Commonwealth of Kentucky
Department of Insurance - Division of Health Insurance Policy and Managed Care
Utilization Review Registration Application Instructions

Instructions for submitting new or renewal applications. The following pages are the application for initial or renewal of registration to conduct utilization review in Kentucky. Applicants are required to complete all sections and provide all necessary documentation as evidence of compliance with KRS 304.17A-600 through 304.17A-615, and, as applicable, 806 KAR 17:280 and 806 KAR 17:290. The completed application and supporting documentation must be submitted in a binder with the contents separated by labeled section tabs.

The completed application and supporting documentation, accompanied by a filing fee of one thousand dollars ($1,000.00) made payable to the Kentucky State Treasurer, should be sent to the following:

Kentucky Department of Insurance
Division of Health Insurance Policy and Managed Care
Utilization Review Registration and Appeals Branch
POB 517
Frankfort, KY 40602

Instructions for submitting changes to utilization review policies and procedures. Any proposed changes to utilization review policies and procedures previously filed with the Department of Insurance that occur outside of the normal new or renewal application process must be submitted for review and approval prior to implementation, in accordance with KRS 304.17A-607(3). A filing fee of fifty dollars ($50), made payable to the Kentucky State Treasurer, must accompany any revisions.

Please submit the changes in the following manner:

1. Complete the face sheet (Page 2 of this document) in its entirety;
   a. Identify and report the specific policy and/or procedure that is being revised;
   b. Report the existing language in the policy and/or procedure information and proposed change (e.g., Current language: "8:00 a.m. to 4:30 p.m. EST"; Proposed language: "7:30 a.m. to 5:00 p.m. EST") **OR** submit both a redlined and a final copy;
   c. Report the rationale for the change (e.g., hours of operation changed to promote efficiency in operations); and
2. Include an attestation on company letterhead that is signed and dated by the appropriate officer(s) of the organization and/or legal counsel. The attestation should include that the information and material submitted is "true and accurate to the best of my knowledge and the applicable Kentucky statutory and regulatory requirements were considered prior to proposing the change."

Commonwealth of Kentucky
Department of Insurance
Division of Health Insurance Policy and Managed Care
Utilization Review Registration Application Face Sheet

_____	_____
Company Name	Phone No.

_____	_____	_____
DBA Name	Primary Contact Person	Fed. Tax ID. No.

_____	_____
Business Address	Business Address

_____
Fax Number

****

Check Appropriate Box

☐ Application for Initial or Renewal of Registration to conduct Utilization Review - Filing fee of $1,000.00

☐ Changes to previously approved Utilization Review Application - Filing fee of $50.00

A FILING CANNOT BE ACCEPTED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE
and
Make Check Payable to Kentucky State Treasurer

Certificate of Person Responsible for filing

I certify that I have been authorized by the board of directors or management committee of the company or organization listed above to make this filing.

_____	_____	_____
Name (Manual Signature Required)	Position	Date

_____
Name (Print or type)

For Department of Insurance Administrative Services Staff Only

Date: _____ Amount: _____ Check No.: _____ Initials: _____

UTILIZATION REVIEW REGISTRATION APPLICATION
(Indicate not applicable (N/A) where appropriate)

1. Primary Contact Person for questions regarding this Application

Name/Title _____

Mailing Address _____

_____

Phone Number _____

Fax Number _____

E-Mail Address _____

3. Type of Utilization Review Entity (check all that apply to business in Kentucky):

☐ Insurer
☐ Private Review Agent for self-insured plans
☐ Private Review Agent for an Insurer
☐ Limited Health Services Organization (LHSO) or private review agent for an LHSO

SECTION A: CORPORATE PROFILE

1. Please list name, title, phone number, and e-mail address for the following positions:

Chief Executive Officer _____
Name

_____
Title

Corporate Medical/Clinical Director _____
Name

_____
Kentucky License #/Other State License #

_____
Telephone

SECTION A: CORPORATE PROFILE (continued)

Please complete or answer as follows (additional pages may be added for responses).

1. Type of Entity (check all that apply)

   ☐ Corporation ☐ Partner ☐ Association ☐ Limited Liability Co.

   ☐ For-profit ☐ Not-for-Profit ☐ Public ☐ Private

   ☐ Mutual ☐ Stock ☐ Other (Please specify) _____

2. Date of Incorporation or formation as legal entity (mm/dd/yyyy) _____

3. State of Incorporation _____

4. Describe the Applicant's governing structure, including Board of Directors and standing committees, and the administration and operation of its organization. Please include an organizational chart.

5. Lines of business (check all that apply). ☐ Medicare ☐ Medicaid ☐ Indemnity

   ☐ Workers' Compensation ☐ Clinical specialty carve out (specify)_____

   ☐ Utilization Management ☐ CMO ☐ External Review Organization

   ☐ Network ☐ HMO ☐ PPO ☐ IPA ☐ PHO/PSO

   ☐ Benefits Administration ☐ Home Health Care ☐ Other_____

6. Provide the name and type of business of each corporation or other organization that the Applicant controls or with which it is affiliated, and the nature and extent of the affiliation or control.

7. If the Applicant has delegated certain functions, please list the contracted companies, indicate which services they perform, and provide the information requested below. If no functions have been delegated, check "not applicable" as follows. ☐ Not applicable

   For each company, identify the following information:
   - Name and title of contact person for the site
   - Delegated site street address
   - Phone and fax numbers of contact person
   - List of services provided
   - A description of the oversight activities and how frequently the activities are monitored, both on- and off-site (attach a copy of subcontract agreement).

8. a. Has the Applicant ever been refused registration or certification to conduct utilization review?
   ☐ YES ☐ NO

   b. If yes, please explain _____

SECTION A: CORPORATE PROFILE (continued)

9. a. Is the Applicant certified to perform utilization review in other states?
☐ YES ☐ NO
b If yes, list the states. _____

_____

10. a. Is the Applicant currently accredited or certified by the NCQA?
☐YES ☐NO (If yes, please provide a copy of the current accreditation certificate.)

b. If yes, check type(s) of accreditation/certification:
☐ MCO ☐ MBHO ☐ CVO ☐ POC ☐ Other-Identify _____

11. a. Is the Applicant currently accredited in Health UM by URAC?
☐YES ☐NO (If yes, please provide a copy of the current accreditation certificate.)

b. If yes, specify type of accreditation(s): ☐ Full ☐ Conditional

12. Indicate the days of week and hours of operation for Kentucky business.

_____

SECTION B: ADMINISTRATION AND OPERATION

1. Agency employees. Please specify the number of employees by full-time staff, part-time staff, and consultants. Attach curriculum vitae and job description for the Medical/Clinical Director.

	Number of Full-time Staff	Number of Part-time Staff	Number of Consultants
Administrative	_____	_____	_____
Physicians	_____	_____	_____
Chiropractors	_____	_____	_____
Kentucky-licensed	_____	_____	_____
Optometrists	_____	_____	_____
Kentucky-licensed	_____	_____	_____
Registered Nurses	_____	_____	_____
Clerical	_____	_____	_____
Other (Specify)	_____	_____	_____

SECTION B: ADMINISTRATION AND OPERATION (continued)

2. Attach the name of the company the Applicant utilizes for access to specialists and subspecialists for reviews, or a listing of consulting physicians who are available to conduct specialty reviews. The list should include name, state of licensure, license number, medical specialty or subspecialty, and board certification status.

3. If the Applicant is not accredited by URAC or NCQA, provide documentation of qualifications of personnel who developed the specific utilization review criteria/procedures relating to specialty and subspecialty areas of review (e.g., mental health, OB/GYN, surgery, internal medicine, etc.).

4. The following documentation must be submitted with this application.

   a. A copy of the utilization review policies and procedures for evaluation and decision making, including pre-authorization, pre-admission, continued stay authorization and retrospective reviews, including:

      (1) A written summary or flow chart summarizing each review process, with review time frames and references to any required forms, letters, etc.

      (2) A description and name of review criteria upon which utilization review decisions are based and policies and procedures to support the consistent application.

      (3) Any additional standards for the consideration of special circumstances, if applicable.

      (4) For private review agents only, the names of the entities for which utilization review is being performed in the state.

      (5) A certification signed by an authorized representative that utilization screening criteria and review procedures applied in review determinations are established with input from appropriate health care providers and approved by physicians.

   b. A copy of each policy and procedure and any related forms (including template copies of all notices of adverse determinations, coverage denials and appeals determination letters sent to covered persons, authorized persons and providers through the final determination) that demonstrate compliance with each requirement applicable to the insurer or private review agent in KRS 304.17A-607, 304.17A-611, 304.17A-615, 304.17A-617, 304.17A-619, and 304.17A-623, and Section 4(1) of 806 KAR 17:280, and Section 2 of 806 KAR 17:290.

   c. A copy of the policy and procedure that affords physicians and other participating providers the opportunity to review and comment on protocols pursuant to KRS 304.17A-607(1)(k).

   d. KRS 304.17A-607(1)(f) states that where an insurer, its agent, or private review agent provides or performs utilization review, the company must be accessible to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6 p.m., including Federal holidays. Please provide a policy and procedure which addresses this accessibility requirement.

SECTION B: ADMINISTRATION AND OPERATION (continued)

e. A copy of policies and procedures to ensure compliance with reporting requirements set forth in KRS 304.17A-607(3) and 806 KAR 17:280, sec. 3(2); 806 KAR 17:280, sec. 11; and 806 KAR 17:280, sec. 9.

f. If the Applicant is an insurer or is delegated responsibility for conducting internal appeals, the policy and procedure addressing the record-keeping requirement in 806 KAR 17:280, sec. 7.

g. A copy of policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed, including template confidentiality agreements that employees and/or physician consultants are required to sign.

h. A copy of policies and procedures relating to the resolution of complaints of covered persons and providers as well as complaints that may be filed with the Kentucky Department of Insurance.

i. For private review agents only, a list of clients for which utilization review is being performed in Kentucky, and a copy of the policy and procedure addressing the requirement to notify the Kentucky Department of Insurance when that list is revised as required by KRS 304.17A-607(3).

j. For insurers only, a copy of the written procedures for determining whether a requested service, treatment, drug or device is covered, as required by KRS 304.17A-603(1).

SECTION C. CORPORATE ATTESTATION OF APPLICANT

On company letterhead, formally attest to the items listed below and submit with the application. Similar language may be used. The attestation must be signed and dated by the appropriate officer(s) of the organization and/or legal counsel. The Applicant is attesting that the following are true:

1. The information and material contained in this application is true and accurate to the best of my knowledge.

2. The documentation submitted as evidence for meeting the Kentucky statutory and regulatory requirements has been reviewed by the appropriate personnel and reflects the Applicant's current structure and processes.

3. The Applicant organization, to the best of its knowledge, is in compliance with applicable state and federal laws governing confidentiality of health care information and state laws as they pertain to the Applicant's business.

4. The Applicant understands that the Department of Insurance will rely on this information and material in making its decision regarding the registration and that any distorted facts or misrepresentations may disqualify the Applicant from registration or result in revocation of the registration at any time.