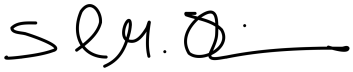
Elite Health Plan **POLICY AND PROCEDURE**	Elite Health
Name: Elite Health Plan Standard Organization Determination Policy	Policy Number: **UM-MED-14**
Department: Utilization Management	Effective Date: 1/27/2026 Date Revised: 10/09/2026 Date Approved: 10/09/2026
Reviewed and Accepted By: Dr. Sunil Shivaram MD, Dr. Sri Gorty, MD, Kristina Fletcher UM Manager	**Chief Medical Officer Signature:**  Page **1** of **5**

PURPOSE:

Elite Health Plan, Inc. has established this policy to define key requirements associated with our contractual obligations to the Centers for Medicare and Medicaid Services (CMS) as a Medicare Advantage Prescription Drug (MAPD) plan.

This policy outlines the expedited organization determination process to ensure clear timeframes by which Elite Health Plan shall make an Standard Organization Determination (SOD). These specific procedures ensure a consistent and appropriate approach in delivering services to our members, as well as to providers, vendors, and other stakeholders.

SCOPE:

This policy applies to the CMS Medicare Advantage Prescription Drug (MAPD) Program and addresses the requirements and processes related to Utilization Management and the requirements for decisioning an Standard Organizational Determination.

Applicable personnel at Elite Health Plan, Inc, Delegated IPAs and Medical Groups follow this policy. This document is intended to describe processes necessary to meet regulatory requirements as of the effective date above.

DEFINITIONS:

Term	Description
Adverse Determination Letter	A written notice that the Health Plan members receive explaining why a service was denied for payment in whole or in part, advising the member of his/her right to an appeal or reconsideration of the decision.
Appointment of Representative	Member's Representative

Appeal	Any of the procedures that deal with the review of adverse organization determinations on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the member must pay for a service. These procedures include reconsideration by the Health Plan or the state's Quality Improvement Organization (QIO), which is Health Services Advisory Group (HSAG) in the state of California, and, if necessary, any other CMS-sanctioned independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.
CMS	Centers for Medicare and Medicaid Services – The agency within the US Federal Government that is charged with the execution and maintenance of the law defining the prescription drug program for senior citizens, the disabled, and the infirm.
MA	Medicare Advantage
PD	Prescription Drug

POLICY:

Elite Health Plan Standard Organization Determination Policy

Elite Health Plan will make a Standard Organization Determination (SOD) in accordance with this policy. Standard determinations may also be performed by First Tier, Downstream, and Related Entities (FDR) if delegated.

An SOD is a request for services that must be processed within:

- 72 hours for Part B drug requests
- 7 days for a medical item or service request

The timeframe includes both working and non-working hours (evenings, weekends, and holidays) and is measured from the receipt of the request to notification of the member and practitioner.

Who can request an SOD?

- Members
- Member's representative
- Physicians (affiliated or non-affiliated with Elite Health Plan)

An SOD is any determination made by Elite Health Plan or its delegate regarding approval or denial of services, in whole or in part. All decision-making timeframes in this policy represent maximum limits. Each case will be assessed individually, following established medical standards. Elite Health Plan accepts information or evidence from all sources regarding standard organization determinations. The Utilization Management (UM) Department is responsible for reviewing each request and deciding whether to approve or deny the standard organization determination within required timeframes.

Elite Health Plan or its delegate may extend the standard determination timeframe by up to 14 calendar days if:

- The request is not for a Part B drug
- The member requests the extension
- Elite Health Plan or its delegate justifies the need for additional information and explains how the delay benefits the member

Notification Requirements

Elite Health Plan or its delegate will notify the member of a standard organizational determination within 7 days of receiving the request unless an extension is taken in the member's best interest. Extensions may apply only to item or service requests (not Part B drugs) and only when waiting for additional information from a non-contracted provider that could allow approval. Extensions cannot be taken if records are missing from a contracted provider. After three documented good faith attempts to obtain information, if it remains unavailable, the request may be denied for lack of medical necessity.

Withdrawals and Dismissals

If an enrollee or authorized party withdraws a request before a decision is issued, Elite Health Plan will send a written notice of dismissal to all parties.

Appeals

If a member disagrees with the organization's determination, they may request an expedited appeal.

Tracking and Compliance

Alignment and its delegates maintain procedures for tracking SOD requests in a secure, centralized system accessible only to authorized staff. This ensures compliance with timeframes and HIPAA standards. Failure to provide timely notice of a standard determination constitutes an adverse determination, which may be appealed

PROCEDURE:

- The Utilization Management department will process all authorization requests according to Elite Health Plan's Policies and Procedures.
- The UM department will process the authorization by approving or denying the requests.
- Elite Health Plan utilizes approved criteria to make decisions to approve, partially approve, or deny the requests. Reviewing, authorizing or denying will be assigned based on the appropriate health care professional.
- A written notice of the organizational determination will be sent in writing to the requesting provider and the member within the regulatory timeframes.

    - **Verbal Notification to member**:

        1. A verbal notification for a standard/routine Part B drug request will occur no later than 72 hours from receipt of the request.

    - **Requesting Provider Written Notification**:

        1. A written notification will be sent within 72 hours from the receipt of the request for a standard/routine Part B drug to the requesting provider.
        2. A written notification will be sent within 7 days from the receipt of the request for a standard medical/item to the requesting provider.

- **Member Written Notification**:

    1. The standard organizational determinations will be mailed to the members within 7 days of the receipt of the request.
    2. Elite Health Plan utilizes a mail vendor to process outgoing Standard Organizational Determinations. Outgoing Organizational Determinations are due to the mail vendor no later than 9:00am PST, Monday through Saturday. Any letter created after 9:00am PST will be mailed within two business days.

- When additional information is needed from a non-contracted provider to determine the most appropriate course of action, this information must be requested within 7 days of receipt of the request for the SOD to meet the 7 day timeframe. If an extension is required for items and services, Elite Health Plan or Delegate may take an additional fourteen (14) calendar days if it justifies the need for additional information. Elite Health Plan or delegate will notify the member, in writing, of the reasons for the delay and inform the member of the right to file an expedited grievance if the member disagrees with the decision to grant the extension.

- Elite Health Plan or its delegate will inform a member when an adverse organization determination occurs. This includes situations where:
    - A requested service is denied, in whole or in part, including the type or level of service the member believes should be provided.
    - Services are discontinued or reduced, and the members believe continued services are medically necessary.
    - Approval, provision, or arrangement of a member's service is not completed in a timely manner.
    - The Integrated Denial Notice (IDN) form will be used to notify the member of the adverse determination. If the member has an authorized representative, a copy of the IDN will also be sent to that representative.

REFERENCE:

REVISION NOTES:

(In addition to redline, provide a high-level overview of general revision reasons)

Date of Revision:	Revised by:	General Revision Notes
10/31/2025	Kristina Fletcher	Reviewed and revised
1/27/2026	Kristina Fletcher	Approved By UMC
10/09/2026	Kristina Fletcher	Revised