

## Article - Insurance

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§15–10B–05.

(a) In conjunction with the application, the private review agent shall submit information that the Commissioner requires including:

(1) a utilization review plan that includes:

(i) the specific criteria and standards to be used in conducting utilization review of proposed or delivered health care services;

(ii) those circumstances, if any, under which utilization review may be delegated to a hospital utilization review program; and

(iii) if applicable, any provisions by which patients, physicians, or hospitals may seek reconsideration;

(2) the type and qualifications of the personnel either employed or under contract to perform the utilization review;

(3) a copy of the private review agent's internal grievance process if a carrier delegates its internal grievance process to the private review agent in accordance with § 15-10A-02(l) of this title;

(4) the procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and health care providers 7 days a week, 24 hours a day in this State;

(5) if applicable, the procedures and policies to ensure that a representative of the private review agent is accessible to health care providers to make all determinations on whether to authorize or certify an emergency inpatient admission, or an admission for residential crisis services as defined in § 15-840 of this title, for the treatment of a mental, emotional, or substance abuse disorder within 2 hours after receipt of the information necessary to make the determination;

(6) the policies and procedures to ensure that all applicable State and federal laws to protect the confidentiality of individual medical records are followed;

(7) a copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;

(8) a list of the third party payors for which the private review agent is performing utilization review in this State;

(9) the policies and procedures to ensure that the private review agent has a formal program for the orientation and training of the personnel either employed or

under contract to perform the utilization review;

(10) a list of the persons involved in establishing the specific criteria and standards to be used in conducting utilization review; and

(11) certification by the private review agent that the criteria and standards to be used in conducting utilization review are:

(i) objective;

(ii) clinically valid;

(iii) compatible with established principles of health care; and

(iv) flexible enough to allow deviations from norms when justified on a case by case basis.

(b) (1) At least 10 days before a private review agent requires any revisions or modifications to existing specific criteria and standards to be used in conducting utilization review of proposed or delivered services, the private review agent shall submit those revisions or modifications to the Commissioner.

(2) At least 10 days before a private review agent requires specific criteria and standards to be used in conducting utilization review of proposed or delivered services in which there are no existing criteria or standards, the private review agent shall submit the criteria and standards to the Commissioner.

(c) On the written request of any person or health care facility, the private review agent shall provide 1 copy of the specific criteria and standards to be used in conducting utilization review of proposed or delivered services and any subsequent revisions, modifications, or additions to the specific criteria and standards to be used in conducting utilization review of proposed or delivered services to the person or health care facility making the request.

(d) The private review agent may charge a reasonable fee for a copy of the specific criteria and standards or any subsequent revisions, modifications, or additions to the specific criteria to any person or health care facility requesting a copy under subsection (c) of this section.

(e) A private review agent shall advise the Commissioner, in writing, of a change in:

(1) ownership, medical director, or chief executive officer within 30 days of the date of the change;

(2) the name, address, or telephone number of the private review agent within 30 days of the date of the change; or

(3) the private review agent's scope of responsibility under a contract.

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