

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
SEPTEMBER 30TH.**

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 Public Act 11- 58 in support of the application for license of the above named company.

Provide the information required for each of the following items in the order presented.

1. Describe the company's procedures (standard and expedited) for providing notification of its prospective, concurrent and retrospective determinations regarding certification. Attach as Exhibit 1A examples of approval letters sent to covered persons and, and if applicable, the covered person's authorized representative/provider of record. Attach as Exhibit 1B an example of the company's description of its notification process, including timelines for reviews and notifications.

2. *Attach as Exhibit 2A sample copies of all denial letters (all levels) sent to covered persons and, if applicable, the covered person's authorized representative/provider of record.*

*Please review Public Act 11-58 regarding **all** of the information that must be included in the notice of an adverse determination. For purposes of the requirement to include information regarding the insured's ability to contact the Insurance Commissioner or the Office of the Healthcare Advocate for assistance, please use the following contact information:*

*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 state that all internal appeals have been exhausted;*
- *Must include the CPT/ICD-9 diagnostic code(s) relating to the denial; and*
- *Must include 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:*
- *[External Review Consumer Guide](#) and [Request for External Review Application](#)*

3. *Attach as Exhibit 3A a copy of the company's grievance procedures, broken down by type of grievance: prospective, concurrent, retrospective and expedited, including timelines for reviews and notifications.*

4. *Describe the procedure by which the company assures that that an appropriate clinical peer is available to review the adverse determination, taking into account all comments, documents records and other information relevant to the request. Confirm that prior to issuing a decision the covered person or the covered person's authorized 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.*

5. Describe the process by which the company's written clinical criteria and review procedures are developed, evaluated and revised, including how practitioners are involved in this process. If using protocols from outside sources, please identify., Connecticut General Statutes §38a-482a and §38a-513c require that the following definition of medical necessity be used for insurance plans delivered, issued for delivery, renewed, continued or amended in this state:

"Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.'

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Any insurer, health care center, hospital and medical service corporation or other entity that has entered into any national settlement agreement will not be required to include the statutory definition of medical necessity until the expiration of any such agreement.

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

7. 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.

8. 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.

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

10. Please complete and forward the attached survey.

Complete and sign the following acknowledgement

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 Public Act 11-58. 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)

Utilization Review Survey

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

Name of Person Completing Survey: _____

Title: _____

Telephone #: _____

e-mail address: _____

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

- | | | |
|---------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Outpatient | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Other: _____ | |

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

- HMO _____
- Licensed Indemnity Insurance Company _____

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

4. Describe the professional liability coverages maintained with respect to legal liability: _____

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

- Clerical Nurse Provider Other _____

Does that person have:

- 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? _____

Is training given on an on-going basis? _____

9. How are reviewers evaluated for job performance? _____

10. Describe the data processing system employed for maintaining enrollee medical information 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 which the company has contracted out for services and the name and CT license # of such company providing such services:* _____

