Attachment A: Minimum Process Requirements for Retrospective Authorization Utilization Review

Function	Required Procedure	Timeframe	Responsible Party	Oversight By
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), (d); 4905(k); 29 CFR 2560.503-1(f)(2)(iii)(B)	• 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 30 days 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(d); 29 CFR 2560.503-1(f)(2)(iii)(B)	• 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 30 days of receipt of request. If request is not complete, within 15 days of receipt of all or 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
Written Notice §§4902(a)(4) and (5), 4903(d), (e)	• Process to create and send notice of approvals and denials 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 notice.	At time of determination	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.	Agent Specified	Clinical Peer	Medical Director

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Time Allowed to File Appeal §4904(c); 29 CFR 2560.503-1(h)(3)(i)		Must allow insureds at least 180 days and providers 45 days from receipt of adverse determination		
Appeal Intake §§4902(a)(4), 4904(a), (a-1), (c)	• Process to conduct intake, data collection and perform non-clinical review functions. • Process to accept appeals from insured, and from provider on their own behalf, 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
Written Acknowledgement §§4902(a)(2), 4904(c)	• Process to ensure written acknowledgement is sent to insured; this notice may be combined with appeal determination.	Within 15 days	Trained staff	Licensed Health Care Professional
Information Needed §§4902(a)(2), 4904(a-1), (c), 4905(k); 11 NYCRR Part 410.9(b)	• If more information needed, process to request information from insured and provider in writing, and monitor for timely response; ensure appeal is not pended indefinitely and determination is made even if no response to requested information is received. • If delegated to Agent, for out of network appeal, process to request information needed as per § 4904(a-1) if submitted information is incomplete.	Request additional information within 15 days; if partial response, written request for missing information sent in 5 business days	Trained staff	Licensed Health Care Professional
Review §§4902(a)(1) and (3), 4904(c),(d); 29 CFR 2560.503-1(h)(3)(ii)	• 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 appeal 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), 4904(c),(d); 29 CFR 2560.503-1(h)(3)(ii); (i)(2)(iii)	• Process to ensure adverse decisions are made by different clinical peer. • Process to keep record of decision and set up authorizations on systems as required.	60 days of receipt of the appeal for one level of appeal or 30 days of receipt of each appeal for two levels of appeal	Clinical Peer (who did not make initial decision and is not subordinate of clinical peer who made initial determination)	Medical Director

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Written Notice §§4902(a)(4), 4904(c); 11 NYCRR Part 410.9(e); 29 CFR 2560.503-1(i)(2)(iii)	• 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.	2 business days of determination but no later than 60 days of receipt of the appeal for one level of appeal or 30 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 Insurance Only) §§4902, 11 NYCRR Part 410.9(e); 29 CFR 2560.503-1(h)(3)(ii); (i)(2)(iii); 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." • Process to accept and review 2nd level appeal for group insurance only. Individual insurance must only have 1 level of internal appeal.	30 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