Title: Timeframes for Review Policy				**Policy Number:** UM - 012
Primary Department: Utilization Management	**LOB:** Medicare Advantage			**Author:** J Murphy
Effective Date: 1/1/2023	**Approval Date:** 12/21/2022	**Original Date:**1/1/2023	**Review Date(s):** 4/26/2023; 12/7/2023	**Archive Date:**
Interactive Related Department(s)				
☐ All Departments ☐ Compliance ☐ Medical Management ☐ Provider Operations ☐ Sales and Marketing	☐ Appeals and Grievances ☐ Customer Service ☐ Member Services ☐ Quality Management ☒ Utilization Management		☐ Care Management ☐ Enrollment ☐ Plan Administration ☐ Claims ☐ 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

To be compliant with decision determination timeframes according to state, regulatory and accrediting agencies.

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 applies to the Utilization Management Department.

REFERENCES

- Medicare Managed Care Manual Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
- 42 CFR § 422.568(b)(1) and (2)
- Medicare Managed Care Manual Chapter 6

RESPONSIBLE PARTIES

- Vice President of Health Services
- Chief Medical Officer

DEFINITIONS

- **Adverse Organization Determination** means that Troy Medicare 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 Troy Medicare'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 Troy Medicare or its delegated entity that does not express dissatisfaction or invoke Troy Medicare's grievance, coverage or appeals process, such as a routine question about a benefit.

- **Medical Exigency Standard** means the requirement that Troy Medicare 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 Troy Medicare 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 Troy Medicare that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Troy Medicare
    3. Troy Medicare'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 Troy Medicare
    4. Reduction, or premature discontinuation of a previously authorized ongoing course of treatment
    5. Failure of Troy Medicare 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.

- **Reconsideration** means an enrollee's first step in the appeal process after an adverse organization determination; Troy Medicare or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

- **Successful Verbal Notification** is considered delivered on the date (and time, if applicable) a Troy Medicare 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 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.

Troy Medicare must authorize or provide the service or benefit as expeditiously as the enrollee's health condition requires, but no later than the timeframes noted herein (based on when the request was received).

GUIDELINES

1. **Pre-Service Organization Determination Review**:
    a) **Expedited Requests for coverage of items or services**. As expeditiously as the enrollee's health condition requires, but in no case later than 72 hours after receiving the request for items and services. If medical information is needed from a non-contract provider, Troy must request the necessary information within 24 hours of receipt of the request.
        i. **Extension**. Troy Medicare may extend the processing time period for up to 14 days following the receipt of an expedited pre-service organization determination, if the enrollee requests the extension, or if Troy justifies a need for additional information and documents how the delay is in the best interest of the enrollee and additional medical evidence from a non-contract provider is needed

in order to make a decision favorable to the enrollee, or the extension is justified due to extraordinary, exigent or other non-routine circumstances and is in the enrollee's interest.
    - When extensions are used, Troy Medicare must issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon the expiration date of the extension.

b) **Standard Requests for coverage of items or services**. Within 14 calendar days of the receipt of request for an organization determination.
    i. **Extension**. Troy Medicare may extend the processing time period for up to 14 days following the receipt of a standard pre-service organization determination if the enrollee requests the extension or if Troy Medicare justifies a need for additional information and documents how the delay is in the best interest of the enrollee. Troy Medicare must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.
        - When extensions are used, Troy Medicare must issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon the expiration date of the extension.

c) **Standard request for coverage of Part B drugs**. Determination shall be made within 72 hours from the receipt of the request.

d) **Expedited request for coverage of Part B drugs**. Determination shall be made 24 hours after receiving the request for Part B drugs.

2. **Retrospective Review**:
Troy Medicare will issue a determination within 30 calendar days of the receipt of request for a utilization management determination. Retrospective requests with necessary information must be submitted to Troy within 90 days of the service/admission,

3. **Concurrent Review**:
    a) For reductions or terminations in a previously approved course of treatment, Troy Medicare will issue a written denial determination far enough in advance of the reduction or termination to allow for an appeal of the determination to be completed; and
    b) For requests to extend a current course of treatment, Troy Medicare will issue the determination within:
        1. 24 hours of the request for an expedited organization determination, and the request was received at least 24 hours before the expiration of the currently certified period or treatments; or
        2. 72 hours of the request for an expedited organization determination, and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

- N/A

APPROVALS

Jen Murphy

Vice President, Medical Management

12 / 27 / 2023

Date

S. Scott

Utilization Management Committee

12 / 22 / 2023

Date

Revision History

Revision Date	Revised by Whom	Revisions Made
12.21.2022	J Murphy	Initial policy
4.26.2023	J Murphy	Review by Policy Committee
12.7.2023	J Murphy	Annual review by Utilization Management Committee