765 The City Drive South, Orange Ca 92868

P&P #: 002	*Expedited Organizational Determinations*	**Page** 1 of 5
TITLE:	Astiva Health Utilization Management Policy for Expedited Referral Requests	
APPROVED:	12/6/2023	
APPROVED:	Dr. Jason Chung, MD, Chief Medical Officer	
APPROVED:	Utilization Management Committee	
DEPARTMENT:	Utilization Management	
☒ **MEDICARE** ☒ **MEDI-CAL** ☐ **COMMERCIAL** [use as applicable]		

***POLICY**:*

This policy outlines the Utilization Management process to ensure the Expedited Organizational Determinations at Astiva Health meet the Centers for Medicare and Medicare Services (CMS) standards.

SCOPE:

Astiva Health Plan

Delegated IPA/Medical Groups

PURPOSE:

The purpose of this policy is to ensure Astiva Health members receive timely referrals based on the Initial Organization Determination. This policy outlines standards and timeframes by which Astiva Health shall make a Expedited Organizational Determination for a referral submitted by a provider. The Centers for Medicare and Medicaid Services (CMS) requires each Medicare Advantage Prescription Drug (MAPD) Health Plan to review requests for services and process these requests quickly and efficiently to ensure not to delay the member's care. Astiva Health and Delegates are required to follow the CMS Expedited Organization Determinations in accordance with this policy. Astiva Health may delegate Expedited Organization Determinations to an IPA/Medical Group or MSO based on contractual agreements. Once an Expedited Organization Determination is made, the decision is communicated to the member/members' representative, and provider, by Astiva Health or a delegated IPA/Medical Group within the expedited timeframe from receipt of request for services. The timeframes in this policy are maximum timeframes and Astiva Health will treat every case appropriately based on its medical urgency, and at a minimum, in assessing the individual's medical condition. Evidence of Coverage (EOC) clearly explains the standard organization determination procedures. It is the responsibility of Astiva Health or the Delegator to notify members about any

changes to the initial organization determination process (i.e., address changes, fax number changes, etc.) at least thirty-(30) days in advance of the effective date of the change.
Astiva Health or Delegate ensures that all members have equal access to and can fully participate in the Initial Organization Determination (IOD) process by aiding for those with limited English proficiency, visual disorders, or other communicative impairments. Translation services for approvals, adverse determination letters, forms, responses, appeals and grievances, interpretation services and telephone relay systems will be as required.
The request for an Expedited Organization Determination shall be made at any time by the following:

- A member or the member's authorized representative
- Any provider that furnishes, or intends to furnish, services to a member or
- Legal representative of a deceased member(s).

Astiva Health and the delegated group(s) shall make Expedited Organization Determinations no later than seventy-two hours (72) calendar days from receipt of request for services. If the request is made for a Part B service, the plan or delegate must make a Expedited Organization Determination no later than twenty-four hours (24) hours from receipt of request for services. An extension may not be taken for part B drug requests or when Astiva is unable to obtain medical records from a contracted provider. If at least three (3) documented good faith attempts to obtain the information have been completed and the information is still not forthcoming, Astiva Health may deny the request for lack of established medical necessity. If a member disagrees with the Expedited Organization Determination, the member may request an expedited reconsideration. The Utilization Management (UM) Department is responsible for reviewing each request and deciding whether to approve or deny the request within the specified timeframe.

DEFINITIONS:

Adverse Determination — Written notice that is provided to the Health Plan members denying a request for payment or in whole or in part, that advises the member of his/her right to a reconsideration of the decision.

Appeal — Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service. An Appeal may include Reconsideration by Astiva Health and if necessary, the Independent Review. Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.

CMS The Centers for Medicare & Medicaid Services oversees the federally and state funded insurance programs for seniors, persons with disabilities (Medicare) and low income (Medicaid) who are deemed eligible for these benefits.

Grievance Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the way Astiva Health or a delegated entity provides health care services, regardless of whether any remedial action can be taken. A member may make a complaint or dispute, either orally or in writing, to Astiva Health, a provider, or a facility. A grievance may also include a complaint that Astiva Health or Delegate refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration timeframes. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Member Astiva Health beneficiary/enrollee of healthcare organization.

NCQA National Committee for Quality Assurance is an accreditation body that is highly respected in the industry and has been appointed by Congress to aid in developing standards for Special Needs Plans (SNPs) including but not limited to the SNP Model of Care requirements. Additionally, health plans and providers who voluntarily request NCQA Accreditation undergo an in-depth review and survey of their operations and quality improvement processes and results to prove their value to consumers and other purchasers of insurance. Accreditation may or may not be granted. When granted the accreditation is for specified functional areas and is for a specified timeframe.

FWA FWA is Fraud, Waste, and Abuse (a term used to reference the entire gamut of inappropriate behavior, activities, practices, etc. related to perpetrating crimes against members or related to government funding)

HHA The United States Department of Health and Human Services (HHS), is a cabinet-level executive branch department of the U.S. federal government created to protect the health of all Americans and providing essential human services. Its motto is "Improving the health, safety, and well-being of America. Various States also have a Health & Human Services Department for the citizens of their State.

PROCEDURES:

- All requests for authorization of services will be processed according to Astiva Health policies and procedures.
- Astiva Health utilizes approved criteria to make an educated decision whether to approve, partially approve, or deny a request.
- In the event the Medical Director is unable to decide based on the information given, contacting a board-certified specialist in the same or similar specialty may be necessary to assist in the decision-making process.
- Responsibility of reviewing, authorizing, or denying will be assigned to the appropriate health care professional.
- Astiva Health and/or Delegate will consider timeliness when completing the request for a Expedited Organization Determination
    - For part C requests the referral must be completed no later than seventy-two hours (72) hours after receipt of the request for services.
    - For part B drug requests, decision and notification must be completed within (24) hours from the receipt of the request.
- Upon finalizing a referral, the member and submitting provider will be provided either oral or written notification of the decision.

- **Authorization Request Documentation**:
    - Providers office(s) seeking prior authorization must submit a complete authorization request package.
        - The package should include:
            - Patient Information: Full name of the member, date of birth, and identification number.
        - Provider Information:
            - Including the name of the provider, contact information, NPI, and professional credentials if required.
        - Clinical Documentation:
            - Submit short description and CPT codes for requested service.
            - Include clinical records supporting the medical necessity of the requested treatment or procedure, including diagnostic findings, such as X-rays, photographs, or scans.
            - A detailed treatment plan outlining the procedures to be performed.
            - Relevant medical and dental history.
            - Any alternative treatment options considered.
        - Supporting Documentation:
            - Include any additional documents that may aid in the authorization process, such as specialist consultations, second opinions, or relevant peer-reviewed research articles.

- **Member Rights and Responsibilities**:
  - Members retain appeal rights for pre-authorization of services which are denied.
- **Confidentiality and Privacy**:
  - All documentation will be securely stored and solely used for provision of members' care and quality and utilization improvement activities. All relevant confidentiality and privacy laws are in effect.
- **Policy Review and Updates**: This policy will be reviewed as needed by the Utilization Management Committee.

REFERENCES / CITATIONS:

Medicare Managed Care Appeals & Grievances | CMS

Organization Determinations | CMS

HISTORY:

Date	Summary of Significant Changes to P&P
10/18/2023	• New Policy
12/6/2023	• Approved by UM Committee