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 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, including for policies issued or renewed after 1/1/17 for a step therapy protocol override determination.	Request information within 3 business days (bd) and allow 45 days to submit. Effective for policies issued or renewed after 1/1/17 for a step therapy protocol override determination, request supporting rationale and documentation within 72 hours and allow 45 days to submit.	Trained staff.	Licensed Health Care Professional.
Review §§ 3216(i)(30)(D), 3216(i)(31-a), 3221(l)(6)(D); 3221(l)(7-b) 4303(k)(4), 4303(l-2), 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 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 insured and consistent with the treatment service levels within the OASAS system.			Licensed Health Care Professional or Clinical Peer.	Medical Director.

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	• Effective for policies issued or renewed on and after 1/1/17, process to ensure that prior authorization is not conducted for inpatient substance use disorder treatment provided at OASAS-certified facilities that participate in the issuer's provider network. • Effective for policies issued or renewed on and after 1/1/17, process to ensure that prior authorization is not conducted for a 5 day supply of prescribed medications for the treatment of substance use disorder where an emergency condition exists. • 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(b), (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 a decision is not made within 3 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	If request is complete, within 72 hours of receipt of request. If request is not complete, within 48 hours of the earlier of receipt of necessary information or the end of the 48 hour period. Effective for policies issued or renewed after 1/1/17 for an expedited step therapy protocol override determination, if	If request is complete, within 3 bd of receipt of the 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 of the end of the 45 day period if no information received. Effective for policies issued or renewed	Approvals: Licensed Health Care Professional or Clinical Peer. Denials: Clinical Peer.	Medical Director.

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	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.	request includes supporting documentation and rationale, within 24 hours of receipt of request. If request does not include supporting rationale and documentation, within the earlier of 24 hours of receipt of supporting rationale and documentation or 48 hours of the end of the 48 hour period. For an expedited formulary exception request, within 24 hours of receipt of the request. For court ordered treatment, within 72 hours of receipt of the request.	after 1/1/17, for a standard step therapy protocol override determination, within the earlier of 72 hours of receipt of the supporting rationale and documentation, 15 days of receipt of partial information, or 15 days after the end of the 45 day period if no information received. For a standard formulary exception request, within 72 hours of receipt of the request. For court ordered treatment, within 72 hours of receipt of the request.		
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.	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.
Written Notice §§4902(a)(4) and (5), 4903(b), (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, 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.	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 the information or 3 days after the verbal	If request is complete, within 3 bd of receipt of the request. If request is not complete, within the earlier of 3 bd of receipt of necessary information, 15 days	Trained Staff may transmit notice (adverse determinations must be made by clinical peer).	Licensed Health Care Professional.

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	• Process to ensure all required information is included in notice. • 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.	notification. Effective for policies issued or renewed after 1/1/17 for a step therapy protocol override determination, if request is complete, within 24 hours of receipt of request. If request is not complete, within the earlier of 24 hours of receipt of supporting rationale and documentation or 3 days after the verbal notification. For an expedited formulary exception request, within 24 hours of receipt of the request. For court ordered treatment, within 3 bd of receipt of the request.	of receipt of partial information, or 15 days of the end of the 45 day period if no information received. Effective for policies issued or renewed after 1/1/17, for a step therapy protocol override determination, within the earlier of 72 hours of receipt of the supporting rationale and documentation, 15 days of receipt of partial information, or 15 days after the end of the 45 day period if no information received. For a standard formulary exception request, within 72 hours of receipt of the request. For court ordered treatment, within 3 bd of receipt of the request.		
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	1 bd of request.	1 bd of request.	Clinical Peer.	Medical Director.

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Function	Required Procedure	Timeframe		Responsible Party	Oversight By
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	approval notice to insured and provider. • Process to maintain record of decision.				
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); 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 accept appeal of a determination that an out-of-network service is not materially different from an alternate in network service. • Process to accept appeal of a determination that a referral should not be granted for an out-of-network provider because an in-network provider is available. • Process to expedite review when Agent determines or provider believes immediate appeal is warranted. • 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).			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.	Not required.	Within 15 days.	Trained staff.	Licensed Health Care Professional.
Information Needed §§4902(a)(2), 4904(a-1), (a-2), (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	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.

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	information in writing. • For an appeal of an out-of-network service denial or an out-of-network referral denial, process to request information needed as per § 4904(a-1) and (a-2) if submitted information is incomplete.				
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 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), 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 a final adverse determination (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	The lesser of 72 hours of receipt of the appeal or 2 bd after all information.	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.	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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Function	Required Procedure	Timeframe		Responsible Party	Oversight By
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	approval of the coverage.				
Written Notice §§4902(a)(4), 4904(c),(d); 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 (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 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 FAD 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.