Denied Authorization? What Providers Should Do Next

When a prior authorization or service request is denied, providers have several options to request review and support patient care. Acting quickly and submitting focused clinical information improves the likelihood of timely resolution.

MEMBER APPEALS: THE PRIMARY PATHWAY

An **appeal** requests a formal re-review of a denial based on medical necessity, coverage criteria, or new clinical information.

Important: Trillium must have the member's or the member's authorized representative's written or verbal consent to open an appeal. If Trillium does not have that written or verbal consent, the appeal will not be started.

Timing matters

- Appeals must be **received within 60 days** of the denial notice.
- Standard appeals are decided within **16 calendar days.**
- Reviews may be extended up to **14 additional days** if needed (with notification).

How to submit

- **Phone:** 1-877-600-5472 (TTY: 711)
- **Fax:** 1-844-850-4861
- **Mail:** Trillium Community Health Plan, ATTN Appeals, PO Box 11740, Eugene, OR 97440
- **Written appeal** using the Request to Review a Health Care Decision form

Providers may submit appeals **with written member authorization** or support member-submitted appeals with clinical documentation.

EXPEDITED (FAST) APPEALS

Request an **expedited appeal** when waiting for a standard appeal could seriously jeopardize a member's **life, health, or ability to function.**

- May be requested by **phone or fax**
- If an appeal is expedited, a decision is issued within **72 hours.**
- If an appeal is determined not to meet expedited criteria, the request converts to a standard appeal timeline.
- If you submit an expedited appeal, we will call you and the member to confirm receipt or tell you it has been changed to a standard appeal. We will also call and write to you and the member to tell you the final decision.

PEER TO PEER: CLARIFICATION, NOT A DECISION

Providers may request a **peer-to-peer discussion** with a Trillium physician reviewer.

- Call **1-877-600-5472** for medical discussions or **1-833-913-1004** for pharmacy.
- Must be requested **within 2 business days** of the denial

Important:
Peer-to-peer discussions **do not replace an appeal**, and the **denial cannot be overturned** during the call. These discussions are most useful for clarifying criteria, identifying missing documentation, and determining whether an appeal is appropriate.

SERVICES ALREADY IN PROGRESS

If a member was **already receiving the service** and it was stopped:

- The member (or authorized representative) may request **continuation of services.**
- The request must be made **within 10 days** of the denial letter (or before the effective date, whichever is later).
- Providers should clearly document ongoing clinical need.

STATE HEARINGS (AFTER AN APPEAL)

If an appeal is denied, members may request a state hearing within 120 days of the Notice of Appeal Resolution letter.

Providers may support hearings by submitting records or clinical statements with member authorization.

PROVIDER TIP

Appeals are most successful when they clearly explain **why the requested service is medically necessary now**, what alternatives have been tried, and the **risk of delay or denial.**

If you have any questions, please contact your Provider Engagement Account Manager.