Utilization Review Determination Time Frames

The purpose of this chapter is to reference utilization review (UR) determination time frames. It is not meant to completely outline the UR determination process. The following review types are outlined in this chapter:

- Prospective (Pre-Service) Review of Non-Urgent Services
- Prospective (Pre-Service) Review of Urgent Services
- Concurrent Review of Urgent Services
- Refer to the Utilization Management Guidelines chapter for more detailed instructions regarding UR determinations.

Written notice of authorization requirements are applicable to determinations for fully insured HMO, POS and PPO products[1]. Tufts Health Plan does not rescind coverage of previously approved services unless it is determined that intentional misrepresentation or fraudulent practices have occurred. With respect to self-insured groups, upon request, Tufts Health Plan will provide written notice of authorization. In all instances, Tufts Health Plan strives to conduct UR determinations and provide notice of these determinations within a reasonable period, appropriate to the medical circumstances.

Note: A provider is defined as a health care practitioner, facility, or vendor.

The following information is specific to members covered under a fully insured Rhode Island plan:

- A peer-to-peer attempt to communicate must be made/documented prior to the first level appeal determination.
- For prospective reviews of non-urgent and non-emergent health care services, a response within one business day of the request for a peer-to-peer discussion
- For concurrent and prospective reviews of urgent/emergent health care services, a response within a reasonable period of time of the request for a peer-to-peer discussion
- For retrospective reviews, a response prior to the internal level appeal decision
- Denial letter must include 180 day filing limit in which to file an appeal and RI appeal information
- In the event the member or an authorized representative fails to follow Tufts Health Plan's claims procedures for a prospective (pre-service) claim of non-urgent services, Tufts Health Plan will notify the member or the authorized representative, as appropriate, of this failure as soon as possible and no later than five (5) calendar days following the failure and this notification must also inform member of the proper procedures to file a pre-service claim. If the prospective (pre-service) claim relates to urgent or emergent health care services, Tufts Health Plan will notify and inform member or the authorized representative, as appropriate, of the failure and proper procedures within twenty-four (24) hours following the failure. Notification may be oral unless written notification is requested by the member or authorized representative.

Note: For the purposes of this document, verbal and written notices to providers and members must occur as expeditiously as the member's health requires, but no longer than the time frames specified below.

[1] The time frames outlined in this document are also applicable to Tufts Health Direct. Refer to the Tufts Health Public Plans Provider Manual for more information on Tufts Health Direct.

Review Type: Prospective (Pre-Service) Review of Non-Urgent Services

UR that is performed prior to an admission or other course of treatment:

Decision Timeframe	Decision within 2 business days of receipt of the necessary information but not later than business 15 days from receipt of request
Extension Rules	Decision time frame may be extended (if necessary) due to reasons outside the control of Tufts Health Plan. **For MA fully insured plans:** • A Request for More Information (RFMI) is made within two business days of receiving the original request, allowing 10 business days for the provider to respond • If a member needs to facilitate or be involved in obtaining more information the time to respond is 45 business days • Once the requested additional information is received, the determination must be completed within two business days. **For RI fully insured plans:** Within the 45 business days if any information is received a decision must be rendered within 2 business days. If **no** information is received in the 45-day window, a decision must be made within the balance of initial 15 days allotted time. If the Plan has any information on which to render a determination (beyond simply the request itself), a medical necessity determination will be rendered based on the information available.
Notice of Authorization Determination	• Verbal notice must be given to the provider within 24 hours of the authorization determination • Written notice for fully insured products must be sent to the provider and member within 1 business day of the verbal notice, but no later than 15 business days from receipt of the request
Notice of Denial Determination	• Verbal notice must be given to the provider within 24 hours of the denial determination • Written notice must be sent to the provider and member within 1 business day of verbal notice but cannot surpass 15 business days in total. * Any request for coverage received for which a decision, verbal notification or written notification is due on Friday or over the weekend must be completed by the close of business on Friday.

Review Type: Prospective (Pre-Service) Review of Urgent Services

UR performed for requests for coverage of medical care or treatment with respect to which the application of the time periods for making nonurgent coverage determinations:

- could seriously jeopardize the life or health of the member or others, due to the member's psychological state, or the ability of the member to regain maximum function, or
- in the opinion of a physician with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

The process of rendering the decision and completing the notice must not exceed 72 hours.

Decision Timeframe	Decision and notification as soon as possible considering medical exigencies and always within 2 business days of receipt of the necessary information but not later than 72 hours of receipt of the request.
Extension Rules	The decision timeframe may be extended, if necessary, once for 48 hours if Tufts Health Plan is unable to render a determination based on lack of information required to complete review. • Within 24 hours after receipt of the coverage request, verbal notice must be provided to the provider, specifying information required to complete the determination. The verbal notice must specify that the additional information must be received by Tufts Health Plan within 48 hours of the verbal request from Tufts Health Plan. • Prospective review must be completed as soon as possible, considering the medical exigencies, but no later than 48 hours after the earlier of a) the receipt of information, or b) the end of the period afforded the member/provider to provide the information. *Please note that for RI fully insured Plans, if the Plan has any information on which to render a determination (beyond simply the request itself), a medical necessity determination will be rendered based on the information available.
Notice of Authorization Determination	Verbal notice to the requesting provider, must occur as soon as possible, taking into account the medical exigencies and always within 24 hours of the decision, but no later than 72 hours of the receipt of the request. • Verbal notice for authorizations must be completed by end of day Friday. • Written notice for fully insured commercial products must be sent to the requesting provider and the member within 1 business day of verbal notice • If the written authorization notice is requested by the member, provider, or facility the written notice will be sent within 72 hours of the request.
Notice of Denial Determination	Verbal notice to the requesting provider must occur as soon as possible, considering the medical exigencies, and always within 24 hours of the decision but no later than 72 hours of receipt of the request. • The provider must be verbally informed of the process of initiating the expedited appeals. • Written Notice must be sent to the provider and member within 1 business day of verbal notice, but no later than 72 hours of receipt of the request. *Any request for coverage received for which a decision, verbal notification or written notification is due on Friday or over the weekend must be completed by the close of business on Friday.

Review Type: Concurrent Review of Urgent Services

UR performed during a hospital stay or other course of treatment. It includes review of requests for extended stays or additional services.

UR performed for requests for coverage of medical care or treatment with respect to which the application of the time periods for making non-urgent coverage determinations:

- could seriously jeopardize the life or health of the member or others, due to the member's psychological state, or the ability of the member to regain maximum function, or
- In the opinion of a physician with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Note: Must always consider request concurrent urgent if request made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments

*The whole process of rendering the decision and completing the notice must not exceed 72 hours.

Decision Timeframe	As soon as possible, considering the medical exigencies and always within 24 hours of the receipt of the request.
Extension Rules	The decision timeframe may be extended, if necessary, once for 48 hours if Tufts Health Plan is unable to render a determination based on lack of information required to complete review
Notice of Authorization Determination	Verbal notice to the provider as soon as possible, considering the medical exigencies, but always within 24 hours of receipt of the request. Written notice must be sent to the provider and the member within 24 hours of the receipt of the request. • Within one working day of verbal notice.
Notice of Denial Determination	Verbal notice to the provider must occur as soon as possible, considering the medical exigencies and always within 24 hours of the receipt of the request. • Written notice must also be sent to the provider and the member within 24 hours of receipt of request. For inpatient cases, written notice may be provided via facsimile. *Any request for coverage received for which a decision, verbal notification or written notification is due on Friday or over the weekend must be completed by the close of business on Friday.

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