MARYLAND INSURANCE ADMINISTRATION

PRIVATE REVIEW AGENT
APPLICATION FOR CERTIFICATION

Instructions: Answer each question and return the completed form and all attachments to:

Medical Director/Private Review Agent Oversight Unit
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202-2272

A check or money order in the amount of $1,500.00 payable to the Maryland Insurance Administration must accompany this application. ***Type all information.*** Note: If your response to a question is too long to fit in the text box, please provide your answer on a separate sheet of paper, ensure that the attachment is clearly labeled, and include a specific cross-reference to the attachment within the text box.

PART I: IDENTIFICATION OF APPLICANT

1. Name of Applicant: _____

   Former Name, If Applicable: _____

   Address:

   Telephone Number: (_____) _____

   Facsimile: (_____) _____

2. Corporate Legal Structure of Applicant (select appropriate item below and complete the Ownership Disclosure at the end of the application):

   ☐ Sole Proprietorship
   ☐ Partnership
   ☐ Limited Liability Company
   ☐ S Corporation
   ☐ Corporation

3. Identify a contact person who will be available to respond to inquiries from the Maryland Insurance Administration:

Name: _____

Job Title & Department: _____

Address:

Telephone number: (_____) _____

Facsimile: (_____) _____

Email Address: _____

4. At what time(s) during the normal business day will the contact person be available by telephone? Please respond using Eastern Standard Time as your reference.

_____

PART II: SCOPE OF UTILIZATION REVIEW BEING REQUESTED

5. For which of the following populations is the applicant seeking to obtain certification to provide utilization review services in Maryland (select as many as necessary)?

- ☐ Commercial/Private Insured
- ☐ Self-Funded/Self-Insured
- ☐ Medicaid
- ☐ Other (please specify):

6. Submit a list of every insurer, non-profit health service plan, health maintenance organization, and dental plan organization for whom the applicant is performing utilization review in Maryland. For each entity, provide the complete corporate name and address, the contract commencement date, and the term of the contract. If the applicant does not currently have a contract with any of these entities, please respond "N/A."

7. Submit a list of any third party payors (other than the entities identified in Question 6 above) for whom the applicant is performing utilization review in Maryland. For each entity, provide the complete corporate name and address, the contract commencement date, and the term of the contract. If the applicant does not currently have a contract with any of these entities, please respond "N/A."

8. Submit a list of every third party administrator for whom the applicant is performing utilization review in Maryland. For each entity, provide the complete corporate name and address, the contract commencement date, and the term of the contract. If the applicant does not currently have a contract with any of these entities, please respond "N/A."

9. For which of the following health care service categories is the applicant seeking to obtain certification to provide utilization review services (select as many as necessary)?

- ☐ Medical
- ☐ Psychiatric (Behavioral Health)
- ☐ Substance Use Disorder
- ☐ Pharmacy
- ☐ Dental
- ☐ Other (please specify):
- ☐ Vision
- ☐ Physical Therapy
- ☐ Radiology
- ☐ Chiropractic

10. For which of the following types of utilization review is the applicant seeking to obtain certification to perform (select as many as necessary)?

- ☐ Pre-authorization
- ☐ Concurrent
- ☐ Retrospective
- ☐ Pre-admission
- ☐ Admission
- ☐ Emergency admission
- ☐ Second surgical opinion
- ☐ Discharge planning
- ☐ Step therapy/fail first protocol

☐ External Review
☐ Other (please specify):

11. If the type of utilization review to be performed (Question 10) will vary depending on the health care service category (Question 9), and/or if the health care service category (Question 9) will vary depending on the population to be served (Question 5), please provide a brief outline of the scope of utilization review services to be performed within each category and population.

    Example: "For the commercial/private insured population, retrospective review will be performed for dental services; for the self-funded/self-insured population, pre-authorization, concurrent review, and retrospective review will be performed for medical, psychiatric, and substance use disorder services."

    If the scope of utilization review services will not vary as described above, please respond "N/A."

12. Are there any circumstances under which utilization review may be delegated to a hospital? If yes, attach documentation describing the circumstances, and include a cross-reference to the appropriate attachment in the space below.

    ☐ Yes ☐ No

13. Are there any circumstances under which utilization review functions may be delegated or subcontracted to another entity such as an external review organization? If yes, provide the complete corporate name and address of each entity, and attach documentation clearly describing the scope and extent of each delegation arrangement. Include a cross-reference to the appropriate attachment in the space below.

    ☐ Yes ☐ No

14. Is the applicant seeking to obtain certification to issue the formal written notice of adverse decisions (non-certifications) to patients covered under insured plans offered by insurers, non-

profit health service plans, health maintenance organizations, or dental plan organizations in Maryland?

☐ Yes ☐ No

15. Is the applicant seeking to obtain certification to administer the internal grievance process on behalf of insurers, non-profit health service plans, health maintenance organizations, or dental plan organizations offering insured plans in Maryland?

☐ Yes ☐ No

16. Submit a list of every insurer, non-profit health service plan, health maintenance organization, and dental plan organization who has delegated the internal grievance process to the applicant. For each entity, provide the complete corporate name and address, the contract commencement date, and the term of the contract. If the applicant does not currently have a contract with any of these entities, please respond "N/A."

PART III: DOCUMENTATION OF POLICIES AND PROCEDURES

17. Identify the specific criteria and standards used in conducting utilization review of proposed or delivered health care services:

(a) For nationally recognized criteria and standards, provide the title, author, publisher, publication date and edition of the criteria and standards being used. Also describe the frequency with which the criteria are updated and evaluated for appropriateness.

(b) For criteria and standards that are internally developed or are otherwise not nationally recognized, submit the following:

- Copies of the specific standards, criteria, and interpretive guidelines being used (electronic submission via a CD or Flash drive is acceptable)
- Dates that the criteria, standards, and interpretive guidelines were developed and last evaluated or updated
- List of the names and professions of the health care providers involved in establishing and updating the specific criteria and standards used for utilization review
- List of written resources used to develop, evaluate, and update the criteria

(c) If the applicant is seeking to obtain certification to perform utilization review for patients covered under insured contracts subject to § 15-839 of the Insurance Article, submit the Maryland-specific criteria and standards for the review of surgical treatment of morbid obesity, as required by COMAR 31.10.33.

(d) If the applicant is seeking to obtain certification to perform utilization review for patients covered under insured health benefit plans that: 1) cover Maryland residents; and 2) include benefits for habilitative services, submit the Maryland-specific criteria and standards for the review of habilitative services for the treatment of autism and autism spectrum disorders, as required by COMAR 31.10.39.

18. Submit a written protocol for ***each*** type of review selected in Question 10. The protocol should describe the entire utilization review process beginning with the time the review personnel receive a request for authorization, through the time that a determination is made to certify or deny the request. The specific time frames in which the applicant makes all determinations should be clearly outlined. Additionally, the types of denials that are statutorily prohibited in Maryland (see §§ 15-10B-06 and 15-10B-07 of the Insurance Article) must be specifically addressed.

19. Submit a copy of all forms that are completed during the review process, including, if applicable, the standard Uniform Treatment Plan form used for the utilization review of mental illness, emotional disorder, and a substance abuse disorder services. Include a description of the purpose of each form and how the form is used by utilization review staff.

20. Identify the types of individuals who are authorized to make adverse decisions (non-certifications). Submit the names and qualifications of the persons authorized to make adverse decisions (attach curriculum vitae or job description). Include a description of the manner in which adverse decisions-makers are compensated.

21. If applicable, describe the procedure for handling an immediate reconsideration of an initial utilization review determination (peer-to-peer review).

22. If the applicant is seeking to obtain certification to issue written notices of adverse decisions on behalf of a carrier as indicated in Question 14, submit a written protocol describing the timing and content of the adverse decision notice. Attach a copy of a sample adverse decision notice to the written protocol. If the answer to Question 14 is "No," please respond "N/A."

23. If the applicant is seeking to obtain certification to administer the internal grievance process on behalf of a carrier as indicated in Question 15, submit a written protocol for the grievance process, which addresses all of the following items. If the answer to Question 15 is "No," please respond "N/A."

(a) Identify the types of individuals who are authorized to make grievance decisions. Submit the names and qualifications of the persons authorized to make grievance determinations (attach curriculum vitae or job description).

(b) Include a description of the timing and content of the grievance determination notice. Attach a copy of a sample grievance decision notice to the written protocol.

(c) Describe the grievance procedure for a non-emergency case.

(d) Describe the grievance procedure for handling an emergency case. The procedure should include information about:

(1) Who will make the determination whether an emergency case exists;

(2) How the determination will be made about the existence of an emergency case;

(3) How the patient, his representative, or health care provider will be notified if the private review agent does not have sufficient information to complete the grievance process, and how it will be communicated to the patient, his representative or health care provider that

the private review agent will assist the patient, his representative or health care provider in gathering the necessary information without further delay; and

(4) How the grievance decision notice will be communicated to the patient, his representative, or health care provider.

24. Identify the types of personnel other than physicians who are either employed or under contract to perform utilization review for the applicant. Submit the names, job titles, and qualifications of all non-physicians performing utilization review.

25. Submit the policies and procedures which ensure that the applicant has an orientation program for nurses, physicians and other health care professionals who are either employed or under contract to perform utilization review.

26. Submit the policies and procedures which ensure that the applicant has a formal program for ongoing training/continuing education for nurses, physicians and other health care professionals who are either employed or under contract to perform utilization review.

27. Submit a sample presentation schedule for orientation and a sample presentation schedule for training for nurses, physicians and other health care professionals.

28. Submit the policies and procedures developed to ensure that all applicable state and federal laws protecting the confidentiality of individual medical records are followed.

29. Submit the policies and procedures developed to ensure that a representative of the applicant is reasonably accessible to patients and providers 7 days a week, 24 hours a day in this State. The procedural guidelines must clearly address how the applicant handles utilization review determination requests during and after business hours, including weekends and holidays. The procedures should describe the qualifications of staff members who handle after-hour requests to

demonstrate that individuals authorized to make after-hour determinations are available when necessary.

30. If applicable, submit the policies and procedures to ensure that an applicant's representative is accessible to health care providers to make all determinations on whether to authorize or certify an emergency inpatient admission, or an admission for residential crisis services, for the treatment of a mental, emotional, or substance abuse disorder within 2 hours after receipt of the information necessary to make the determination. The procedural guidelines must clearly address how the applicant handles utilization review determination requests during and after business hours, and should describe the qualifications of staff members who handle after-hour requests.

31. Submit a copy of the materials (informational pamphlets, booklets, evidence of coverage statements, etc.) designed to inform a patient, his representative, or a health care provider of the requirements of the utilization review plan.

CRITERIA CERTIFICATION

We hereby certify that the criteria and standards used in conducting utilization review are:

(I) objective;

(II) clinically valid;

(III) compatible with established principles of health care; and

(IV) flexible enough to allow deviations from norms when justified on a case by case basis.

I. Medical Director (typed): _____

Signature: _____

II. Responsible Officer of Applicant (typed): _____

Signature: _____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION MAY BE PROSECUTED UNDER APPLICABLE STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR REVOCATION OF CERTIFICATION.

OWNERSHIP DISCLOSURE

Legal Name of Applicant: _____

Trading Name of Applicant: _____

Please submit a list of the names, titles, and addresses of all owners, partners, officers, and directors, as applicable (attach additional pages as necessary)

Name and Title: _____

Business Address: _____

_____

Name and Title: _____

Business Address: _____

_____

Name and Title: _____

Business Address: _____

_____

Name and Title: _____

Business Address: _____

_____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION MAY BE PROSECUTED UNDER APPLICABLE STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR REVOCATION OF CERTIFICATION.

The information required herein is continuing in nature and, as the individual responsible for preparing this document, I agree to furnish an update on any information in this application.

_____
Signature of Preparer

_____
Title Date