765 The City Drive South, Orange CA 92868

P&P #: 001	Standard Organizational Determination Process	**Page** 1 of 6
TITLE:	Astiva Health Utilization Management Policy for Standard Referral Requests	
APPROVED:	12/6/2023	
APPROVED:	Jason Chung MD, Chief Medical Officer	
APPROVED:	Utilization Management Committee	
DEPARTMENT:	Utilization Management	
☒ **MEDICARE** ☒ **MEDI-CAL**		

***POLICY**:*

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

SCOPE:

Astiva Health Plan Members

Delegated IPA/Medical Groups

PURPOSE:

The purpose of this policy is to ensure Astiva Health members receive timely referrals based on the Organization Determination. This policy outlines the standards and timeframes by which Astiva Health shall make a Standard 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 not to delay the member's care. Astiva Health and Delegates are required to follow guidelines set by CMS Standard Organization Determinations in accordance with this policy.

Astiva Health may delegate Standard Organization Determinations to an IPA/Medical Group or MSO based on contractual agreements. Once a Standard Organization Determination is made, the decision is communicated to the member/members' representative, and referring provider, by Astiva Health or a delegated IPA/Medical Group within the standard 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. The Evidence of Coverage (EOC) explains the standard organization determination procedures.

Astiva Health or the Delegated responsibility ensures that all members have equal access to and can fully participate in the Standard 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 provided as required. It is the responsibility of Astiva Health or the Delegated entity 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.

The request for a Standard Organization Determination shall be made at any time (via oral, written, fax) by the following:

- A member or the member's authorized representative (upon verification of required member authorization and documentation, ex: AOR Form, POA, Advanced Directive)
- Any provider that furnishes, or intends to furnish, services to a member or
- Legal court-appointed representative of a deceased member(s).

Astiva Health and/or the delegated group(s) shall make a Standard Organization Determination no later than fourteen (14) 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 Standard Organization Determination no later than seventy-two (72) hours from receipt of request for services. An extension may 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 Standard Organization Determination, the member may request a standard 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.
The appeals process requires a review of an adverse organization determination by an MA plan Medical Director. The decision is based on evidence and findings submitted by a party to the organization, MA plan. If a determination is made to uphold the initial appeal, a second level appeal may be filed with the Astiva Health Plan. This process involves an independent review entity to help make the adverse plan decision.

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 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 or representative 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, including professionalism.

Member Astiva Health beneficiary/enrollee of healthcare organization.

FWA Fraud, Waste, and Abuse (a term used to reference a range of inappropriate or illegal behavior, activities, practices, etc. related to acts on or behalf of members or related to government funding)

HHS The United States Department of Health and Human Services (HHS), is a cabinet-level executive branch department of the U.S. government created to protect the health of all Americans and providing essential human services. States also have a Health & Human Services Department with state-level jurisdiction.

PROCEDURES:

- All requests for authorization of services will be processed according to Astiva Health policies and procedures.
- Astiva Health utilizes standard 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 UM department clinical staff.
- Astiva Health and/or Delegate will consider timeliness when completing the request for a Standard Organization Determination
    - For part C requests the referral must be completed no later than fourteen (14) calendar days after receipt of the request for services.
    - For part B drug requests, decision and notification must be completed within 72 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.

Monitoring & Auditing:

Astiva Health Utilization Management and Medical Services Management utilize the following sources to create key performance metrics that are used to monitor the Part C appeals process on a monthly and quarterly basis for Astiva Health Plan and its delegated IPAs. Astiva Health Compliance and the Delegation Oversight Committee utilize industry-recognized audit tools in collaboration with the following information to perform quarterly audits of Astiva internal LOB and contracted IPAs per the Delegation Oversight Audit policy and procedure:

- CMS-defined Part C Reporting metrics and
- CMS Program Audit Protocols & Data Requests
- ODAG Tables – EOD/SOD/Claims/Reopenings
- HIC ODAG Audit Tools
- CMS Fraud Alert HPMS Memos
- Quarterly FWA CMS Risk Assessments
- Astiva Health Plan Risk Assessment and Work Plan

REFERENCES / CITATIONS:

Medicare Managed Care Appeals & Grievances | CMS

Organization Determinations | CMS

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

ATTACHMENTS

A. Process Flow – Part C Appeals

B.

HISTORY:

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

ATTACHMENT A: Part C Appeals Process Flow

Appendices

Appendix 1 – Medicare Managed Care (Part C) Appeals Process Overview