 days following the receipt of a standard or expedited pre-service organization determination if:
  - i. The enrollee requests the extension or
  - ii. If the plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee and
  - iii. The authorization request is not for coverage of part b drug (extensions are not allowed per CMS guidance for Part B drug authorizations)

### **3. Untimely Organization Determination**

- a. In the event that Troy does not render an Organization Determination within the regulatory timeframe for either a standard or expedited request, the failure itself constitutes an adverse Organization Determination and may be appealed.

### **4. Appeal Rights**

- a. The member, authorized representative or treating provider has the right to appeal the Organization Determination if it involves an adverse decision. Specific instructions on how to file a standard appeal and expedited (fast-track) appeal (Reconsideration) are included in the CMS-approved denial notices.

### **5. Withdrawal of a Request for an Initial Determination**

- a. Troy will allow the party that submits a request for an initial determination to make a verbal or written request to withdraw the request at any time before the decision is issued. For verbal withdrawal requests, Troy will clearly document the

- date and the reason why the party chose not to proceed with the initial determination procedures. Written requests will be attached to the case file.
- b. Troy will send a written confirmation of that withdrawal to the party within 3 calendar days of receipt of the withdrawal request, clearly indicating which request is being withdrawn.

#### **ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES**

- UM-003 Denials and Terminations Policy
- UM-012 Timeframes for Review Policy

#### **APPROVALS**

*Jen Murphy*

**Vice President, Medical Management**

12 / 28 / 2023

**Date:**

*L. Scott*

**Utilization Management Committee**

12 / 28 / 2023

**Date**

#### **Revision History**

<b>Revision Date</b>	<b>Revised by Whom</b>	<b>Revisions Made</b>
11.1.2022	J Murphy	Initial policy version.
4.26.2023	J Murphy	Review by Policy Committee
12.7.2023	J Murphy	Annual review by Utilization Management Committee. Added related policies.