MARYLAND CERTIFICATE OF REGISTRATION FOR PRIVATE REVIEW AGENTS

COMPILING AND FORMATTING THE APPLICATION

In order to be approved for certification, the applicant must be able to demonstrate compliance with Maryland's laws and regulations. The application should be submitted in the following manner:

- Cover letter
- Table of Contents
- Body of the Application--The body of the application should be sequenced according to the questions noted in the application.
- Attachments--Place each attachment in the section within the body of the application to which it pertains.
- Miscellaneous Information--Information that is unrelated to the certification process *will not* be reviewed.

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GUIDELINES

I. APPLICATION OVERVIEW

A. FILING REQUIREMENTS

Persons or entities performing utilization review in the State of Maryland are required under §§15-1001 and 15-10B-03(a) of the Insurance Article to obtain a certificate of registration by the State Insurance Commissioner. In Maryland, utilization review includes reviews and decisions rendered by external review organizations. The term utilization review includes decisions to certify or authorize health care services, adverse decisions, and grievance decisions.

B. SUBMITTING THE APPLICATION

A new applicant or a private review agent seeking re-certification should submit an application following the instructions provided in this application packet.

A check or money order in the amount of $1,500.00, made payable to the Maryland Insurance Administration, must accompany each application.

Your Maryland certificate of registration is not transferable and expires on the second anniversary of its effective date, unless renewed for another 2-year term. If this is your renewal application, it must be a complete application, with any changes from the previous application clearly noted. *This is also applicable to any revisions or submissions of the application during the review period.*

A certificate holder is required under §15-10B-05 of the Insurance Article to:

- Submit any newly adopted criteria or standards to the Commissioner at least 10 days before using the newly adopted criteria or standards.
- Submit any revised or modified criteria and standards to the Commissioner at least 10 days before using the revised or modified criteria and standards.
- Advise the Commissioner, in writing, of any change in:
    1. ownership, medical director, or chief executive officer within 30 days of the date of the change;
    2. the name, address, or telephone number of the private review agent within 30 days of the date of the change; or
    3. the private review agent's scope of responsibility under a contract**.**

II. PREPARATION GUIDELINES FOR APPLICANTS

The applicant should read through the entire application packet prior to developing its application, in order to understand the application review process.

If the applicant needs assistance in interpreting Maryland laws and regulations or has questions or concerns about the application process, the applicant may contact the analyst reviewing the application.

Because a certificate issued under Title 15, Subtitle 10B of the Insurance Article relates only to utilization review activities, only information that is specific to utilization review services should be provided. All narrative descriptions, policies and procedures, and other documentation included in the application should be submitted with this focus in mind. Information outside the scope of the requirements for certification will not be reviewed.

Utilization review in Maryland is defined as a system for reviewing the appropriate and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients. This includes external reviews of health care resources and services.

Accreditation by the American Accreditation HealthCare Commission/URAC (URAC) or the National Committee for Quality Assurance (NCQA) does not satisfy the requirements for certification in Maryland.

The applicant must designate a contact person to respond to inquiries from the Maryland Insurance Administration. The contact person should be knowledgeable in both the clinical and administrative aspects of the applicant's UM process, as well as the requirements of Maryland law. The contact person should have the authority to speak on behalf of the applicant and to quickly make the changes necessary to implement any corrections required to comply with Maryland law.

Because a large portion of utilization management (UM) is related to clinical processes, the applicant's clinical personnel should be involved in preparing the application. Due to the complexity of the laws and regulations, a regulatory compliance analyst or a designee in the legal department may be helpful in preparing a compliant application.

Prior to submitting the application, it is recommended that the applicant’s legal, administrative and clinical personnel review it for completeness, compliance, accuracy and consistency.

In Maryland, utilization review is defined in such a manner that it includes reviews conducted by independent review or external review organizations that are affiliated with, under contract with, or acting on behalf of a Maryland business entity, or a third party that pays for, provides, or administers health care services to citizens in this State.

Applicants who subcontract or delegate any aspect of utilization review must provide the following information:

- name(s) of the subcontracted entity;
- description of those aspects of the service review process that are subcontracted and those that the applicant maintains;
- a description of the applicant's oversight responsibilities; and
- a list of the clinical criteria and standards used by the subcontracted entity.

Separate from the applicant's review procedures manual, must be an overview (narrative description) of the applicant's utilization review process. This description should begin with the time the UM review personnel receive a request for pre-authorization or authorization, through the time that a determination is made to certify or deny the request.

All attachments and forms submitted with the application should be attached, where appropriate, with a description of their use.

III. CERTIFICATION GUIDELINES

The requirements for certification are addressed by the questions on the application. The applicant is required to submit information specific to the question being asked.

If an application is found to be incomplete, or the information provided is unclear or is insufficient to demonstrate compliance in any given area, the analyst will draft a comment letter requesting revisions to the current policies and procedures, additional information and/or clarification.

Incomplete, unclear or poorly organized applications dramatically slow down the certification process. Therefore, it is *strongly* recommended that the applicant conduct a self-audit to determine if the application materials are in compliance with Maryland law, and that any corrections or revisions to the company's policies are responsive.

IV. APPLICATION

Below are guidelines to assist applicants with filing requirements.

In conjunction with the application, the applicant shall submit information that the Commissioner requires including:

1. ***A utilization review plan that includes a written protocol describing each type of review performed. Refer to Items 9 and 10b of the application. See §15-10B-06 of the Insurance Article.***

Submit the following documentation as evidence of meeting this requirement:
Written protocols for all items checked in Item 9 of the application. The protocol should define the type of review conducted. The descriptions of the protocols for the types of review conducted in Item 9 of the application must include information regarding the time frames in which decisions to certify or authorize health care services are made. The protocols should also include the time frame and the manner in which the patient, facility and physician are notified of the applicant's decision to authorize services.

2. Copies of specific criteria and standards used in conducting utilization review. Refer to Item 10a of the application. See §15-10B-05(a)(1) of the Insurance Article.

Submit the following documentation as evidence of meeting this requirement:

1. If the criteria and standards are nationally recognized, submit a list of interpretive guidelines. Identify the title, author, publisher, publication date and edition of the criteria and standards being used.

2. If the criteria and standards are not nationally recognized, submit copies of specific standards, criteria, and interpretive guidelines that were developed by your organization. Include the date that the criteria, standards, and interpretive guidelines were developed. Submit a copy of the names and professions of the health care providers involved in establishing the specific criteria and standards used for utilization review.

Points to Consider:

1. The documentation must support the fact that they are established, and periodically evaluated and updated.

2. For internally developed criteria submit:
   a. A list of the written resources used to develop, as well as to evaluate and update the criteria;
   b. A list of the providers or health care professionals who were consulted to develop, as well as to update the criteria, and their credentials;
   c. The date the criteria were developed, as well as last evaluated and updated; and
   d. A Table of Contents.

3. For commercial/nationally recognized criteria, the frequency in which the applicant:
   a. Obtains criteria set updates/revisions, and;
   b. Re-evaluates the criteria's appropriateness.

4. Comprehensive narrative description of how the service review personnel apply the criteria set(s)/standards/guidelines either alone or in combination with one another to make authorization determinations.

3. The forms that are completed during the review. Refer to Item 10d of the application.

Submit the following documentation as evidence of meeting this requirement:

1. Forms used to complete the utilization review process.
2. If the company performs on-line reviews, print the computer screen and submit the information for review.

Points to Consider:

If the applicant conducts utilization review of behavioral health services, submit the authorization form that the applicant requires health care providers to complete for authorization.

4. A written protocol describing the applicant's internal grievance process. Refer to Items 10c and 10f of the application. See §§15-10A-02 through 15-10A-05, 15-10B-07, 15-10B-08 and 15-10B-09.1 of the Insurance Article.

Submit the following documentation as evidence of meeting this requirement:

A. Adverse Decisions:

1. Describe the process by which an adverse decision is made for non-emergency and emergency cases.
2. Submit the names and qualifications of the persons who are authorized to make adverse decisions.

   Submit the following documentation as evidence of meeting this requirement:

   - ♦ List of the physicians employed by your organization, as well as your contracted/subcontracted physician/mental health professional/dental consultants, their specialty/subspecialty and areas of expertise.
   - ♦ Job description for the applicant's medical director(s).
   - ♦ Job descriptions for all physician consultants involved in the service reviews, including initial adverse and grievance decisions.
   - ♦ If job descriptions are not available for the contracted/subcontracted physicians, mental health professionals and dental consultants, submit the curriculum vitae. If CVs are not available, provide a narrative description related to their required qualifications.
3. Include a description of the timing and content of the notice of an adverse decision.

B. Grievance Decisions for Non-Emergency Cases:

1. Describe the grievance procedure for a non-emergency case.
2. Submit the names and qualifications of the persons who are authorized to make grievance determinations.

   Submit the following documentation as evidence of meeting this requirement:

   - ♦ List of the physicians employed by your organization, as well as your contracted/subcontracted physician/mental health professional/dental consultants, their specialty/subspecialty and areas of expertise.
   - ♦ Job description for the applicant's medical director(s).

- ♦ Job descriptions for all physician consultants involved in the service reviews, including initial adverse and grievance decisions.
- ♦ If job descriptions are not available for the contracted/subcontracted physicians, mental health professionals and dental consultants, submit the curriculum vitae. If CVs are not available, provide a narrative description related to their required qualifications.

3. Include a description of the timing and content of the notice of a grievance determination.

C. Grievance Decisions for Emergency Cases:

1. Describe the procedure for handling an emergency case.
2. The grievance procedure should include information about:
   (i) Who will make the determination whether an emergency case exists;
   (ii) How the determination will be made about the existence of an emergency case;
   (iii) 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
   (iv) How the patient, his representative, or health care provider will be notified of the grievance decision.

D. Peer to Peer Consultations/Reconsideration:

Describe the procedure for handling a reconsideration of a utilization review determination.

6. The type and qualifications of persons performing utilization review. This requirement generally relates to non-physicians. If physicians other than those described in Item 10c are used, include them here. Refer to Items 10g and 10h of the application. See §15-10B-05(a)(2) and 15-10B-11(5) of the Insurance Article.

<u>Submit the following documentation as evidence of meeting this requirement:</u>

1. Statement or listing indicating the "types" of personnel who conduct service review activities, i.e., RN, MSW, Ph.D., paraprofessional, including:
   - Number of full time personnel doing reviews
   - Number of part time personnel doing reviews
2. Physician/mental health professional/dental consultants, their specialty/subspecialty and areas of expertise.
3. Job description for the applicant's medical director(s).
4. Job descriptions for all physician consultants involved in the service reviews, including initial adverse and grievance decisions.
5. If job descriptions are not available for the contracted/subcontracted physicians, mental health professionals and dental consultants, submit the curriculum vitae. If

CVs are not available, provide a narrative description related to their required qualifications.

7. The policies and procedures that ensure that the applicant has a formal program for orientation <u>and</u> training for nurses, physicians and other health care professionals. Refer to Item 10i and j of the application. See §15-10B-05(a)(9) of the Insurance Article.

<u>Submit the following documentation as evidence of meeting this requirement:</u>

1. Submit the policies which state that there is a formal program for orientation and training for physicians and non-physicians relating to how the applicant performs utilization review.
2. Submit the *procedural guidelines* that the applicant has in place to ensure that there is a formal program for orientation and training for physicians and non-physicians relating to utilization review.
3. Submit the policies supporting the education of personnel regarding utilization review.
4. Submit the content of the new employee (professional, paraprofessional and administrative support personnel) and contracted/subcontracted consultant orientation and training programs related to utilization review.

8. An outline of the presentation schedule for orientation <u>and</u> training for nurses, physicians and other health care professionals. Refer to Item 10k of the application.

<u>Submit the following documentation as evidence of meeting this requirement:</u>

Submit a sample outline presentation schedule or agenda for an orientation program **and** a training program.

9. A copy of the materials designed to inform a patient or health care provider of the requirements of the utilization review plan. Refer to Item 10l of the application. See §15-10B-05(a)(7) of the Insurance Article.

<u>Submit the following documentation as evidence of meeting this requirement:</u>

1. A copy of the materials designed to inform a patient or health care provider of the requirements of the utilization review plan.
2. Include any pamphlets, booklets, evidence of coverage statements, etc.

10. A copy of the policies and procedures developed to ensure that the applicant's representative is reasonably accessible to patients and providers 24 hours a day, 7 days a week in this State. Refer to Item 10m of the application. See §15-10B-05(a)(4) of the Insurance Article.

<u>Submit the following documentation as evidence of meeting this requirement:</u>

1. Submit the policies which state that there is a 24 hours a day, 7 days a week availability policy.

2. Submit the *procedural guidelines* that the applicant has in place to ensure that there is a *person* available 24 hours a day 7 days per week.

Points to Consider:

1. The procedural guidelines should include the steps that the applicant has in place to ensure that there is compliance with this requirement.
2. The procedural guidelines must address how the applicant handles requests during and after business hours, including weekends and holidays. Weekend and holidays are not exempt in any manner from any of the time frames imposed in the Statute and regulations.
3. Any 24-hour time frame requirement begins with the date and time the request is made, and refers to actual time and not business hours.

11. If the applicant conducts utilization review of behavioral health services, a copy of the policies and procedures to ensure that the 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. Refer to Item 10n of the application. See §15-10B-05(a)(5) of the Insurance Article.

Submit the following documentation as evidence of meeting this requirement:

1. The applicant may send a separate policy and procedure to comply with this requirement or may include the procedure as a part of its 24/7 accessibility procedures.
2. The policy must show compliance with the 2-hour timeframe for determinations. The procedural guidelines must address how the applicant handles requests during and after business hours, including weekends and holidays. Weekend and holidays are not exempt in any manner from the 2 hour time frame.

12. A copy of the policies and procedures developed to ensure that the all applicable State and federal laws protecting the confidentiality of individual medical records are followed. Refer to Item 10o of the application. See §15-10B-05(a)(6) of the Insurance Article.

Submit the following documentation as evidence of meeting this requirement:

1. Submit the policies supporting the education of personnel about confidentiality of all medical records prior to the handling of these records.
2. Content of the new employee (professional, paraprofessional and administrative support personnel) and contracted/subcontracted consultant orientation and training programs related to confidentiality of a patient's medical records.
3. Policies and procedural guidelines for handling medical records.
4. Identify a person in management that is responsible for ensuring compliance with the applicant's policies and procedures regarding confidentiality.