Attachment A: Minimum Process Requirements for Concurrent 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), (c); 4905(k), 29 CFR 2560.503-1(f)(2)(i) and (iii)	• If more information is 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 1 business day (bd) and allow 45 days to submit; for home care following inpt admission on Friday or day before holiday, request information within 72 hours if less. Effective for policies issued or renewed after 1/1/17 for a standard step therapy protocol override determination, request supporting rationale and documentation within the earlier of 72 hours or 1 bd and allow 45 days to submit.	Trained staff.	Licensed Health Care Professional.
Review §§ 3216(i)(30)(D), 3221(l)(6)(D); 4303(k)(4), 4902(a)(1), (3), (9), (10), (11)	• Process to conduct utilization review against written clinical criteria; keep records of health professional or clinical peer conducting review and specific criteria used. • For individual and small group insurance, process to review a request for coverage of a			Licensed Health Care Professional or Clinical Peer.	Medical Director.

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	non-formulary drug (formulary exception request). • Effective for policies issued or renewed on and after 1/1/17, for utilization review of substance use disorder treatment, process to use only evidence-based and peer reviewed clinical review tools designated by the Office of Alcoholism and Substance Abuse Services (OASAS) that are appropriate to the age of the patient and consistent with the treatment service levels within the OASAS system. • Effective for policies issued or renewed on and after 1/1/17, process to ensure that inpatient substance use disorder treatment at an OASAS-certified facility that participates in issuer's provider network is not subject to concurrent review for the first 14 days of the inpatient admission if the facility notifies the issuer of both the admission and the initial treatment plan within 48 hours of the admission. After the first 14 days of the inpatient admission, the Agent may review the entire stay to determine medical necessity. The Agent shall only deny coverage for any portion of the first 14 days of the inpatient admission on the basis that the treatment is not medically necessary if such treatment was contrary to the evidence-based and peer reviewed clinical review tool used by the Agent which is designated by OASAS. • Effective for policies issued or renewed on and after 4/12/18, process to ensure that outpatient substance use disorder treatment at an OASAS-certified facility that participates in issuer's provider network is not subject to concurrent review for the first two weeks of continuous treatment, not to exceed 14 visits, of the outpatient treatment if the facility notifies the issuer of both the start of treatment and the initial treatment plan within 48 hours of the start of treatment. After the first two weeks of				

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	continuous treatment, not to exceed 14 visits, the Agent may review the entire stay to determine medical necessity. The Agent shall only deny coverage for any portion of the initial two weeks of continuous treatment, not to exceed 14 visits, for outpatient treatment on the basis that the treatment is not medically necessary if such treatment was contrary to the evidence-based and peer reviewed clinical review tool used by the Agent which is designated by OASAS. • Effective for policies issued or renewed after 1/1/17, when establishing a step therapy protocol, process to use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. When conducting utilization review for a step therapy protocol override determination, process to use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for the insured and the insured's medical condition.				
Determination §§4902(a)(1) and (4), 4903(c), (c-1), (c-2), (c-3), and (g); 29 CFR 2560.503-1(f)(2)(i) and (iii); 45 CFR 147.136(b)(2)(ii)(F), (b)(3)(ii)(F)	• 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. • Process to ensure that if request and all information is received prior to discharge, home care provided while review was pending is not denied for lack of medical necessity or prior authorization. • Process to ensure that if request for inpatient treatment for substance use disorder is submitted at least 24 hours prior to discharge from an inpatient admission, coverage for the inpatient substance use disorder treatment provided while review was pending is not	For a request to extend treatment beyond the previously approved number if requested at least 24 hours in advance, determination made within 24 hours of receipt of request. For an inpatient substance use disorder treatment requested 24 hours prior to discharge, within 24 hours of receipt of the request.	Within the earlier of 1 bd of receipt of all information, 15 days of receipt of partial information, or 15 days of the end of the 45 day period if no information is received; for home care following inpt admission on Friday or day before holiday, within 72 hours after all information is received, if earlier.	Approvals: Licensed Health Care Professional or Clinical Peer. Denials: Clinical Peer.	Medical Director.

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	denied for lack of medical necessity or prior authorization. • Process to ensure that if a decision is not made within 1 bd of receipt of necessary information, the failure to meet the timeframe is deemed an adverse determination subject to appeal. In addition, process to ensure that there will be a deemed exhaustion of internal claims and appeals processes if the Agent fails to adhere to utilization review requirements and timeframes unless it is a de minimis violation that does not cause prejudice or harm to the insured so long as the Agent demonstrates that the violation was for good cause or due to matters beyond the control of the Agent and that the violation occurred in the context of an ongoing, good faith exchange of information between the Agent and the insured. The insured may request a written explanation of the violation from the Agent, and the Agent must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. • Effective for policies issued or renewed after 1/1/17 for a step therapy protocol override determination, process to ensure that if a decision is not made within 24 hours of receipt of supporting rationale and documentation for expedited reviews, or 72 hours of receipt of supporting rationale and documentation for standard reviews, the failure to meet the timeframe is deemed an approval of the coverage.	For other requests, if complete, within the earlier of 72 hours or 1 bd of receipt of the request. If the request is not complete, within the earlier of 1 bd or 48 hours of receipt of the information, or 48 hours of the end of the 48-hour period if no information is received Effective for policies issued or renewed after 1/1/17 for an expedited step therapy protocol override determination, within the earlier of 24 hours of receipt of the information or 48 hours of the end of the 48-hour period if no information is received. For an expedited formulary exception request, within 24 hours of receipt of the request.	Effective for policies issued or renewed after 1/1/17 for a standard step therapy protocol override determination, within the earlier of 72 hours or 1 bd of receipt of the information, 15 days of receipt of partial information, or 15 days of the end of the 45-day period if no information is received. For a standard formulary exception request, within 72 hours of receipt of the request.		
Verbal Notice §§4902(a)(4), 4903(c), 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.	At time of determination.	At time of determination.	Trained Staff may transmit notice (adverse determinations must be made by clinical peer).	Licensed Health Care Professional.

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	• A reasonable effort to contact by phone is defined as at least two attempts by phone. Each attempt must be at least one hour apart to be considered a new attempt. The Agent must wait until someone answers the phone, the call goes to voicemail, or ten rings have occurred (in that order). If the call goes to voicemail, the Agent must leave a voicemail.				
Written Notice §§4902(a)(4) and (5), 4903(c), (e), 29 CFR 2560.503-1(g)(2); 45 CFR 156.122(c)	• 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; including number of continued or extended services approved, new total of approved services, date of onset of services and time of next review. • For formulary exception request denials, process to provide the name(s) of drugs on the issuer's formulary that may be covered for the insured.	At time of determination.	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.	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 at least 180 days after receipt of adverse determination.			
Appeal Intake §§4902(a)(4), 4904(a), (a-1), (b), (c); 45 CFR 147.136(b)(3)(ii)(G); 45 CFR 156.122(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 expedite review of appeal for continued, extended, additional services, or home care following inpatient admission. • Process to ensure that if an insured or the			Trained staff.	Licensed Health Care Professional.

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	insured's provider files an expedited internal and external appeal within 24 hours from receipt of an adverse determination for inpatient substance use disorder treatment that was initially requested 24 hours prior to discharge from an inpatient admission and for which coverage was provided while the initial utilization review determination was pending, coverage is not denied for lack of medical necessity or prior authorization while an appeal determination by the Agent or external appeal agent is pending. • For group insurance only, process to accept a standard appeal following an upheld expedited appeal (if standard appeal upheld, new final adverse determination (FAD) is issued). • An appeal of a formulary exception denial is only permitted if the initial review of the request and the appeal are both completed within the same timeframe (24 hours for expedited, 72 hours for standard reviews).				
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(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.	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)	• 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 (who did not make initial decision and is not the subordinate of clinical peer who made initial determination).	Medical Director.

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	clinical peer other than clinical peer who made initial determination and that the clinical peer is not the subordinate of the clinical peer who made the initial determination.				
Determination §§4902(a)(4), 4904(b), (c), (d), (e), 29 CFR 2560.503-1(h)(3)(ii); (i)(2)(i) and (ii), 45 CFR 147.136(b)(2)(ii)(C)(2); (b)(3)(ii)(C)(2)	• Process to ensure adverse appeal decision is made 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. • Process to keep record of decision and set up authorizations on systems as required. • Process to ensure that before the Agent issues FAD based on a new or additional rationale, the insured is provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the FAD is required to be provided to give the insured a reasonable opportunity to respond prior to that date. • Process to ensure that if a decision is not made within 2 bd of receipt of necessary information for expedited appeals, or 60 days of receipt of necessary information for standard appeals, the failure to meet the timeframe is deemed an approval of the coverage.	The lesser of 72 hours of receipt of the appeal or 2 bd of receipt of necessary information For an inpatient substance use disorder treatment requested 24 hours prior to discharge, within 24 hours of receipt of the request	For services that require prior authorization, the earlier of 2 bd of receipt of necessary information or 30 days of receipt of the appeal if one level of appeal and 15 days of receipt of the appeal if two levels of appeals. For services that do not require prior authorization, the earlier of 2 bd of receipt of necessary information or 60 days of receipt of the appeal for one level of appeal or 30 days of receipt of the appeal if two levels of appeals.	Clinical Peer (who did not make initial decision and is not the subordinate of clinical peer who made initial determination).	Medical Director.
Written Notice §§4902(a)(4), 4904(b), (c), (d); 11 NYCRR Part 410.9(e) and (f), 29 CFR 2560.503-1(h)(3)(ii); (i)(2)(i) and (ii)	• Process to create and send notice of approval and 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.	24 hours of determination but no later than: For services that require prior authorization, 30 days of receipt of the appeal if one level of appeal and	Trained Staff may transmit notice (adverse determinations must be made by clinical peer).	Licensed Health Care Professional.

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			15 days of receipt of the appeal if two levels of appeals. For services that do not require prior authorization, 60 days of receipt of the appeal for one level of appeal or 30 days of receipt of the appeal if two levels of appeals.		
2nd Level Appeal (If Offered for Group Insurance Only) §4904(b); 11 NYCRR Part 410.9(e); 29 CFR 2560.503-1(h)(3)(ii); (i)(2)(i) and (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 1st level appeal, regardless of whether or not a 2nd level appeal is requested and that by choosing to request a 2nd 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 for services that require prior authorization; 30 days of receipt of the appeal for services that do not require prior authorization.	Clinical Peer (who did not make initial decision and is not subordinate of clinical peer who made initial determination).	Medical Director.