

UTAH ADVERSE PREAUTHORIZATION DETERMINATION SURVEY INSTRUCTIONS For Reporting Year 2025

As required by Utah Code § 31A-22-650, all Fraternal, Health, Life and Property & Casualty insurers in Utah that offer comprehensive hospital & medical (major medical) business in the Individual, Small Group, or Large Group Markets are required to complete and file this survey. All other insurers are exempt.

The completed survey form must be submitted to the Utah Insurance Department **by April 1st of each year**. Submit the completed survey to the Utah Insurance Department **HEALTH RESEARCH*Notify All** using the secure file upload website at <https://forms.uid.utah.gov/fileUploads/>. No other methods of data submission will be accepted.

Failure to submit the survey by the deadline may result in enforcement action and penalties pursuant to Utah Code § 31A-2-308. Questions regarding completion of the survey should be directed to the Research Analyst via email to healthresearch@utah.gov.

SIGNATURE FORM

This survey includes a business confidentiality signature form. The UID collects this survey data with the intent and understanding that these records are classified as protected records under § 63G-2-305(2). The signature form is available from the website along with the instructions and survey.

The signature form should be filed along with the survey. This signature form ensures that the data is properly classified as a protected record under § 63G-2-305(2). A version of this signature form is a standard part of the annual Utah Adverse Benefit Determination Survey. Any representative of your company can sign the form. Please sign and date the signature form and submit an electronic copy (e.g., Adobe PDF format) along with the survey to the Utah Insurance Department A copy will be kept on file along with your survey.

DEFINITION OF COMPREHENSIVE HOSPITAL & MEDICAL

Comprehensive Hospital and Medical

Business that includes major medical, comprehensive medical and other hospital-surgical medical benefit plans intended to serve as the insured member's primary health benefit coverage. This category includes H16 Major Medical health benefit plans filed via SERFF as H16I, H16G, HOrg02I, or HOrg02G. Exclude all H15 Hospital, Medical, Surgical expense plans that are designed to function as a supplement to a primary health benefit plan (see Hosp-Med Surgical (Supplement Only)). Also exclude all Short-Term Limited Duration plans .

Hosp - Med - Surgical (Supplement Only)

Business that includes any hospital only, medical only, surgical only hospital and medical, hospital and surgical, medical and surgical, and hospital, medical and surgical expense plans are designed to function

as a supplement to a primary health benefit plan.). This category includes H15I or H15G Hospital, Medical, Surgical expense plans intended to supplement primary coverage (e.g., H16 Major Medical plans). Exclude all Comprehensive Hospital & Medical plans. Also exclude all Short-Term Limited Duration plans.

Short-term Limited Duration

Business that meets the definition of Short-Term Limited Duration plans under §31A-1-301(175).

Short-term limited duration health insurance means a health benefit plan that: (a) after taking into account any renewals and extensions, has a total duration of no more than 36 months; and (b) has an expiration date that is less than 12 months after the original effective date of coverage. Short-term limited duration plans have limited medical benefits and are not considered a “health benefit plan” under Chapter 30 of the Utah Code. This category includes short-term limited duration plans filed through SERFF as H16I, H16G, H15I, or H15G with a State Sub-TOI of Short Term. Exclude all Comprehensive Hospital & Medical plans or Hospital Medical-Surgical (Supplement Only) plans.

TERMINOLOGY USED IN THE SURVEY

Adverse Preauthorization Determination means a determination by an insurer that requested health care does not meet the insurer's preauthorization requirements.

Authorization is a determination by an insurer for health care subject to a preauthorization requirement:

1. The proposed drug, device, or covered services meets all applicable requirements, restrictions, limitations, and clinical criteria established by the insurer;
2. The drug, device, or covered service is covered by the enrollee’s insurance policy; and
3. The insurer will provide coverage for the drug, device, or covered service in accordance with the terms of the insurance policy, including all applicable cost-sharing responsibilities of the enrollee.

Calendar Year means the time period from January 1 to December 31.

One Week means seven calendar days after the calendar day on which the insurer received the request for authorization. For example, if a preauthorization request is received on December 1st, one week is December 8th. All preauthorization requests completed (i.e., the provider is notified on day 8 and each subsequent day (e.g., December 9th and thereafter) are counted as exceeding one week.

Preauthorization Request is a request for authorization of health care with a preauthorization requirement. This includes both authorizations (the request was approved) and adverse preauthorization determinations (the request was denied). If a preauthorization request was processed more than once, count the final determination of the request as of the end of the reporting year. "Completed" means that the insurer processed the preauthorization request, made a determination, and notified the provider.

Preauthorization Requirement is a requirement by the insurer that an enrollee obtain prior authorization before receiving a covered drug, device, or service. This does not apply to urgent or emergency care.

Reporting Requirement means before April 1st of each year, an insurer with a preauthorization requirement shall report to the Department, for the preceding calendar year, the percentage of authorization requests, excluding claims involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider of an authorization or adverse preauthorization determination more than one week after the day in which the insurer received the request for authorization.

Part 1

PREAUTHORIZATION REQUESTS BY AUTHORIZATION AND ADVERSE PREAUTHORIZATION DETERMINATION

All data in Part 1 should represent the total comprehensive hospital and medical business activity authorizations and adverse preauthorizations.

Total Number of Preauthorization

Enter the total number of preauthorization requests completed during the reporting calendar year "Completed" means that the insurer processed the preauthorization request, made a determination, and notified the provider. Count the number of requests by each unique date of service (the date the request was made). The number of requests completed should equal the number of authorizations completed (approvals) and adverse preauthorization determinations completed (denials) reported in this survey (lines 4 and 6).

Number of Preauthorization Requests Received But Not Completed

Enter the total number of preauthorization requests received but were not completed. "Not completed" means that the insurer received the preauthorization request during the reporting calendar year, but the request was not processed as of the end of the year. This could happen if a request was received in one calendar year and completed in the next calendar year. Count the number of requests by each unique date of service (the date the request was made).

Total Number of Authorizations Completed

Enter the total number of authorizations (approvals) completed during the reporting calendar year. Count authorizations by each unique date of service (the date the request was made). This count includes authorizations completed after one week (line 5). It should be a count of all the authorizations completed.

Number of Authorization Completed After One Week

Enter the total number of authorizations (approvals) completed after one week during the reporting year. Count authorizations by each unique date of service (the date the request was made). This count excludes authorizations completed within 7 days. Count only those that were completed after one week.

Total Number of Adverse Preauthorization

Enter the total number of adverse preauthorization determinations (denials) completed during the reporting year. Count determinations by each unique date of service (the date the request was made). This count includes adverse preauthorization determination completed after one week (line 7). It should be a count of

all the adverse preauthorization determinations completed.

Number of Adverse Preauthorization Determinations After One Week

Enter the total number of adverse preauthorization determinations (denials) completed after one week during the reporting year. Count determinations by each unique date of service (the date the request was made). This count excludes adverse preauthorization determinations completed within 7 days. Count only those that were completed after one week.



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