Commonwealth of Kentucky
Department of Insurance – Division of Health, Life Insurance and Managed Care

Utilization Review Registration Application Instruction

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 single Portable Document Format "PDF" document bookmarked to correspond to the sections of the application. If multiple areas are satisfied by one policy or procedure bookmark the section of the policy or procedure for each requirement. The electronic document shall be sent via email to the Department at DOI.UtilizationReview@ky.gov. Contact the department to request alternative methods for submission of large documents.

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, shall be sent to the following:

Kentucky Department of Insurance
500 Mero Street
Mail Drop: 2 SE 11
PO Box 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 307.17A-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")

AND 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 shall 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."

3. All documents shall be submitted in a bookmarked electronic version via email DOI.UtilizationReview@ky.gov.

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 $1,000.00

☐ Changes to previously approved Utilization Review Application – Filing Fee $50.00

A FILING WILL NOT 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 or Electronic 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 non-applicable (N/A) where appropriate)

1. Primary Contact Person for questions relating to this Application

   Name/Title _____

   Mailing Address _____

   _____

   Phone Number _____

   Fax Number _____

   E-mail Address _____

2. Type of Utilization Review Entity (check all that apply for Kentucky business)

   ☐ Insurer
   ☐ Private Review Agent for Self-Insured ERISA Plans
   ☐ Private Review Agent for an Insurer
   ☐ Limited Health Service Organization (LHSO) or private review agent for an LHSO
   ☐ Private Review Agent for Self-Insured Non-ERISA Plans

SECTION A: CORPORATE PROFILE

1. Please list name, title, phone number, and email 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.

   ☐ Not-For-profit ☐ For-profit ☐ Public ☐ Private

   ☐ Mutual ☐ Stock ☐ Other (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 administration and operation of the organization. Please include an organizational chart.

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

   ☐ Workers' Compensation ☐ Clinical specialty (specific) _____

   ☐ 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 full address
   - Phone and fax numbers of the contact person
   - List of services provided
   - A description of the oversight activities and how frequently the activities are monitored, both on and off site (attached a copy of the 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, provide a listing of the states _____

   _____

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

   b. Check type(s) of accreditation/certification:
   ☐ MCO ☐ MBHO ☐ COV ☐ 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. Is the Applicant accredited in any other national accreditation organization?
   ☐ YES ☐ NO (If yes, please provide a copy of the current accreditation certificate.)

13. Please provide the website address where the policies and procedures and any prior authorization lists can be viewed pursuant to KRS 304.17A-603(3) and (4).

_____

14. Days/Hours of Operation for Kentucky business: _____

SECTION B: ADMINISTRATION & OPERATION

Bookmark all items requested under this section with a bookmark of section B, Administration and Operation and sub-bookmarks as identified below.

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 shall [~~should~~] include name, state of licensure, license number, medical specialty or subspecialty, and board certification status.

3. Applicants not accredited by URAC or NCQA, or other nationally recognized accreditation organization shall 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. **Accessibility** – Provide the policies/procedures demonstrating compliance with the following Kentucky requirements for accessibility:

a. Hours of Operations/Contact Information pursuant to KRS 304.17A-607(1)(e) and (f)

b. Access attempts by a provider pursuant to KRS 304.17A-615

c. Utilization Review volume data pursuant to 806 KAR 17:280 Section 10

5. **Personnel** – Provide the policies/procedures demonstrating compliance with the Kentucky requirements for personnel pursuant to KRS 304.17A-607(1) and KRS 304.17A-545(1), as applicable. Ensure that policies/procedures provide documentation that only the appropriate specialty or subspecialty provider is making the review decisions as required by KRS 304.17A-607(1)(b). Include a listing of the consulting physicians with their state of licensure, license number, medical specialty or subspecialty and board certification status.

6. **Review Timeframes** – Provide the following documentation and bookmark the items as identified in the electronic Application document pursuant to KRS 304.17A-600(17), KRS 304.17A-607, KRS 304.17A-619 and 29 CFR 2560.503-1. Provide UR policies and procedures for evaluation and decision making for the following:

i. Pre-Authorization

ii. Pre-Admission Authorization

iii. Concurrent Review (continued stay) Authorization

iv. Retrospective Reviews

Provide the following for each of the above items:

a) A written summary or flow chart summarizing each review process, with review timeframes and references to any required forms or letters.

b) A description and name of review criteria upon which Utilization Review decisions are based and policies and procedures to support the consistent application of such criteria.

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

d) The names of the Applicants clients for which Utilization Review services are provided in Kentucky **(required of Private Review Agents & Insurers providing services to other companies/plan sponsors)**.

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

7. **Determination Notices/Appeals** – Provide a copy of each policy, procedure, and any related forms bookmarked as identified below that demonstrate compliance with each requirement applicable to the insurer or Private Review Agent in KRS 304.17A-603, KRS 304.17A-607, KRS 304.17A-611, KRS 304.17A-615, KRS 304.17A-617, KRS 304.17A-619, KRS 304.17A-623, 806 KAR 17:280 and 806 KAR 17:290.

i. Adverse Determinations Policy/Procedure – KRS 304.17A-607, KRS 304.17A-617, KRS 304. 17A-545, & 806 KAR 17:280.

(a) Adverse Determination Letter Templates – KRS 304.17A-607, KRS 304.17A-617, KRS 304. 17A-545, & 806 KAR 17:280

ii. Coverage Denials Policy/Procedure – KRS 304.17A-607, KRS 304.17A-617, KRS 304. 17A-545, & 806 KAR 17:280

SECTION B: ADMINISTRATION AND OPERATION (continued)

(a) Coverage Denial Letter Templates - KRS 304.17A-607, KRS 304.17A-617, KRS 304. 17A-545, & 806 KAR 17:280

iii. Appeals Policy/Procedures – KRS 304.17A-617, KDOI Bulletin 2011-08, & KRS 304.17A-619.

(a) Appeal Letter Templates - KRS 304.17A-617, KDOI Bulletin 2011-08, & KRS 304.17A-619.

8. **External Review** – Provide a copy of each policy, procedure, and any related forms that demonstrate compliance with KRS 304.17A-623, KRS 304.17A-625, KRS 304.17A-627, KDOI Bulletin 2011-04, & 806 KAR 17:290 as applicable.

9. **Department Requirements** – Provide a copy of each policy, procedure, and any related forms that demonstrate compliance with KRS 304.17A-607, 806 KAR 17:280, & KDOI Bulletin 2011-08.

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 evidenced 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 Protected Health Information and state laws as they pertain to the Applicant's business.

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