JAMES J. DONELON
COMMISSIONER OF INSURANCE
STATE OF LOUISIANA

P.O. Box 94214
Baton Rouge, Louisiana 70804-9214
Phone (225) 342-5900
Fax (225) 342-3078
http://www.ldi.state.la.us

MEDICAL NECESSITY REVIEW ORGANIZATION APPLICATION

GENERAL INSTRUCTIONS

This packet is designed to assist the individual preparing the application in complying with our requirements and procedures. The forms and procedures of the application process are designed to facilitate our review of the application. Therefore, it is extremely important that all applicants comply fully with the instructions and requirements set forth in this packet.

All communication should be directed to:

Louisiana Department of Insurance
Company Licensing Division
P.O. Box 94214
Baton Rouge, LA 70804-9214
Phone: (225) 219-4318
Fax: (225) 342-7401

While our Department will be happy to assist you and answer any questions you may have, we ask that you thoroughly review all instructions and forms before contacting us.

1) All submittals in association with this application must reach us via the United States Postal Service or a carrier with interstate business. Hand delivery is not acceptable and any information arriving in this manner will be returned without review. In addition, all correspondence must be sent to the attention of the Company Licensing Division to assure prompt receipt and handling.

2) Submit only a fully completed application. Submittal of a partially completed application will cause processing delays and may result in disapproval.

3) Do not alter the forms contained in this packet. If you feel the requirements do not apply to your situation, notify us. We will supply the proper form, if appropriate, and/or answer any questions you have about the forms.

4) All original items submitted become the property of the Louisiana Department of Insurance and <u>will not be returned</u>.

5) All certified documents required in the application must be dated within ninety (90) days of submittal of the application.

6) All entries in the application forms must be typed or printed. Illegible entries or responses will be considered incomplete and may result in the disapproval of the application.

7) When designating a contact person for the application process, please remember that our staff will communicate only with that individual. The application process is considered confidential and will not be discussed with any person other than the named contact person. We must be notified in writing of any change in the contact person.

8) We must be notified of any changes in the applicant or the information submitted in association with this application which occur while the application is under review. This includes changes in officers and directors and changes in address or domicile. Failure to notify us of such changes may result in disapproval of the application.

9) If, for some reason, an item which would otherwise be required is not available, a written explanation must be supplied upon submission.

10) Each exhibit requested in Section 4 of the attached application must be clearly labeled and dated.

11) It is the responsibility of the applicant to insure that none of the responses and submittals in association with this application conflict with the information filed with the domiciliary state. Conflicting information will result in the disapproval of the application.

REGISTRATION WITH THE LOUISIANA SECRETARY OF STATE

Submitting this application to the Louisiana Department of Insurance does not in any way dismiss a corporation from the requirements of registration with the Louisiana Secretary of State. It is the responsibility of the corporation to contact that Office and make whatever arrangements may be necessary. The address and telephone number are given below.

Louisiana Secretary of State
Corporations Division
P.O. Box 94215
Baton Rouge, LA 70804-9215
(225) 925-4704

SPECIAL INSTRUCTIONS FOR NOTARIZATION PAGE

The signatures which appear on the final page of the application are determined by the legal structure of the applicant. Below are the expected variations and the instructions for who should sign the application in each case.

IF THE APPLICANT IS A(N)....	THE APPLICATION SHOULD BE SIGNED BY...
Individual	the applicant
Corporation	the president and secretary
Association	the president and secretary
Partnership	two partners
Trust	two trustees
Any other	contact the Department for instructions

WAIVER OF EXHIBITS

An applicant may request that Exhibits A, B, and/or C in Section 6 of this application be waived if the requested information is currently on file with the Louisiana Department of Insurance in association with another license held by the entity. To qualify for the waiver the applicant must specify the types of license for which the information has previously been submitted and the information must be current.

Any person who has filed the biographical affidavit requested in Exhibit D in association with another application may, in lieu of filing a complete affidavit, supply a signed and notarized statement confirming that there have been no material changes to the information filed previously and include a reference to the date of the previous affidavit and the name of the entity and type of license for which it was previously filed.

COMMON QUESTIONS

The following are some of the most commonly asked questions regarding the application package and process.

Q: Where can I find the laws and regulations governing medical necessity review organizations in Louisiana?

A: The laws governing medical necessity review organizations can be found in Chapter 7 of Title 22 of the Louisiana Revised Statutes (LRS 22:3070 et seq.). For your convenience, a copy of the statutes and rules are available on the Department of Insurance's web page at www.ldi.state.la.us.

Q: What is the time frame for the review of an application?

A: This Department reviews all applications as soon after submittal as possible. The review process can be expected to take from sixty (60) to ninety (90) days from receipt of a complete application. Please take this time frame into account when considering deadlines and operation schedules for the applicant.

Q: Can the forms in the application packet be recreated on a word processor for completion by the applicant?

A: No. The forms in this packet are designed for ease of recognition by our staff and, in many cases, in strict compliance with statutory wording requirements. Therefore, any changes in the format or wording of the forms will cause delays in the review and may lead to the disapproval of the application. The forms are, however, available in MS Word format via electronic mail upon request.

Q: Can we meet with the Department for a preliminary review of our application prior to submission?

A: Yes. Our staff will be happy to meet with representatives of the applicant to review the application before it is actually submitted. It should be noted, however, that this courtesy review is to help assure completeness only and our Division will not issue a preliminary approval or disapproval of the application prior to submission. Any application sent to this Office via U.S. Mail will be considered submitted for review and will not be eligible for a pre-review. You may make an appointment for preliminary review by contacting the Company Licensing Division of the Louisiana Department of Insurance. Preliminary reviews will be performed only with an appointment.

Q: What is the difference between an authorized medical necessity review organization and a licensed medical necessity review organization?

A: Only health insurance issuers such as insurance companies and health maintenance organizations licensed in this state qualify may be authorized as a medical necessity review organizations. The application requirements for this type of entity are fewer because the entities are already required to maintain much of the needed information in association with their Certificate of Authority as an insurer. All other entities are required to be licensed.

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APPLICATION TO ACT AS A MEDICAL NECESSITY REVIEW ORGANIZATION IN THE STATE OF LOUISIANA

GENERAL INFORMATION (Type or Print)

APPLICANT NAME: _____

TRADE NAME: _____

FEI OR SOCIAL SECURITY NO.: _____ **DOMICILE:** _____

HOME OFFICE ADDRESS: _____

_____

_____

CONTACT _____ **CONTACT TITLE:** _____

CONTACT ADDRESS: _____

_____

_____

PHONE: _____ **FACSIMILE:** _____

E-MAIL: _____

† This Office will only communicate with the named contact person.

TYPE OF APPLICATION (Check one)

☐ **LICENSE** ☐ **AUTHORIZATION (Health Insurance Issuers Only)**

NAIC # of Applicant (including Holding Company Number) _____

FEES Health Insurance Issuers are not required to pay the fee.	
Initial Application	**$ 1,500.00**

SECTION 2 - INTERROGATORIES

All of the following questions must be answered for every applicant. ATTACH A FULL EXPLANATION FOR ANY "YES" ANSWERS

1) Has the applicant ever had an application denied by any regulatory authority?	☐ **YES**	☐ **NO**
2) Has the applicant ever been subject to any regulatory action including cease and desist orders, revocation of license or similar actions?	☐ **YES**	☐ **NO**
3) Has the applicant ever changed its name?	☐ **YES**	☐ **NO**
4) Within the last five years, has the applicant merged or consolidated with any other entity?	☐ **YES**	☐ **NO**
5) Within the last five years, has the applicant undergone a change in ownership of five percent or more?	☐ **YES**	☐ **NO**
6) Is the applicant presently negotiating or inviting negotiations or acting as party to a counterletter which would result in a merger or consolidation with any other entity or which would result in a change of ownership of five percent or more?	☐ **YES**	☐ **NO**
7) Does the applicant contemplate a change in management or any transaction which would normally result in a change of management within the foreseeable future?	☐ **YES**	☐ **NO**
8) Is the applicant owned, operated or controlled, directly or indirectly, by any other state or province, district, territory or nation or any governmental subdivision or agency?	☐ **YES**	☐ **NO**
9) Is the applicant a plaintiff or defendant or subject in any legal action?	☐ **YES**	☐ **NO**
10) Does the applicant have any material professional, familial or financial interest with any entity which will be used to perform external reviews of any case?	☐ **YES**	☐ **NO**
11) Does the applicant own or control a health insurance issuer, health benefit plan, a national, state or local trade association of health benefit plans, or a national, state, or local trade association of health care providers?	☐ **YES**	☐ **NO**
12) Is the applicant owned or controlled by a health insurance issuer, health benefit plan, a national, state or local trade association of health benefit plans, or a national, state, or local trade association of health care providers?	☐ **YES**	☐ **NO**
13) Is the applicant a party to any agreement or understanding with any insurer in which the effect of the agreement is to make the amount of the applicant's commission, fees, or charges contingent upon savings realized in the adjustment, settlement, and payment of losses covered by the insurer's obligations?	☐ **YES**	☐ **NO**
14) Has any person who is presently an officer, director or owner of five percent or more of the applicant ever been convicted of or pleaded guilty or nolo contendere in any jurisdiction to a felony?	☐ **YES**	☐ **NO**

SECTION 3 - LIST OF CONTRACTS WITH INSURERS

List the name and address of all health insurance issuers with which the applicant is currently contracted as a medical necessity review organization in Louisiana.

INSURER NAME	INSURER ADDRESS

SECTION 4 - LIST OF CONTRACTS WITH INDEPENDENT REVIEW ORGANIZATIONS

List the name and address of all independent review organizations (IRO) with which the applicant is currently contracted, a brief description of the type of review performed by each independent review organization, and a copy of the executed contract. Applicants are required to file copies of executed contracts with IROs within 30 days of the date of each such contract. .

NAME:		**S.S.#:**	
STREET:	**CITY:**	**STATE:**	**ZIP:**
TYPE OF REVIEW			
NAME:		**S.S.#:**	
STREET:	**CITY:**	**STATE:**	**ZIP:**
TYPE OF REVIEW			
NAME:		**S.S.#:**	
STREET:	**CITY:**	**STATE:**	**ZIP:**
TYPE OF REVIEW			
NAME:		**S.S.#:**	
STREET:	**CITY:**	**STATE:**	**ZIP:**
TYPE OF REVIEW			
NAME:		**S.S.#:**	
STREET:	**CITY:**	**STATE:**	**ZIP:**
TYPE OF REVIEW			
NAME:		**S.S.#:**	
STREET:	**CITY:**	**STATE:**	**ZIP:**
TYPE OF REVIEW			
NAME:		**S.S.#:**	
STREET:	**CITY:**	**STATE:**	**ZIP:**
TYPE OF REVIEW			

SECTION 5 - LIST OF MANAGEMENT AND OWNERS

Below give a complete list of all persons responsible for the conduct of affairs of the applicant. This list should include all officers, all directors, all members (in the case of a limited liability company or similar entity) all partners (in the case of a partnership), all trustees, all executive committee members and any natural person(s) owning, directly or indirectly, ten percent or more of the applicant and any other person who exercises control or influence over the affairs of the applicant.

Name	Position	Ownership Percentage

SECTION 6 - EXHIBITS

1) EXHIBIT A - COPY OF THE ARTICLES OF INCORPORATION, ARTICLES OF ASSOCIATION, PARTNERSHIPAGREEMENT OR OTHER SUCH ORGANIZATIONAL DOCUMENTS AND ALL AMENDMENTS THERETO of the applicant certified by the proper domiciliary official. The certification must be original and dated within ninety (90) days of submission.

2) EXHIBIT B - COPY OF THE BY-LAWS, RULES, REGULATIONS OR SIMILAR DOCUMENT OF THE APPLICANT certified as true and correct by the secretary of the applicant. The certification must be original and dated within ninety (90) days of submission.

3) EXHIBIT C - TRADE NAME CERTIFICATE issued by the Secretary of State of Louisiana. This item must be supplied by any applicant utilizing a trade name in Louisiana.

4) EXHIBIT D - BIOGRAPHICAL AFFIDAVITS for all persons responsible for the conduct of affairs of the applicant. This shall include all officers, directors, partners (in the case of a partnership), trustees, executive committee members, the medical director and any person who owns, directly or indirectly, five percent or more of the applicant and any other person who exercises control or influence over the affairs of the applicant and all individuals designed to make adverse medical necessity determinations. The National Association of Insurance Commissioners biographical affidavits should be used. If necessary this form can be obtained by contacting the Company Licensing Division of the Louisiana Department of Insurance.

5) EXHIBIT E – DESCRIPTION OF PROCEDURES used in making medical necessity determinations that describes all review activities performed for one or more health benefit plans. The description shall include all of the items listed below. IF THE EXACT FORMAT GIVEN BELOW IS NOT FOLLOWED, THE APPLICANT MUST INCLUDE AN INDEX SHEET PROVIDING THE PAGE AND PARAGRAPH LOCATION OF EACH OF THE ITEMS.

- **The methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services.**
- **Data sources and clinical review of criteria used in decision-making. The appropriateness of clinical review criteria shall be fully documented.**
- **The process for conducting appeals of adverse determinations including informal reconsiderations.**
- **Samples of written notifications of adverse determination and letters of appeals.**
- **Mechanisms to ensure consistent application of review criteria and compatible decisions.**
- **Data collection processes and analytical methods used in assessing utilization of health care services.**
- **Provisions for assuring confidentiality of clinical and proprietary information.**
- **The organizational structure, including any review panel or committee, quality assurance committee, or other committee that periodically accesses health care review activities and reports to the health benefit plan.**

SECTION 6 – EXHIBITS (Continued)

- **The medical director's responsibilities for day-to-day program management.**
- **Any quality management program utilized by the applicant.**
- **The number of toll-free numbers maintained to assure reasonable access to the applicant's review staff and procedures to assure such toll-free numbers are operational for any period of time that an authorization, certification, or approval of coverage is required.**

6) EXHIBIT F – COPY OF THE FORMS OF ALL CONTRACTS in use or to be used by the applicant with health insurance issuers, nonfederal government health benefit plan or other group health plan for making determinations of medical necessity. These forms shall not include fees charged.

7) EXHIBIT G – COPY OF THE FORM OF ALL CONTRACTS OR EMPLOYMENT AGREEMENTS in use or to be used by the applicant with individuals that make medical necessity determinations.

8) EXHIBIT H – GENERAL DESCRIPTION OF OPERATION of the MNRO, which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge or encumber the independent medical judgment of treating physicians or health care providers.

9) EXHIBIT I - A DETAILED DESCRIPTION of the corporate organizational structure of the applicant, its parent company and all affiliates. This description should include a chart showing the ownership percentages for any persons owning 10% or more of all affiliated entities up to and including the ultimate controlling person. For a sample chart please go to our web site at http://www.ldi.state.la.us/Licensing/Company/index.htm

10) EXHIBIT J – For individuals designated to make adverse medical necessity determinations, provide the following information.

- **A description of the types of determinations that will be made by the individual and the type of license that will be required to support such determinations; and**
- **For clinical peers, a statement that the individual has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.**
- **An attestation statement that no adverse determination will be made regarding any medical procedure or service outside the scope of such individual's expertise.**

SECTION 7 - GENERAL INFORMATION

1) Below provide the exact location of the principal place of business where the applicant will be operating.

_____

_____

_____

_____

2) Give the name, address, telephone number and e-mail address of the representative of the applicant designated to receive, review and resolve all grievance addressed to the applicant.

_____

_____

_____

_____

Phone_____E-mail_____

3) Give the name, address, license number, state of issuance of the license and specialty of the medical director of the applicant.

_____

_____

_____

_____

License Number:_____State of Issuance_____

Specialty_____

4) Give the toll free number(s) established by the applicant to receive information related to external review.

_____

SECTION 7 - GENERAL INFORMATION

5) If available, give the URL or World Wide Web address of the applicant.

_____

6) Give the name and telephone number of the contact person in charge of maintaining the name, address, and qualifications of all individuals designated to make adverse determinations as required in Section 3073 (A)(8).

_____

NOTARIZATION

STATE OF _____

COUNTY OR PARISH OF_____

BEFORE ME, the undersigned authority, personally appeared _____

and _____ **who, after being duly sworn, did depose and say that all information contained in this application and all attachments thereto is, to the best of his/her knowledge, true, complete and correct.**

_____	_____
Witness' Signature	**Signature of Applicant or Authorized Representative**
_____	_____
Witness' Printed Name	**Printed Name and Title of Authorized Representative**
_____	_____
Witness' Signature	**Signature of Authorized Representative of Applicant**
_____	_____
Witness' Printed Name	**Printed Name and Title of Authorized Representative**

SWORN TO and subscribed before me this _____ **day of** _____**, 20**___**.**

_____

Notary Public's Signature

_____

Notary Public's Printed Name

My Commission Expires _____