



Troy Medicare Policy and Procedure

Title: Utilization Management Committee		Policy Number: UM-009		
Primary Department: Medical Management	LOB: Medicare Advantage		Author: J. Murphy	
Effective Date: 1/1/2024	Approval Date: 12/7/2023	Original Date: 1/1/2024	Review Date(s): 11/05/2024; 11/11/2025	Archive Date:
Interactive Related Department(s)				
<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"/> Customer Service <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	

NOTE:

On 6/16/2025, CMS issued guidance (an HPMS memo titled “Exercising Enforcement Discretion Regarding the Requirements under 42 CFR §§ 422.137(c)(5), and 422.137 (d)(6) and (7)”) indicating the following:

Effective immediately, CMS will:

1. Suspend enforcement of the requirement that all UM committees include at least one member with expertise in health equity as specified at 42 CFR § 422.137(c)(5);
2. Suspend enforcement of the requirement to conduct the annual health equity analysis as specified at 42 CFR § 422.137(d)(6); and
3. Suspend enforcement of the requirement to publicly post the results of such analysis as specified at 42 CFR § 422.137(d)(7).

POLICY PURPOSE

Troy Health, Inc., as a Medicare Advantage organization, is required to have a Utilization Management (UM) Committee in place that oversees the use of UM policies and procedures, including prior authorization.

The purpose of this policy is to demonstrate Troy’s commitment to comply with all applicable federal and state regulatory requirements. Troy Medicare and Troy Health are hereby referred to as “Troy” for the purpose of this policy.

Troy Health, Inc. is committed to complying with all regulations and requirements for Medicare Advantage Plans, and applicable federal and state laws, including health care fraud and identity theft laws.

SCOPE

This policy applies to the Medical Management department.

REFERENCES

- 42 CFR §§ 422.137; 422.138; 422.101; 422.202

RESPONSIBLE PARTIES

- Chief Medical Officer
- Vice President, Medical Management

DEFINITIONS

- Local Coverage Determination (LCD) – a decision by Medicare and its administrative contractors that provide coverage information and determine whether services are reasonable and necessary. These guidelines apply only to the areas of the country over which the local Medicare Administrative Contractor, who author/adopts the LCD, has jurisdiction.
- National Coverage Determination (NCD) – a decision by Medicare and its administrative contractors that provide coverage information and determine whether services are reasonable and necessary. These guidelines apply across the United States wherever Medicare provides health coverage.
- Prior Authorization – 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
- Utilization Management (UM) – the process and techniques used to evaluate the appropriateness and medical necessity of health care procedures, services, and treatments provided to patients on a case-by-case basis.

POLICY

Federal regulations and Troy's Medicare Advantage contract with CMS require the designation of a UM Committee. The function of the UM Committee is to provide oversight of the UM program, and approve the UM policies and procedures and the services to which the UM applies.

The responsibilities of the UM Committee must include, but are not limited to:

1. At least annually, review the policies and procedures for all utilization management, including prior authorization, used by Troy. Such review must consider:
 - a. The services to which the utilization management applies;
 - b. Coverage decisions and guidelines for Traditional Medicare, including NCDs, LCDs, and laws; and
 - c. Relevant current clinical guidelines.
2. Approve only utilization management policies and procedures that:
 - a. Use or impose coverage criteria that comply with the requirements and standards at [§ 422.101\(b\)](#);

- b. For prior authorization policies, comply with requirements and standards at [§ 422.138](#);
 - c. Comply with the standards in [§ 422.202\(b\)\(1\)](#); and
 - d. Apply and rely on medical necessity criteria that comply with [§ 422.101\(c\)\(1\)](#).
3. Revise the UM policies and procedures as necessary to comply with the standards in [§ 422.137](#), including removing requirements for UM for services and items that no longer warrant UM.
4. Clearly articulate and document processes to determine that the requirements under [paragraphs \(c\)\(1\)](#) through [\(4\)](#) of [§ 422.137](#) have been met, including the determination by an objective party of whether disclosed financial interests are conflicts of interest and the management of any recusals due to such conflicts.
5. Document in writing the reason for its decisions regarding the development of UM policies. Troy may not use any UM policies and procedures for basic or supplemental benefits on or after January 1, 2024, and annually thereafter, unless those policies and procedures have been reviewed and approved by the UM Committee.
6. Beginning January 1, 2025, include at least one member with expertise in health equity. Expertise in health equity includes educational degrees or credentials with an emphasis on health equity; experience conducting studies identifying disparities amongst different population groups; experience leading organization-wide policies, programs, or services to achieve health equity; or experience leading advocacy efforts to achieve health equity.
7. Beginning in 2025, annually conduct a health equity analysis of the use of prior authorization.
 - A. The final report of the analysis must be approved by the member of the committee with expertise in health equity before it is publicly posted.
 - B. The analysis must examine the impact of prior authorization on enrollees with one or more of the following social risk factors:
 - a. Receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid.
 - b. Disability status is determined using the variable original reason for entitlement code (OREC) for Medicare using the information from the Social Security Administration and Railroad Retirement Board record systems.
 - C. The analysis must use metrics specified in 42 CFR 422.137(d)(6)(iii), calculated for enrollees with the specified social risk factors and enrollees without the specified social risk factors, to conduct the analysis at the plan level using data from the prior contract year regarding coverage of items and services excluding data on certain drugs.
 - D. By July 1, 2025, and annually thereafter, publicly post the results of the health equity analysis of the utilization management policies and procedures on the plan's website meeting the specified requirements at 42 CFR 422.137(d)(7).

Troy's Approach to Utilization Management and Prior Authorization

Troy's UM policies and procedures contain clinical criteria used by Troy's medical management teams for precertification, prior authorization and appropriateness of care and coverage determination. The criteria are specific to the clinical characteristics of the Troy member population seeking the treatment and services. The needs of individual members must be considered and are addressed through the application of clinical criteria. Coverage decisions are based on widely used treatment guidelines and peer reviewed clinical studies.

Troy's UM policies provide general information regarding our clinical processes. Services may or may not be covered by Troy Medicare. The member's plan documents provide specific coverage information.

Troy applies Medicare coverage rules for medical necessity determinations of medical services. Coverage determination decisions are made in accordance with all current evidence of coverage, CMS internet-only manuals & CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). In the absence of Medicare coverage rules, NCDs or LCDs, Troy may use tools developed by third parties, such as the Milliman Clinical Guidelines (MCG) to assist in determining coverage and administering health plan benefits.

Troy's UM policies and MCG clinical guidelines are not intended to be used without the independent clinical judgment of a qualified healthcare provider taking into account the specific circumstances of each member's case. The UM policies and MCG clinical guidelines do not constitute the practice of medicine or medical advice. Treating healthcare providers are solely responsible for diagnosis, treatment and medical advice.

Troy requires that providers obtain prior authorization before rendering services. Failure to do so may be grounds for denial resulting in provider liability. Troy reserves the right to conduct a medical necessity review at the time the claim is reviewed.

PROCEDURE

1. The UM Committee will meet at least annually, or more frequently if necessary.
2. The UM Committee charter is a founding document that defines the roles and responsibilities, the mission, the composition of the Committee and standard protocols.
3. The UM committee composition must:
 - a. Include a majority of members who are practicing physicians.
 - b. Include at least one practicing physician who is independent and free of conflict relative to Troy Medicare.
 - c. Include at least one practicing physician who is an expert regarding care of elderly or disabled individuals.
 - d. Include members representing various clinical specialties (for example, primary care, behavioral health) to ensure that a wide range of conditions are adequately considered in the development of the Troy's UM policies.

4. The UM Committee must review, revise as appropriate, and approve the Troy UM policies and procedures for basic or supplemental benefits before January 1, 2024, and annually thereafter.
5. Troy's CMP-005 Conflicts of Interest and Conflict Committee policy and Code of Conduct, including review by Troy's Conflict Committee, will apply. Each Committee member is required to abide by Troy's disclosure policies.
6. Review the reason for Troy's approach and decisions regarding the development of UM policies.
7. An agenda, record of Committee attendance, and meeting minutes are required for the UM Committee.
8. All Utilization Management Committee documents must be retained for a period of not less than 10 years.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

- CMP-005 Conflicts of Interest and Conflict Committee
- Troy Code of Conduct
- HPMS memo titled "Exercising Enforcement Discretion Regarding the Requirements under 42 CFR §§ 422.137(c)(5), and 422.137 (d)(6) and (7)", dated 6/16/2025

APPROVALS

Jennifer Murphy
Jennifer Murphy (Nov 24, 2025 09:35:33 EST)

Chief Clinical Officer

11/24/2025

Date

Sally Scott
Sally Scott (Nov 23, 2025 22:37:26 EST)

UM Committee

11/23/2025

Date

Revision History:

Date	Author	Revision Notes
12/5/2023	J. Murphy	Initial version
11/05/2024	J. Murphy	Revised policy and procedure sections, and approach to utilization management. Annual Review completed in Utilization Management Committee Meeting
11/11/2025	J. Murphy	Annual review by the Utilization Management Committee. Added note regarding CMS' exercising enforcement discretion. Revised policy purpose,