



PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF MANAGED CARE
"Interim"

APPLICATION FOR CERTIFICATION AS A UTILIZATION REVIEW ENTITY

NOTE: Act 68 gives utilization review (UR) entities, subject to the Act and operating in Pennsylvania prior to January 1, 1999, until January 1, 2000, to apply for certification.

UR entities wishing to pursue the option to conduct external grievance reviews of consumer appeals must also complete the additional questions on the supplement to this application and be certified before being placed on a rotational list for such reviews.

INSTRUCTIONS

The application is divided into five (5) parts and a supplement:

- Part I - General Information
- Part II - Organization and Structure
- Part III - Narrative/Demonstration of Compliance with Standards
- Part IV - Attachments
- Part V - Statements of Responsibility (Certifications)
- Supplement - Assignment of External Grievance Appeals

Complete the responses to the questions in Part I in the spaces provided. To answer the questions in Parts II-IV and the Supplement, please submit narrative and attachments (labeled to correspond with questions).

Part V must be signed and dated.

When the application has been completed, submit the original and one (1) copy to:

Pennsylvania Department of Health
Bureau of Managed Care
Attn: Utilization Review Certification
Room 909 Health and Welfare Building
7th and Forster Streets
Harrisburg, PA 17120

Any material change of information set forth in this application will require notification to the Department of Health, at the above address, within thirty (30) days of the change.

Part I: GENERAL INFORMATION

1. Specify the name, address, telephone number and fax number of the entity as it should appear on the Department's official list of certified UR entities:

2. Enter the name, title, address, direct telephone number and fax number of the primary contact person to answer questions concerning the application:

3. Specify the location (address) of your principal office which will be conducting Pennsylvania UR business:

4. If your entity is currently approved, certified or accredited for conducting UR by a nationally recognized accrediting body, specify the name(s) of the organization(s):

Attach a copy of any such approval, certification or accreditation.

5. If currently operating in Pennsylvania, indicate the length of time in operation:

6. If applicable, list each managed care plan in Pennsylvania for which your entity currently conducts utilization review:

7. List three (3) clients in Pennsylvania for which your entity has conducted utilization review. Include the name, address, telephone number and position of contact persons for such clients: (This information may be used for reference purposes to assess past performance, especially its ability to meet review time frames.)

8. List all other States where you have received required certification to conduct UR activities:

Have you ever been sanctioned or had your authority suspended in another State? If yes, explain.

Part II: ORGANIZATION AND STRUCTURE
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1. Provide a copy of the articles of incorporation and bylaws (or similar documents) which regulate the internal affairs of the entity.
- 2.* Provide a chart showing the internal organizational structure of the entity's management and administrative staff.
- 3.* Submit biographical information (curriculum vitae) about the entity's officers, directors and executives.
4. If the entity is publicly held, supply the name of each stockholder or owner of more than five (5) percent of any stock or options.
- 5.* Provide the name and type of business of each corporation or other organization that the entity controls or with which it is affiliated .
 - A. Describe the nature and extent of the affiliation or control.

- B. Provide a chart or document which clearly identifies the relationship between your entity and each corporation or organization listed.
6. Provide a utilization review plan that includes a summary description of review guidelines, protocols and procedures, standards and criteria to be used in conducting utilization review activities in PA. Also, describe your mechanism for assessing the interrater reliability of reviewers in order to assure consistency in decision making.

* **NOTE:** *Information provided in response to these questions may be stamped as “confidential and proprietary” and not subject to public disclosure.*

Part III: COMPLIANCE WITH STANDARDS
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1. Describe the entity’s ability to:
 - A. Provide toll-free telephone access at least 40 hours per week during normal business hours;
 - B. Maintain a telephone answering service or recording system during non-business hours; and
 - C. Respond to each telephone call received by an answering service or recording system within one (1) business day of receipt of the call.
2. Describe the entity’s ability to comply with confidentiality provisions of the Act and all other applicable state and federal laws governing confidentiality.
3. Describe the entity’s procedures for protecting the confidentiality of medical records.
4. Explain the entity’s procedures for ensuring that a health care provider is able to verify that an individual requesting information on behalf of the managed care plan is a legitimate representative of the UR entity/plan.
5. Describe the entity’s ability, addressing staffing and resources, to meet the time frames specified in the Act, specifically:
 - A. Completion and communication of the results of a prospective UR decision within two (2) business days of the receipt of all supporting information necessary to complete the review;
 - B. Completion and communication of the results of a concurrent review within one (1) business day of the receipt of all supporting information necessary to complete the review; and
 - C. Completion and communication of the results of a retrospective UR decision within thirty (30) days of the receipt of all supporting information necessary to complete the review.
6. Describe the entity’s ability to notify the health care provider (within 48 hours of receipt of a request for review) of the need for additional facts or documents to complete its review.

7. Discuss the entity's system for ensuring that personnel conducting a utilization review have current licenses or other required credentials in good standing, without restrictions, from the appropriate agencies.
8. If the UR entity proposes to utilize licensed psychologists to perform utilization reviews for behavioral health care services, it must request approval to do so. The request shall include: a description of the credentialing criteria and process the entity utilizes to ensure that a behavioral health service reviewed by the psychologist falls within the psychologist's scope of practice; that his/her clinical experience is sufficient to review specific cases assigned; and any other standards the entity has adopted for approval of its licensed psychologists. The request shall also certify that no licensed psychologist shall review the denial of payment for inpatient health care or a prescription drug.
9. Explain the entity's system for maintaining a written record of UR decisions adverse to enrollees, including a detailed justification for the decision and all required notifications to the health care provider and the enrollee, for a period not less than three (3) years; to provide to the Department, if requested, these adverse decision records; and, to provide summary information and data on all grievance appeals decided.

Part IV: ATTACHMENTS

1. Include all attachments under Part IV.
2. Label attachments to correspond with the Part, number and letter of the item to which you are responding.
3. Label any attachments relating to the "Supplement" accordingly.

Part V: STATEMENTS OF RESPONSIBILITY

The following must be signed by an official authorized by the applicant to make such certification:

1. All utilization review activities shall be conducted in accordance with the requirements of Act 68 and the Statement of Policy, including the confidentiality provisions;
2. Any utilization review decision which results in the denial of payment for a health care service shall be made by a licensed physician or approved licensed psychologist; any decision not resulting in a denial shall be made by persons having appropriate credentials or licenses in good standing;
3. All external grievance decisions shall be made by one or more licensed physicians or approved licensed psychologists in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed (applicable only to entities seeking certification to conduct external grievance appeals);
4. Compensation from a managed care plan to conduct UR services shall not contain incentives, direct or indirect, for the UR entity or any employee, consultant or other person performing services on its behalf, to approve or deny payment for the delivery of any health care service; and
5. All data, information and statements in this application for certification are factual to the best of my knowledge, information and belief.

Date

Signature

Name (Printed)

Title or Position

**SUPPLEMENT TO APPLICATION
FOR UR ENTITIES TO BE ASSIGNED EXTERNAL GRIEVANCE
APPEALS**

1. If your agency is to be placed on a rotational list to receive and decide grievance appeals, indicate which category it meets:

- _____ (a) Receive and decide any and all grievance appeals
- _____ (b) Receive and decide only behavioral health appeals (mental health and drug and alcohol related)

2. Specify the name, title, address, direct telephone number and fax number of a primary and at least one back-up designee for the purpose of prompt communication regarding assignment of grievance appeals:

- (a) Primary: Name: _____
Title: _____
Address: _____
Telephone #: _____
Fax #: _____
- (b) Back-up: Name: _____
Title: _____
Address: _____
Telephone #: _____
Fax #: _____

3. List and describe any potential conflict of interest which would preclude the entity's review of an external grievance for a managed care plan (e.g. ownership or affiliation with a competing MCO or health insurance company).

4. Describe the entity's ability to have available, either through written agreement or other acceptable means, an adequate mix of appropriately licensed and credentialed reviewers to effectively conduct UR for all types of health care appeals, or behavioral health appeals only, in compliance with the

requirements established by the Act and Statement of Policy.

In particular, that an external grievance decision shall be made by: (i) licensed physicians or approved licensed psychologists in active clinical practice in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed; or (ii) physicians currently certified by a board approved by the American Board of Medical or Osteopathic Specialists in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed.

5. Indicate the entity's agreement to provide information to the Department, upon request, regarding fees charged for UR services. This information will be used for the purpose of comparing fees among all certified UR entities in response to a complaint by a managed care plan, enrollee or provider that the fees of a particular certified UR entity are excessive. *(This fee information shall be confidential and proprietary.)*
6. Describe the entity's ability and commitment to maintain all information obtained in the review of grievance appeals, including outcomes, confidential from affiliated entities or persons who may be direct or indirect competitors to any managed care plan being reviewed.
7. Describe the entity's ability to meet the sixty (60) day time frame specified in Act 68 to complete and communicate in writing, a decision regarding an external grievance appeal to the appropriate parties which contains the basis and clinical rationale for the decision.