Attachment A: Minimum Process Requirements for Prior Authorization Utilization Review

Function	Required Procedure	Timeframe		Responsible Party	Oversight By
		Expedited/ Urgent	Standard		
Request Intake §§4902(a)(6), 4903(a)(1)	• Process to conduct intake, data collection and perform non-clinical review functions. • Process to accept requests by phone as well as in writing. Optional: Fax, electronic, web portal, VRS.			Trained staff (non-clinical tasks only)	Licensed Health Care Professional
Information Needed §§4902(a)(2), 4903(a)(1),(b), 4905(k), 29 CFR 2560.503-1(f)(2)(i) and (iii)	• If more information needed, process to request information and monitor for timely response. • Process to ensure request is not pended indefinitely and determination is made even if no response to requested information is received.	Request information within 24 hours and allow 48 hours to submit	Request information within 3 business days (bd) and allow 45 days to submit	Trained staff	Licensed Health Care Professional
Review §4902(a)(1) and (3)	• Process to conduct utilization review against written clinical criteria; keep records of health professional or clinical peer conducting review and specific criteria used.			Licensed Health Care Professional or Clinical Peer	Medical Director
Determination §§4902(a)(1) and (4), 4903(b), 29 CFR 2560.503-1(f)(2)(i) and (iii)	• Process to ensure adverse decisions are made by clinical peer (including denials for lack of information). • Process for approvals to be made by health professional or clinical peer. • Process to keep record of decision and set up authorizations on systems as required.	If request is complete, within 72 hours of receipt of request. If request is not complete, within the earlier of 48 hours of receipt of necessary information or the end of the 48 hour period	If request is complete, within 3 bd of receipt of request. If request is not complete, within the earlier of 3 bd of receipt of necessary information, 15 days of receipt of partial information, or 15 days after the end of the 45 day period if no information received	Approvals: Licensed Health Care Professional or Clinical Peer Denials: Clinical Peer	Medical Director
Verbal Notice §§4902(a)(4), 4903(b), 29 CFR 2560.503-1(g)	• Process for reasonable effort to contact insured and provider by phone or in person to transmit approval or denial of request and record contact or attempts.	If request is complete, within 72 hours of receipt of the request. If request is not complete, within	If request is complete, within 3 bds of receipt of the request. If request is not complete, within 3 bds of receipt of	Trained Staff may transmit notice (adverse determinations must be made by clinical peer)	Licensed Health Care Professional

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		the earlier of 48 hours of receipt of the information or the end of the 48 hour period.	the information or if all information is not received, within 15 days of the end of the 45 day period.		
Written Notice §§4902(a)(4) and (5), 4903(b), (e), 29 CFR 2560.503-1(g)(2)	• Process to create and send notice of approvals and denials to insured and provider in writing. (Optional, for insureds if agreed upon in advance: fax, electronic) • Process to transmit written notification to the provider electronically in a manner and form agreed upon by the parties. • Process to ensure all required information is included in notice.	If request is complete, within 3 bds of receipt of request. If request is not complete, within the earlier of 3 bds of receipt of the information or 3 days after the verbal notification.	If request is complete, within 3 bds of receipt of the request. If request is not complete, within 3 bds of receipt of the information or if all information is not received, within 15 days of the end of the 45 day period.	Trained Staff may transmit notice (adverse determinations must be made by clinical peer)	Licensed Health Care Professional
Reconsideration (Peer to Peer) §§4902(a)(1), 4903(f)	• Where case was not previously discussed with provider, process to accept communication from providers and refer to clinical peer for review of decision. • Upon outcome of reconsideration, process to resend initial adverse determination or approval notice to insured and provider. • Process to maintain record of decision.	1 bd of request	1 bd of request	Clinical Peer	Medical Director
Time Allowed to File Appeal §4904(c), 29 CFR 2560.503-1(h)(3)(i)		Must allow insureds 180 days from receipt of adverse determination			
Appeal Intake §§4902(a)(4), 4904(a),(a-1), (b), (c)	• Process to conduct intake, data collection and perform non-clinical review functions. • Process to accept appeals by phone and in writing. Optional: Fax, electronic, web portal, VRS. • Process to accept appeal of a determination that an out-of-network service is not materially different from an alternate in network service (if this function is delegated to Agent).			Trained staff	Licensed Health Care Professional

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	• Process to accept appeal of a determination of an out-of-network referral denial. • Process to expedite review when Agent determines or provider believes immediate appeal is warranted. • Process to accept a standard appeal following an upheld expedited appeal (if standard appeal upheld, new FAD is issued).				
Written Acknowledgement §§4902(a)(2), 4904(c)	• Process to ensure written acknowledgement is sent to insured; this notice may be combined with appeal determination.	Not required	Within 15 days	Trained staff	Licensed Health Care Professional
Information Needed §§4902(a)(2), 4904(a-1), (b), (c), 4905(k); 11 NYCRR Part 410.9(b)	• If more information needed, process to request information from insured and provider, and monitor for timely response; ensure appeal is not pended indefinitely and determination is made even if no response to requested information is received. • For standard appeal, if information submitted is not complete, process to request missing information in writing. • If delegated to Agent, for out-of-network appeal, process to request information needed as per § 4904(a-1) and (a-2) if submitted information is incomplete.	Request additional information immediately by phone or fax, follow with written request	Request additional information within 15 days; if partial response, written request for missing information sent in 5 bd	Trained staff	Licensed Health Care Professional
Review §§4902(a)(1) and (3), 4904(b),(c),(d); 29 CFR 2560.503-1(h)(3)(ii)	• If appeal is expedited, process to ensure access to a clinical peer within 1 bd. • Process to conduct utilization review against written clinical criteria; keep records of clinical peer conducting review and specific criteria used. • Process to ensure appeal is conducted by clinical peer other than clinical peer who made initial determination and the clinical peer making the determination is not the subordinate of the clinical peer who made the initial determination.			Clinical Peer (who did not make initial decision and is not subordinate of clinical peer who made initial determination)	Medical Director
Determination §§4902(a)(4),	• Process to ensure adverse decisions are made by different clinical peer and that clinical peer is	The lesser of 72 hours of receipt	30 days of receipt of the	Clinical Peer (who did not make initial	Medical Director

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4904(b)(2),(c),(d),29 CFR 2560.503-1(h)(3)(ii); (i)(2)(i) and (ii)	not the subordinate of the clinical peer who made the initial determination. • Process to keep record of decision and set up authorizations on systems as required.	of the appeal or 2 bd after all information	appeal for one level of appeal or 15 days of receipt of each appeal for two levels of appeal	decision and is not subordinate of clinical peer who made initial determination)	
Written Notice §§4902(a)(4), 4904(c); 11 NYCRR Part 410.9(e) and (f); 29 CFR 2560.503-1(i)(2)(i) and (ii)	• Process to create and send notice of approvals and denials (final adverse determinations [FAD]) to insured and provider in writing (optional, if agreed upon in advance: fax, electronic, or for providers, web portal) • Process to ensure all required information is included in FAD notice.	24 hours of determination but no later than 72 hours from receipt of appeal.	2 bd of determination but no later than 30 days of receipt of the appeal for one level of appeal or 15 days of receipt of each appeal for two levels of appeal	Trained Staff may transmit notice (adverse determinations must be made by clinical peer)	Licensed Health Care Professional
2nd Level Appeal (If Offered for Group Coverage Only) §§4902, 4904(b)(2); 11 NYCRR Part 410.9(e); 29 CFR 2560.503-1(h)(3)(ii); (i)(2)(i) & (ii); 45 CFR 147.136(b)(3)(ii)(G)	• Process to ensure that FAD states in bold "that time to file External Appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal." • If Agent considers standard appeal following an upheld expedited appeal a 2nd Level appeal, the 2nd level appeal must meet requirements for standard appeal and, if upheld, must result in a final adverse determination with external appeal rights. • Process to accept and review 2nd level appeal for group insurance only. Individual insurance must only have 1 level of internal appeal.	72 hours of receipt of 1st level appeal request (1st and 2nd level expedited appeals must be completed within 72 hours total)	15 days of receipt of the appeal	Clinical Peer (who did not make initial decision and is not subordinate of clinical peer who made initial determination)	Medical Director