§ 4903. Utilization review determinations. 1. Utilization review shall be conducted by:

(a) Administrative personnel trained in the principles and procedures of intake screening and data collection, provided, however, that administrative personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed health care professional;

(b) A health care professional who is appropriately trained in the principles, procedures and standards of such utilization review agent; provided, however, that a health care professional who is not a clinical peer reviewer may not render an adverse determination; and

(c) A clinical peer reviewer where the review involves an adverse determination.

2. (a) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information, or for inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. The notification shall identify; (i) whether the services are considered in-network or out-of-network; (ii) and whether the enrollee will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment or co-insurance; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an enrollee may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

* (b) With regard to individual or group contracts authorized pursuant to article forty-four of this chapter, for utilization review determinations involving proposed mental health and/or substance use

disorder services where the enrollee or the enrollee's designee has, in a format prescribed by the superintendent of financial services, certified in the request that the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, the utilization review agent shall make a determination and provide notice of such determination to the enrollee or the enrollee's designee by telephone within seventy-two hours of receipt of the request. Written notice of the determination to the enrollee or enrollee's designee shall follow within three business days. Where feasible, such telephonic and written notice shall also be provided to the court.

* NB Effective until January 1, 2027

* (b) With regard to individual or group contracts authorized pursuant to article forty-four of this chapter, for utilization review determinations involving proposed mental health and/or substance-related and addictive disorder services where the enrollee or the enrollee's designee has, in a format prescribed by the superintendent of financial services, certified in the request that the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, the utilization review agent shall make a determination and provide notice of such determination to the enrollee or the enrollee's designee by telephone within seventy-two hours of receipt of the request. Written notice of the determination to the enrollee or enrollee's designee shall follow within three business days. Where feasible, such telephonic and written notice shall also be provided to the court.

* NB Effective January 1, 2027

* 3. (a) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, or requests for inpatient substance use disorder treatment, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone

and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday and except, with respect to inpatient substance use disorder treatment, within twenty-four hours of receipt of the request for services when the request is submitted at least twenty-four hours prior to discharge from an inpatient admission. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

(b) Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

(c) Provided that a request for inpatient treatment for substance use disorder is submitted to the utilization review agent at least twenty-four hours prior to discharge from an inpatient admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for the inpatient substance use disorder treatment while a determination by the utilization review agent is pending.

* NB Effective until January 1, 2027

* 3. (a) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, or requests for inpatient substance-related and addictive disorder treatment, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of

receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday and except, with respect to inpatient substance-related and addictive disorder treatment, within twenty-four hours of receipt of the request for services when the request is submitted at least twenty-four hours prior to discharge from an inpatient admission. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

(b) Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

(c) Provided that a request for inpatient treatment for substance-related and addictive disorder is submitted to the utilization review agent at least twenty-four hours prior to discharge from an inpatient admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for the inpatient substance-related and addictive disorder treatment while a determination by the utilization review agent is pending.

* NB Effective January 1, 2027

3-a. A utilization review agent shall grant a step therapy protocol override determination within seventy-two hours of the receipt of information that includes supporting rationale and documentation from a health care professional which demonstrates that:

(a) The required prescription drug or drugs is contraindicated, will likely cause an adverse reaction by or physical or mental harm to the enrollee;

(b) The required prescription drug or drugs is expected to be ineffective based on the known clinical history and conditions of the enrollee and the enrollee's prescription drug regimen;

(c) The enrollee has tried the required prescription drug or drugs

while under their current or a previous health insurance or health benefit plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action and such prescription drug or drugs was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(d) The enrollee is stable on a prescription drug or drugs selected by their health care professional for the medical condition under consideration, provided that this shall not prevent a utilization review agent from requiring an insured to try an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug or drugs; or

(e) The required prescription drug or drugs is not in the best interest of the enrollee because it will likely cause a significant barrier to the enrollee's adherence to or compliance with the enrollee's plan of care, will likely worsen a comorbid condition of the enrollee, or will likely decrease the covered enrollee's ability to achieve or maintain reasonable functional ability in performing daily activities.

3-b. For an enrollee with a medical condition that places the health of the insured in serious jeopardy without the prescription drug or drugs prescribed by the insured's health care professional, the step therapy protocol override determination shall be granted within twenty-four hours of the receipt of information that includes supporting rationale and documentation from a health care professional demonstrating one or more of the standards provided for in subdivision three-a of this section.

3-c. Upon a determination that the step therapy protocol should be overridden, the health care plan shall authorize immediate coverage for the prescription drug or drugs prescribed by the enrollee's treating health care professional. Any approval of a step therapy protocol override determination request shall be honored until the lesser of either treatment duration based on current evidence-based treatment guidelines or twelve months following the date of the approval of the request or renewal of the enrollee's coverage.

4. A utilization review agent shall make a utilization review

determination involving health care services which have been delivered within thirty days of receipt of the necessary information.

5. (a) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

(i) the reasons for the determination including the clinical rationale, if any;

(ii) instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and an external appeal pursuant to section forty-nine hundred fourteen of this article;

(iii) notice of the availability, upon request of the enrollee, or the enrollee's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal; and

(iv) for an adverse determination related to a step therapy protocol override request, information that includes the clinical review criteria relied upon to make such determination and any applicable alternative prescription drugs subject to the step therapy protocol of the utilization review agent.

(b) A utilization review agent may provide notice of an adverse determination related to a step therapy protocol override determination electronically pursuant to subdivision nine of this section, including by electronic mail or through the health care plan's member portal and provider portal. An electronic notice of such an adverse determination may meet the requirements of subparagraph (iv) of paragraph (a) of this subdivision by linking to information posted on the website of the health care plan.

6. In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the enrollee's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one business day of receipt of the

request and shall be conducted by the enrollee's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, the utilization review agent shall provide notice as required pursuant to subdivision five of this section. Nothing in this section shall preclude the enrollee from initiating an appeal from an adverse determination.

7. Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an adverse determination subject to appeal pursuant to section forty-nine hundred four of this title, provided, however, that failure to meet such time periods for a step therapy protocol as defined in subdivision seven-f-three of section forty-nine hundred of this title or a step therapy protocol override determination pursuant to subdivisions three-a, three-b and three-c of this section shall be deemed to be an override of the step therapy protocol. A utilization review agent's failure to comply with any of the step therapy protocol requirements required in subdivisions five and six of section forty-nine hundred two of this title shall be considered a basis for granting an override of the step therapy protocol, absent fraud.

8. The commissioner, in conjunction with the superintendent of financial services, shall develop standards for prior authorization requests to be utilized by all health care plans for the purposes of submitting a request for a utilization review determination for coverage of prescription drug benefits under this article. The department and the department of financial services, in development of the standards, shall take into consideration existing electronic prior authorization standards including National Council for Prescription Drug Programs (NCPDP) electronic prior authorization standard transactions.

9. A utilization review agent shall have procedures for obtaining an enrollee's, or enrollee's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the commissioner. Written and telephone

notification to an enrollee or the enrollee's designee under this section may be provided by electronic means where the enrollee or the enrollee's designee has informed the organization in advance of preference to receive such notifications by electronic means. An organization shall permit the enrollee and the enrollee's designee to change the preference at any time. To the extent practicable, such written and telephone notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The utilization review agent shall retain documentation of preferred notification methods and present such records to the commissioner upon request.