Arkansas Department of Health

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Governor Mike Beebe
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Arkansas Utilization Review Certification Program Checklist

A certificate is required for: *A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, and may not conduct utilization review in this state unless the Arkansas Board of Health has granted the private review agent a certificate.* Arkansas Act 537 of 1989 (A.C.A. 20-9-901 - 20-9-914)

Following is a Checklist of information required by the Rules & Regulations for Utilization Review in Arkansas (enclosed) that must accompany an application for certification as a Private Review Agent. Any format may be used; however, all items must be addressed appropriately and completely as requested. Applications requiring additional information to complete the review process will be held open until the applicant has been notified of the deficiencies by telephone, fax and mail, and given a specified time frame to comply. The application/processing fee is $2500.00 for two years and not refundable.

Please Do not answer N/A on checklist questions, state; **Do not provide this service.**

1. Complete the enclosed *Application for Certification* and *Application Affidavit* (please type).

2. Submit a cover letter that describes the type of organization and explains in detail the lines of business and services available in Arkansas.

3. Describe the utilization review plan for inpatient and outpatient health care services in relation to the types of review and review processes listed in A-I. Submit complete policies and procedures with time frames, methods of notification, forms used during the review process, and samples of notification letters used for both certification and non-certification decisions.

A. Prospective review (includes preadmission, admission and preauthorization);
B. Concurrent/continued stay review;
C. Reconsideration;
D. Second surgical opinion;
E. Non-certification or non-authorization;
F. Lack of information or administrative denial;
G. Retrospective review;
H. Bill review; and
I. Any other direct or negotiated cost reduction review activity.

4. Describe the clinical review criteria currently in use and the policies and procedures for update or modification. If non-licensed staff authorize (certify or approve) requests for care, include a sample of the scripts in use.

5. Submit policies and procedures for oversight of delegated functions.

6. Describe the expedited and standard appeal processes in relation to the elements listed in A-E. Submit complete policies and procedures with time frames, methods of notification, forms used and samples of appeal outcome letters for both certification and non-certification decisions resulting from expedited and standard reviews.

A. Daily availability of physician consultants;
B. Provide the name and qualifications of each physician, chiropractic or dental consultant making appeals determinations;
C. Resumes on other personnel directly involved in appeal determinations;

D. Assurance that physician consultants performing primary review/denial will not be involved in same case appeal; and

E. Policy statement indicating that all appeals physicians, dentists and chiropractors hold an active and unrestricted license in their respective states.

7. Submit case management policies and procedures to include number of staff and their qualifications and position responsibilities.

8. Submit disease management policies and procedures to include staff utilized and scope of services.

9. Submit a written description of the quality management program that defines the program's scope, activities, objectives and structure, as well as the responsibilities and roles of the quality management committee.

10. Submit curriculum vitae, qualifications, position responsibilities and a copy of the current license (unrestricted) for the medical director or senior clinical staff person.

11. Provide the name, number, type and qualifications of personnel either employed or under contract to perform utilization review to include physician, chiropractic or dental consultants utilized if different from those conducting appeals.

12. Submit job descriptions/ responsibilities for review staff (clinical and non-clinical). Provide a summary of job responsibilities for physicians on contract. Submit resumes for supervisory staff.

13. Submit the policies and procedures used to verify the current licensure and credentials of utilization review personnel and consulting physicians.

14. Submit the policies and procedures to ensure a representative is accessible to patients and providers five days a week during normal daily business hours in this state, and that a free telephone number is provided with adequate lines available and staffed. State the procedure for after hours, weekend and holiday inquires. State your policy for taping telephone conversations.

15. Submit policies and procedures to protect the privacy, security and confidentiality of individual health information. Indicate how this information is stored, maintained and destroyed.

16. State the policy and procedure for collecting patient information in order to perform utilization review. Indicate the information collected, who may provide it, how it is shared and with whom.

17. Submit samples of materials or information designed to describe/communicate the utilization review process or services available to patients, providers or employees, and how to obtain services or submit a grievance or appeal.

18. Submit a client listing of the health plans, health insurers, third party payers or others for which you provide any type of utilization review/management services.

19. Submit an outline or synopsis of the orientation/training program for medical director, physician consultants, and both clinical and non-clinical utilization review staff.

20. State a policy for notifying a provider that he/she has been targeted for 100% intensified or professional review.

21. Submit an organizational chart that includes oversight responsibility within the utilization review program.

22. State the numbers of offices from which you conduct utilization review and provide site specific information.

23. Indicate the date utilization review operations originally started.

24. Remit a check for $2500.00 made payable to the Arkansas Department of Health.

<u>Place the check on top of the renewal application and mail to UR Program Manager at letterhead address.</u>

For questions or assistance with the renewal application process, contact 501.661.2201 or fax 501.661.2165.