§ 4901. Registration of utilization review agents. 1. Every utilization review agent who conducts the practice of utilization review shall biennially register with the commissioner and report, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subdivision two of this section.

2. Such report shall contain a description of the following:

(a) The utilization review plan;

(b) Those circumstances, if any, under which utilization review may be delegated to a utilization review program conducted by a facility licensed pursuant to article twenty-eight of this chapter or pursuant to article thirty-one of the mental hygiene law;

(c) The provisions by which an enrollee, the enrollee's designee, or a health care provider may seek reconsideration of, or appeal from, adverse determinations by the utilization review agent, in accordance with the provisions of this title, including provisions to ensure a timely appeal and that an enrollee, the enrollee's designee, and, in the case of an adverse determination involving a retrospective determination, the enrollee's health care provider, is informed of their right to appeal adverse determinations;

(d) Procedures by which a decision on a request for utilization review for services requiring preauthorization shall comply with timeframes established pursuant to this title;

(e) A description of an emergency care policy, which shall include the procedures under which an emergency admission shall be made or emergency treatment shall be given;

(f) A description of the personnel utilized to conduct utilization review including a description of the circumstances under which utilization review may be conducted by:

(i) administrative personnel,

(ii) health care professionals who are not clinical peer reviewers, and

(iii) clinical peer reviewers;

(g) A description of the mechanisms employed to assure that administrative personnel are trained in the principles and procedures of intake screening and data collection and are appropriately monitored by

a licensed health care professional while performing an administrative review;

(h) A description of the mechanisms employed to assure that health care professionals conducting utilization review are:

(i) appropriately licensed, registered or certified; and

(ii) trained in the principles, procedures and standards of such utilization review agent;

(i) A description of the mechanisms employed to assure that only a clinical peer reviewer shall render an adverse determination;

(j) Provisions to ensure that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:

(i) not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours and to ensure response to accepted or recorded messages not later than the next business day after the date on which the call was received; or

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subdivision three of section forty-nine hundred three of this title or an expedited appeal filed pursuant to subdivision two of section forty-nine hundred four of this title, on a twenty-four hour a day, seven day a week basis;

(k) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical and treatment records are followed;

(l) A copy of the materials to be disclosed to an enrollee or prospective enrollee pursuant to this title and section forty-four hundred eight of this chapter;

(m) A description of the mechanisms employed by the utilization review agent to assure that all contractors, subcontractors, subvendors, agents and employees affiliated by contract or otherwise with such utilization review agent will adhere to the standards and requirements of this title; and

(n) A list of the payors for which the utilization review agent is performing utilization review in this state.

3. Upon receipt of the report, the commissioner shall issue an acknowledgment of the filing.

4. A registration issued under this title shall be valid for a period of not more than two years, and may be renewed for additional periods of not more than two years each.

5. A health maintenance organization licensed pursuant to article forty-three of the insurance law or certified under article forty-four of this chapter shall not be required to register as a utilization review agent, provided that such health maintenance organization has otherwise provided the information required pursuant to subdivision two of this section to the commissioner.

6. The clinical review criteria and standards contained within the utilization review plan and the list of payors required pursuant to paragraph (n) of subdivision two of this section shall not be subject to disclosure pursuant to the provisions of article six of the public officers law.