Elite Health Plan **POLICY AND PROCEDURE**	Elite Health
Name: Elite Health Plan Expedited Organization Determination Policy	Policy Number: **UM-MED-13**
Department: Utilization Management	Effective Date: 1/1/2026 Date Revised: 10/5/2026 Date Approved: 10/5/2026
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 Expedited Organization Determination (EOD). 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 Expedited Organizational Determination.

Applicable personnel in 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 Expedited Organization Determination Policy

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

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

- **24 hours** for Part B drug requests
- **72 hours** for a medical item or service request

This expedited timeframe applies because the standard referral process could seriously jeopardize the member's life, health, or ability to regain maximum function. 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 EOD?

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

Requests may be made when:

- The member's life, health, or ability to regain maximum function is at risk
- The members believe services should be furnished directly or arranged/provided (and they have not already received the services outside the plan network)

An EOD 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 expedited organization determinations. The **Utilization Management (UM) Department** is responsible for reviewing each request and deciding

whether to approve or deny expedited status and the organization determination within required timeframes.

Elite Health Plan or its delegate may extend the expedited 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

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.

Notification Requirements

Elite Health Plan or its delegate will notify the member of an expedited determination within **72 hours** 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.

Appeals

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

Emergent Services

Services meeting the "prudent layperson" definition of emergency do **not** require prior authorization and should never be delayed for EOD evaluation.

Tracking and Compliance

Alignment and its delegates maintain procedures for tracking EOD 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 an expedited determination constitutes an **adverse determination**, which may be appealed

PROCEDURE:

1. The Utilization Management department will process all authorization requests according to Elite Health Plan's Policies and Procedures.
2. The UM department will process the authorization by approving or denying the requests.

3. 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.
4. Elite Health Plan shall make an expedited organizational determination if a member's health condition requires, but no later than the required regulatory timeframe.
5. A verbal notification will be attempted for all expedited determinations.
6. A written notice of the organizational determination will be sent in writing to the requesting provider and the member within the regulatory timeframes.

    - **Requesting Provider Oral/Written Notification**:

        1. A verbal notification for a Part B drug request will occur no later than 24 hours from receipt of the request.
        2. A verbal notification for medical services/items will occur no later than 72 hours from receipt of the request.
        3. The written organizational determination will be mailed to the provider within 72 hours of the oral notification.
        4. If unable to reach the providers' office or leave a voicemail the utilization management department will make a total of 3 documented good faith attempts.

    - **Member Oral/Written Notification**:

        5. A verbal notification for a Part B drug request will occur no later than 24 hours from the receipt of the request.
        6. A verbal notification for medical services/items will occur no later than 72 hours from receipt of the request
        7. The written organizational determinations will be mailed to the members within 72 hours of the oral notification.
        8. If unable to reach members or leave voicemail the utilization management department will make a total of 3 documented good faith attempts.

    - **Written Notification Mail Timeline**

    1. Elite Health Plan utilizes a mail vendor to process outgoing Expedited Organizational Determinations. Outgoing Expedited 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 the following business day.
    2. The Bolger Mail Vendor drop time to USPS is 12 noon Pacific Standard Time each business day.

7. When additional information is needed from a non-contracted provider to determine the most appropriate course of action, this information must be requested within 24 hours of receipt of the request for the EOD to meet the seventy-two (72) hour 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.

8. 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:

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Effective November18, 2024
2024-medicare-managed-care-and-part-d-appeals-guidance-update_508-112024.pdf

REVISION NOTES:

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

Date of Revision:	Revised by:	General Revision Notes
10/29/2025	Kristina Fletcher	Created
1/1/2026	Kristina Fletcher	Revised
10/5/2026	Kristina Fletcher	Revised policy name/number