

Utilization Review Determination Timeframes for Tufts Medicare Preferred Members

Note:

- The purpose of this chart is to reference utilization review determination timeframes. It is not meant to completely outline the UR Determination process. See your departments policies for more detailed instructions regarding UR determinations..
- Written Notice of Authorization will be sent to members or providers upon request.
- A provider is defined as a health care professional, facility or vendor.
- In all instances, Tufts Health Plan strives to conduct utilization review determinations and provide notice of these determinations within a reasonable period of time, appropriate to the medical circumstances.

Review Type	Decision Timeframe	Extension Rules	Notice of Authorization Determination	Notice of Denial Determination
<p>Whether to Expedite a Request for a Determination Any request for coverage for medical care or treatment with respect to which the member or a physician believes applying standard organization timeframes could seriously jeopardize the member’s life, health or ability to regain maximum function.</p>	<p>A decision must be made within 24 hours.</p> <p>The Medicare Health Plan must automatically expedite the determination if a physician makes or supports the request.</p> <p>Requests for cases that only involve claims for payment of services that the member has already received cannot be expedited</p>	<p>N/A</p>	<p>N/A</p>	<p>If the plan denies the request for an expedited determination, it must automatically transfer the request to the standard time frame. Give the enrollee prompt oral notice of the denial including the enrollee rights and subsequently deliver with 3 calendar days written notice that:</p> <ul style="list-style-type: none"> • Explains that the organization will automatically transfer and process the request using the 14 days standard timeframe. • Informs the enrollee of the right to file and expedited grievance if he/she disagrees. • Informs the member of

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				<p>the right to resubmit a request for an expedited determination and that if the enrollee gets physician support applying standard organizational timeframes could seriously jeopardize the member's life, health or ability to regain maximum function, the request will automatically be expedited.</p>
<p>Prospective Expedited Urgent Utilization Review (UR) performed prior to an admission or other course of treatment in which the application of the time period for making non-urgent determinations could seriously jeopardize the member's life, health or ability to regain maximum function.</p>	<p>Determination and notification must occur as expeditiously as the member's health requires but no later than 72 hours of receipt of the request. Total Time including decision on whether to expedite a request is 72 hours.</p>	<p>The timeframe may be extended up to 48 hours. If extended, the member must be notified in writing within 24 hours.</p>	<p>Verbal notification must occur as expeditiously as the member's health requires but no later than 72 hours of receipt of request or an additional 48 hours if an extension was granted.</p> <ul style="list-style-type: none"> • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. 	<ul style="list-style-type: none"> • Verbal notification must occur to the requesting provider as expeditiously as the member's health requires but no later than 72 hours of receipt of request (or an additional 48 hours if an extension was granted.) • Additionally, written notification must be sent within 3 calendar days of verbal notice. • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the requesting provider as expeditiously as the member's health requires and within 72

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				<p>hours of receipt of request (or an additional 48 hours if an extension was granted.)</p> <ul style="list-style-type: none"> • Simply mailing the letter within the timeframe is insufficient.
<p>Concurrent Expedited Urgent UR that is performed during a hospital stay or other course of treatment in which the application of the time period for making non-urgent determinations could seriously jeopardize the member's life, health or ability to regain maximum function.</p>	<p>Determination and notification must occur as expeditiously as the member's health requires but no later than 24 hours of the receipt of request.</p>	<p>No extension</p>	<p>Verbal notification must occur as expeditiously as the member's health requires but no later than 24 hours.</p> <ul style="list-style-type: none"> • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. <p>Written notification must be sent to the member and the requesting provider within 24 hours of the receipt of request..</p>	<ul style="list-style-type: none"> • Verbal notification to the requesting provider must occur as expeditiously as the member's health requires but no later than 24 hour notification must be sent within 3 calendar days of the verbal notice. • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the member and the requesting provider no later than 24 hours after receipt of request (or an additional 48 hours if an extension was granted.) • Simply mailing the letter within the timeframe is insufficient
<p>Standard Prospective & Concurrent Non-Urgent <i>Prospective Non-Urgent</i> is</p>	<p>Determination and notification must be completed as expeditiously as the member's health</p>	<p>The timeframe may be extended up to 14 calendar days from the receipt of the request for coverage. The</p>	<ul style="list-style-type: none"> • Verbal notice to provider must occur as expeditiously as the member's health requires 	<ul style="list-style-type: none"> • Verbal notice to provider must occur as expeditiously as the member's health requires

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<p>UR that is performed prior to an admission or other course of treatment. <i>Concurrent Non-Urgent</i> is UR that is performed during a hospital stay or other course of treatment.</p>	<p>condition requires, but no later than 14 calendar days after receipt of request.</p>	<p>member must then be notified of the extension in writing using CMS approved template.</p>	<p>but no later than 14 calendar days after receipt of request (or an additional 14 days if an extension was granted.)</p> <ul style="list-style-type: none"> • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the member as expeditiously as required but no later than 14 calendar days after receipt of request (or an additional 14 days if an extension was granted.) 	<p>but no longer than 14 calendar days after the receipt of request (or an additional 14 days if extended.)</p> <ul style="list-style-type: none"> • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the member and provider as expeditiously as the member's health requires but no later than 14 calendar days after the receipt of request (or an additional 14 days if an extension was granted.)
<p>Retrospective Review UR of services after they have been provided to the member.</p>	<p>Determination and notification must be made within 30 calendar days of the receipt of request for coverage.</p>	<p>An extension may be granted once for 15 calendar days due to lack of information. If within 30 calendar days the information received is inadequate a written notice must be sent to the member and provider with the information required to complete the coverage determination, specifying that additional information is needed within 45 calendar days.</p> <p>The timeframe for making the</p>	<p>An optional written notification may be sent to the provider and member within 60 calendar days of the request or an additional 15 calendar days if an extension was granted.</p>	<ul style="list-style-type: none"> • Written notification authorizations must be sent to the provider within 60 calendar days of the request unless an extension was granted. • Written notification denials must be sent to the provider and member within 60 calendar days of the request unless an extension was granted

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		<p>determination is suspended from the date of written noticed until the earlier of:</p> <ol style="list-style-type: none"> 1. Date response received 2. Date established for furnishing requested information. <p>Once the information is received, or the 45 days expire, the review determination must be completed within 15 calendar days.</p>		