UTILIZATION REVIEW LICENSE APPLICATION

The format below must be followed in preparing an application for a license to conduct utilization review. Applications should be completed as directed, signed and acknowledged by the applicant's president or other duly authorized representative. Applications will not be considered complete until all required information is submitted. Completed applications must be returned to:

Regular mail: Connecticut Insurance Department, Life & Health Division, PO Box 816, Hartford, CT 06142-0816
Overnight mail or hand delivery: 153 Market St., 7th Floor, Hartford, CT 06103

ALL UTILIZATION REVIEW LICENSES EXPIRE ANNUALLY ON DECEMBER 31ST.

Name of Company: _____

Address: _____

_____

Telephone: _____ **Toll Free**: _____

Business Hours (eastern time**)** _____

Contact Person: _____ **Direct #:** _____

e-mail address: _____

The following information is submitted as evidence of compliance with the requirements found in the most recently amended versions of Section §§38a-591a et seq. of the Connecticut General Statutes (C.G.S.) in support of the application for licensing of the above named company. Please note that any material change in the information in a request for licensure or renewal must be filed with the Insurance Commissioner within 30 calendar days after the change. Please note that all responses, letters and data provided should be Connecticut specific. Applications that include processes, letters or data for jurisdictions other than Connecticut will be rejected.

THE APPLICATION AND ALL SUPPORTING MATERIALS MUST BE CONNECTICUT SPECIFIC FOR FULLY INSURED PLANS. ANY APPLICATION THAT CONTAINS PROVISIONS REGARDING JURISDICTIONS OUTSIDE OF CONNECTICUT OR FOR SELF-FUNDED PLANS WILL BE REJECTED.

IF YOUR COMPANY PROVIDES UTILIZATION REVIEW SERVICES FOR BOTH MEDICAL/SURGICAL SERVICES AND MENTAL HEALTH/ SUBSTANCE ABUSE DISORDERS, YOU MUST SEPARATELY NOTE PROCEDURES FOR EACH CATEGORY OF SERVICES IN ALL RESPONSES AS THE REQUIREMENTS HAVE BEEN EXPANDED OR MODIFIED FOR MENTAL HEALTH/SUBSTANCE ABUSE SERVICES.

Provide the information required for each of the following items:

1. Verify that the utilization review program uses documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically. Indicate whether the company has developed its own clinical criteria or if purchased, provide the name of the vendor(s).
2. Verify that clinical review criteria and links to any rule, guideline, protocol or other similar criterion relied upon to make an adverse determination are posted on the company's web site.
3. Verify that clinical review criteria will be made available upon request to authorized government agencies.
4. A. Describe the company's procedures for standard and expedited/urgent care requests for providing notification for each of the following:

    1) Prospective Determinations
    2) Concurrent Determinations
    3) Retrospective Determinations

    B. Verify that in accordance with C.G.S. Section §38a-591c and §38a-591d that the health plan or its designated utilization review agent shall:

    1) Contract with health care professionals to administer the utilization review program. Describe procedures to ensure the appropriate professionals are being designated to conduct the review and are applying the clinical review criteria consistently.
    2) Contract with clinical peers to evaluate the clinical appropriateness of an adverse determination. Include a description of how the company assures that an appropriate clinical peer is available to conduct such evaluations.
    3) Collect only information necessary, including pertinent clinical data, to make the utilization review or benefit determination.
    4) Ensure that such review is conducted in a manner to ensure the independence and impartiality of the individual or individuals involved in making the utilization review or benefit determination.
    5) Have all appeals conducted and evaluated by a clinical peer that was not involved in the initial or previous adverse determination.
    6) Make no decisions regarding the hiring, compensation, termination, promotion or other similar matters of such clinical peers based on the likelihood that such peers will support the denial of benefits.
    7) Have data systems sufficient to support the utilization review program activities and to generate management reports.
    8) Provide covered persons and participating providers with access to its utilization review staff through a toll-free number or by electronic means.
    9) Coordinate the utilization review program with other medical management activity such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures and process for assessing member satisfaction and risk management.
    10) Routinely assess the effectiveness and efficiency of the utilization review program.

    C. Verify that the company is in compliance with timeframes and notification processes for initial reviews (standard and expedited/urgent).

    Please note that C.G.S. §38a-591defines an urgent request as a request: For which the time period for a non-urgent care request could seriously jeopardize the life or health of covered person or the ability to regain maximum function, or

1) That in the opinion of a health care professional with knowledge of the covered persons medical condition, the time period for non-urgent requests would subject the covered person to severe pain that cannot be managed without the service or treatment being requested, or
2) For a Substance Use Disorder, as described in section §17a-458, C.G.S., or for co-occurring Mental Disorder, or
3) For a Mental Disorder requiring (i) inpatient services, (ii) partial hospitalization, as defined in section §38a-496, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.

5. Attach sample copies of approval notices sent to covered persons and, if applicable, the covered person's authorized representative/provider of record.

6. Attach sample copies of all adverse determination notices (initial denial through final appeal) sent to covered persons and, if applicable, the covered person's authorized representative/provider of record. The notices must be Connecticut-specific and include a brief description of all appeal rights including the timeframes for filing, the next steps to initiate the appeal and the name and toll-free number of the department responsible for administering the appeal.

   All determination notices must be clear as to who the Utilization review entity and the carrier is within the notice.

   All adverse determination notices must include a statement that such appeals are sometimes successful and that the covered person or authorized representative may benefit from free assistance the Office of the Healthcare Advocate in filing a grievance. In accordance with Bulletin HC-98, the Department requests that the notice also include contact information for the Consumer Affairs Division of the Connecticut Insurance Department. The notice must also state that the covered person or authorized representative has the right to ask their health care professional for narratives, letters and treatment notes and is encouraged to submit such documentation for the health carrier's consideration during the review of an adverse determination.

   The contact information is shown below:

   State of Connecticut Insurance Department
   Consumer Affairs Unit
   PO Box 816
   Hartford, CT 06142-0816
   Tel: 860-297-3900 or 1-800-203-3447
   cid.ca@ct.gov

   State of Connecticut
   Office of the Healthcare Advocate
   PO Box 1543
   Hartford, CT 06144
   1-866-466-4446
   Healthcare.advocate@ct.gov

   In addition, the final denial letter must include:

1) a statement that all internal appeals have been exhausted;
2) the CPT/ICD-9 diagnostic code(s) relating to the denial; and
3) a copy of the consumer guide and external review application published by the Insurance Department regarding the external review process. To download a copy of the external review consumer guide and application for reproducing and distribution, please access the Department web site at: http://www.ct.gov/cid/lib/cid/External_Appeal_Consumer_Guide.pdf (guide) and http://www.ct.gov/cid/lib/cid/External_Review_Application.pdf (application).

All notices of adverse determination must include a copy of the specific rule, guideline, protocol, or other similar criterion relied upon to make the determination or include a statement that a specific rule, guideline, protocol or other similar criterion was relied upon and will be provided free of charge upon request. All notices of adverse determination shall provide a link to such rule, guideline, protocol or other similar criterion on the **health carrier's website.**

7. Include a copy of the company's grievance procedures, broken down by type of grievance: prospective, concurrent, retrospective and expedited/urgent, including timelines for reviews and notifications.

8. Describe the procedure by which the company assures that the appropriate clinical peer takes into account all comments, documents, records and other information relevant to the review of the adverse determination .

9. Confirm that all concurrent determinations (both standard & urgent) shall have their treatment continued without liability to the covered person until the covered person has been notified of the review decision.

10. Describe any peer to peer consultation offered to the covered person's health care professional following an initial adverse determination, including time frames for initiating such consultations. Confirm that if such consultation occurs prior to the initiation of any grievance by the covered person or his authorized representative or health care professional, it shall not be considered a grievance of the initial adverse determination.

11. Describe the process for disclosing new or additional information. Confirm that prior to issuing a decision, the covered person or the covered person's representative/provider of record, if applicable, is provided, free of charge, any new or additional evidence relied upon and any new or additional scientific or clinical rationale used. Confirm that such information is provided sufficiently in advance of the date a decision is required to permit the covered person or authorized representative a reasonable opportunity to respond.

12. Describe the process by which the company's written clinical review criteria and review procedures are developed, evaluated and revised, including how practitioners are involved in this process. Identify the source of the clinical review criteria if purchased or licensed from a vendor.

    If doing utilization review for mental health and substance abuse services, indicate whether the clinical review criteria used is that required in Conn. Gen. Statute §§38a-591c, separately for substance abuse and mental health indicating for adults as well as for children and adolescents. Describe any additional clinical review criteria developed or purchased to address advancements in technology or types of treatment not covered in the required criteria. Confirm that any such criteria is based on sound clinical evidence and evaluated periodically.

13. State the hours (in eastern time) during which the company's review staff is available by toll-free telephone.

14. State the number of nurses, practitioners and other licensed health professionals making utilization review decisions for the company and describe their professional qualifications. Supporting material may be attached.

15. Describe the company's procedures to ensure compliance with applicable state and federal laws protecting the confidentiality of medical records. Supporting material may be attached.

16. Confirm that no person engaged in utilization review receives any compensation based on the number of denials.

17. Attach the completed certification (Attachment 1) and survey (Attachment 2) that follow.

ATTACHMENT 1

THE FOLLOWING CERTIFICATION MUST BE COMPLETED WHEN APPLYING FOR OR RENEWING A UTILIZATION REVIEW LICENSE

I, _____, _____
(PRINTED NAME) (TITLE)

of _____, hereby acknowledge that I have
(COMPANY)

read the foregoing request and attached materials, that the information provided is true and accurate and offered in support of this license application in accordance with Conn. Gen. Stat.§§38a-591a et seq. as amended from time to time. I understand that any material changes in the information contained in this application must be filed with the Commissioner, as an amendment hereto, within thirty days of such change.

_____
(SIGNATURE)

_____
(DATE)

Rev 6/16

Rev. 8/18

ATTACHMENT 2

THE FOLLOWING SURVEY MUST BE COMPLETED WHEN APPLYING FOR OR RENEWING A UTILIZATION REVIEW LICENSE

Utilization Review Survey

Name of Company: _____ Tax ID/FEIN #:_____

UR License Number (For renewals only)_____

Primary contact for questions:
Name: _____
Title: _____
Telephone #: _____
e-mail address:_____

1. Type of Utilization Review conducted: (check all that apply)

☐ Inpatient ☐ Mental Health ☐ Vision
☐ Outpatient ☐ Substance Abuse ☐ Dental
☐ Chiropractic ☐ Other: _____

2. UR conducted in Connecticut for: (check all that apply and list companies)

☐ HMO _____
_____
_____

☐ Licensed Indemnity Insurance Company _____
_____
_____

3. How is the UR company reimbursed for services?
_____
_____
_____
_____

4. Describe the professional liability coverage's maintained with respect to legal liability:
_____
_____
_____
_____

5. Who in your organization has first contact with a request for authorization?

☐ Clerical ☐ Nurse ☐ Provider ☐ Clinical Peer ☐ Automated System
☐ Other _____

Indicate whether this contact has:

Authority to approve services	☐ YES	☐ NO
Authority to deny services	☐ YES	☐ NO
Authority to negotiate services	☐ YES	☐ NO

6. Does the reviewer look at the coverage available under the enrollee's health contract to ensure that services are covered and policy maximums have not been reached prior to authorizing services?

☐ YES ☐ NO

7. How are reviewers compensated?

_____
_____
_____
_____

8. What training is provided to case reviewers?

_____
_____
_____
_____

Describe any ongoing training programs?

_____
_____
_____
_____

9. How are reviewers evaluated for job performance?

_____
_____
_____
_____

10. Describe the data processing system employed for maintaining enrollee medical information that is used in the UR decision:

_____
_____
_____
_____
_____
_____

11. Describe procedures and systems in place regarding confidentiality of individual patient information:

12. Has the UR company received URAC accreditation? ☐ YES ☐ NO

13. List all states where the company is currently licensed to perform UR:

14. Have any market conduct examinations of the company's utilization review activities been conducted by any state regulatory authority?

☐ YES ☐ NO

If yes, please list state(s) and dates of examination:

15. Have any sanctions, fines, revocation, or restriction of licensure been imposed by any regulatory agency regarding its utilization review activities?

☐ YES ☐ NO

If yes, please explain:

16. Describe the organizational structure of the company, including parents, affiliates and subsidiaries:

_____
_____
_____
_____
_____
_____
_____

17. List all utilization review services that the company has contracted out for services and the name and CT license # of such company providing such services:

_____
_____
_____
_____
_____
_____
_____

18. List current website(s) and links to specific rules, guidelines, protocols or other criterion that are relied on to make an adverse determination.

_____
_____
_____
_____

19. For renewal applications, describe any material modifications you are making to the information provided in the most current application on file with the Insurance Department. This should include but not be limited to any material modifications to processes or the criteria used. Attach documentation as appropriate.

_____
_____
_____
_____
_____
_____