NEBRASKA DEPARTMENT OF INSURANCE
P.O. BOX 82089
LINCOLN, NE 68501-2089

APPLICATION FOR CERTIFICATE TO TRANSACT BUSINESS AS A UTILIZATION REVIEW AGENT PURSUANT TO Neb.Rev.Stat. §44-5401 et seq.

TYPE OF ENTITY:

A. Check one Corporation Partnership Other _____
Please specify

1. Name of Applicant: _____

2. Federal I.D. # _____ Date Incorporated _____
D/M/Y

3. Principal Business Address: _____
Street Address

_____
City State Zip Code Telephone #

4. Mailing Address: _____
Street Address

_____
City State Zip Code Telephone #

5. Which classes or types of insurance will the applicant be conducting in Nebraska?

_____

6. Submit with the application documentation that the applicant has received approval or accreditation by the Utilization Review Accreditation Commission, Inc., or NCQUA.

7. Remit with the application a check in the amount of $300.00 in payment of the application fee.

(OVER)

8. List below the principal officers responsible for the operations, management and control of the applicant name herein:

Name _____ Title _____
Business Address: _____
Residence Address: _____
Social Security Number: _____

Name _____ Title _____
Business Address: _____
Residence Address: _____
Social Security Number: _____

Name _____ Title _____
Business Address: _____
Residence Address: _____
Social Security Number: _____

Name _____ Title _____
Business Address: _____
Residence Address: _____
Social Security Number: _____

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

This application must be signed by all named in position #8 above.

State of _____

County of _____

Subscribed to in my presence and duly sworn this _____ day of _____, 20____.

_____
Notary Public

DOI-URA
2-2006

Article 54
UTILIZATION REVIEW

Section

44-5416 Act, how cited.

Sections 44-5416 to 44-5431 shall be known and may be cited as the Utilization Review Act.

44-5417 Purpose of act.

The purpose of the Utilization Review Act is to establish requirements and standards of operation for certification of medical utilization review agents. It is proper for the state to oversee utilization review agents as a part of the state's regulation and supervision of the business of insurance and to encourage effective, efficient, and consistent utilization review.

44-5418 Terms, defined.

For purposes of the Utilization Review Act:

(1) Adverse determination means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefor denied, reduced, or terminated;

(2) Ambulatory review means utilization review of health care services performed or provided in an outpatient setting;

(3) Case management means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(4) Certification means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(5) Clinical review criteria means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(6) Closed plan means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan;

(7) Concurrent review means utilization review conducted during a patient's hospital stay or course of treatment;

(8) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(9) Department means the Department of Insurance;

(10) Director means the Director of Insurance;

(11) Discharge planning means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(12) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(13) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(14) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. Facility does not include physicians' offices;

(15) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(16) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(17) Health care provider or provider means a health care professional or a facility;

(18) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(19) Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(20) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(21) Network means the group of participating providers providing services to a managed care plan;

(22) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(23) Participating provider means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(24) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing;

(25) Prospective review means utilization review conducted prior to an admission or a course of treatment;

(26) Retrospective review means utilization review of medical necessity that is conducted after health services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(27) Second opinion means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(28) Significant beneficial interest means the ownership of any financial interest that is greater than the lesser of (a) five percent of the whole or (b) five thousand dollars;

(29) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment;

(30) Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review does not include elective requests for clarification of coverage; and

(31) Utilization review agent means any person, company, health carrier, organization, or other entity performing utilization review. The following shall not be considered utilization review agents:

(a) An agency of the federal government;

(b) An agent acting on behalf of the federal government or a federally qualified peer review organization or the State of Nebraska but only to the extent that the agent is providing services to the federal government or the State of Nebraska;

(c) An agency of the State of Nebraska;

(d) Internal quality assurance programs conducted by hospitals, home health agencies, preferred provider organizations, health maintenance organizations, other managed care entities, clinics, or

private offices for purposes other than for allowing, denying, or making a recommendation on allowing or denying a covered person's claim for payment;

(e) Nebraska licensed pharmacists, pharmacies, or organizations thereof while engaged in the practice of pharmacy, including the dispensing of drugs, participating in drug utilization reviews, and monitoring of patient drug therapy;

(f) Any person performing utilization review of workers' compensation benefits but only to the extent that the person is providing utilization review of workers' compensation benefits;

(g) Any individual or group employed or used by a utilization review agent certified under the Utilization Review Act when performing utilization review for or on behalf of such agent, including nurses and physicians; and

(h) An employee benefit plan or any person on behalf of an employee benefit plan to the extent that the activities of such plan or person are exempt from state regulation of the business of insurance pursuant to the federal Employee Retirement Income Security Act of 1974, as amended.

44-5419 Utilization review agent; certificate required; term.

On or after July 1, 1993, a utilization review agent may not conduct utilization review upon a covered person in this state unless the agent is granted a certificate by the director. Certificates granted under the Utilization Review Act shall be valid for two years from the date of issuance.

44-5420 Certificate; application; fee.

(1) An applicant for a certificate as a utilization review agent shall submit an application to the department upon a form which may be obtained from the department. The application shall be signed and verified by the applicant.

Along with the application, the applicant shall pay the application fee of three hundred dollars.

(2) As a part of the application, the applicant shall submit the following:

(a) Documentation that the applicant has received approval or accreditation by the American Accreditation HealthCare Commission/URAC, or a similar organization which has standards for utilization review agents that are substantially similar to the standards of the American Accreditation HealthCare Commission/URAC, and which has been approved by the director;

(b) A statement of the street and mailing address of the entity, telephone number of the entity, and a list of the principal officers of the entity responsible for its operation, management, and control; and

(c) Such other reasonable information or documentation as the department requires for enforcement of the Utilization Review Act.

44-5421 Certificate; director; grant or deny; notice and hearing requirements.

The director shall grant or deny a certificate within forty-five days of receipt of a completed application under section 44-5420. The director shall deny a certificate if the applicant does not meet the requirements of the Utilization Review Act. If a certificate is denied, the director shall notify the applicant by certified mail and shall specify the reasons for denial in the notice. The applicant shall have ten days from the date of receipt of the notice to request a hearing before the director pursuant to the Administrative Procedure Act, or he or she may reapply and respond to the reasons for the denial.

44-5422 Utilization review agents; procedures applicable; exceptions.

(1) Utilization review agents operating in this state shall comply with the following provisions:

(a) A utilization review agent, employees of a utilization review agent, or persons acting on behalf of a utilization review agent may not refer a patient who has undergone utilization review by that utilization review agent, employee, or person to:

(i) A health care facility or other provider in which the utilization review agent owns a significant beneficial interest; or

(ii) The utilization review agent's own health care practice;

(b) A utilization review agent, employees of a utilization review agent, or persons acting on behalf of a utilization review agent shall not accept or agree to accept any sum from any person for bringing or referring a patient to a health care provider;

(c) A utilization review agent shall not compensate employees or persons acting on behalf of the utilization review agent based directly on the number of adverse determinations;

(d) A utilization review agent shall allow a minimum of twenty-four hours following an emergency admission, service, or procedure for a covered person or his or her representative to notify the utilization review agent and request certification or continuing treatment for the condition;

(e) A covered person or an attending physician on behalf of a covered person may request an appeal of a decision not to approve or certify for clinical reasons. For such appeal, a covered person or attending physician on behalf of a covered person shall, upon request, have timely access to the clinical basis for the decision, including any criteria, standards, or clinical indicators used as a basis for such recommendation or decision;

(f) During a final appeal of a decision not to certify or approve for clinical reasons, a utilization review agent shall assure that a physician is reasonably available to review the case, except that if the health care services were provided or authorized by a provider other than a physician, such appeal may be reviewed by a nonphysician provider whose scope of practice includes the

treatment or services. Hospitals, health care providers, or representatives of the covered person may assist in an appeal; and

(g) A utilization review agent shall comply with the standards adopted by the organization that has granted the agent approval or accreditation and upon which the certificate was granted by the director, whether or not action is taken by such organization to enforce the standards.

(2) Subdivisions (1)(a) and (b) of this section shall not apply to a utilization review agent, employees of the utilization review agent, or other persons acting on behalf of such utilization review agent who refer a patient to:

(a) The health care provider or facility that participates in a health maintenance organization in which the patient is enrolled; or

(b) A preferred provider network of participating providers or facilities to which the patient would otherwise be referred as part of the patient's insurance contract or policy.

44-5423 Utilization review agent; notify director of changes; when.

A utilization review agent shall notify the director within five working days of any change of the agent's approval or accreditation status or of any material change in the information contained in the agent's application or renewal or that the agent no longer meets the requirements of the Utilization Review Act.

44-5424 Certificates; renewal; fee.

Certificates granted under the Utilization Review Act may be renewed prior to their expiration date upon the filing of the following with the department (1) a renewal fee of one hundred dollars, (2) a statement detailing any changes in the information or documentation filed with the initial application, and (3) such other reasonable information as the department requires for enforcement of the act.

44-5425 Health carrier; oversight of utilization review activities.

A health carrier shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of the Utilization Review Act and applicable rules and regulations are met. The health carrier shall also ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

44-5426 Utilization review program; use of clinical review criteria.

A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review

criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to authorized government agencies.

44-5427 Description of review procedures; toll-free number.

(1) In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures.

(2) A health carrier shall include a summary of its utilization review procedures in enrollment materials intended for prospective covered persons.

(3) A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

44-5428 Agent violation; notice; hearing.

If the director finds that any utilization review agent doing business in this state is engaging in any violation of the Utilization Review Act and that a proceeding in respect thereto would be in the public interest, he or she shall issue and serve upon such utilization review agent a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

44-5429 Violation; penalty.

If, after the hearing, the director finds a utilization review agent has violated the Utilization Review Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the utilization review agent charged with the violation a copy of the findings and an order requiring the utilization review agent to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Utilization Review Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the utilization review agent's license to do business in this state if the utilization review agent knew or reasonably should have known it was in violation of the act.

44-5430 Violation of cease and desist order; penalty.

Any utilization review agent who violates a cease and desist order of the director under section 44-5429 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the utilization review agent's license to do business in this state.

44-5431 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Utilization Review Act.