D to EditPolicy and Procedure No: UM 150.5	**Revision No: 5**
Division: Care Management	
Department: Utilization Management	
Title: PHP Organizational Determinations	
Effective Date: 3/27/2017	
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Reviewed/Revised by: Tiffany Smith	**Review/Revision Date: 12/5/2025**
Approving Committee: Utilization Management Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

This policy and procedure describes how PHP (the Health Plan's) Utilization Management (UM) Department processes organization determinations.

Policy:

The Health Plan processes organization determinations in a timely manner in accordance with the guidelines outlined in the CMS Managed Care Manual Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Procedure:

Standard Organization Determination Process

1. A request for service, procedure or durable medical equipment is received by the Health Plan, any unit in the Health Plan, or a delegated entity (including a delegated entity that is not responsible for processing).

2. The Authorization Coordinator or Utilization Review Nurse reviews the request to determine if the service requires authorization.

    a. If the service does not require authorization, the requester is notified.

    If the request requires authorization, an authorization is created to reflect the request.
3. The appropriate Utilization Management staff reviews the request for medical necessity.

4. If the request includes sufficient information to approve the request based on medical necessity, the Utilization Review Nurse or Authorization Coordinator will:

    a. Update the authorization to reflect the favorable organization determination within seven (7) calendar days of receipt.

        i. Authorizations for Part B drugs will be updated to reflect a favorable organization determination within seventy-two (72) hours of receipt.

    b. Generate the approval letter.

    c. Fax the approval letter to the requesting provider.

d. Mail the approved letter to the member.

e. Call the member and provide verbal notification of approval.

5. If the request is submitted without supporting clinical documentation, the Utilization Review Nurse or Authorization Coordination will:

    a. Make an outreach attempt to the requesting provider to request clinical information to support the medical necessity of the request.

    b. After three (3) attempts, if the requested information is not received, the Utilization Review Nurse or Authorization Coordination will ensure that a Integrated Denial Notice (IDN) letter is sent to the requesting provider and the request will be administratively denied.

6. If the request does not include *sufficient* information to approve the request based on medical necessity, the Utilization Review Nurse will:

    a. Consult with the Medical Director and/or Director of Care Coordination to review the information provided and what information is necessary to support the medical necessity review.

    b. Make an outreach attempt to the requesting provider to request additional clinical information to support the medical necessity of the request.

7. If the requesting provider does not or cannot supply additional information, and the nurse is unable to approve the request based on the licensed medical necessity criteria or there are no medical necessity criteria for this request, the Utilization Review Nurse will:

    a. Document a narrative of the clinical information received in the UM notes in the member's electronic record, the criteria used to determine medical necessity and outstanding clinical information needed to establish medical necessity.

    b. Refer the case to the Medical Director for review and final decision.

8. The Medical Director will review the request for medical necessity, based on all clinical information available, utilizing the Medicare Coverage Database, InterQual Guidelines, or other evidence-based clinical practice guidelines and/or clinical judgment and make a final determination.

9. The Medical Director will notify the Utilization Review Nurse of the organization determination.

10. The Utilization Review Nurse or Authorization Coordinator will process a favorable organization determination as indicated in Procedure Step 4.

11. If the organization determination is unfavorable in any aspect, the Utilization Review Nurse will review the denial language provided by the medical director to ensure it includes the specific reason for the denial. When providing the decision, the enrollee's presenting medical condition, disabilities, and special language requirements, if any, are considered.

a. The Utilization Review Nurse will issue a written notification using the CMS approved template which includes:

   i. The Medical Director /Physician reviewer's specific denial language indicating the reason for the denial.

   ii. Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (as mandated by 42 CFR 422.570 and 422.566 (b) (3).

   iii. For service denials, a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process.

   iv. The enrollee's right to submit additional evidence in writing or in person.

   v. An explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).

12. All unfavorable organization determinations are subject to review by the Director of Care Coordination, or their designee, to ensure that all CMS Organization notification requirements and timeliness standards are met.

13. Once the unfavorable notification has been reviewed and the denial language approved, the Utilization Management staff will:

    a. Call the member and the requesting provider to provide notification of the organization determination to deny the request within seven (7) days from receipt of the request.

       i. Part B drugs will be updated to reflect a favorable organization determination within seventy-two (72) hours of receipt.

       ii. If seven (7) calendar / seventy-two (72) hour deadline is missed, notification must be sent to the IRE. UM will notify IRE using defined IRE procedures available on the IRE website.

    b. Fax the unfavorable notification to the requesting provider.

       Mail the unfavorable notification to the member.

    c. UM staff will update UM notes and the authorization system with the denied service, procedure, or equipment.

14. The Health Plan retains completed case files for a period of ten (10) years, at minimum.

<u>Expedited Organization Determination Process</u>

1. A request for expedited review for a service, procedure or equipment is received by the Utilization Management Department from an enrollee, An enrollee's representative, or any physician.

2. Utilization Management staff reviews the request to determine if the service requires authorizations.

3. If the request requires authorization, the requester is notified.

4. If the request requires authorization, an authorization is created to reflect the request.

5. The appropriate Utilization Management staff reviews the request to determine if the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

    a. If the expedited standard is not met, Utilization Management staff will:

        i. Transfer the request to the standard initial determination process.

        ii. Give the enrollee prompt verbal notice of the denial to expedite the request.

        iii. Deliver a written notice within three (3) calendar days of the verbal notice of the denial to expedite the request.

6. Follow the Standard Organization Determination Process Procedure above. The Utilization Management staff reviews the request for medical necessity.

7. If the request includes sufficient information to approve the request based on medical necessity, Utilization Management staff will:

    a. Update the authorization to reflect the approved Organization Determination

    b. Generate the approval letter

    c. Fax the approval letter to the requesting provider

    d. Mail the approval letter to the member.

8. If the request is submitted without supporting clinical documentation, the Utilization Review Nurse or Authorization Coordinator will:

    a. Make an outreach attempt to the requesting provider to request clinical information to support the medical necessity of the request.

    b. After three (3) attempts, if the requested information is not received, the Utilization Review Nurse or Authorization Coordinator will ensure that a LOMI (Lack of Medical Information) letter is sent to the requesting provider and the request will be administratively denied.

9. If the request does not include *sufficient* information to approve the request based on medical necessity, the Utilization Review Nurse will:

    a. Consult with the Medical Director/Director of Utilization Management and Care Coordination. Review the information provided and what information is necessary to support the medical necessity review.

a. Make an outreach attempt to the requesting provider to request additional clinical information to support the medical necessity of the request.

10. If the requesting provider does not or cannot supply additional information, and the nurse is unable to approve the request based on the licensed medical necessity criteria OR there is no medical necessity criteria for the request, the Utilization Review Nurse will:

    a. Document a narrative of the clinical information received in the UM electronic record, the criteria used to determine medical necessity and outstanding clinical information needed to establish medical necessity.

    b. Refer the case to the Medical Director for review and final decision.

11. The Medical Director will review the request for medical necessity, based on all clinical information available, utilizing the Medicare Coverage Database, InterQual Guidelines, or other evidence-based clinical practice guidelines and clinical judgment and make a final determination.

12. UM Staff will process an approved Organization Determination as indicated in procedure step F.

13. If the Organization Determination is to deny the request, UM Staff will review the denial language provided by the Medical Director to ensure it includes the specific reason for the denial that considers the enrollee's presenting medical conditions, disabilities, and special language requirements, if any.

14. Utilization Management staff will generate the denied Organization Determination letter using the CMS approved template which includes:

    a. Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (as mandated by 42 CFR 422.570 and 422.566 (b)(3);

    b. For service denials, a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process.

15. All denied Organization Determinations are subject to review by the Director of Utilization Management and Care Coordination and designee to ensure that all CMS Organization Determinations and timeliness standards are met.

16. Once the denied Organization Determinations letter has been reviewed and approved, Utilization Review Nurse will:

    a. Call the member and requesting provider to provide notification of the organization's determination to deny the referral request within seventy-two (72) hours from receipt of the expedited request.

        i. If expedited deadline is missed, notification must be sent to the IRE. UM will notify IRE using defined IRE procedures available on the IRE website.

    b. Fax the denied Organization Determination letter to the requesting provider

c. Mail the denied Organization Determination letter to the member.

17. Utilization Management staff will update the authorization system with the denied service, procedure or equipment.

18. The Health Plan retains completed case files for a period of ten (10) years, at a minimum.

15. Change of Review Priority

a. After a request is initiated as a standard or expedited review, a provider may contact the Health Plan to change the review priority (standard or expedited). If the provider indicates that the enrollee's health requires an expedited decision, the Health Plan must begin the applicable expedited review period at the time they receive the physician's request to expedite the decision.

i. A change of priority does not allow for extra review time. If the remaining standard review period is less than the applicable expedited review period, the original standard deadline still applies.

Retroactive Authorizations

1. Providers can submit Retro Authorization requests for services performed no more than sixty (60) days prior the date of submission of the Retrotroactive Authorization request.

Extensions

1. Approved authorizations can be extended for up to sixty (60) days from the end date of the original authorization.

Prior Authorization Metrics Reporting

1. Effective January 1, 2026, so comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization final rule, the Health Plan must publicly report certain Prior Authorization metrics from the previous calendar years on their website. The Health Plan's Compliance Department ensures this report is posted by the deadline of March 31 of each calendar year.

2. The Health Plan's Director of Utilization Management and designated Information Technology resources will be responsible for preparing the report. See Attachment B. The metrics that are required to be publicly posted on the Health Plan's website are:

a. A list of all medical items and services that require prior authorization (excluding drugs).

b. For standard prior authorization requests, aggregated for all items and services:

i. Percentage approved in the calendar year

ii. Percentage denied in the calendar year

iii. Percentage approved in the calendar year after appeal Note: This should be a subset of the total number of standard prior authorization requests appealed.

iv. The average (mean) and median response times that elapsed between the submission of a request and a determination by the payer Note: This should be measured from the time the payer receives the request, not when it is sent by the provider.

c. For expedited prior authorization requests, aggregated for all items and services:

i. Percentage approved in the calendar year

ii. Percentage denied in the calendar year

iii. Percentage approved in the calendar year after appeal Note: This is an optional metric and should be a subset of the total number of expedited prior authorization requests appealed.

iv. The average (mean) and median response times that elapsed between the submission of a request and a determination by the payer Note: This should be measured from the time the payer receives the request, not when it is sent by the provider.

d. The percentage of requests where the timeframe for review was extended, per programmatic rules, 1 and the request was approved. Note: Though such a breakout is optional, CMS highly recommends differentiating between standard requests that were extended and approved and expedited requests that were extended and approved.

Definitions:

1. Appeal: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

2. CMS: Centers for Medicare and Medicaid Services.

3. Concurrent: Received during ongoing treatment, (e.g. Inpatient Hospitalization).

4. Dismissal: A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

5. Enrollee: An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).

6. Expedited request: A request that applies exclusively to pre-service requests where the member, member's representative or requesting physician indicates that standard processing of the reconsideration could seriously jeopardize the enrollee's life, health, or ability regain maximum function. Expedited requests are processed within seventy-two (72) hours of receipt.

7. Independent Review Entity (IRE)**:** An independent entity contracted by CMS to review adverse level 1 appeal decisions made by the Health Plan. Under Part C, an IRE can review Health Plan dismissals.

8. Inquiry: Any verbal or written request for information to a plan or its delegated entity that does not express dissatisfaction or invoke a plan's grievance, coverage or appeals process, such as a routine question about a benefit.

9. Medical Director (MD/DO): A physician who has sufficient medical and other expertise, including knowledge of Medicare coverage criteria with current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States, or the District of Columbia.

10. Medically necessary or medical necessity: A medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature.

11. Organization Determination: An organization determination is any determination (i.e. an approval, partial approval, or denial) made by the Medicare Health Plan, or its delegated entity with respect to the following:

    a. Payment for temporarily out of the area renal dialysis services;

    b. Payment for emergency services, post-stabilization care, or urgently needed services;

    c. Payment for any other health services furnished by a provider (other than the Medicare Health Plan), that the enrollee believes:

        i. Are covered under Medicare or

        ii. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare Health Plan.

    d. Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the enrollee believes should be furnished or arranged by the Medicare Health Plan;

    e. Reduction, or premature discontinuation, of previously authorized ongoing course of treatment; or

    f. Failure of the Medicare Health Plan 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 adversely affects the health of the enrollee.

12. Pre-Service: Receive prior to a service, procedure or equipment being rendered or delivered.

13. Reconsideration: The first level in the appeals process which involves a review of an adverse organization determination by the Health Plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the Health Plan or CMS. The term may also refer to the second level of appeal in which an independent review entity reviews an adverse Health Plan decision.

14. Representative: As defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Unless otherwise provided in the applicable law, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable. A valid Appointment of Representation (AOR) form must be completed and on file in order for an individual other than the member to act on the member's behalf.

15. Retrospective: Received after a service, procedure, or equipment has been rendered or delivered.

16. Timeliness Standard for Organization Determinations: **(Attachment A)**

    a. Standard: Pre-Service: Seven (7) calendar days; 72 hours for Part B drugs.

    b. Expedited: Pre-Service: Seventy-two (72) hours; 24 hours for Part B drugs.

Monitoring:

The Compliance Department submits organization determination data to CMS on an annual basis. The reports are due as follows:

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Reporting Period	January 1- March 31	April 1- June 30	July 1- September 30	October 1- December 31
Data due to CMS/HPMS	Last Monday of February	Last Monday of February	Last Monday of February	Last Monday of February

In addition, the monitoring results are reported to the Utilization Management Committee at least quarterly.

This policy is updated, as necessary, reviewed and approved annually by the Utilization Management Committee.

Reference(s):

1. Federal Regulations at 42 CFR 422, Section M

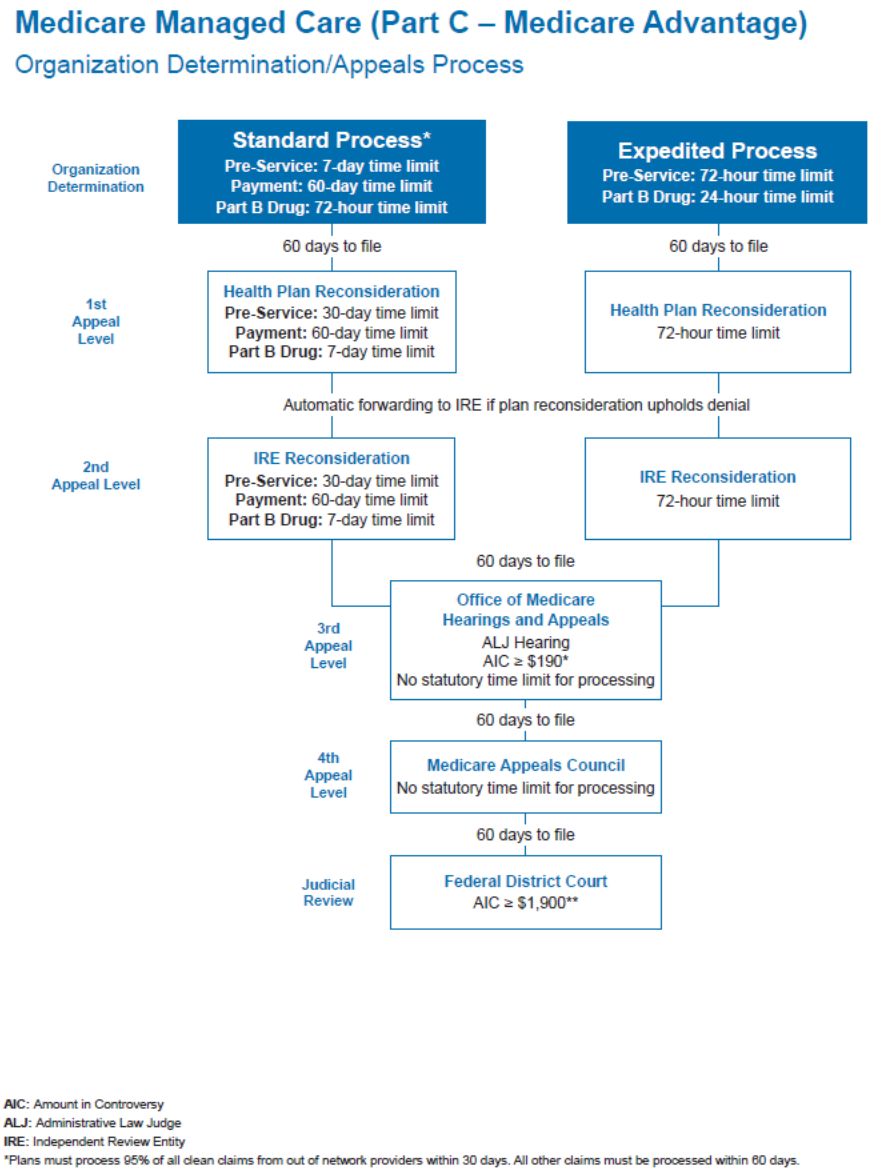
2. Medicare Managed Care Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

3. Title 22, CCR Section 53858

4. PHP Evidence of Coverage

Attachments:

Attachment A



AIC: Amount in Controversy
ALJ: Administrative Law Judge
IRE: Independent Review Entity
*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be processed within 60 days.

Attachment B

PRIOR AUTHORIZATION METRICS REPORTING – OVERVIEW & TEMPLATE

To comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization final rule, starting in 2026 impacted payers — Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs) — must publicly report certain prior authorization metrics from the previous calendar year on their websites.

While not required, we encourage payers to present metrics in a clear, visual format, such as bar charts or pie charts. We highly recommend reporting both counts and percentages so the public can understand the scope of requests. An example is included in the template below.

Metrics to be publicly reported on an impacted payer's website:

- A list of all medical items and services that require prior authorization (**excluding** drugs).
- For standard prior authorization requests, aggregated for all items and services:
  1. Percentage approved in the calendar year
  2. Percentage denied in the calendar year
  3. Percentage approved in the calendar year after appeal
     Note: This should be a subset of the total number of standard prior authorization requests appealed.
  4. The average (mean) and median response times that elapsed between the submission of a request and a determination by the payer
     Note: This should be measured from the time the payer receives the request, not when it is sent by the provider.
- For expedited prior authorization requests, aggregated for all items and services:
  1. Percentage approved in the calendar year
  2. Percentage denied in the calendar year
  3. Percentage approved in the calendar year after appeal
     Note: This is an **optional** metric and should be a subset of the total number of expedited prior authorization requests appealed.
  4. The average (mean) and median response times that elapsed between the submission of a request and a determination by the payer
     Note: This should be measured from the time the payer receives the request, not when it is sent by the provider.
- The percentage of requests where the timeframe for review was extended, per programmatic rules,[1] and the request was approved.
  Note: Though such a breakout is **optional**, CMS highly recommends differentiating between standard requests that were extended and approved and expedited requests that were extended and approved.

Note: We provide recommended denominators for these metrics in the template below.

1

Reporting levels:

- Metrics should be reported separately for each line of business:
  - MA organizations: report at the MA contract level
  - State Medicaid and CHIP FFS programs: report at the state level
  - Medicaid managed care plans and CHIP managed care entities: report at the plan level
  - QHP issuers on FFEs: report at the issuer level

Additional resources on prior authorization reporting requirements can be found here.

Reporting format:

While the below template is not required, we encourage payers to present data visually. Should impacted payers choose to use this template, they should replace the sample data with their own data before posting to their websites.

REFERENCES

1. For MA plans, per 42 CFR 422.568(b)(2) and 42 CFR 422.572(b), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For applicable integrated plans, per 42 CFR 422.631(d)(2)(ii), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For state Medicaid FFS programs, per 42 CFR 440.230(e)(1)(i), beginning in 2026, standard requests may be extended for up to 14 days under certain circumstances.

   For Medicaid managed care plans, per 42 CFR 438.210(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For state CHIP FFS programs, per 42 CFR 457.495(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For CHIP managed care entities, per 42 CFR 457.1230(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To comply with the CMS Interoperability and Prior Authorization final rule, [Enter Organization Name] is required to annually report aggregated prior authorization metrics on our website. Specifically, this includes a list of all medical items and services (excluding drugs) that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Publicly reporting these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: [enter contact information].

Reporting Period: [Enter reporting year]

These are the medical items and services for which we require prior authorization (excluding drugs)

Insert a list of, or link to, all medical items and services that require prior authorization (excluding drugs)

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframes:

- For MA plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For state CHIP FFS programs, 14 days for **standard requests** (non-urgent)
- For Medicaid managed care plans and CHIP managed care entities, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For QHP issuers on the FFEs, 72 hours for **expedited requests** (urgent) and 15 days for **standard requests** (non-urgent)

There are no Medicaid FFS program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no CHIP FFS program required decision timeframes for expedited prior authorization requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires [MA plans, state Medicaid agencies, Medicaid managed care plans, state CHIP agencies, CHIP managed care entities] to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent)
- 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	40,000	50,000	80%
Request denied	10,000	50,000	20%

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 7 days	29,500	50,000	59%
(optional) Request denied within 7 days	5,500	50,000	11%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	7,500	50,000	15%
(optional) Request denied after time for review was extended	2,500	50,000	5%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	3,000	5,000	60%
(optional) Request denied after appeal	2,000	5,000	40%

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved			
Request denied			

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 72 hours			
(optional) Request denied within 72 hours			

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*			
(optional) Request denied after time for review was extended			

*As noted on the first page of this template, it is optional to report this metric separately for standard prior authorizations and expedited prior authorizations.

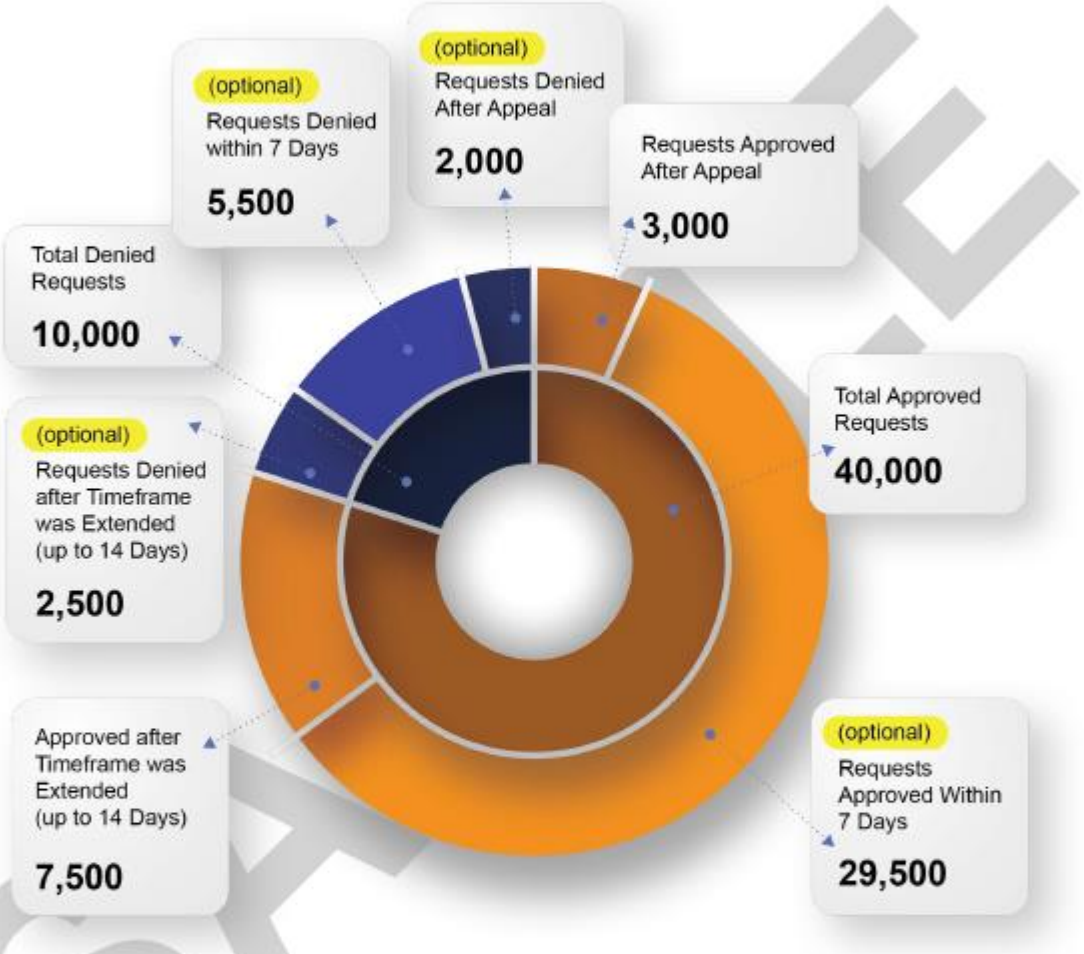
	How many times this happened	Out of total appeals	Percentage
(optional) Request approved only after appeal			
(optional) Request denied after appeal			

Time Between Receiving a Prior Authorization Request and Sending a Decision

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)	5 days	4 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	1 day	1 day

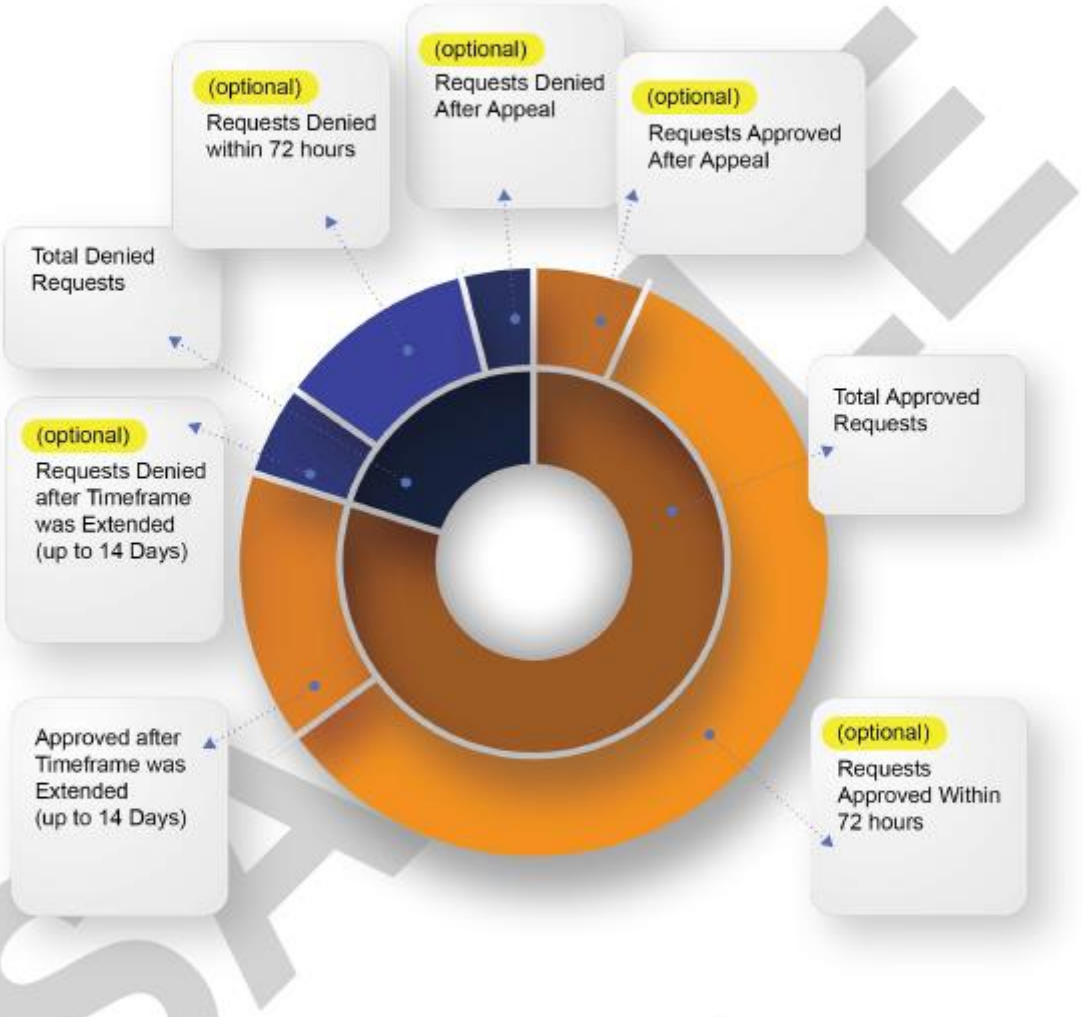
SAMPLE

In 2024, we received a total of 50,000 standard (non-urgent) prior authorization requests for our covered patients. 80% of those requests were approved:



The mean (average) time that it took to make standard prior authorization decisions was	5 days
The median (middle) time that it took to make standard prior authorization decisions was	4 days

In YEAR, we received a total of XXXXX expedited (urgent) prior authorization requests for our covered patients. XX% of those requests were approved:



The mean (average) time that it took to make expedited prior authorization decisions was **X day(s)**

The median (middle) time that it took to make expedited prior authorization decisions was **X day(s)**