Application for Certification or Renewal as a Certified Review Entity (CRE) or an Independent Review Organization (IRO)

Act 146 of 2022 (40 P.S. §991.2101, et seq.) requires entities to be certified to perform utilization review (UR) on behalf of managed care plans or insurers, and to conduct external grievance and external adverse benefit determination appeals. A certified review entity (CRE) currently certified under Act 68 of 1998 and its regulations, 28 Pa. Code, Chapter 9, Subchapter K, must continue to comply with the requirements of Act 146, which amended Act 68, as well as the regulations, in order to maintain certification. Certification for entities that only conduct UR activities must be renewed every three years, commencing three years following the date of the initial certification, unless otherwise subjected to additional review, suspension, or revocation. Certification for entities that conduct external appeals of grievances and adverse benefit determinations must be renewed every two years, commencing two years following the date of the initial certification, unless otherwise subjected to additional review, suspension, or revocation. An entity approved as a CRE may be approved as an IRO.

Applicants are strongly advised to thoroughly review Act 146 and 28 Pa. Code, Chapter 9, Subchapter K prior to submitting an application for initial or renewal certification. Applicants may contact the Bureau of Managed Care (Bureau) at 717-787-4192 or [RA-INBURMNGDCAREPRDR@pa.gov](mailto:RA-INBURMNGDCAREPRDR@pa.gov) to obtain additional guidance or to notify the Bureau of their intent to submit an application and request access to the secure SharePoint.

Please note that all information provided as part of the application for initial certification or certification renewal is available to the public.

## Application Instructions

1. Parts I through IV must be completed by all applicants. There are also two supplemental sections, which the applicant may need to complete, depending upon anticipated activities:

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| Part I | General Information and Background |
| Part II | Organization and Structure |
| Part III | Utilization Review Program |
| Part IV | Certification - Statement of Responsibility |
| Supplement I | Delegation of Internal Complaint and Grievance Appeal Process |
| Supplement II | Assignment of Medical Assistance and CHIP External Grievance Appeals and Commercial External Adverse Benefit Determination Appeals  Supplement |

1. Entities requesting certification to perform only UR must complete Parts I – IV.
2. Entities requesting UR certification who are expecting to be delegated the internal complaint, grievance, or adverse benefit determination appeal process must also complete Supplement I, in addition to Parts I - IV.
3. Entities requesting certification to review external grievance and adverse benefit determination appeals must complete Parts I - IV and Supplements II. Questions in Parts I – IV that pertain strictly to UR may be answered “not conducting UR” if the applicant does not, or will not, be conducting UR on behalf of Pennsylvania managed care plans or insurers.
4. All questions must be answered with a narrative response and/or a response referencing an attachment. If any question is believed to be “not applicable,” you must briefly state why you think the question does not apply.
5. Responses must be supported and accompanied by the relevant policies to fully demonstrate compliance with Pennsylvania-specific requirements. If national policies are submitted, they must be accompanied by Pennsylvania-specific addenda.
6. Clearly label all attachments and make sure to reference the attachment in the narrative response on the application. Also, highlight specific compliance elements within attached policies, etc.
7. The application is a Microsoft® Word table, which, to help facilitate an efficient and timely review, may be completed without changes to format or font. It is designed to be completed electronically so that the table cells will expand as answers are entered into the document.
8. Part IV (Statement of Responsibility) must be signed and dated by an officer of the corporation with appropriate authority.
9. Submit the application and all attachments electronically to your SharePoint site as directed by the Bureau.
10. The application fees and certification periods are:

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|  | Initial Certification | | Certification Renewal | |
|  | Fee | Duration | Fee | Duration |
| CRE Only: To conduct UR on behalf of managed care plans | $1,000 | 3 years | $500 | 3 years |
| CRE and IRO: To conduct UR and external grievance and adverse benefit determination appeals | $2,000 | 2 years | $1,000 | 2 years |
| IRO Only: To conduct external grievance and adverse benefit determination appeals as | $2,000 | 2 years | $1,000 | 2 years |

**To make a payment:**

1. Go to: <https://www.bpp.ob.pa.gov/Customer>
2. Select the 3rd payment type:

To [make a payment](https://www.bpp.ob.pa.gov/Customer/PaymentForm) for **any other Commonwealth of PA Service, Fee or Program**

1. On the Make a Payment page, enter your name, address, and email
2. The following fields must be completed, in order for your payment to be properly credited to the Pennsylvania Insurance Department.
   * Agency: Select **Insurance** from the drop-down menu
   * Program ID: Select **081- BMC FEES** from the drop-down menu
   * Amount: Enter the appropriate **payment amount**
   * Payment Reference: Enter the **Company Name**
3. Select the Payment Method – ACH (free) or Credit Card

Please call Bureau staff at (717) 787-4192 for assistance or with questions regarding the application.

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| General Information and Background (to be completed by all applicants) | |
| Type of Application: ( ) INITIAL () RENEWAL | |
| 1. | Q: Indicate below the category(ies) for which you are seeking certification. |
| A: (  ) CRE - Utilization review and internal appeals  (  ) IRO - Independent Review of External Grievance and Adverse Benefit Determination Appeals |
| 2. | Q: For the ***applicant seeking certification***, please provide the corporate name, address, telephone number and fax number, as it should appear on the Bureau’s official lists of CRE and/or IRO entities; also provide the names of the Chief Executive Officer (CEO), the Chief Operating Officer (COO) and Chief Financial Officer (CFO). (28 Pa. Code 9.743)(b)(3)) |
| A: |
| 3. | Q: Provide the address, telephone, and fax numbers of the principal office that will be conducting UR or internal appeals for Pennsylvania clients, if different than that provided in question 2. If more than one location/office will be conducting UR or internal appeals for Pennsylvania managed care plans or insurers, provide the requested information for each location. (28 Pa. Code 9.743)(b)(2)(i)) |
| A: |
| 4. | Q: Provide the name, title, address, phone, and fax numbers of the contact person for  this application. |
| A: |
| 5. | Q: If the applicant is currently operating in Pennsylvania, indicate the length of time  in operation and a brief description of the scope and nature of the services performed. (28 Pa. Code 9.743(b)(5)(viii)) |
| A: |
| 6. | Q: List all managed care plans and insurers in Pennsylvania for which the applicant currently performs UR or internal appeals, including the start date of the contract for services and a brief description of the scope and nature of the UR or internal appeal services performed for each Plan listed. (28 Pa. Code 9.743(b)(4)) |
| A: |
| 7. | Q: For reference purposes, list three managed care plans and/or insurers in Pennsylvania for which the applicant has previously conducted UR or internal appeals. Include the name of the Plan and a Plan contact person including title, address, and telephone number. If you had no managed care or insurer clients in PA, provide the same information for clients in other states. (28 Pa. Code 9.743(b)(5)(ix))    Note: Applicants for an IRO certification should provide the same information for three external review clients. |
| A: 1.  2.  3. |
| 8. | Q: List the names of all Third Party Administrators (TPAs) in Pennsylvania for which the applicant conducts utilization review. (28 Pa. Code 9.743(e)) |
| A: |
| 9. | Q: List all other states where the applicant has received state certification, licensure, or  any form of approval to conduct utilization review activities. (28 Pa. Code 9.743(e)) |
| A: |
| 10. | Q: Is the applicant currently approved, certified, or accredited for conducting utilization  review by a nationally recognized accrediting organization? If yes, provide the name  and effective date of each and attach a copy of the approval, certification, or  accreditation certificate or notice. (28 Pa. Code 9.743(b)(5)(vii)) |
| A: (  ) Yes (  ) No |
| 11. | Q: Has the applicant ever been denied certification or accreditation by any other state or  national agency? If yes, identify the accrediting organization and provide a brief  explanation of the reason(s) for denial. (28 Pa. Code 9.743(e)) |
| A: (  ) Yes (  ) No |
| 12. | Q: Has the applicant ever been sanctioned by or had its authority suspended in another  state? If yes, provide all states, dates of the sanction(s), a brief explanation of the  sanction(s), and remedial measures implemented as a result of the sanction(s). (28 Pa. Code 9.743(e)). |
| A: (  ) Yes (  ) No |

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| 13. | Q: Check the types of utilization review to be performed by the applicant. | | | | |
| A: (  ) Prospective (  ) Concurrent (  ) Retrospective | | | | |
| 14. | Q: Check all types of services for which the applicant performs utilization review, listing all others in the space provided. | | | | |
| A: | (x) |  | (x) |  |
|  |  | Inpatient services |  | Outpatient services |
|  |  | Outpatient surgery |  | Skilled nursing services |
|  |  | Inpatient rehabilitation |  | Outpatient rehabilitation services |
|  |  | Outpatient diagnostic services |  | Home health |
|  |  | Dental |  | Vision |
|  |  | Outpatient pharmacy |  | Durable Medical Equipment |
|  |  | Behavioral health inpatient services |  | Behavioral Health outpatient services |
|  |  | Other: | | |

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| Organization Structure (to be completed by all applicants) | |
| 1. | Q: Provide a copy of the Articles of Incorporation and Bylaws (or similar documents) that regulate the internal affairs of the applicant. (28 Pa. Code 9.743(b)(2)(ii)) |
| A: |
| 2. | Q: If the applicant is publicly held, provide the name of each stockholder or owner of  more than five percent of any stock or options. (28 Pa. Code 9.743(b)(2)(iii)) |
| A: |
| 3. | Q: Provide the name and type of business of each corporation or other entity that the  applicant controls or with which it is affiliated. Describe the nature and extent of each relationship. (28 Pa. Code 9.744(a)(1)) |
| A: |
| 4. | Q: Provide an organizational chart identifying the applicant’s relationship with all  affiliated entities, including parent/holding company and all subsidiaries. (28 Pa. Code 9.744(a)(1)) |
| A: |
| 5. | Q: Provide two organizational charts:  (a) showing the applicant’s key management and administrative staff positions,  including names and reporting relationships. This chart should include the CEO,  Medical Director(s), Utilization Management (UM) Director, UR Director, etc.  (b) showing the applicant’s UM and UR department, including the number and types of positions.  If any positions are currently vacant, please identify and describe plans to fill. (28 Pa. Code 9.743(b)(2)(iv), (b)(3)) |
| A: |
| 6. | Q: Submit professional resumes or curriculum vitae for the applicant’s officers  (President/CEO, etc.), and the directors/managers of clinical areas involved in  UR activities (e.g., Medical Director(s), UM Director, UR Director, etc.). (28 Pa. Code 9.743(b)(3), 9.745(a)(1)) |
| A: |
| 7. | Q: Provide the number of personnel conducting UR, by specific qualification or specialty (i.e., the number of physicians, psychiatrists, psychologists, RNs, LPNs, and/or others). (See, e.g. 28 Pa. Code 9.744(a)(4)(ii)) |
| A: |

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| Utilization Review Program(to be completed by all applicants) | |
| 1. | Q: List all toll-free telephone numbers that will be available for enrollees and providers to call for UR activities and approvals, including the location(s) that will be answering each toll-free number and the hours/days of operation staff will be available to answer each number. (40 P.S. 991.2152(a)(1)(i), 28 Pa. Code 9.743(b)(5)(i)) |
| A: |
| 2. | Q: How will calls be answered after-hours? (40 P.S. 991.2152(a)(1)(ii), 28 Pa. Code 9.743(b)(5)(i)) |
| A: |
| 3. | Q: Will the applicant respond to each telephone call received by an answering service  or recording system within one business day of receipt of the call? (40 P.S. 991.2152(a)(1)(iii), 28 Pa. Code 9.743(b)(5)(i)) |
| A: () Yes () No (provide explanation below) |
| 4. | Q: Submit policies describing how the applicant will comply with the confidentiality  provisions of Act 146 and all other applicable state and federal laws governing  Confidentiality. (See, e.g., 40 P.S. 991.2131, 991.2164.10; 28 Pa. Code 9.743(b)(5)(iv)). |
| A: |
| 5. | Q: Describe the applicant’s procedures for protecting the confidentiality of medical  records. (28 Pa. Code 9.743(b)(5)(iv)). |
| A: |
| 6. | Q: Describe the applicant’s procedure by which a health care provider can verify  the legitimacy of the applicant's personnel when they call the provider to request  protected health information. (28 Pa. Code 9.743(b)(5)(v)) |
| A: |
| 7. | Q: Provide a program description that describes the scope of the program (type of  reviews conducted, nature of services reviewed, etc.) and sequentially explains the  decision-making process, from the handling of an initial request to the issuance of a  decision (approval, partial denial, or denial). This explanation should identify the  level or type of staff responsible for conducting each step in the process. (40 P.S. 991.2164.10(a)) |
| A: |
| 8. | Q: Describe the applicant’s process for ensuring and monitoring that those personnel  conducting reviews have current licenses or other required credentials in good  standing, without restrictions, from the appropriate agencies. (40 P.S. 991.2164.10(b)) |
| A: |
| 9. | Q: Describe the applicant’s system for ensuring consistency in decision making,  such as inter-rater reliability reviews, etc. (40 P.S. 991.2164.10; 28 Pa. Code 9.743(e)) |
| A: |
| 10. | Q: Identify the clinical criteria that will be used by the applicant. If purchased, indicate whether modifications were or will be made by the applicant. If internally developed, state when and how the criteria were first developed, how many years in actual usage, and when criteria were last updated. (40 P.S. § 991.2154(b)) |
| A: |
| 11. | Q: How often are the clinical criteria reviewed by the applicant? Describe the process  and frequency with which criteria will be modified and adopted. (40 P.S. 991.2154(b)(1)(iv); 28 Pa. Code 9.752(b)(2)). |
| A: |
| 12. | Q: Describe how the development of the criteria included input from health care  providers in active clinical practice. (40 P.S. 991.2154(b); 28 Pa. Code 9.752(b)(1)) |
| A: |
| 13. | Q: Describe how the applicant will make providers aware of their ability to request  criteria and the process the applicant will use to release criteria to providers  upon request. (40 P.S. 991.2154(a)(4)). |
| A: |

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| 14. | Q. Describe how the applicant will notify the health care provider within two business days of its receipt of a request for UR of the specific additional information or documentation necessary to complete the review. (40 P.S. 991.2152(a)(7) (citing 40 P.S. 991.2155)) |
| A: |
| 15. | Q: Once all reasonably necessary information is received by the applicant, utilization  review decisions must be made and communicated to the enrollee, the health care  provider, and the insurer or managed care plan within the timeframes required by (40 P.S. 991.2152(a)(4.1) (citing 40 P.S. 991.2155). |
| A: |
| 16. | Q: Applicants must provide written or electronic confirmation of the decision to the  enrollee, the health care provider, and the insurer or managed care plan. Describe how the  applicant will issue written or electronic confirmation to the parties. (40 P.S.991.2152(a)(4.1) (citing 40 P.S. 991.2155). |
| A: |
| 17. | Q: Applicants must conduct UR according to, and base decisions on, the medical necessity and/or appropriateness of the requested service, the enrollee’s individual circumstances, and the applicable contract language concerning benefits and exclusions, pursuant to 40 P.S. §991.2152(4), 40 P.S. 991.2155, 45 C.F.R. 147.136 and 29 C.F.R. 2560.503-1(g). Describe how the applicant will ensure UR decisions incorporate all three of these aspects. |
| A: |
| 18. | Q: A UR decision denying payment based on medical necessity and/or appropriateness must be made by a licensed physician pursuant to 40 P.S. § 991.2152(c) (citing 40 P.S. 991.2155). Describe how the applicant will accomplish this. |
| A: |
| 19. | Q: Approval from the Bureau is required if the applicant intends for licensed psychologists to issue UR decisions denying payment issued in matters concerning behavioral health pursuant to 40 P.S. § 991.2152(d). Does the applicant intend to have denial decisions issued by licensed psychologists? (Note: licensed psychologists may not review the denial of payment for inpatient health care or prescription drugs.) |
| A: (  ) Yes (  ) No  If yes, answer question 20. If no, skip to question 21. |
| 20. | Q: If utilizing licensed psychologists, provide the credentialing criteria for such reviewers and describe the process used to ensure that any psychologist reviewers are reviewing only those cases that fall within the psychologist’s scope of practice and that his/her clinical experience provides sufficient experience to review specific cases assigned. (28 Pa. Code 9.743(c)(2)). |
| A: |
| 21. | Q: Approval from the Bureau is required if the applicant intends for licensed dentists to issue UR decisions denying payment in matters concerning dental services pursuant to 40 P.S. § 991.2152(e). Does the applicant intend to have denial decisions issued by licensed dentists? |
|  | A: |
| 22. | Q: If utilizing licensed dentists, provide the credentialing criteria for those reviewers and describe the process used to ensure that any dentist reviewers are reviewing only those cases that fall within the dentist’s scope of practice and that his/her clinical experience provides sufficient experience to review specific cases assigned. (40 P.S. 991.2152(e)). |
|  | A: |
| 23. | Q: Written or electronic denial notifications must include the contractual basis and  clinical reasons for the denial and the procedures and timeframes to appeal the  decision. Provide samples of the letters the applicant will use to confirm denial  decisions. (Note: Decisions that approve less than the full services requested,  or services somehow other than requested, are considered denials.) (28 Pa. Code 9.752(f)) |
| A: |
| 24. | Q: Explain the applicant’s system for maintaining a written record of UR decisions adverse to enrollees, including a detailed justification for the decision and all required notifications to the enrollee and the health care provider, for a period not less than three years; to provide to the Bureau, if requested, these adverse decision records; and to provide summary information and data on all appeals decided, if applicable. (28 Pa. Code 9.743(b)(5)(vi)) |
| A: |
| 25. | Q: The applicant must conduct an annual evaluation of the UR program that includes an assessment of: the timeliness of decisions, the appropriateness of clinical criteria, the consistency of decision-making by staff through inter-rater reliability studies, and staff resources and training. This annual assessment must be approved by the Quality Assurance/Improvement Committee and presented to the Board of Directors. Please confirm that such an annual evaluation of the UR system is conducted, approved, and reported accordingly. (Note: Board meeting minutes may be required to verify compliance with this requirement.) (28 Pa. Code 9.751(b)) |
| A: |
| 26. | Q: Will the applicant be accepting delegation to perform internal complaint,  grievance, and/or adverse benefit determination reviews on behalf of the managed care plan? |
| A: (  ) Yes (  ) No  If yes, you must also complete Supplement I. |

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| Certification - Statement of Responsibility (to be completed by all applicants) An officer of the corporation with appropriate authority must execute this certification. | | |
| YES | NO | Please check the appropriate box for **each** response to the following: |
|  |  | All utilization review (UR) activities will be conducted in accordance with the confidentiality requirements of Act 146 (40 P.S. § 991.2131) and regulations related to managed care plans, found at 28 Pa. Code, Chapter 9. |
|  |  | Procedures for protecting the confidentiality of medical records will comply with the confidentiality provisions in Section 2131 of the Act and other applicable State and Federal laws and regulations imposing confidentiality requirements. |
|  |  | Any UR decision which results in the denial of payment for a health care service will be made by a licensed physician, approved licensed psychologist, or approved dentist. Any decision not resulting in a denial will be made by persons having appropriate credentials or licenses in good standing. All decisions will be provided in writing and will include the basis and clinical rationale for the decision in accordance with 40 P.S. § 991.2152. |
|  |  | Compensation from a managed care plan or insurer to a CRE, employee, consultant, or other person performing UR on its behalf will not contain incentives, direct or indirect, to approve or deny payment for the delivery of any health care service in accordance with 40 P.S. § 991.2152. |
|  |  | The Bureau will have access to the books, records, staff, facilities, and other information, including UR decisions, it finds necessary to determine whether a CRE is qualified to maintain its certification in accordance with Act 146 and other applicable State and Federal laws and regulations. |
|  |  | **Applicable only to entities delegated internal complaints, grievances, and adverse benefit determinations:** Internal complaints and grievances and expedited grievances will be reviewed and processed in accordance with Act 146 and Subchapter I. |
|  |  | **Applicable only to entities seeking certification to conduct external grievance and adverse benefit determination appeals:**   1. When performing external grievance and adverse benefit determination appeals, the CRE is willing and able to participate in the Bureau of Managed Care procedure for assignment of all external reviews on a rotational basis; 2. All external grievance and adverse benefit determination decisions will be made by one or more licensed physicians, approved licensed psychologists, or approved dentists in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed; and 3. The CRE will review the internal grievance or adverse benefit determination appeal decision based on whether the health care service denied by the internal grievance or adverse benefit determination process is medically necessary and/or appropriate under the terms of the plan. When reviewing a decision relating to emergency services, the CRE will utilize the emergency service standards of Act 146, the regulations, the prudent layperson standard, and the enrollee’s certificate of coverage. |
|  |  | An applicant applying for certification to perform UR must demonstrate to the Bureau that it has the ability to perform UR (and review of grievance and adverse benefit determination appeals, if applicable) based on medical necessity and/or appropriateness, without bias in accordance with 40 P.S. § 2151. |

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| **YES** | **NO** | Please answer the following questions and provide a detailed explanation for each “yes” answer. |
|  |  | Have any of the applicant’s officers, directors, or management personnel ever been involved in a bankruptcy proceeding as an officer, director, or senior manager of a corporation? |
|  |  | Have any of the applicant’s officers, directors, or management personnel ever been convicted of a state or federal offense related to health care? |
|  |  | Have any of the applicant’s officers, directors, or management personnel ever been listed by a state or federal agency as disbarred, excluded, or otherwise ineligible for state or federal program participation? |
|  |  | Have any of the applicant’s officers, directors, or management personnel ever been convicted of a criminal offense that would call in to question the individual’s ability to operate a certified review entity? |
|  |  | Have any of the applicant’s officers, directors, or management personnel ever had any malpractice or civil suits, penalties, or judgments against them? |
| All data, information, and statements in this application for certification are factual to the best of my knowledge, information, and belief.   |  |  | | --- | --- | | Signature | Title | | Name (printed) | Date | | | |

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| SUPPLEMENT I FOR ENTITIES DELEGATED THE PROCESSING APPEALS OF  INTERNAL COMPLAINTS, GRIEVANCES, AND ADVERSE BENEFIT DETERMINATIONS | |
| 1. | Q: Indicate below whether the applicant will be delegated to process internal complaints, grievances, and adverse benefit determinations. Throughout this section, please preface each response with a statement or other indication that identifies what types of appeals (complaints, grievances, and/or adverse benefit determinations) the response pertains.  (The Bureau uses the codes C, G, and ABD to indicate type and level.) |
| A: (  ) internal complaints (  ) second-level complaints  (  ) internal grievances (  ) internal adverse benefit determination appeals |
| 2. | Q: Confirm and provide procedures or policy demonstrating that the applicant is allowing an enrollee at least 45 days to file an initial complaint or grievance appeal (28 Pa. Code 9.702(d)(1)) or at least 60 days to file an appeal of an adverse benefit determination (29 CFR 2560.503-1(h)(2)(i)), from the date of the occurrence of the issue being appealed or from the date of the enrollee’s receipt of notice of the UR decision. (Complaint appeals may also be filed by the enrollee’s representative; grievance, and adverse benefit determination appeals may be filed by the enrollee’s representative or a health care provider, with the enrollee’s written consent.) |
| A: |
| 3. | Q: Describe all processes an enrollee, enrollee representative, or health care provider may use to file internal complaint, grievance, or adverse benefit determination appeals. If there are different requirements by type and level of appeal, please detail this in your response. |
| A: |
| 4. | Q: Provide policies, procedures, guidelines, or other documents used by the applicant  to classify an appeal as either a complaint, a grievance, or an adverse benefit determination. |
| A: |
| 5. | Q: Provide a sample acknowledgement letter to the enrollee (enrollee representative or health care provider) confirming receipt of an internal appeal. (See 28 Pa. Code 9.703(c)(1)(i), 9.705(c)(1)(i)). This confirmation must include the following information:   * whether the applicant considers the matter under appeal to be a complaint, a grievance, or an adverse benefit determination and that the enrollee may question this classification by contacting the Bureau; * that the enrollee may appoint a representative to act on the enrollee’s behalf; * that the enrollee may review information related to the appeal upon request   and/or submit additional material to be considered;   * that the enrollee may request the aid of an employee of the applicant who   has not participated in previous decisions to aid in preparing the enrollee’s  appeal, at no charge to the enrollee; and   * if the applicant chooses to permit attendance at the internal review, that the   enrollee may attend. |
| A: |
| 6. | Q: Describe the composition of the internal complaint review committee and provide  samples of the log sheets used to document the specific individuals serving as the  internal complaint committee. (40 P.S. 991.2141; 28 Pa. Code 9.703) |
| A: |
| 7. | Q: Describe the composition of the internal grievance review committee and provide  samples of the log sheets used to document the specific individuals serving as the  internal grievance committee. (40 P.S. 991.2161; 28 Pa. Code 9.705) |
| A: |
| 8. | Q: Describe the composition of the internal adverse benefit determination review committee and provide samples of the log sheets used to document the specific individuals serving as the internal adverse benefit determination committee. |
| A: |
| 9. | Q: Confirm and provide procedures or policies demonstrating that the applicant will  complete internal complaint, and grievance appeals and arrive at decisions within 30 days of receipt of request; and complete adverse benefit determination appeal reviews and arrive at decisions within 60 days of receipt of requests for appeal. (40 P.S. 991.2141, 991.2161, 991.2164; 29 CFR 2560.503-1(i)). |
| A: |
| 10. | Q: Within five business days of an internal complaint, grievance, or adverse benefit determination appeal decision, written notification must be provided to the enrollee. Verify and provide procedures or policies that this timeframe will be met. (40 P.S. 991.2141, 991.2161, 991.2164; 29 CFR 2560.503-1(i)). |
| A: |
| 11. | Q: Provide sample internal decision letters, for each type of appeal, to the enrollee  (enrollee representative or health care provider). The decision notification must  include the following information:   * a statement of the issue reviewed by the internal review committee; * the specific reasons for the decision; * references to the specific Plan provisions on which the decision is based; * any internal rule, guideline, protocol, or criterion relied on in making the decision,   and how to obtain the internal rule, guideline, protocol, or criterion;   * for grievances and adverse benefit determinations, an explanation of the scientific or clinical judgment for the   decision, applying the terms of the Plan to the enrollee’s medical circumstances; and   * how to request an external review of the internal grievance or adverse benefit determination decision, including process,   location to file, and timeframe in which to file.   * How to request a second level internal review of a complaint decision, including process, location to file, and timeframe in which to file.   (See 28 Pa. Code 9.703, 9.705; 29 CFR 2560.503-1(g)) |
| A: |
| 12. | Q: Provide a sample acknowledgment letter to the enrollee (enrollee representative  or health care provider) confirming receipt of a second-level internal complaint review. (28 Pa. Code 9.703(c)(2)(i)). The confirmation must include an explanation of the second-level review procedures and the following information:   * a statement that, and an explanation of how, the enrollee may request the aid of an employee of the applicant, who has not participated in previous decisions on the case, to help prepare the second-level appeal, at no charge to the enrollee; * the enrollee, the enrollee’s representative, and the health care provider have the right to appear before the second-level review committee; and * the applicant will provide 15 days advance written notice of the date and time scheduled for the committee meeting. |
| A: |
| 13. | Q: Describe the composition of the second-level internal complaint review committee and provide samples of the log sheets used to document the specific individuals serving as the second-level complaint committee. (28 Pa. Code 9.703(c)(2)(ii)) |
| A: |
| 14. | Q: Where will second-level complaint review committee meetings be held? (please include information about remote meeting options) (28 Pa. Code 9.703(c)(2)(iii)) |
| A: |
| 15. | Q: How will the applicant provide reasonable flexibility in terms of time and travel  distance when scheduling second-level complaint review meetings to facilitate the enrollee’s  attendance? Applicants should allow enrollees to participate by conference call or  other appropriate means if necessary. (28 Pa. Code 9.703(c)(2)(iii)) |
| A: |
| 16. | Q: Provide the applicant’s procedures for conducting the second-level complaint review meeting (such as who may attend the meeting; the introduction of persons attending the meeting, their  roles, voting status, etc., for the enrollee; materials to be presented and considered). (28 Pa. Code 9.703(c)(2)(iii)) |
| A: |
| 17. | Q: How will the proceedings (electronic recording, verbatim transcript, summary) be  memorialized and maintained? (28 Pa. Code 9.703(c)(2)(iv)) |
| A: |
| 18. | Q: Confirm and provide procedures or policies demonstrating that the applicant will  complete second-level complaint reviews and arrive at decisions within 45 days of receipt of requests for appeal. (28 Pa. Code 9.703(c)(2)(v)) |
| A: |
| 19. | Q: Within five business days of a second-level complaint decision, written  notification must be provided to the enrollee. Verify and provide procedures or  policies that this timeframe will be met. (28 Pa. Code 9.703(c)(vi)) |
| A: |
| 20. | Q: Provide sample second-level complaint decision letters to the enrollee  (enrollee representative or health care provider) (28 Pa. Code 9.703(c)(2)(vii)). The decision notification must include the following information:   * a statement of the issue reviewed by the second-level complaint review committee; * the specific reasons for the decision; * references to the specific Plan provisions on which the decision is based; * any internal rule, guideline, protocol, or criterion relied on in making the decision, and how to obtain the internal rule, guideline, protocol, or criterion; * how to appeal to the next level, including process, location to file, and timeframe in which to file. |
| A: |
| 21. | Q: For internal grievance and adverse benefit determination appeal reviews, describe how the applicant will meet the requirement to include in the review a licensed physician, approved licensed psychologist, or licensed dentist in the same or similar specialty, as would typically manage or consult on the health care service in question. (40 P.S. 991.2161(d), 991.2164, 28 Pa. Code 9.705(c)(3)) |
| A: |
| 22. | Q: Provide procedures or policies on the processing of health care provider-initiated grievance or adverse benefit determination appeals, including when and how enrollee consent is obtained, the required elements comprising consent, the provider’s responsibilities in this process, etc. |
| A: |
| 23. | Q: Confirm and provide procedures or policies demonstrating how the applicant will  complete expedited appeal requests. (See, e.g., 40 P.S. 991.2161, 991.2164; 28 Pa. Code 9.709)) |
| A: |

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| SUPPLEMENT II  FOR ENTITIES TO BE ASSIGNED EXTERNAL GRIEVANCE AND  ADVERSE BENEFIT DETERMINATION APPEALS  \*External Grievance Reviews are for MA or CHIP Managed Care Plans\*  \*External Adverse Benefit Determination Reviews are for Commercial Plans\* | |
| 1. | Q: Is the applicant applying to conduct external grievance and adverse benefit determination appeal reviews of physical and behavioral health appeals, physical health appeals only, or behavioral health appeals only? |
| A: (  ) Physical and Behavioral health  (  ) Physical health only  (  ) Behavioral health only |
| 2. | Q: Has the applicant conducted independent medical review of medical necessity appeal decisions issued by Medical Assistance (MA) or Children's Health Insurance Program (CHIP) managed care plans or Insurers? If so, has the applicant been conducting such reviews for at least three years? Describe the extent of the applicant’s experience, including such information as the number of states and/or companies where this type of review has been performed, the number of such reviews conducted by the applicant per year, etc. (Do not include reviews conducted for workmen’s compensation, disability, etc.) |
| A: |
| 3. | Q: List all the states for whom you have conducted, or for whom you are currently conducting, independent medical reviews for external medical necessity appeals. Provide a contact name and phone number for three of these states for reference purposes. (28 Pa. Code 9.743(e)) |
| A: |
| 4. | Q: Does the applicant have experience reviewing appeal cases involving patient  populations covered by MA or CHIP managed care plans or Insurers? (28 Pa. Code 9.743(e)) |
| A: |
| 5. | Q: Has the applicant’s experience included independent medical reviews of appeal cases involving experimental/investigational procedures or equipment? If so, how many such reviews has the applicant conducted per year, on average, for the last three years? Also, provide some examples of the types of experimental case reviews conducted. (28 Pa. Code 9.743(e)) |
| A: |
| 6. | Q: Provide a list of all Pennsylvania MA or CHIP managed care plans and Insurers, with whom the applicant has any type of business arrangement. Describe the nature of each arrangement and/or the services performed. Provide a contact name and phone number for three of these for reference purposes. (28 Pa. Code 9.743(b)(4)) |
| A: |
| 7. | Q: Describe the current capacity of the applicant’s administrative staff, in terms of the number and types of positions designated and ready to conduct Pennsylvania external review business. (28 Pa. Code 9.744(a)(4)) |
| A: |
| 8. | Q: Describe the applicant’s ability to have administrative staff available to process appeal cases during business hours, 8:00 a.m. to 5:00 p.m., Eastern Standard Time, Monday through Friday. (40 P.S. 991.2152(a)(1)(i)) |
| A: |
| 9. | Q: Describe how the applicant will process appeals on weekends and holidays. (40 P.S. 991.2152(a)(1)(ii), 28 Pa. Code 9.743(b)(5)(i)). |
| A: |
| 10. | Q: List the names, titles, addresses, telephone and fax numbers, and email addresses of a primary and at least one back-up person who will be responsible for processing external grievance and adverse benefit determination appeal requests and making review assignments. (28 Pa. Code 9.744(a)(2)) |
| |  |  | | --- | --- | | A: Primary: | Back-up: | |
| 11. | Q: Describe the applicant’s capacity for receiving both paper and electronic transmission of grievance and adverse benefit determination appeal case documents and correspondence. |
| A: |
| 12. | Q: The applicant must have access to a contracted and credentialed network of physician reviewers, which includes all the general specialties represented by the American Board of Medical Specialties, the subspecialties of oncology, and physician reviewers specializing in transplantation. In addition, the applicant must have a process to access other specialists/subspecialists as necessary. Please describe these arrangements. (28 Pa. Code 9.744(a)(4)(ii)). |
| A: |
| 13. | Q: Provide a listing of the number of reviewers available for each medical specialty and subspecialty who will be available to review grievance and internal adverse benefit determination appeals. The pool of reviewers should have sufficient depth to accommodate conflicts of interest with a plan, provider, member, or subject of the appeal or to accommodate the unavailability of reviewers for other reasons. (28 Pa. Code 9.744(a)(4)(ii)) |
| A: |
| 14. | Q: How will the applicant handle obtaining the services of a reviewer if all the contracted physician reviewers in a specialty are not available? (28 Pa. Code 9.744(a)(4)(ii)) |
| A: |
| 15. | Q: Describe the applicant’s screening process for physician, psychologist, and dentist conflicts of interest. (40 P.S. 991.2164.10(d)) |
| A: |
| 16. | Q: Describe how the applicant will ensure that an external grievance or external adverse benefit determination appeal decision is made by a licensed physician, approved licensed psychologist, or licensed dentist, in active clinical practice and/or board certified in the same or similar specialty, that would typically manage or recommend treatment for the health care service being appealed. (40 P.S. 991.2161, 991.2164.5) |
| A: |
| 17. | Q: Describe how the applicant will obtain, within 24 hours, the services of a qualified peer reviewer from any specialty or subspecialty as needed for an expedited grievance or adverse benefit determination appeal review. (28 Pa. Code 9.707(b)(5)(viii)). |
| A: |
| 18. | Q: Does the applicant have staff on-call 24 hours per day, 7 days per week to handle expedited/emergency situations? Describe the applicant’s ability to process, issue, and communicate a decision on an expedited grievance appeal within two business days or an adverse benefit determination within 72 hours from receipt of the case file, including the availability of administrative staff and physician, psychologist, or dentist reviewers on weekends and on State holidays. (40 P.S. 991.2164.10(a)(2)). |
| A: |
| 19. | Q: Are physician, psychologist, and dentist reviewers required to be available evenings, weekends, and holidays? (40 P.S. 991.2164.10(a)(1)(i)) |
| A: |
| 20. | Q: Describe the applicant’s capability of having communication with its physician, psychologist, and dentist reviewers on a 24 hour-per-day/7 day-per-week basis? (40 P.S. 991.2164.10(a)(1)(i)) |
| A: |
| 21. | Q: Describe the system or process the applicant has in place to track assigned cases and to ensure it meets the deadline for issuing a written decision to all parties (the enrollee, the health care provider, the authorized representative, the MA or CHIP managed care plan or Insurer, and the Pennsylvania Insurance Department (PID) within 60 days for external grievance appeals or within 45 days for external adverse benefit determination appeals, or alternate timeframes designated by PID on occasion as warranted. (40 P.S. 991.2164.10(a)(1)(i)) |
| A: |
| 22. | Q: Describe how the process in Question 21 (assigning and tracking cases) will be performed on weekends and holidays as necessary for expedited appeals. |
| A: |
| 23. | Q: Describe how the applicant’s review process includes consideration of the health plan’s contract/benefit language? How is this incorporated into the review and decision-making process? Do the applicant’s decision letters include an explanation of how the applicable contract language relates to the medical necessity decision issued? (28 Pa. Code 9.707, 9.708). |
| A: |
| 24. | Q: Decision letters must include:   * + 1. a description of the denial,     2. the date the IRO received the assignment from PID,     3. the date the review was conducted,     4. the date of the IRO decision     5. a statement of the decision,     6. the basis and clinical rationale for the decision, including references to the evidence or documentation, including evidence-based standards, considered in reaching the IRO's decision     7. contractual reference,     8. a list of documents reviewed,     9. the credentials and experience of the reviewer,     10. and, for MA or CHIP external grievance appeals, a statement that the decision can be appealed by either party within 60 days of receipt to a court of competent jurisdiction.   Provide three redacted sample decision letters for review, including one involving an experimental/investigational case.  (28 Pa. Code 9.707, 9.708; 29 CFR 2560.503-1(j)). |
| A: |
| 25. | Q: Describe how the applicant will ensure that decision letters contain all required elements and are free from grammatical, spelling, and other errors. (28 Pa. Code 9.707, 9.708; 29 CFR 2560.503-1(j)). |
| A: |
| 26. | Q: Describe the applicant’s ability to translate case information received and to issue decision letters in alternative languages if necessary and to ensure that such translation occurs in a timely manner, enabling the applicant to meet required timeframes, including expedited timeframes. (28 Pa. Code 9.707, 9.708; 29 CFR 2560.503-1(j)) |
| A: |
| 27. | Q: How often are the applicant’s computer records backed up? (28 Pa. Code 9.743(e)) |
| A: |
| 28. | Q: Describe the applicant’s contingency plans for emergencies or events when staff cannot get into the office to conduct business? How does the applicant ensure continuity of operations in these types of situations? (40 P.S. 991.2164.10(a)(1)(i)) |
| A: |
| 29. | Q: Provide the pricing structure charged by the applicant for reviews, including expedited reviews. This information will be used for the purpose of comparing fees among all certified independent review entities to determine the reasonableness of the applicant’s fees. (40 P.S. 991.2164.9(d)(4)). |
| A: |