N.Y.S. DEPARTMENT OF FINANCIAL SERVICES
Insurance Division
Health Bureau

# Utilization Review Agent Report Application and Attestation

Utilization Review Agents must report to the Department of Financial Services every two years pursuant to Insurance Law Article 49. There is no application fee. Answer all questions, attach additional pages and requested documentation as necessary. Sign and submit to: Department of Financial Services, Insurance Division, Health Bureau, One Commerce Plaza, Albany, NY 12257 or submit electronically to URAgentReport@dfs.ny.gov (Attestation must be in PDF format). Questions? Call (518) 486-7815 or email URAgentReport@dfs.ny.gov.

Applying for: ☐ New Report ☐ Renewal ☐ Modification ☐ Name Change

## Section A

| Corporate Name of Applicant: | | |
|---|---|---|
| Previously Reported Name (if any): | | |

## Section B

| Name of Chief Executive Officer: Last: | First: | Middle Initial: |
|---|---|---|
| Title: | | |
| Street Address | | |
| City: | State: | Zip: |
| Phone: | Fax: | |
| Email: | | |

## Section C

| Name of Contact Person (if different from above): Last: | First: | Middle Initial: |
|---|---|---|
| Title: | | |
| Street Address | | |
| City: | State: | Zip: |
| Phone: | Fax: | |
| Email: | | |

## Section D

Tax Status:

☐ Privately Held ☐ Not for Profit ☐ Publicly Traded-for Profit

Federal Employer ID Number:

☐ Attach Certificate of Incorporation in New York State or other documentation that the Agent has been approved by the Secretary of State to do business in New York State.

☐ Attach a corporate organization chart demonstrating the position of the Agent, subsidiaries and any parent organizations in the corporate structure. (Required for renewal if changed from previous submission.) An internal organization chart is not required.

☐ Attach list of all insurers and municipal cooperative health benefit plans for which the Agent is performing utilization review in New York State. If none, anticipated contract date: ____________________________

## Section E

**1. Agent will provide utilization review services as described in Article 49 of the New York Insurance Law for (check ALL that apply):**

- ☐ Insurers subject to Insurance Law Article 32
- ☐ Insurers subject to Insurance Law Article 43
- ☐ Municipal Cooperative Health Benefit Plans certified pursuant to Insurance Law Article 47
- ☐ Student health plan established under Insurance Law § 1124

**2. Agent will conduct the following utilization review functions:**

Full Report

- ☐ All UR Functions

**OR**

Limited Report (Check **ALL** that apply)

- ☐ Prior Authorization
- ☐ Concurrent Review
- ☐ Retrospective Review
- ☐ Issue Initial Adverse Determinations
- ☐ Step Therapy Protocol Override Determinations
- ☐ Formulary Exception Requests
- ☐ Review of Appeals
- ☐ Review of Out-of-Network Service Appeals (see IL §§4900(g-6) and 4904(a-1))
- ☐ Review of Out-of-Network Referral Appeals (see IL §§4900(g-6-a) and 4904(a-2))
- ☐ Issue Final Adverse Determinations
- ☐ Process response/compliance for External Appeals

**3. Agent will subdelegate utilization review functions to (check ALL that apply):**

- ☐ Another NYS UR Agent:____________________________________________________________
- ☐ PHL Article 28 licensed facility
- ☐ Mental Hygiene Law Article 31 licensed facility
- ☐ Other:____________________________________________________________________

Describe circumstances under which delegation will occur:

______________________________________________________________________________

______________________________________________________________________________

- ☐ No subdelegation

**4. Agent will review medical necessity for the following services (check ALL that apply):**

- ☐ Comprehensive health care services (specialty, inpatient and ancillary)
- ☐ Home health care following an inpatient stay
- ☐ Mental health treatment
- ☐ Substance use disorder (SUD) treatment

- ☐ Specific health care service:
- ☐ Dental
- ☐ Oncology
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Radiology
- ☐ Vision
- ☐ Other: ______________________________________________

Name of MH Clinical Review Tool: ______________________________

Date OMH Approved MH Clinical Review Tool : ____________________

Name of SUD Clinical Review Tool: _____________________________

**5. Agent is accredited by the Utilization Review Accreditation Commission (URAC):**

- ☐ YES, current certificate attached.
- ☐ NO

6. **Agent's utilization review policies and procedures also comply with (check ALL that apply):**
   ☐ 29 CFR Part 2560 and 2590 for group health plans
   ☐ 45 CFR Parts 146 and 147 for individual market and group market
   ☐ Other: ____________________
   ☐ Not applicable. Describe:____________________

7. **Agent filed a Utilization Review Report with the NYS Department of Health**:
   ☐ YES Date Filed: ____________________
   ☐ NO

## Section F

**Check one:**

☐ The Agent's full UR documentation is attached. (Complete all Sections.)

☐ There have been no material changes made to the Agent's UR documentation previously submitted to the Department of Financial Services. (Complete the UR Requirements for Mental Health and SUD Treatment the first time an application is submitted after 11/19 and proceed to Section H.)

☐ Material changes have been made to the Agent's previously submitted UR documentation as follows: (Complete Sections F, G and H for revised material only.)

**Instructions for Section F:** Complete the relevant parts of Section F. The items completed in Section F must match the utilization review functions and services selected in Section E above.

| Agent is Compliant with the Following Requirements and Prohibitions | Y | N | NYS Cite[1] | Indicate Location: Policy and Page Number |
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| **General Utilization Review Requirements** | | | | |
| 1. The Agent maintains the confidentiality of all records in accordance with applicable federal and state laws. | ☐ | ☐ | §4901(b)(11)<br>§4902(a)(7)<br>§4905(a)(1) | |
| 2. In no event, will information obtained by the Agent be used by persons other than health care professionals, medical record technologists, or administrative personnel who have been appropriately trained. | ☐ | ☐ | §4905(h) | |
| 3. Administrative personnel, health care professionals, and clinical peer reviewers performing utilization review are appropriately trained; licensed, registered, certified, and credentialed as required; and supervised. | ☐ | ☐ | §4901(b)(6)-(8)<br>§4903(a)<br>§4905(c) | |
| 4. The Agent does not permit or provide compensation or anything of value (including decisions on hiring, promotion, or termination) to persons conducting UR based on: a percentage of the amount by which a claim is reduced for payment, or the number of claims, or cost of services for denied authorizations or payments; or any other method that encourages the rendering of adverse determinations. | ☐ | ☐ | §4905(d)<br>45 CFR 147.136(b)(2)(ii)(D)<br>45 CFR 147.136(b)(3)(ii)(D) | |
| 5. A health care professional providing care to an insured is prohibited from serving as a clinical peer reviewer for health care provided to that insured. | ☐ | ☐ | §4905(o) | |
| 6. The Agent will not transfer liability for the Agent's activities, actions, or omissions to the health care provider. | ☐ | ☐ | §4905(n) | |
| 7. The Agent will not take any action to penalize or discourage an insured or provider from appealing or seeking dispute resolution or judicial review of an adverse determination. | ☐ | ☐ | §4905(l) | |
| 8. The Agent will operate not less than 40 hours per week. The Agent has a telephone system capable of accepting, recording, or providing instruction to incoming calls during non-business hours to ensure a response is provided by the next business day OR the Agent is capable of responding to concurrent review requests and expedited appeals on a 24/7 basis. | ☐ | ☐ | §4901(a)(10)<br>§4902(a)(6) | |

[1] All statutory references are to the Insurance Law.

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| 9. The Agent's Utilization Review Plan includes the following:<br>• Process for developing written clinical review criteria;<br>• Description of clinical review criteria to be used;<br>• Description of practice guidelines and standards for determining medical necessity;<br>• Process for scheduled review and evaluation of clinical review criteria; and<br>• Description of qualification and experience of personnel responsible for development, and evaluation of clinical review criteria. | ☐ | ☐ | §4900(j)<br>§4901(b) | |
| 10. Definition of Medical Necessity. | ☐ | ☐ | §4324(a)(1)<br>§3217-a(a)(1) | |
| 11. The Agent will not conduct UR more frequently than necessary to assess medical necessity. | ☐ | ☐ | §4905(f) | |
| 12. The Agent will collect only information necessary to make a UR determination and will not routinely require providers to code requests or submit medical records for all patients. During prior and concurrent reviews, only the necessary and relevant sections of medical records will be requested, if needed, to verify medical necessity. | ☐ | ☐ | §4905(g) | |
| 13. Definition of Emergency Condition. | ☐ | ☐ | §4900(c) | |
| 14. In any event, the Agent will not require or suggest any insured or provider notify or contact the Agent, or obtain prior authorization, before the provision of emergency care, including emergency treatment or an emergency admission. The Agent will not deny emergency services on retrospective review if care was provided to treat or stabilize an emergency condition. | ☐ | ☐ | §4900(c)<br>§4901(b)(5)<br>§4902(a)(8)<br>§4905(m) | |
| **UR Requirements for Initial Determinations** | | | | |
| 1. The Agent will not conduct UR at the site of provision of health care services unless the conditions of Insurance Law §4905(i) are met. The Agent will not base an adverse determination on a refusal to consent to observe any health care service. | ☐ | ☐ | §4905(i)<br>§4905(j) | |
| 2. The Agent will not base an adverse determination on lack of access to medical records (lack of information) unless reasonable notice has been provided to the insured, their designee, or their provider (insured is also notified) that the information is required. | ☐ | ☐ | §4905(k) | |
| 3. Upon retrospective review, the Agent will not modify standards or criteria used to preauthorize a service. The Agent will not deny payment for a preauthorized service unless the conditions of Insurance Law §3238 are met. | ☐ | ☐ | §4905(e)<br>§3238 | |
| 4. If the Agent fails to meet required timeframes to make an initial determination, the Agent will consider the decision to be an adverse determination subject to appeal. | ☐ | ☐ | §4903(g) | |
| **UR Requirements for Initial Determinations and Appeals** | | | | |
| 1. The Agent permits a designee (an authorized representative) to act on behalf of the insured in pursuing a request for benefits and an appeal of an adverse determination. | ☐ | ☐ | §4903(b)<br>§4903(c)<br>§4904(a)<br>29 CFR 2560.503-1(b)(4) | |
| 2. All adverse determinations and final adverse determinations are rendered by clinical peer reviewers. The clinical peer reviewer rendering the determination on the appeal is not the clinical peer reviewer who made the adverse determination or the subordinate of such clinical peer reviewer. | ☐ | ☐ | §4900(b)(1)<br>§4903(a)(3)<br>§4904(d)<br>45 CFR 2560.503-1(h)(3)(ii) | |
| 3. The Agent ensures that statements of clinical rationale for adverse determinations and final adverse determinations will, at a minimum, identify:<br>• The insured and the nature of his/her medical condition;<br>• The medical service, treatment, or procedure in question;<br>• The basis or bases on which the Agent determined that the service, treatment, or procedure is or was not medically necessary or experimental/investigational (with specific use of terms), which shall demonstrate that the agent considered | ☐ | ☐ | §4903(e)(1)<br>§4904(c)(1)<br>§4904(a-1)<br>§4904(a-2)<br>11 NYCRR 410.9(e)(1) | |

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| insured-specific clinical information in its determination; and<br>• For final adverse determinations of out-of-network service denials, the alternate service available in-network and how to access the service.<br>• For final adverse determinations of out-of-network referral denials, the names of in-network health care provider(s) identified by the insurer that have the appropriate training and experience to meet the particular health care needs of the insured and are able to provide the requested health service.<br><br>The Agent ensures that statements of reason and clinical rationale for adverse determinations will be sufficiently specific to enable the insured and the insured's health care provider to make an informed judgment regarding 1) whether or not to appeal the adverse determination or final adverse determination, and 2) the grounds for such an appeal. | | | | |
| **UR Requirements for Appeals** | | | | |
| 1. If the Agent fails to meet required timeframes to make a final determination on an appeal, the Agent will reverse the initial adverse determination. | ☐ | ☐ | §4904(e) | |
| **External Appeal Process Requirements** | | | | |
| 1. The Agent will participate in the external appeal process and abide by the decisions of the external appeal agent on behalf of a contracted insurer pursuant to Article 49 Title 2 and 11 NYCRR 410. | ☐ | ☐ | §4910<br>§4914<br>11 NYCRR 410.9(e) | |
| **UR Requirements for Mental Health and SUD Treatment** | | | | |
| ***Mental Health Treatment*** | | | | |
| 1. Provide a description of how the Agent, when conducting utilization review for a mental health condition, will use evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient, and deemed appropriate and approved for such use by the Office of Mental Health (OMH). | ☐ | ☐ | §4902(a)(12) | |
| 2. Provide a description of the process to ensure that the clinical peer reviewer making a determination on a mental health condition is either: (1) a physician who possesses a current and valid license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health treatment; or (2) a health care professional other than a physician who specializes in behavioral health and has experience in the delivery of mental health treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration, or if none exists, is credentialed by the national accrediting body appropriate to the profession. | ☐ | ☐ | §4900(b)(1)(D) | |
| 2. Provide a description of the process to ensure that prior authorization is not conducted for inpatient mental health treatment for individuals under 18 years of age provided at hospitals licensed by OMH that participate in the insurer's provider network. | ☐ | ☐ | § 3216(i)(35)(G)<br>§ 3221(l)(5)(G)<br>§ 4303(g)(8) | |
| 3. Provide a description of the process to ensure that inpatient mental health treatment for individuals under 18 years of age provided at an OMH-licensed hospital that participates in insurer's provider network is not subject to concurrent review for the first 14 days of the inpatient admission if the facility notifies the insurer of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, the Agent may retrospectively review the entire stay to determine medical necessity. | ☐ | ☐ | § 3216(i)(35)(G)<br>§ 3221(l)(5)(G)<br>§ 4303(g)(8) | |
| ***Substance Use Disorder (SUD) Treatment*** | | | | |
| 1. Provide a description of how the Agent, when conducting utilization review for SUD treatment, will use an evidence-based and peer reviewed clinical review tool that is appropriate to the age of the patient. For utilization review conducted in this State, provide a description of how the Agent will use an evidence-based and peer | ☐ | ☐ | §4902(a)(9) | |

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| reviewed clinical tool designated by OASAS that is consistent with the treatment service levels within OASAS system. | | | | |
| 2. Provide a description of the process to ensure that the clinical peer reviewer making a determination on SUD treatment is either: (1) a physician who possesses a current and valid license to practice medicine and who specializes in behavioral health and has experience in the delivery of SUD treatment; or (2) a health care professional other than a physician who specializes in behavioral health and has experience in the delivery of SUD treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration, or if none exists, is credentialed by the national accrediting body appropriate to the profession. | ☐ | ☐ | §4900(b)(1)(C) | |
| 3. Provide a description of the process to ensure that prior authorization is not conducted for inpatient SUD treatment provided at OASAS-certified facilities that participate in the insurer's provider network. | ☐ | ☐ | §3216(i)(30)(D)<br>§3221(l)(6)(D)<br>§4303(k)(4) | |
| 4. Provide a description of the process to ensure that inpatient SUD treatment at an OASAS-certified facility that participates in insurer's provider network is not subject to concurrent review for the first 28 days of the inpatient admission if the facility notifies the insurer of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 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 first 28 days of the inpatient admission on the basis that such treatment was not medically necessary if the treatment was contrary to the evidence-based and peer reviewed clinical review tool that is designated by OASAS. | ☐ | ☐ | § 3216(i)(30)(D)<br>§ 3221(l)(6)(D)<br>§ 4303(k)(4) | |
| 5. Provide a description of the process to ensure if a request for inpatient treatment for SUD 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 denied for lack of medical necessity or prior authorization. | ☐ | ☐ | §4903(c) | |
| 6. Provide a description of the process to ensure that prior authorization is not conducted for outpatient SUD treatment provided at OASAS-certified facilities that participate in the insurer's provider network. | ☐ | ☐ | §3216(i)(31)(E)<br>§3221(l)(7)(E)<br>§4303(l)(5) | |
| 7. Provide a description of the process to ensure that outpatient SUD treatment at an OASAS-certified facility that participates in insurer's provider network is not subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the facility notifies the insurer of both the start of treatment and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, the Agent may review the entire treatment to determine medical necessity. The Agent shall only deny coverage for any portion of the initial four (4) weeks of continuous treatment, not to exceed 28 visits, on the basis that such treatment was not medically necessary if the treatment was contrary to the evidence-based and peer reviewed clinical review tool that is designated by OASAS. | ☐ | ☐ | §3216(i)(31)(E)<br>§3221(l)(6)(E)<br>§4303(l)(5) | |
| 8. Provide a description of the process to ensure that prior authorization is not conducted for the formulary forms of prescribed medications for the SUD treatment, including a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization, and medication for opioid overdose reversal covered under the policy prescribed or dispensed to an insured. | ☐ | ☐ | §3216(i)(31-a)(A) & (B) §3221(l)(7-b)(A) & (B) §4303(1-2)(1) & (2) | |
| **UR Requirements for Step Therapy Override Determinations** | | | | |
| 1. Step Therapy Override Determinations Clinical Review Criteria<br>• For establishing step therapy protocols, a description of how the Agent will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. | ☐ | ☐ | §4902(a)(10) & (11) | |

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| • A description of how the Agent will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for the insured and the insured's medical condition when conducting utilization review for a step therapy override determination. | | | | |
| 2. For step therapy protocol override determinations, if the Agent fails to meet required timeframes to make an initial determination, the Agent will approve the request. | ☐ | ☐ | §4903(g) | |
| **UR Requirements for Home Care Services** | | | | |
| 1. If a request for home health care services and all necessary information is submitted to the Agent prior to discharge from an inpatient admission, the Agent will not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services provided while the determination by the Agent is pending. | ☐ | ☐ | §4903(c) | |

## Section G

**1. The Agent will ensure that all utilization review determinations, whether adverse or not, are made within the timeframes provided by Insurance Law Article 49. The Agent will ensure that all adverse determinations are made within the timeframes provided by 29 CFR Part 2560, 29 CFR Part 2590, and 45 CFR Parts 146 and 147, as applicable. The Agent's utilization review processes meet the minimum requirements described:**

☐ Attachments A: Minimum Process Requirements for Prior Authorization, Concurrent and Retrospective Authorization Utilization Review.

**2. Will the Agent conduct some or all utilization review functions though an off-shore operations center?**

☐ Off-shore operation centers will be used and the following conditions will be met:

- Off-shore operations are limited to commercial business only;
- All clinical professionals will be licensed in the US;
- Payment for off-shore services will be made to an account located in a US financial institution; and
- Off-shore staff will be trained in and comply with federal and NYS confidentiality requirements and documentation of training will be retained.

☐ Off-shore operation centers will not be used to conduct utilization review functions.

**3. The following template notices are attached for UR functions conducted and all applicable product lines:**

☐ Initial Adverse Determination
☐ Initial Denials for Out-of-Network Referral Request and Out-of-Network Service Request
☐ Adverse Determination for a Formulary Exception Request
☐ Final Adverse Determinations
☐ External Appeal Standard Description and Application
☐ The Agent will not issue adverse determinations

**4. The Agent will ensure that the procedures for electronic notifications, including the procedures for obtaining an insured's preference for receiving electronic notifications of initial or final adverse determinations, comply with Insurance Law § 4903(i) and 4904(c)(2) and guidance.**

☐ The Agent confirms that procedures for electronic notifications and the procedures for obtaining the insured's preference for notifications of initial or final adverse determinations comply with Insurance Law § 4903(i) and 4904(c)(2) and any guidance.

☐ Agent does not provide notifications (electronic, telephone, or written) of initial or final adverse determinations.

**5. The Agent will ensure that all utilization review processes and determinations, whether adverse or not, comply with the Mental Health Parity and Addition Equity Act.**

☐ The Agent conducts utilization review in a manner that is compliant with the Mental Health Parity and Addiction Equity Act (42 USC § 300gg-26 & 29 USC § 1185a) and its implementing regulations.

☐ The Agent does not perform utilization review for mental health or substance use disorder treatment.

| Section H | |
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| **Attestation:**<br><br>I, ____________________________________________________ (Chief Executive Officer) subscribe and affirm as true, under penalty of perjury, the information included in this application and reported to the New York State Department of Financial Services.<br><br>I further attest that the Agent will conduct utilization review in a manner compliant with federal and New York State Law and regulation, including the Mental Health Parity and Addiction Equity Act. If the policies or procedures of the Agent are found by the New York State Department of Financial Services to be non-compliant, the Agent will modify such policies or procedures, as directed by the New York State Department of Financial Services, within thirty (30) days.<br><br>I further agree that the filing of the Utilization Review Report is valid only as long as the conditions listed in Section E exist. At such time that the Utilization Review Agent intends to change the utilization review services offered, an amended report will be submitted to the New York State Department of Financial Services prior to implementing any contract for the provision of these services.<br><br>I further attest that, if the registered Agent's Corporate Name has changed, all utilization review functions, policies and procedures as previously reported to the Department of Financial Services have not changed, except where material changes have been reported in this application. | |
| Signature: | Date: |