



Title: Administrative Denial			Policy Number: UM - 011
Primary Department: Utilization Management	LOB: Medicare Advantage and DSNP		Author: J Murphy
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Interactive Related Department(s)			
<input type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing <input checked="" type="checkbox"/> Medical Management	<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 this policy is to state the circumstances in which Administrative Denials are issued.

Troy Health, Inc. is committed to complying with all regulations and requirements for Medicare Advantage Plans, and applicable federal and state 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;
- Medicare Claims Processing Manual, Chapter 1, Section 90.

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. Medical Directors are licensed in the state(s) served by Troy Medicare.

Request for Concurrent Authorization- A request from a provider for Inpatient, Observation, Acute Rehabilitation, Skilled Nursing, Comprehensive Outpatient Rehabilitation, and Home Health Agency services in which a member is currently admitted or actively engaged in a course of treatment/care.

Request for Pre-Service Authorization- A request from a provider for an item/service/Part B drug prior to the provision of the item/service/Part B drug.

Service- Inclusive of all 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.

UM Coordinator- a non-licensed professional who provides administrative assistance to the Utilization Management Department.

UM Nurse- a licensed nurse who performs preliminary evaluation of requests for services/items.

POLICY

All requests for services/items are initially reviewed by the UM Nurse. UM Nurses thoroughly review all documents in the request with the goal of applying appropriate medical necessity criteria as per Troy Medicare Policy *UM – 008 Medical Necessity Guidelines for Coverage Determination*. In situations where information is missing from a request, Troy attempts to gather necessary documentation for a medical necessity review.

Administrative denials are issued when a medical necessity determination cannot be made. The following scenarios result in administrative denial:

1. **Requests without any clinical information.** An administrative denial is issued when there is no clinical information whatsoever. If an ICD 10 is included, this is considered clinical information and will be processed outside of the administrative pathway. If records are not received by Troy prior to the expiration of the applicable regulatory timeline, an administrative denial is issued.
2. **Submitted documents do not specify an actual request.** In situations where there is no identifiable request for service/item(s), an administrative denial is issued.
3. **Failure to notify Troy within 24 hours of an emergent inpatient admission.** Requests for authorization of Inpatient admissions received over 24 hours after the admission date and time will be denied administratively for the entirety of the admission, including all ancillary charges.
4. **Post-service requests** for authorization of any service/item that requires prior authorization are administratively denied. The lack of a pre-service request prevented Troy from applying medical necessity criteria and as such, these requests are uniformly denied administratively.
5. **Ineligible status.** Requests for services for patients that are not currently enrolled in Troy Medicare are denied administratively. The exception to this rule is during institutional admissions (Inpatient Hospital, Long-term Acute Care Hospital, Acute Rehabilitation Facilities, Skilled Nursing Facilities) wherein the patient was actively enrolled with Troy Medicare upon admission. In these circumstances, Troy Medicare applies medical necessity criteria through discharge and approves or denies the days accordingly.
6. **Benefit Ineligibility.** The service is not covered under the member's policy at the time the service is requested or provided, or a limited benefit has been exhausted

PROCEDURE

1. The UM Nurse receives a request and determines that:
 - a. There is no clinical information in the request (as outlined above).
 - b. There is no actual service specified on the request.
 - c. The request is for an inpatient admission in which notice is received >24 hours after admission date and time.
 - d. The request is for a service that requires prior authorization, and the service has already been provided.
 - e. The request is for a patient not actively enrolled with Troy Medicare or is for a patient not actively enrolled with Troy Medicare on the date of an institutional admission.
 - f. The request is for a benefit not covered under the member's policy or for a benefit that has already been exhausted.
2. The UM Nurse refers the case back to a UM Coordinator to process as an administrative denial.

3. The UM Coordinator creates and transmits provider and member notification regarding the administrative denial and documents this in the clinical software system.

4. Administrative denial language is as follows:

Troy Medicare received a request that cannot be processed. This request is denied administratively (without review by a Troy Medicare nurse and/or doctor). ***Insert one of the 6 scenarios below.*** The rules that Troy Medicare used to make this decision are found in Troy Medicare Policy *UM-011, Administrative Denials*.

- ☐ Your provider did not send medical records to Troy Medicare. Without medical records, Troy Medicare cannot tell whether what is requested is medically necessary (needed). Troy Medicare reached out to your provider but did not receive a response.
- ☐ Your provider did not clearly say what was being requested. Troy Medicare cannot determine what is needed for your care. Without knowing what is requested, we are unable to say whether the care is medically necessary (needed). Troy Medicare reached out to your provider but did not receive a response.
- ☐ The hospital sent us notice that you were admitted after the deadline. Hospitals must notify Troy Medicare within 24 hours of your being admitted to a hospital. Failure to do so results in an administrative denial.
- ☐ Troy Medicare received a request for a service or item that was already provided to you. This service or item requires Prior Authorization (Troy Medicare must authorize the request ahead of time). Because your provider did not obtain Prior Authorization before supplying the service or item, the request is administratively denied.
- ☐ ***(To provider only)*** Troy Medicare received a request for a service or item for a patient that is not currently enrolled in Troy Medicare. This request is denied administratively as this patient's care is not the liability of Troy Medicare.
- ☐ Troy Medicare received a request for a service or item <<that is not covered by your insurance policy>> or << that has already been exhausted under your insurance policy.>>

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

- *Troy Medicare Policy – UM-008 Medical Necessity Guidelines for Coverage Determination*
- *Troy Medicare Policy – UM-011 Administrative Denials*

APPROVALS

Jen Murphy

Vice President, Medical Management

12 / 27 / 2023

Date

L. Scott

Utilization Management Committee

12 / 22 / 2023

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