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, or web portal.		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 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 30 days and allow 45 days to submit. 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 §§3242; 4329; 4902(a)(1), (3), (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. • Process to review a request for coverage of a non-formulary drug (formulary exception request). • 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.		Licensed Health Care Professional or Clinical Peer.	Medical Director.

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Review of Mental Health and SUD Treatment §§ 4900(b); 4902(a)(9), (12)	• For utilization review of SUD treatment, process to use an evidence-based and peer reviewed clinical review tool that is appropriate to the age of the patient. When conducting utilization review of SUD treatment provided in New York, process to use an evidence-based and peer reviewed clinical review tool designated by the Office Addiction Services and Supports (OASAS) that is consistent with the treatment service levels within the OASAS system. • For utilization review of SUD treatment, process to ensure that clinical peers who make adverse determinations are 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. • For utilization review of a mental health treatment, process to use only evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient, deemed appropriate and approved for such use by the Office of Mental Health (OMH). • For utilization review of mental health treatment, process to ensure that clinical peers who make adverse determinations are 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.		Licensed Health Care Professional or Clinical Peer.	Medical Director.
Determination §§3242; 4329; 4902(a)(1), (4); 4903(c-1), (c-3), (d), (g); 29 CFR 2560.503-1(f)(2)(iii)(B); 45 CFR	• 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.	Medical Director.

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147.136(b)(2)(ii)(F), (b)(3)(ii)(F)	• Process to ensure that if a decision is not made within 30 days 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. • For a step therapy protocol override determination, process to ensure that if a decision is not made within 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 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.	Denials: Clinical Peer.	
Written Notice §§3242; 4329; 4902(a)(4), (5); 4903(d), (e); 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. • For formulary exception request denials, process to ensure that the first denial is considered the final adverse determination (FAD) and all required information is included in FAD, including the name(s) of clinically appropriate prescription drugs on the issuer's formulary to treat the insured.	At time of determination. For a standard formulary exception request, within 3 bd of receipt of the request.	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 the insured's 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 to Specify.	Clinical Peer.	Medical Director.
Time Allowed to File Appeal §4904(c); 29 CFR 2560.503-1(h)(3)(i)		Must allow insureds and their designees at least 180 days and providers 45 days from receipt of adverse determination.		

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Appeal Intake §§3242; 4329; 4902(a)(4); 4904(a), (a-1), (c); 45 CFR 156.122(c)	• Process to conduct intake, data collection, and perform non-clinical review functions. • Process to accept appeals from insured, and from providers on their own behalf, by phone and in writing. Optional: Fax, electronic, web portal. • An appeal of a formulary exception denial is not permitted as the initial denial is the FAD.		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 410.9(b)	• If more information needed, process to request missing 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.	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), (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), (e); 29 CFR 2560.503-1(h)(3)(ii); (i)(2)(iii); 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 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	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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Function	Required Procedure	Timeframe	Responsible Party	Oversight By
	coverage.			
Written Notice §§4902(a)(4); 4904(c), (d); 11 NYCRR 410.9(e); 29 CFR 2560.503-1(i)(2)(iii)	• 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.	2 bd 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 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 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." • 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.