Notice of Initial Adverse Determination Requirements

A notice of initial adverse determination must be issued in compliance with 42 U.S.C. § 300gg-19; 45 C.F.R. § 147.136; 29 C.F.R. § 2560.503-1; 29 C.F.R. § 2590.715-2719; N.Y. Insurance Law §§ 3238 and 4903; and N.Y. Public Health Law § 4903. To ensure compliance with both New York and federal laws and regulations, an initial adverse determination notice must include all the following information:

REQUIREMENT	AUTHORITY
1. The notice must be written in a culturally and linguistically appropriate manner.	45 CFR § 147.136(b)(2)(ii)(E)
2. Date of service.*	45 C.F.R. § 147.136(b)(2)(ii)(E)(1) Insurance Law § 4903(e)
3. Name of health care provider who provided or will provide the service.*	45 C.F.R. § 147.136(b)(2)(ii)(E)(1) Insurance Law § 4903(e)
4. The claim amount, if applicable.	45 C.F.R. § 147.136(b)(2)(ii)(E)(1)
5. The reason for the determination, including clinical rationale, if any. The reason must include the denial code, if any, and its corresponding meaning. The clinical rationale should include an explanation of the scientific evidence or clinical judgment used, applying the terms of the plan to the insured's medical circumstances.*	Insurance Law § 4903(e)(1) Public Health Law § 4903(5)(a) 45 C.F.R. § 147.136 (b)(2)(ii)(E)(3) 29 C.F.R. § 2560.503-1(g)(1)(i) 29 C.F.R. § 2560.503-1 (g)(1)(v)(B)
6. Notice of the availability, free of charge, upon request, of the clinical review criteria, internal rule, protocol, or guideline relied upon to make such determination.*	Insurance Law § 4903(e)(3) Public Health Law § 4903(5)(c) 29 C.F.R. § 2560.503-1(g)(1)(v)(A)
7. Notice of the availability, upon request, of the diagnosis code and its corresponding meaning.	45 C.F.R. § 147.136(b)(2)(ii)(E)(1)
8. Notice of the availability, upon request, of the treatment code and its corresponding meaning.	45 C.F.R. § 147.136(b)(2)(ii)(E)(1)
9. Instructions on how to initiate standard and expedited appeals, including timeframes within which an appeal must be filed and decided.*	Insurance Law § 4903(e)(2) Public Health Law § 4903(5)(b) 45 C.F.R. § 147.136(b)(2)(ii)(E)(4) 29 C.F.R. § 2560.503-1(g)(1)(iv) 29 C.F.R. § 2560.503-1(g)(1)(vi)
10. A statement that the appeal may be filed by phone or in writing, including address and phone number.*	Insurance Law § 4904(c) Public Health Law § 4904(3)
11. Instructions on how to file an external appeal, including timeframes for filing an external appeal.*	Insurance Law § 4903(e)(2) Public Health Law § 4903(5)(b)
12. Specification of what, if any, additional information must be provided to, or obtained by, the utilization review agent in order to render a decision on appeal.*	Insurance Law § 4903(e)(3) Public Health Law § 4903(5)(c) 29 C.F.R. § 2560.503-1(g)(1)(iii)

13. A statement of insured's right to bring a civil action under § 502(a) of ERISA.	29 C.F.R. § 2560.503-1(g)(1)(iv)
14. A statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established under 42 U.S.C. § 300gg-93 to assist insureds with the appeal process.	45 C.F.R. § 147.136(b)(2)(ii)(E)(5)

ADDITIONAL REQUIREMENTS FOR PREAUTHORIZATION DENIALS AND APPROVALS	
REQUIREMENT	**AUTHORITY**
1. Notice whether the services are considered in-network or out-of-network.*	Insurance Law § 4903(b)(1)
2. Notice whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable copayment, coinsurance, or deductible.*	Insurance Law § 4903(b)(1)
3. The dollar amount the issuer will pay if the service is out-of-network, if applicable.*	Insurance Law § 4903(b)(1)
4. Information explaining how the insured may determine the anticipated out-of-pocket cost for out-of-network services in a geographical area or ZIP code based upon the difference between what the issuer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network services, if applicable.*	Insurance Law § 4903(b)(1)
5. Notice that preauthorization approval may authorize visits that may exceed the limits of the policy and would not be covered if the insured subsequently reaches the policy limits before the services are received.*	Insurance Law § 3238(a)(3)

* This item is applicable to a notice of an initial adverse determination issued by a utilization review agent for stand-alone dental or vision insurance.