62M.19 ANNUAL REPORT TO COMMISSIONER OF HEALTH; PRIOR AUTHORIZATIONS.

On or before September 1 each year, each utilization review organization must report to the commissioner of health, in a form and manner specified by the commissioner, information on prior authorization requests for the previous calendar year. The report submitted under this subdivision must include the following data:

(1) the total number of prior authorization requests received;

(2) the number of prior authorization requests for which an authorization was issued;

(3) the number of prior authorization requests for which an adverse determination was issued;

(4) the number of adverse determinations reversed on appeal;

(5) the 25 codes with the highest number of prior authorization requests and the percentage of authorizations for each of these codes;

(6) the 25 codes with the highest percentage of prior authorization requests for which an authorization was issued and the total number of the requests;

(7) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued but which was reversed on appeal and the total number of the requests;

(8) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued and the total number of the requests; and

(9) the reasons an adverse determination to a prior authorization request was issued, expressed as a percentage of all adverse determinations. The reasons listed may include but are not limited to:

(i) the patient did not meet prior authorization criteria;

(ii) incomplete information was submitted by the provider to the utilization review organization;

(iii) the treatment program changed; and

(iv) the patient is no longer covered by the health benefit plan.

History: *2024 c 127 art 57 s 31*