**STATE OF NEW HAMPSHIRE**
**INSURANCE DEPARTMENT**
**21 South Fruit Street**
**Suite 14**
**Concord NH 03301**
**TELEPHONE 603-271-2261 FAX 603-271-1406**

**Roger A. Sevigny,**
**Commissioner**

# LONG TERM CARE INDEPENDENT REVIEW ORGANIZATION CERTIFICATION APPLICATION

NH Code of Administrative Rules INS 3601.30 provides for independent review of a long-term care insurer's determination that the benefit trigger for receiving long term care benefits under the policy has not been met. The NH Insurance Department is responsible for maintaining a list of certified or approved independent review organizations qualified to review the insurer's benefit trigger determination. This independent review is governed solely by the provisions of INS 3600, not by the general external review provisions.

## APPLICATION PACKAGE CONTENTS

- **Instructions**
- **Certification Requirements**
- **Application Form**
- **Personal Background Disclosure Statement Form**
- **Medical Director Professional Background Disclosure Form**
- **Provider Network Conflict of Interest Affirmation Form**
- **Authorization/Release Form**
- **Conflict of Interest Affirmation Form**

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**Roger A. Sevigny**
**Commissioner**

## LONG TERM CARE INDEPENDENT REVIEW ORGANIZATION CERTIFICATION APPLICATION

# INSTRUCTIONS

- Please type or print responses.
- Mark each response with the number of the corresponding item on the application. Mark all attachments similarly.
- Submit bound application and use appropriately numbered tabs (3 ring binder is acceptable).
- Submit all information except where exceptions are identified.
- Submit one original and one copy of the application package.
- Incomplete applications will not be processed.
- For renewal certificates, submit application at least two months prior to expiration date of current certificate.
- False or misleading statements may result in denial or revocation of certificate and/or other penalty authorized by law.

Mail completed application package to:

Kathleen Belanger, Director of External Review
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

Questions may be addressed to:

Kathleen Belanger, Director of External Review
603-271-7973, Ext. 216
kathleen.belanger@ins.nh.gov

## PLEASE NOTE THE FOLLOWING CERTIFICATION REQUIREMENTS:

I. NH Code of Administrative Rules INS 3601.30(e) authorizes the New Hampshire Insurance Department to certify a qualified long-term care insurance independent review organization that meets all of the following requirements:

(1) Has on staff, or contracts with, a qualified and licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment (e.g. physical therapy, occupational therapy, neurology, physical medicine and rehabilitation) to conduct the review.

(2) Neither it nor any of its licensed health care professionals is, in any manner, related to or affiliated with an entity that previously provided medical care to the insured.

(3) Utilizes a licensed health care professional who is not an employee of the insurer or related in any manner to the insured.

(4) Neither it nor its licensed health care professional who conducts the reviews receives compensation of any type that is dependent on the outcome of the review.

(5) Provides a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.

(6) Provides the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

(7) Has on staff or contracts with a licensed health care practitioner, as defined by section 7702B(c)(4) of the Internal Revenue Code of 1986, as amended, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

II. NH Code of Administrative Rules INS 3600, Appendix H paragraph (f) states that no entity shall be qualified for certification if it, its employees, agents or licensed health care professionals utilized for benefit trigger reviews are in any manner related to, employed by or affiliated with any of the following for each appeal:

a. The long term care insurer;

b. The insured who has filed the appeal; or

c. Any person who has previously provided medical care or long term care services to the insured.

III. NH Code of Administrative Rules INS 3600, Appendix H (*l*) prohibits independent review organizations, and the employees, agents and licensed health care professionals utilized by the independent review organization, from being subsidiaries of, or owned or controlled by, either of the following:

a. An insurer.

b. A professional or trade association in which the insurer is a member.

**STATE OF NEW HAMPSHIRE INSURANCE DEPARTMENT**
**LONG TERM CARE INDEPENDENT REVIEW ORGANIZATION**
**CERTIFICATION / RECERTIFICATION APPLICATION**

Check One: New ☐ Renewal ☐

Legal Name of Applicant

D/B/A Telephone Number

Mailing Address

City State Zip Code

Street Address

City State Zip Code

Name of Chief Executive Officer

Mailing Address

City State Zip Code Telephone Number (Direct Line)

Tax Status:

Privately Held Corporation ☐ Not for Profit Corporation ☐ LLC ☐

Publicly Traded Corporation ☐ Partnership ☐ Trust ☐ Other (Specify) ☐_____

Federal Tax ID# _____

State of Incorporation_____

List all states in which applicant is incorporated, licensed, certified or otherwise authorized to conduct business. Include name of licensing authority, as applicable. (Attach separate sheet if necessary)

_____

_____

_____

## II. ORGANIZATION OF APPLICANT:

A. Provide a description of the organizational structure of the applicant.

B. Attach copies of certificates of incorporation, articles of organization and by-laws or operating agreement for the applicant.

C. Attach applicant's organizational chart.

D. If applicable, attach a second organizational chart showing all lines of authority within a holding company or parent/subsidiary system.

E. List and describe the scope and relationship of all agreements between the applicant and health care services entities, health care providers and management service organizations.

## III. MANAGEMENT OF APPLICANT:

A. Provide a list of all management employees with independent review responsibilities, including a description that sets forth the independent review responsibilities of each position.

B. Provide a completed and notarized Conflict of Interest Affirmation Form (see attached), executed by the Chief Executive Officer of the applicant on behalf of all directors, officers, partners, members, trustees, Medical Director, senior management employees (sr. vice president and higher) and owners and beneficial owners of the applicant.

C. Provide the names of all entities and organizations owned or controlled by the applicant and the applicant's owner, including the state of incorporation or formation.

D. Provide completed Personal Background Information Forms (see attached) for all owners, beneficial owners, directors, members, partners, trustees, officers, Medical Director, and senior management employees of the applicant (Sr. VP and higher).

E. Provide a description of the Medical Director's responsibilities for selecting and matching peer reviewers, and for quality control programs.*

***IMPORTANT NOTE:** Approval of this application will be highly dependent upon the applicant's response to section III, E above. If the response indicates that any person other than the applicant's Medical Director is responsible for selecting and matching peer reviewers for each individual case, the application will not be approved. If current practice permits an individual who is not a licensed medical doctor to select and approve matched peer reviewers, the applicant will be notified that a change in procedure will be necessary to obtain certification as an IRO in New Hampshire. This can significantly delay approval of the application. Applicants are encouraged to make any necessary procedural changes prior to submission of the application.

F. Medical Director must complete and submit the enclosed Medical Director Professional Disclosure Statement form.

G. Attach a completed and notarized Authorization/Release Form (enclosed) for each senior officer (senior vice present and higher), director, partner, trustee, member, Medical Director, and owner of 10% or more, and beneficial owner of the applicant.

## IV. CONTRACTED SERVICE PROVIDERS/ PEER REVIEWERS:

A. Attach a list of all reviewers in the proposed peer review network. Include the name of each reviewer, list each license held, including license number(s) and expiration date(s), state(s) of issue, clinical discipline(s) and all board certifications, if any.

B. Provide a copy of the applicant's procedure that ensures the adequacy and maintenance of the peer review network.

C. Provide a copy of the procedures employed by the medical director which ensure that all peer reviewers conducting independent review are appropriately matched by specialty to conduct peer reviews. At a minimum, procedures should address:

1. Appropriate medical training.
2. Board Certification in appropriate specialties.
3. Training by the applicant to conduct reviews in accordance with all of the applicant's policies and procedures.
4. How applicant ensures peer reviewers are not or have not been the subject of disciplinary action and or malpractice litigation.
5. Criteria used for selecting peer reviewers for reviewer "pool".
6. Criteria used for matching peer reviewers to specific cases.
   The name, title and credentials of the person (s) making and/or reviewing numbers 5 and 6 noted above. *

*See NOTE on Page 5 concerning selection of peer reviewers by Medical Director.

D. Provide a copy of the procedures used to ensure that peer reviewers assigned to review a particular appeal, do not have a prohibited conflict of interest pursuant to NH Code of Administrative Rules INS 3600 and Appendix H thereto.

E. Attach a copy of the standard peer reviewer contract form/template used by the applicant to engage peer reviewers.

F. Attach enclosed provider network Conflict of Interest Affirmation form completed by president or CEO of the applicant.

G. Provide a copy of the applicant's peer reviewer compensation schedule or policy.

## V. QUALITY ASSURANCE AND CONFIDENTIALITY:

A. Provide a copy of the quality assurance program established by the applicant and the most recent internal quality assurance oversight report. Provide the name, credentials and phone number of the person (s) responsible for internal review of the applicant's quality assurance programs.

B. Provide a copy of the policies and procedures employed by the applicant to protect the confidentiality of medical and treatment records, including materials, in accordance with applicable state and federal laws.

C. Is the applicant certified by NCQA* (National Committee for Quality Assurance)?
Yes _____ No_____

Is the applicant certified by URAC * (Utilization Review Accreditation Committee)?

Yes_____ No_____

If certified, provide a copy of the applicant's most recent certification(s).

*NOTE: Current URAC and NCQA certifications are optional.

## VI. APPEALS PROCESS SYSTEM:

A. Provide copies of appeals policies and procedures that comply with NH Code of Administrative Rules INS 3600.

B. Provide an illustrative flow chart of the sequence through which an independent review will be processed, from receipt through the notification to the insured, the insurer and the NH Insurance Department. Such description must take into account the requirements of NH Code of Administrative Rules INS 3600.

## VII. FINANCIAL CONDITION:

A. Provide the applicant's most recent year-end audited financial statement, or, if publicly traded, most recent U.S. Securities and Exchange Commission Form 10K and 10Q filings.

## VIII. FEES:

A. Attach a schedule of fees that will be charged for independent reviews. The fee schedule should include price differential information for single reviewer and multiple reviewer case reviews.

## IX. HOLDING COMPANY REGULATORY ACTIONS:

If the applicant is a wholly owned subsidiary of another legal entity, has the applicant's holding company ever been assessed a monetary penalty or had its operating certificate, license or authority suspended or revoked, or had a contract terminated because of failure to comply with provisions governing its conduct or operations?

N/A ☐ YES ☐ NO ☐

**NOTE:** If "YES," complete the following for each violation. Attach additional sheets if necessary.

NAME AND ADDRESS OF ENTITY/OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY THAT IMPOSED THE PENALTY

PENALTY IMPOSED

NAME AND ADDRESS OF ENTITY/OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY THAT IMPOSED THE PENALTY

PENALTY IMPOSED

## X. RECORDKEEPING AND CONFIDENTIALITY:

Attach a copy of the applicant's internal procedure for ensuring compliance with NH Code of Administrative rules INS 3601.30(f) (1) and (2).

## XI. LICENSES AND CERTIFICATES OF AUTHORITY:

Attach a list of all licenses or certificates of authority issued by other states authorizing the applicant to do business as an independent review organization in such states. Include the name of the licensing/certification Page 8 of 8authority, the state, the dates of issue and expiration, and the license or certificate number. Do not include general certificates of authority to do business issued by the Secretary of State, or similar state authority, under a state's general corporate laws.

## XII. CONTACT INFORMATION – NH REVIEWS:

Provide contact information for the applicant's employee who will be responsible for New Hampshire independent reviews:

_____ _____

Name and Title Direct Line Telephone Number

E-Mail address of above contact person _____

_____

Mailing address of above contact person

## XIII. CONTACT INFORMATION - APPLICATION:

Provide contact information for the applicant's employee to be contacted for questions concerning this application:

_____ _____

Name and Title Direct Line Telephone Number

E-Mail address of above contact person _____

_____

Mailing address of above contact person

To be completed by the chief executive officer or other officer authorized by the applicant's board of directors to attest to the accuracy of the contents of this application

## AFFIRMATION

I _____, _____, being duly authorized, hereby subscribe and affirm that the foregoing statements, including statements made in any accompanying papers, have been examined by me and to the best of my knowledge and belief are true, accurate and complete.

_____
Name (Type or Print)

_____ _____
Signature Date

_____
Title

## ACKNOWLEDGEMENT

**State of_____}**

County of_____} ss.

Signed and sworn to before me on this_____ day of _____, 20_____, by

_____ (Name of affirmant)

_____
Notary Public/Justice of the Peace

My Commission Expires_____ (SEAL)
(Date)

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# LONG TERM CARE INDEPENDENT REVIEW ORGANIZATION CERTIFICATION / RECERTIFICATION APPLICATION

## PERSONAL BACKGROUND DISCLOSURE STATEMENT

### INSTRUCTIONS:

- To be completed by each principal/owner/investor of 10% or more of the applicant, and each officer, manager (senior vice president or higher), member, partner, director, beneficial owner, Medical Director and trustee.
- Please type or print. Complete all items. Attach additional sheets as necessary or as indicated. This form may be duplicated if additional copies are required.

DATE: _____

NAME OF IRO APPLICANT: _____

TAX ID#: _____

### 1. IDENTIFYING INFORMATION:

Name of Owner, Officer, Director, Member, Medical Director, Manager, Trustee, Partner, Other _____ (circle all that apply)

_____

Home street address: (do not use P.O. box address, do not use business address)

Street_____ Apt. _____

City_____ State_____ Zip Code_____

_____
Mailing Address (if different)

Other names by which you have been known:

_____

Date of Birth_____ Tax ID Number: _____

Place of Birth_____
(City) (State)

Driver's License #_____State_____

**2. EMPLOYMENT:** Attach a separate sheet listing your work history, beginning with your current employment, and all businesses with which you have been involved, and/or all periods of unemployment for the last 10 years. Include all corporations, partnerships or any other business ventures in which you had an investment or interest of 10% or more, or with which you have been associated as an officer, director, or in a capacity influencing policy or management. Also include dates of association, job title, name and address of the business/employer, description of your duties/responsibilities, name of immediate supervisor and reasons for leaving.

3. **LICENSING HISTORY:** Have you ever had a license to engage in a regulated business or profession revoked, suspended or denied, or been subject to any other disciplinary proceedings, including imposition of fines, by this or any other state licensing authority? _____ If yes, attach a separate sheet, which indicates the dates, type of license held, licensing authority, and reason(s) for revocation, suspension, denial, fine/penalty or disciplinary proceeding.

4. **GENERAL CHARACTER:** Have you ever been convicted of a misdemeanor, felony or other offense involving breach of trust, theft, forgery, deception, false advertising, false statements, fraudulent or dishonest dealing, or similar offense, or had a final judgment entered against you in a civil action upon grounds of fraud, misrepresentation, deceit or similar reason? _____ If yes, list on a separate sheet the type of offense or judgment, the name and address of the court before which the case was heard, docket #, the date of the conviction or judgment and the sentence, penalty or award ordered.

5. **AFFILIATION WITH OTHER HEALTH CARE ORGANIZATIONS**:

INSTRUCTIONS: The purpose of this section is to obtain a complete listing of any health care organizations or insurers with which the owners, officers, directors, partners, members, trustees, executives or medical director of the proposed Applicant have been affiliated within the past 10 years. For purposes of this section of the application, "affiliation with health care organizations or insurers" includes serving as an officer, partner, trustee, ,member, director, management staff, stockholder of 10 percent or more of, or key advisor for, the health care organization or insurer.

A. For the past 10 years, have you owned or operated any health care or health related organizations or any insurers or held a management position or had any affiliations with health care or health related organizations or an insurer in New Hampshire, or in any other state?

YES ☐ NO ☐

**NOTE:** If "YES," complete the following chart:

| Name and Address of Health Care Organization or Insurer | Affiliation Dates From/To | Nature of Affiliation | Licensing Agency |
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B. Are/were any of the above-listed health care organizations or insurers cited by any regulatory body or court for failure to comply with any laws or regulations during your affiliation?

YES ☐ NO ☐

**NOTE:** If "YES" to 5-B above, complete the following: (attach additional sheets as necessary)

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING VIOLATION (name & address)

PENALTY IMPOSED

**6. OTHER INFORMATION:** Provide any other information concerning your personal history you would like considered in reviewing this disclosure statement. Attach additional sheets as necessary.

**STATE OF NEW HAMPSHIRE**
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# MEDICAL DIRECTOR PROFESSIONAL BACKGROUND DISCLOSURE FORM

**To be completed by Medical Director Only**

Name of Medical Director: _____

Name of IRO Applicant**:** _____

**LICENSES:**

| Type of Medical License (Including Specialty) | State Granting License, and Licensing Authority Name and Address | Date Issued | Expiration Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**MEDICAL EDUCATION:**

| Institution | Address | Dates of Attendance | Degree Awarded | Date Received |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

1. Have you ever changed your name or used an alias?

YES ☐ NO ☐

If "YES," attach an explanation including other names(s) date(s) and the reason(s) for each change. Include copies of any relevant court orders approving such name change(s), unless marriage is the reason for the name change.

2. Except for minor traffic violations, have you ever been indicted, convicted, had a sentence suspended, or been pardoned of a conviction for any crime?

YES ☐ NO ☐

If "YES", attach an explanation. Include dates, subject matter, court, city and state where action was heard or order was issued, criminal docket number and any other relevant information.

3. Are there any criminal actions pending against you?

YES ☐ NO ☐

If "YES", attach an explanation. Include dates, subject matter, court, city and state where action is pending, docket number and any other relevant information.

4. Have you ever been named as a defendant in any civil action or proceeding alleging medical malpractice or similar cause of action?

YES ☐ NO ☐

If "YES", attach an explanation. Include dates, subject matter, court, city and state where action is pending, docket number and any other relevant information.

5. Have you ever been an owner, officer, trustee, management employee or controlling stockholder of an entity which, while you occupied such position or served in such capacity,

   a. Had its certificate of authority or license to do business in any state suspended or revoked?

   YES ☐ NO ☐

   b. Was denied a certificate of authority, license or contract to do business in any state?

   YES ☐ NO ☐

If "YES" attach an explanation. Include state and regulatory agency information, dates, issue(s), copies of relevant legal or other documents.

## AFFIRMATION:

I hereby subscribe and affirm that the foregoing statements, including statements made in any accompanying papers, have been examined by me and to the best of my knowledge and belief are true, accurate and complete.

_____
Name (Type or Print)

_____ _____
Signature Date

_____
Title

## ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

On this _____day of _____, 20____ before me _____,
(Name of Notary/JP)
the undersigned officer, personally appeared_____ known
(Name of person signing this document)
to me personally or proven to me to be the same person whose name is signed to the foregoing instrument, and acknowledged the execution thereof for the uses and purposes therein set forth. In WITNESS WHEREOF I have hereunto set my hand and official seal.

_____
Notary Public/JP

My Commission expires_____
(Date)

(SEAL)

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# PEER REVIEWER NETWORK CONFLICT OF INTEREST AFFIRMATION FORM

To be completed by the president/CEO of the applicant on behalf of all listed peer reviewers. List each peer reviewer employed by the applicant, or with whom the applicant has a contractual relationship, to conduct reviews. Identify potential conflicts of interest for each reviewer by placing an asterisk (*) next to such reviewer's name. Attach separate sheets as necessary. This form may be duplicated.

| Reviewer Name | State and License #'s | Clinical Specialty | Practice Affiliations |
|---|---|---|---|
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## AFFIRMATION:

I hereby subscribe and affirm that the foregoing statements, including statements made in any accompanying papers, have been examined by me and to the best of my knowledge and belief are true, accurate and complete.

| | |
|---|---|
| _____ | _____ |
| Name (Type or Print) | Signature |
| _____ | _____ |
| Title | Date |

## ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

Signed and sworn to before me on this_____ day of _____, 20_____, by

_____ (Name of affirmant)

_____
Notary Public/Justice of the Peace

My Commission Expires_____
(Date)

(SEAL)

**NH Insurance Department**
**21 South Fruit St., Suite 14**
**Concord, NH 03301**
**603-271-2261**
**Fax: 603-271-1406**

**LTC IRO CERTIFICATION APPLICATION**

**AUTHORIZATION/RELEASE FORM**

**INSTRUCTIONS:** To be completed by each senior officer (senior vice president and higher), director, partner, trustee, member, medical director, and owner or beneficial owner of 10% or more of the applicant. This form may be duplicated. PLEASE TYPE your responses.

Submitted in connection with an application for an Independent Review Organization (IRO) certification pursuant to NH Code of Administrative Rules INS 3600 by:

_____
**(Name of Long Term Care IRO Applicant)**

_____
**(Name of Officer, Owner, Director, Manager, Partner, Trustee, Member, Medical Director)**

I hereby authorize the State of New Hampshire Insurance Department to request and receive reports of police and criminal records from any and all law enforcement officials, and further authorize that such information may be released to the State of New Hampshire Insurance Department by such officials upon presentation of this authorization, or a photocopy hereof. I understand that the State of New Hampshire Insurance Department will utilize any information it receives as a result of this authorization solely for purposes of determining compliance with certification standards set forth in NH Code of Administrative Rules INS 3600, as applicable. I understand that this authorization does not expire.

_____ _____
(Type Name) (Date of Birth)

_____
(Signature) (Date)

_____
(Title)

_____
(Residence Address)

_____
(City, State and Zip Code of Residence)

_____
(Tax ID#)

## ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

This authorization and release instrument was acknowledged before me on the _____day of

_____, 20____ by _____.
(Name of person signing authorization/release)

_____
Notary Public/Justice of the Peace

My Commission Expires_____

(SEAL)

**NEW HAMPSHIRE INSURANCE DEPARTMENT**
21 South Fruit St., Suite 14
Concord, NH 03301
603-271-2261
Fax: 603-271-1406

## LONG TERM CARE INDEPENDENT REVIEW ORGANIZATION APPLICATION

## CONFLICT OF INTEREST AFFIRMATION FORM

I, _____ , Chief Executive Officer of
(Name of Chief Executive Officer)

_____ (the "Applicant"), do hereby attest and affirm
(Name of Applicant)

under penalty of perjury that the Applicant has no disqualifying relationship as described in NH Code of Administrative Rules INS 3600, and further affirm that neither the Applicant nor any of its owners, partners, members, officers, directors, trustees, donors, medical directors, management employees or clinical peer reviewers currently employed or engaged, have any material affiliation prohibited by NH Code of Administrative Rules INS 3600.

Name_____
(Type or Print )
Title_____

Signature_____ Date_____

**ACKNOWLEDGEMENT**

State of_____}

County of_____} ss.

Signed and sworn to before me, on this _____day of _____, 20____,

by_____. (Name of person making statement)

_____ (Signature of Notary Public/Justice of the Peace)

My Commission Expires_____ (Date) (SEAL)