Department of Insurance

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Utilization Review Programs
Certification of Compliance

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I/We, as a duly authorized officer(s) of _____
a licensed Health Insuring Corporation, pursuant to ORC 1751.823, hereby certify to the Ohio Department of Insurance that we have implemented a Utilization Review Program that is in compliance with sections 1751.77 through 1751.82 of the Ohio Revised Code (presented in summary form below).

The Health Insuring Corporation (H.I.C.) assures that if it contracts with a utilization review organization or other entity to perform the utilization review functions required by statute, the H.I.C. will monitor the activities of the utilization review organization or other entity to ensure that these requirements are met. The H.I.C. will also ensure that appropriate personnel have operational responsibility for the conduct of the utilization review program.

The H.I.C. assures that if it conducts utilization review, the utilization review program will be in writing and will describe all review activities for, both delegated and non-delegated including the following:

- Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services
- The use of data sources and clinical review criteria in making decisions
- Data collection processes and analytical methods used in assessing utilization of health care services
- Mechanisms for assuring confidentiality of clinical and proprietary information
- The periodic assessment of utilization review activities, and the reporting of these assessments to the health insuring corporation's board, by a utilization review committee, a quality assurance committee, or any similar committee
- The functional responsibility for day-to-day program management by staff
- Defined methods by which guidelines are approved and communicated to providers and health care facilities

The Utilization Review Program shall do all of the following:

- Use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy
- Use qualified providers to administer the program and oversee review determinations
- Use clinical peers in the same, or in a similar specialty as would typically managed the medical condition, procedure, or treatment under review to evaluate the clinical appropriateness of adverse determinations that are the subject of an appeal

- If utilization review activities are delegated, maintain adequate oversight, including a process by which the H.I.C. evaluates the performance of the organization and maintain copies of
  - A written description of the organization's activities and responsibilities including reporting requirements
  - Evidence of formal approval of the organization's program by the H.I.C.
- Provide members with toll-free access to its utilization review staff
- Obtain information required to make a utilization review determination, including pertinent clinical information and establish a process to ensure that utilization reviewers apply clinical review criteria consistently
- Collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of health care services
- Not include incentives to persons providing utilization review services that would encourage them to make inappropriate review decisions.
- Issue utilization review determinations pursuant to the requirements described below:
  - Make initial determinations within two business days of obtaining all necessary information regarding a proposed admission, procedure, or health care service
  - Notify the provider or health care facility of a determination to certify an admission, procedure, or healthcare service by telephone or fax within three business days of making the initial determination.
  - Notify the provider or health care facility of an adverse determination by telephone within three business days of making the adverse determination and provide written or electronic confirmation of the telephone notification to the member and the provider or health care facility within one business day after making the telephone notification.
  - Make concurrent review determinations within one business day after obtaining all necessary information
  - Notify the provider or health care facility of a determination to certify an extended stay or additional health care services by telephone or fax within one business day after making the determination.
  - Notify the provider or health care facility of an adverse determination by telephone within one business day of making the adverse determination and provide written or electronic confirmation to the member and the provider or health care facility within one business day after the telephone notification. The health care services to the member must be continued with standard copayments and deductibles, if applicable, until the member has been notified of the determination.
  - Make a retrospective review determination within 30 business days after receiving all necessary information.
  - Notify the member and the provider or health care facility of retrospective certification in writing
  - Notify the member and the provider or health care facility of a retrospective adverse determination within five business days of making the adverse determination
- Include written procedures for making expedited utilization review determinations and notifying members and providers or health care facilities, when warranted by the medical condition of the member.

- Include the following in written notification of an adverse determination
  - Principal reason or reasons for the determination
  - Instructions for initiating an appeal or reconsideration of the determination
  - Instructions for requesting a written statement of the clinical rationale used to make the determination; the clinical rationale will be provided upon request to any party that received notice of the adverse determination
- Have written procedures to address the failure or inability of a health care facility, provider or member to provide all necessary information for review
- Give the provider or health care facility an opportunity to request in writing on behalf of the member, a reconsideration of an adverse determination (a written description of this procedure must be included in the utilization review program)
- Require that reconsiderations are made within three business days after receipt of the written request for reconsideration
- Require that reconsiderations be conducted between the provider or health care facility and the reviewer who made the adverse determination; if the reviewer cannot be available within three business days the reviewer may designate another reviewer
- Expedite the reconsideration if required by the seriousness of the medical condition of the member and maintain written procedures for making an expedited reconsideration
- Allow an appeal if the reconsideration does not resolve the difference of opinion
- Will consider failure to make a determination and notification within the time frames specified in 1751.81, an adverse determination for the purpose of initiating an internal review.

The HIC also acknowledges that the Ohio Revised Code requires the utilization review program to include:

- A procedure for a standing referral to a specialist {ORC 1753.14(A)}
- A procedure to provide a referral to a specialist to provide services in the same manner as the PCP for a member with a condition or disease that requires specialized medical care over a prolonged period of time {ORC 1753.14(B)}
- A procedure for getting approval of a non formulary drug when the member cannot take the formulary drug (in cases where the plan offers prescription drug benefits with a restricted formulary) {1753.21(A)(2)}
- A description of the internal technology assessment process {1753.23(D)}

The Health Insuring Corporation acknowledges its responsibility to ensure that a new certification of compliance is filed annually with the Ohio Department of Insurance.

Print Name _____ Print Title _____

Signature _____ Date _____