



**RHODE ISLAND DEPARTMENT OF HEALTH
OFFICE OF MANAGED CARE REGULATION
UTILIZATION REVIEW REPORTING FORM INSTRUCTIONS**
(updated December 2014)

Reporting requirements are establishing pursuant to section 8.0 the Rules and Regulations for the Utilization Review of Health Care Services, (R23-17.12-UR):

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7035.pdf>

TIMEFRAMES: Quarterly report form are due by 3/1, 6/1, 9/1, and 12/1 of each year with the data for the previous quarter. There are no waivers granted for the reporting requirement. All certified agencies must submit quarterly report forms. Certified agencies that do not perform any utilization review activities must still submit quarterly data, however, they may instead submit it as a letter of attestation instead of filling out the form. Such a letter of attestation must include the UR certificate number, and the year and quarter for the information.

NON-COMPLIANCE: Failure to report in accordance with the timeframes will result in a fine determined by the Director (see section 8.4 of R23-17.12-UR).

FORMAT:

- Quarterly report form must be notarized
- Quarterly report form must contain correct UR certificate number
- Quarterly report form must identify the correct year and quarter
- Quarterly report form must identify the category (Commercial, RItCare/Medicaid, or Medicare). Separate quarterly report forms must be submitted for each such category.

HOW TO SUBMIT: Please e-mail a pdf copy of the quarterly report form or the attestation letter to DOH.ManagedCare@health.ri.gov Please include 'Quarterly UR Report' along with the name of your agency in the e-mail heading.

CONTACT INFORMATION: To contact the Office of Managed Care Regulation, please e-mail DOH.ManagedCare@health.ri.gov or call (401) 222-6015.

Rhode Island Department of Health
UTILIZATION REVIEW REPORTING FORM [QUARTERLY REPORT]
Health Care Services -- Utilization Review Act

UR Agency*: _____

UR Certificate #s: _____

Report for _____ Quarter, for Year: _____

Contact: _____ Phone #: (____) _____

Please attest to the following:

"I state that all the information contained in this report is complete, accurate, and correct to the best of my knowledge and belief."

Signed and dated by one of the following: President, CEO, COO, CMO, CIO Date: _____

Signed and dated by Notary Public Date: _____

*If the UR agency has patients in more than one of the following categories, required data elements shall be submitted in separate reports for each. Check the category to which this report applies {choose only one}:

- Commercial RItE Care/Medicaid Medicare

This form is intended for use by Rhode Island certified utilization review (UR) agencies to report data as required by the Health Care Services -- Utilization Review Act [RIGL 23-17.12]. If your organization is a utilization review agency and a health plan, both quarterly data reporting forms must be submitted (in addition to Health Plan Annual Report). For required quarterly data reporting for health plans, please use the applicable Health Plan Data Reporting Form. Note the data required on each form may not correspond since one applies to a utilization review agency and the other applies to a health plan. Hence, the population denominator of the two reports may be different.

- Report required data elements only for individuals who are Rhode Island residents and/or for those who received or requested health care services in Rhode Island.
- The denominator should be based on activities of the UR agency, not those of a specific Health Plan.
- Data shall be due to the Department by 6/1, 9/1, 12/1, and 3/1 of each year and correspond to the previous quarter.
- Health service categories listed in each section are mutually exclusive. Categorize and report multiple complaints, or utilization review requests for services/appeals, according to:
 1. primary issue (diagnosis); or
 2. type of provider (service facility).

- Before compiling required data, see Definitions section (p. 6) for an explanation of all terms & required data elements.
- For all inquiries, please contact:

Rhode Island Department of Health
 Office of Managed Care Regulation
 3 Capitol Hill, Providence, RI 02908
 Phone: (401) 222-6015
 E-mail: DOH.ManagedCare@health.ri.gov

1. **Requests and Claims for Prospective Authorization for Covered Services:**
{This section should only include data on prospective authorization requests and claims/denials for covered services processed through the utilization review program.}

- Report number of requests and claims for prospective authorization the agency received during the quarter in each health service area listed.
- Report number accepted, modified, or otherwise approved.
- Report those prospectively denied for lack of medical necessity.

Service Categories	Number of Prospective Requests & Claims	Accepted, modified, or otherwise approved	Medical necessity denials
Hospital Inpatient			
Hospital Emergency Dept.			
Other Hospital Outpatient			
Sub-acute Inpatient			
Physician			
Other Professional			
Pharmaceutical Supplies			
Substance Abuse			
Mental Health			
Health Education			
Other Covered			
TOTAL			

2. **Requests and Claims for Concurrent Authorization for Covered Services:**
 {This section should only include data on concurrent authorization requests and claims/denials for covered services processed through the plan’s utilization review program.}

- Report number of requests and claims for concurrent authorization the agency received during the quarter in each health service area listed.
- Report number accepted, modified, or otherwise approved.
- Report those concurrently denied for lack of medical necessity.

Service Categories	Number of Concurrent Requests & Claims	Accepted, modified, or otherwise approved	Medical Necessity Denials
Hospital Inpatient			
Hospital Emergency Dept.			
Other Hospital Outpatient			
Sub-acute Inpatient			
Physician			
Other Professional			
Pharmaceutical Supplies			
Substance Abuse			
Mental Health			
Health Education			
Other Covered			
TOTAL			

3. **Requests and Claims for Retrospective Authorization for Covered Services:
 {This section should only include data on retrospective authorization requests and claims/denials for covered services processed through the utilization review program.}**

- Report number of requests and claims for retrospective authorization the agency received during the quarter in each health service area listed.
- Report number accepted, modified, or otherwise approved.
- Report those retrospectively denied for lack of medical necessity.

Service Categories	Number of Retrospective Requests & Claims	Accepted, modified, or otherwise approved	Medical necessity denials
Hospital Inpatient			
Hospital Emergency Dept.			
Other Hospital Outpatient			
Sub-acute Inpatient			
Physician			
Other Professional			
Pharmaceutical Supplies			
Substance Abuse			
Mental Health			
Health Education			
Other Covered			
TOTAL			

4. Appeals (Level 1, Level 2, External)

{This section should only include data on appeals and overturns processed through the utilization review program.}

- Report number of appeals (prospective, concurrent, and retrospective only) of adverse utilization review decisions (denials) at each level, in each health service area listed.
- Report number overturned at each level, in each health service area listed.

Prospective, Concurrent, & Retrospective

Service Categories	Level 1	Overturned	Level 2	Overturned	External	Overturned
Hospital Inpatient						
Hospital Emergency Dept.						
Other Hospital Outpatient						
Sub-acute Inpatient						
Physician						
Other Professional						
Pharmaceutical Supplies						
Substance Abuse						
Mental Health						
Health Education						
Other Covered						
TOTAL						

DEFINITIONS

Adverse Determination means any decision by a review agent not to certify a health care service; provided, however, that a decision by a reviewing agent to certify a health care service in an alternative treatment setting, or to certify a modified extension of stay, or an alternative treatment, shall not constitute an adverse determination if the reviewing agent and the requesting provider are in agreement regarding the decision. Adverse determinations shall include decisions not to certify formulary and non-formulary medication.

All Other Covered Health Care Services includes all other health care services, supplies, and medications, which are not included in the above categories or cannot be identified and allocated.

Appeal:

Level 1 Appeal is when an enrollee, their representative, or a provider seeks a review of a denial by a review agent.

Level 2 Appeal is when an enrollee, their representative, or a provider seeks a review of a decision made at a level 1 appeal.

External Appeal is when an enrollee, their representative, or a provider seeks a review of the decision made at a level 2 appeal. An external appeal is conducted by an unrelated, objective agency designated by the Director of Health pursuant to RIGL 23.17.12.

Overtured means a decision by the health plan to approve payment for a covered (physician, hospital, etc.) service as a result of a review of an appeal.

Concurrent Authorization Denials for Lack of Medical Necessity are adverse determinations (denials) made as a result of a review conducted during a patient's hospital stay or course of treatment. The adverse determination is based on the service being deemed not medically necessary in the given situation. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed.

Health Education Services includes services for enrollee health education including provision to the general public or groups of enrollees of information about health risks, the importance of preventive services, lifestyle modifications, patient compliance with treatment regimens, avoidance of questionable medical interventions. It also includes subsidies for enrollees to join health clubs and exercise groups or other programs, which may reasonably be expected to reduce risks of disease or injury and improve general health. This does not include individual provider-patient advice and counseling.

Hospital Emergency Department Services includes those provided and billed for by the hospital for services in its accident room, emergency room, or emergency department. This includes ancillary services such as lab tests and radiology. Physician services that are billed for by the hospital are included. Services reported as inpatient services should not be included here.

Hospital Inpatient Services includes inpatient services provided by institutions licensed as hospitals. This includes routine and ancillary services. Routine services include room and board (including intensive care units, coronary care units, and other special units), dietary and nursing services, medical-surgical supplies, and other facilities for which the provider does not normally make a separate charge. Ancillary services include laboratory, radiology, drugs, delivery room, and physical therapy services. Substance abuse services and mental health services provided by specialty hospitals should be reported as Substance Abuse or Mental Health Services below. Services provided in independent rehabilitation units of hospitals should be reported as Sub-acute Inpatient Services.

Mental Health Services include inpatient and outpatient services, supplies, and medications for treatment of mental health problems to the extent that these services can be determined. Inpatient services of specialty hospitals are included. Outpatient services of qualified mental health service providers are included here.

Other Hospital Outpatient Services includes all other services and supplies provided and billed for by hospitals which are not included in the above accounts.

Other Professional Services includes services of dentists, optometrists, nurses, clinical personnel such as technicians and technologists, therapists, those involved in vocational and physical rehabilitation, and other paraprofessional health care providers which are not reported in the above accounts or substance abuse/mental health professionals services reported below.

Pharmaceutical Services and Supplies includes prescription drugs and proprietary medications except those included in above service categories.

Physician Services includes services provided and billed for by physicians and physician practices. This includes physician extender services, community health center physician services, and ambulatory surgical services provided in freestanding facilities. Staff model HMOs should report physician services and support services for physicians similar to that, which would be provided in physician office practices in so far as, is reasonable.

Prospective Authorization Denials for Lack of Medical Necessity are adverse determinations (denials) made as a result of a review conducted prior to a patient's hospital stay or course of treatment. The adverse determination is based on the service being deemed not medically necessary in the given situation. Prior Authorization shall mean the same as prospective authorization.

Reasons for Denial:

Not Medically Necessary includes denials for services that are deemed not medically necessary for treatment and denials that result in limiting the amount of services for which payment is made.

Denials Unrelated to UR/Medical Necessity includes denials made for reasons other than medical necessity (e.g.: did not follow procedures for prior authorization).

Requests and Claims for Covered Services are any covered services ordered by a provider and/or in the event of prior authorization, requests by either a provider or a member. Requests and claims may also include those covered services obtained by a member whereby a provider order is not required (e.g. emergency room service).

Retrospective Authorization Denials for Lack of Medical Necessity are adverse determinations (denial) made as a result of a review conducted on health care services that have been rendered. Retrospective review shall not include reviews conducted when the review agency has been obtaining ongoing information. The adverse determination is based on the service being deemed not medically necessary in the given situation.

Sub-acute Inpatient Services includes inpatient services that are not included in the hospital or substance abuse/mental health categories such as skilled nursing homes, intermediate care facilities, and independent rehabilitation units.

Substance Abuse Services includes inpatient and outpatient services, supplies, and medications for treatment of chemical dependency to the extent that these services can be determined. Inpatient services for specialty hospitals and units are included. Outpatient services of chemical dependency psychologists and counselors are included here.

Utilization Review means the prospective, concurrent, or retrospective assessment of the medical necessity and appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient, or group of patients. Utilization review does not mean the elective requests for clarification of coverage or claims review that does not include the assessment of medical necessity and appropriateness of a provider's internal quality assurance program except if it associated with a health care financing mechanism.

Utilization Review Agency means a person, entity, or insurer performing utilization review that is either employed by, affiliated with, under contract with or acting on behalf of:

- a) a business entity doing business in this state; or
- b) a party that provides or administers health care benefits to citizens of this state, including but not limited to a health insurer, self-insured plan, non-profit health services plan, health insurance plan, health insurance service organization, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state; or
- c) a provider.