



Troy Medicare Policy and Procedure

Title: Medical Necessity Review Personnel		Policy Number: UM - 010
Primary Department: Utilization Management	LOB: Medicare Advantage and DSNP	
Effective Date: 11/1/2022	Original Date: 11/28/2022	Review Date(s): 4/26/2023; 12/7/2023, 11/7/2024; 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"/> Sales and Marketing	<input type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Pharmacy <input type="checkbox"/> Claims <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"/> Provider Operations <input type="checkbox"/> Other

Disclaimer: Troy Medicare Utilization Management applies CMS criteria and guidelines, National and Local Coverage Determinations (NCD/LCD), Clinix Internal Review Guidelines, Troy Utilization Review Policies, and MCG (Milliman Criteria Guidelines) Criteria. This suite of guidelines covers the spectrum of inpatient, outpatient, and rehabilitation, and care for medical, surgical, and behavioral health issues. In addition, Troy partners with vendors who provide clinical expertise for specific services.

POLICY PURPOSE

The purpose of this policy is to state when Medical Director review is required for Utilization Management (UM) decisions.

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

The following policy applies to all requests for Organizational Determinations for items/services/Part B drugs and care provided in Inpatient, Observation, Acute Rehabilitation Facilities, Skilled Nursing Facilities, Comprehensive Outpatient Rehabilitation Facilities, and Home Health Agencies.

REFERENCES

- 42 CFR §422.562(a)(4) and 423.562(a)(5);

- 42 CFR Part 422, Subpart M; 42 CFR § 422.566;
- Medicare Managed Care Manual, Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, 8/3/22 version

RESPONSIBLE PARTIES

- Vice President, Health Services
- Chief Medical Officer

DEFINITIONS

Medical Director- a licensed physician who has the overall responsibility for the plan's clinical decision-making and is involved in plan policies and operations including, but not limited to medical and utilization review, formulary administration, processing coverage decisions in accordance with adjudication timeframes and notice requirements, provider/prescriber outreach, and staff training. The Medical Director must be a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia.

UM Nurse- a licensed nurse who performs preliminary evaluation of requests for items/services/Part B drugs and care provided in Inpatient, Observation, Acute Rehabilitation Facilities, Skilled Nursing Facilities, Comprehensive Outpatient Rehabilitation Facilities, and Home Health Agencies.

POLICY

All requests for items/services/Part B drugs and care provided in Inpatient, Observation, Acute Rehabilitation Facilities, Skilled Nursing Facilities, Comprehensive Outpatient Rehabilitation Facilities, and Home Health Agencies are initially reviewed by the UM Nurse. UM Nurses thoroughly review all clinical documents in the request and apply appropriate medical necessity criteria as per Troy Medicare Policy UM – 008. If criteria are met, the UM Nurse will approve the request. If UM criteria are not met, the UM Nurse forwards the request to the Medical Director or designated physician for adjudication.

PROCEDURE

1. The UM Nurse receives a request and first determines if what is being requested requires prior authorization. If prior authorization is not required, the UM Nurse notifies the requestor that authorization is not required.
2. If the UM Nurse determines that a request does require prior authorization, he/she next determines if the clinical information received is sufficient to determine medical necessity. If the UM nurse determines there is insufficient clinical information to complete a medical necessity review, the UM Nurse makes at least 1 attempt to gather the necessary documentation from the requestor. Efforts to obtain clinical information are recorded in the clinical software system. If clinical information is not received and the case is nearing the end of the regulatory timeframe, the UM Nurse forwards the case to the Medical Director or designated physician for review. Care is taken to forward cases such that the Medical Director or designated physician decision and provider and member notifications are made within regulatory timeframes.
3. If the UM Nurse determines there is sufficient clinical information to perform a

medical necessity criteria review, the review is completed by the nurse. If medical necessity criteria are met, the UM Nurse approves the request. The UM Nurse completes provider and member notification as per regulatory requirements.

4. If the UM Nurse determines medical necessity criteria are not met, the UM Nurse documents his/her findings of what criteria are not satisfied and forwards the case to the Medical Director or designated physician for further examination.
5. The Medical Director or designated physician reviews the clinical documents submitted by the requestor and the nurse's review and then applies appropriate medical necessity criteria to render a decision. Criteria used may include; Peer-reviewed published medical journals and Evidence-based consensus studies on a particular topic. Medical necessity criteria used by the Medical Director or designated physician differs from that used by the nurse
6. If the Medical Director or designated physician believes medical necessity criteria are satisfied, he/she will approve the request. If the Medical Director or designated physician believes medical necessity criteria are not met, he/she will deny the request.
7. The Medical Director's or designated physician's decision is then returned to the UM Nurse for provider and member notification as per regulatory requirements.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

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APPROVALS

Jennifer Murphy
Jennifer Murphy (Nov 30, 2025 14:14:59 EST)

Chief Clinical Officer
 11/30/2025

Date

Sally Scott
Sally Scott (Nov 28, 2025 14:30:33 EST)

UM Committee
 11/28/2025

Date

Revision History

Revision Date	Revised by Whom	Revisions Made
11.28.2022	J Murphy	Initial policy
4.26.2023	J Murphy	Review by Policy Committee
12.7.2023	J Murphy	Annual review by Utilization Management Committee
11.4.2024	J Murphy	Revised disclaimer and procedure. Annual review by Utilization Management Committee
11.11.2025	J Murphy	Revised procedure. Annual review by Utilization Management Committee. Revised purpose, definitions, policy and procedure.