Private Review Agent Application for Certification

The items listed below may paraphrase the law or regulation. **The checklist is not required to be filed with the application.** It should be used as a guide in determining which laws and regulations apply to the application. Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland

	Brief Description & Legal Cite	**"X" means missing, incomplete, or incorrect**

A. Application Submission Requirements

A1.	Application fee-$1,500.00 – **§15-10B-04, COMAR 31.10.21.02B(11)**	
A2.	Signed Criteria Certification page – **§15-10B-05(a)(11)**	
A3.	Ownership Disclosure including list of names, titles, and addresses of the officers and directors, where applicable	

B. Scope of utilization review being requested in this State (Application items 5 through 16)

B1.	List of insurers, nonprofit health service plans, health maintenance organizations, and dental plan organizations for which PRA performs utilization review – **§15-10B-05(a)(8)** • Include names, addresses, contract commencement date, and term of the contract	
B2.	List of third party payers for which PRA performs utilization review – **§15-10B-05(a)(8)** • Include names, addresses, contract commencement date, and term of the contract	
B3.	List of third party administrators for which PRA performs utilization review – **§15-10B-05(a)(8)** • Include names, addresses, contract commencement date, and term of the contract	
B4.	If applicable, description of the circumstances under which utilization review has been delegated to a hospital utilization review program – **§15-10B-05(a)(1)(ii)**	
B5.	List of entities, including external review organizations, to which PRA has delegated utilization review decisions • Include names and addresses	

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B6. List of insurers, nonprofit health service plans, health maintenance organizations, and dental plan organizations for which PRA has been delegated the internal grievance process – **§15-10B-05(a)(3); COMAR 31.10.21.02B(1)(i)(ii)** • Include names, addresses, contract commencement date, and term of the contract	

C. Utilization Review Criteria – §15-10B-05(a)(1) (Application Item 17)

C1. If nationally recognized:	
a. Title, author, publisher, and publication date	
b. Frequency in which criteria updated and evaluated for appropriateness	
C2. If internally developed:	
a. Copies of criteria with table of contents	
b. Dates criteria developed	
c. List of providers/health care professionals who were consulted to develop/update the criteria, and their credentials – **§15-10B-05(a)(10)**	
d. List of written resources used to develop, evaluate, and update the criteria	
C3. If performing utilization review for patients covered under health insurance/nonprofit/HMO contracts subject to § 15-839 of the Insurance Article, criteria for the review of surgical treatment of morbid obesity – **COMAR 31.10.33**	
C4. If performing utilization review for patients covered under <u>insured</u> health benefit plans covering Maryland residents that include benefits for habilitative services, criteria and process for the utilization review of treatment for autism and autism spectrum disorders – **COMAR 31.10.39**	
C5. If performing utilization review for patients covered under health insurance/nonprofit/HMO contracts subject to § 15-802 of the Insurance Article, must use the most recent edition of the American Society of Addiction Medicine treatment criteria for addictive, substance–related, and co–occurring conditions ("ASAM criteria") for all medical necessity and utilization management determinations for substance use disorder benefits – **§15-802(d)(5) (amended effective 1/1/20)**	

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C6.	If performing pharmacy utilization review for patients covered under insurance/nonprofit/HMO contracts subject to § 15-142 of the Insurance Article, step therapy or fail first protocols may not be imposed if certain criteria are satisfied – **§15-142(c)**	

D. Time frames – Determinations to authorize or certify – §15-10B-06 (Application item 18)

D1.	A nonemergency course of treatment – within 2 working days after receipt of information necessary to make the determination – **§15-10B-06(a)(1)(i)**	
D2.	An extended stay or additional health care services (concurrent review) – within 1 working day after receipt of information necessary to make the determination – **§15-10B-06(a)(1)(ii)**	
D3.	If prior authorization required for an emergency inpatient or residential crisis admission for treatment of mental health or substance use disorder – within 2 hours after receipt of the information necessary to make the determination – **§15-10B-06(a)(3)**	
D4.	Health care provider must be promptly notified of the determination – **§15-10B-06(a)(1)(iii)**	
D5.	If within 3 calendar days after receipt of the request for authorization of health care services the PRA does not have sufficient information to make the determination, the PRA must inform the provider that additional information must be provided – **§15-10B-06(a)(2)**	

E. Prohibited Adverse Decisions (Application item 18)

E1.	For emergency inpatient admissions, a private review agent may not render an adverse decision solely because the hospital did not notify the private review agent of the emergency admission within 24 hours or other prescribed period of time after that admission if the patient's medical condition prevented the hospital from determining: (1) the patient's insurance status; and (2) if applicable, the private review agent's emergency admission notification requirements – **§15-10B-06(c)**	

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E2.	A private review agent may not render an adverse decision as to an admission of a patient during the first 24 hours after admission when: (i) the admission is based on a determination that the patient is in imminent danger to self or others; (ii) the determination has been made by the patient's physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and (iii) the hospital immediately notifies the private review agent of: 1. the admission of the patient; and 2. the reasons for the admission – **§15-10B-06(d)(1)**	
E3.	A private review agent may not render an adverse decision as to an admission of a patient to a hospital for up to 72 hours, as determined to be medically necessary by the patient's treating physician, when: (i) the admission is an involuntary admission under §§ 10-615 and 10-617(a) of the Health - General Article; and (ii) the hospital immediately notifies the private review agent of: 1. the admission of the patient; and 2. the reasons for the admission – **§15-10B-06(d)(2)**	
E4.	A private review agent may not retrospectively render an adverse decision regarding preauthorized or approved services delivered to a patient unless: (1) the information submitted to the private review agent regarding the services to be delivered to the patient was fraudulent or intentionally misrepresentative; (2) critical information requested by the private review agent regarding services to be delivered to the patient was omitted such that the private review agent's determination would have been different had the agent known the critical information; or (3) the planned course of treatment for the patient that was approved by the private review agent was not substantially followed by the provider – **§15-10B-07(d)**	
E5.	If a course of treatment has been preauthorized or approved for a patient, a private review agent may not revise or modify the specific criteria or standards used for the utilization review to make an adverse decision regarding the services delivered to that patient – **§15-10B-07(e)**	

F. Forms Used to Conduct Utilization Review (Application item 19)

F1.	Copies of forms that are completed during the utilization review process. If PRA performs on-line reviews, printed copies of computer screen shots should be submitted.	

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F2.	If the PRA requires a health care provider to submit a treatment plan in order to conduct utilization review of proposed or delivered services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder, the uniform treatment plan (UTP) form must be submitted – **§15-10B-06(e); COMAR 31.10.21.02-1**	
a.	The PRA may not modify the UTP form, or require the provider to modify the UTP form or submit additional treatment plan forms – **§15-10B-06(e)(ii); COMAR 31.10.21.02-1C and E**	
b.	The PRA must allow the UTP form to be submitted electronically – **§15-10B-06(e)(2)(ii); COMAR 31.10.21.02-1G**	
c.	If telephonic reviews are performed, the PRA may not require the provider to provide any information not requested on the UTP form – **COMAR 31.10.21.02-1I**	

G. Adverse Decision Process (Application items 20, 21, and 22)

G1.	Names and qualifications (job description or CV) of persons making adverse decisions for the following services (where applicable):	
a.	Mental health and substance abuse services – **§15-10B-07(a)(2)**	
b.	Dental services – **§15-10B-07(a)(3)**	
c.	All other services – **§15-10B-07(a)(1)**	
G2.	Adverse decision-makers shall not be compensated by the PRA in a manner that violates §19-705.1 of the Health-General Article or that deters the delivery of medically appropriate care – **§15-10B-07(b)**	
G3.	Reconsideration (optional) – If an initial determination is made by a private review agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, a private review agent may provide the health care provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the health care provider seeking the reconsideration. The discussion, determination, and verbal notice of the determination must take place within 24 hours of the ordering provider's request for the reconsideration – **§15-10B-06(b)**	
G4.	Notice of adverse decision[1]:	

[1] Title 15, Subtitle 10A of the Insurance Article is applicable when the PRA has been delegated the internal grievance process by a carrier and only to adverse decisions for patients covered under insured health benefit plans that are delivered or issued in Maryland.

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a. Document decision in writing after oral communication of the decision has been provided to the member, member's representative, or the health care provider – **§15-10A-02(f)(1)**	
b. Nonemergency case-written notice of the adverse decision sent within 5 working days after the decision was made to the member, the member's representative, and a health care provider acting on behalf of the member – **§15-10A-02(f)(2)**	
c. Emergency case-- written notice of the adverse decision sent within 1 day after the decision has been orally communicated to the member, the member's representative, and a health care provider acting on behalf of the member – **§15-10A-02(j)(1)**	
G5. Content of written notice of adverse decision: **§15-10A-02(f)(2)** • Must include sample adverse decision letter	
a. The specific factual bases for the decision in detail in clear, understandable language	
b. Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based. May not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary."	
c. The name, business address, and business telephone number of: i) the medical director or associate medical director who made the decision if the PRA has been delegated the adverse decision process by a Maryland HMO; or ii) the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the PRA has been delegated the adverse decision process by a carrier that is not an HMO	
d. Written details of the internal grievance process, including a statement that a complaint may be filed with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if: 1) the carrier waives the requirement that the carrier's internal grievance process be exhausted before filing a complaint with the Commissioner; or 2) the carrier has failed to comply with any internal grievance process requirements. – **§15-10A-02(d)(1)(i)**	
e. A statement that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision	

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f. A statement that a complaint may be filed without first filing a grievance if the member, the member's representative, or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner	
g. The Commissioner's address, telephone number, and facsimile number	
h. The disclosure required by COMAR 31.10.18.04 in at least 12-point typeface, with the first sentence in bold capital typeface. The disclosure should be revised as follows to conform to the amended definition of "compelling reason" in COMAR 31.10.18.11: "**THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES**. You may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at (phone number, address, fax, e-mail). The Health Advocacy Unit can help you, your representative, and your health care provider prepare a grievance to file under the carrier's internal grievance procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process. Additionally, you, your representative, or your health care provider may file a complaint with the Maryland Insurance Administration, without having to first file a grievance with the plan, if: (1) The plan has denied authorization for a health care service not yet provided to you; and (2) You, your representative, or your provider can show a compelling reason to file a complaint, including that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the member to be in danger to self or others, or the member continuing to experience severe withdrawal symptoms. INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN (cite policy, plan, certificate, enrollment materials, or other evidence of coverage)."	
i. Notice must be sent in a culturally and linguistically appropriate manner as described in the federal Affordable Care Act – **§15-10A-10**	

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H. Internal Grievance Process[2] (Application item 23)

H1.	Names and qualifications (job description or CV) of persons making the grievance decisions for the following services (where applicable):	
a.	Mental health and substance abuse services – **§15-10B-09.1(3)**	
b.	Dental services – **§15-10B-09.1(2)**	
c.	All other services – **§15-10B-09.1(1)**	
H2.	Must allow a member's representative or a health care provider to file a grievance on behalf of a member – **§15-10A-02(b)(2)(iii)**	
H3.	For retrospective decisions, must allow at least 180 days after receipt of adverse decision to file a grievance – **§15-10A-02(b)(2)(v)**	
H4.	Information Regarding Emergency Case Grievances	
a.	Who will make the determination whether an emergency case exists – **COMAR 31.10.18.07B(1)**	
b.	How the determination will be made about the existence of an emergency case – **COMAR 31.10.18.07B(2)**	
c.	How the member, member's representative or health care provider will be notified if the carrier does not have sufficient information to complete its internal grievance process – **COMAR 31.10.18.07B(3)**	
d.	How the PRA will notify the member, member's representative or health care provider that the PRA will provide assistance in gathering necessary information without further delay in cases where the PRA maintains that insufficient information has been submitted – **COMAR 31.10.18.07B(3)**	
e.	How the notice will be communicated to the member, member's representative, and health care provider – **COMAR 31.10.18.07B(4)**	
H5.	Timing of grievance decision:	
a.	Emergency case-24 hours of the date a grievance is filed – **§15-10A-02(b)(2)(i)**	

[2] Title 15, Subtitle 10A of the Insurance Article is applicable when the PRA has been delegated the internal grievance process by a carrier and only to grievance decisions for patients covered under insured health benefit plans that are delivered or issued in Maryland.

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b. Nonemergency case prospective denial-30 working days after the filing date. The PRA may have an extension not to exceed 30 working days with the member's, member's representative's or health care provider's written approval – **§§15-10A-02(b)(2)(ii), 15-10A-02(h)**	
c. Nonemergency case retrospective denial-45 working days after the filing date. The PRA may have an extension not to exceed 30 working days with the member's, member's representative's or health care provider's written approval – **§§15-10A-02(b)(2)(iv), 15-10A-02(h)**	
d. Insufficient Information - The PRA is required to notify the member, member's representative or a health care provider filing a grievance on behalf of a member within 5 working days of the filing date if more information is required and assist the member, member's representative, or health care provider in gathering the information without further delay – **§15-10A-02(g)**	
H6. Notice of grievance decision:	
a. Emergency case- written notice of grievance decision must be sent within one day after the decision has been orally communicated to member, member's representative or health provider – **§15-10A-02(j)**	
b. Nonemergency case- document grievance decision in writing after oral communication has been communicated to member, member's representative or health care provider acting on behalf of the member. Send written notice within 5 working days after the grievance decision is made to member, member's representative and a health care provider acting on behalf of the member – **§15-10A-02(i)(1)**	
H7. Content of written notice of grievance decision: **§15-10A-02(i)(1)(ii)** • Must include sample grievance decision letter	
a. The specific factual bases for the decision in detail in clear, understandable language	
b. Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based	
c. The name, business address, and business telephone number of : 1) the medical director or associate medical director who made the decision if the PRA has been delegated the grievance process by a Maryland HMO; or ii) the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the PRA has been delegated the grievance process by a carrier that is not an HMO.	

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d. A statement that that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision	
e. The Commissioner's address, telephone number, and facsimile number	
f. A statement that the Health Advocacy Unit is available to assist the member or the member's representative in filing a complaint with the Commissioner	
g. The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit	
h. Notice must be sent in a culturally and linguistically appropriate manner as described in the federal Affordable Care Act – **§15-10A-10**	
H8. Definitions:	
a. Compelling Reason – **COMAR 31.10.18.11 (amended effective 7/30/18)**	
b. Emergency Case – **COMAR 31.10.18.02B(4), COMAR 31.10.18.05A (amended effective 7/30/18)**	
c. Filing Date – **COMAR 31.10.18.02B(5)**	

I. Other Required Information (Application items 24 through 31)

I1.	The types and qualifications of personnel either employed by or under contract to perform utilization review – **§15-10B-05(a)(2)** • There must be a sufficient number of registered nurses, medical records technicians, or similarly qualified persons supported and supervised by appropriate physicians to carry out the PRA's utilization review activities – **§15-10B-11(5)**	
I2.	The policies and procedures to ensure that the private review agent has a formal program for the orientation of the personnel either employed or under contract to perform the utilization review – **§15-10B-05(a)(9)** • Submit a sample presentation schedule or agenda for the orientation program	
I3.	The policies and procedures to ensure that the private review agent has a formal program for the training of the personnel either employed or under contract to perform the utilization review – **§15-10B-05(a)(9)** • Submit a sample presentation schedule or agenda for the training program	

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I4.	The policies and procedures to ensure that all applicable State and federal laws to protect the confidentiality of individual medical records are followed – **§15-10B-05(a)(6)**	
I5.	The procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and health care providers 7 days a week, 24 hours a day in this State – **§15-10B-05(a)(4)**	
I6.	If applicable, the procedures and policies to ensure that a representative of the private review agent 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 as defined in § 15-840 of this title, for the treatment of a mental, emotional, or substance abuse disorder within 2 hours after receipt of the information necessary to make the determination – **§15-10B-05(a)(5)**	
I7.	A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan – **§15-10B-05(a)(7)**	