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Focus Area: Credentialing & Qualifications

Standard CQP 1: Credentialing Program
Individuals conducting reviews have the requisite credentials and experience.

CQP 1-1: Reviewer Credentialing Program

The organization's credentialing program:

a. Requires reviewer verification for credentials: [8]
   i. Specified in the credentialing program
   ii. Prior to assigning a review to a newly hired reviewer
   iii. Prior to scheduled expiration
b. Assigns cases to a reviewer whose credentials are active or have been re-verified prior to scheduled expiration [4]
c. Establishes selection criteria for reviewers [4]

CQP 1-2: Reviewer Licensure

Individuals who conduct reviews:

a. Possess a license or certification in a health profession that is: [8]
   i. Current (i.e., not expired)
   ii. Recognized in the relevant jurisdiction(s)
   iii. Unrestricted and if there is a restriction that is allowed by a relevant jurisdiction, according to the medical director, it is of the type that does not affect the health professional's ability to fulfill the roles and responsibilities of a reviewer
   iv. Of the type and scope that permits them to apply their clinical judgement in consideration of an individual member's clinical needs to render a review determination
   v. Either a Doctor of Medicine or Doctor of Osteopathic Medicine; or is the same license or certification as the ordering practitioner

CQP 1-3: Additional Reviewer Qualifications

Individuals:

a. Who conduct reviews: [8]
   i. Are knowledgeable of the issue under review, or of the current, evidence-based clinical guidelines and novel treatments for the medical or behavioral health condition, disease, treatment or procedure under review
   ii. Have the clinical expertise to manage the medical or behavioral health condition or disease under review
   iii. Possess a medical board certification if they are a Doctor of Medicine, a Doctor of Osteopathic Medicine or a Doctor of Podiatric Medicine
   iv. Have at least five (5) years' full-time equivalent experience providing direct clinical care to patients

Standard CQP 2: Reviewer Credentials Verification and Status Changes

Reviews are conducted by licensed or certified health professionals with the clinical expertise to manage the condition under review.

CQP 2-1: Reviewer Credentials Verification

The organization's:

a. Verification of reviewer credentials includes: [8]
   i. Primary source verification of the requisite licensure or certification required for clinical or legal practice
   ii. Primary source verification of the reviewer's board certification(s) if a reviewer is a Doctor of Medicine, Doctor of Osteopathic Medicine or Doctor of Podiatric Medicine
   iii. Verification of history of sanctions and/or disciplinary actions
   iv. Inclusion on the List of Excluded Individuals/Entities (LEIE) maintained by the Office of Inspector General (OIG), if applicable
   v. Collection of information regarding professional experience, length of time providing direct patient care and when the direct patient care occurred   on COI

CQP 2-2: Reviewer Credential Status Changes

The organization's:

a. Credentialing program requires: [8]
   i. Reviewers to notify the organization in a timely manner of an adverse change in licensure or certification status, including board certification status
   ii. Implementation of a corrective action in response to a reviewer's adverse change in licensure or certification status, including board certification status

Focus Area: Reviewer Conflict of Interest

Standard COI 1: Conflict of Interest
Conflict of interest is defined and addressed for the parties involved in the review process. [M]

COI 1-1: Defining Reviewer Conflict of Interest
Prior to executing a contract to provide services, the organization verifies what constitutes reviewer conflict of interest according to applicable jurisdictional law or regulation as well as contracting entity, including clarification of the following situations regarding conflict of interest:

a. A reviewer has a contract to provide health care services to enrollees of a health benefit plan of an insurance issuer or group health plan that is the subject of a review

b. A reviewer has staff privileges at a facility where the recommended health care service or treatment would be provided if the insurance issuer's or group health plan's previous non-certification is reversed

Standard COI 2: Conflict of Interest Attestation

Reviewers complete a conflict-of-interest attestation for each case they accept.

COI 2-1: Reviewer Conflict of Interest Attestation

For each case they accept, the reviewers attest that they:

a. Do not accept compensation for review activities that is dependent in any way on the specific outcome of the case [8]
b. Were not involved with the specific episode of care prior to referral of the case for review [8]
c. Do not have a material professional, familial, or financial conflict of interest regarding the specific case to be reviewed, to include the following: [8]
    i. Referring entity
    ii. Insurance issuer or group health plan that is the subject of the review
    iii. Covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable
    iv. Any officer, director or management employee of the insurance issuer that is the subject of the review
    v. Any group health plan administrator, plan fiduciary, or plan employee
    vi. Health care provider, or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review
    vii. Facility at which the recommended health care service or treatment would be provided
    viii. Developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the review

Standard COI 3: Credentials Attestation

Reviewers complete credentials, knowledge, experience and no-delegation attestations for each case they accept.

COI 3-1: Reviewer Credentials Attestation

For each case they accept:

a. The reviewer attests to: [8]
   i. Having a scope of licensure or certification that permits management of the issue, medical/behavioral health condition, disease, procedure, or treatment under review
   ii. Current, relevant experience and/or current, relevant knowledge to render a determination for the case under review
   iii. Length of time providing direct patient care
   iv. No delegation of the review rendered

Focus Area: Review Process

Standard RP 1: Case Assessment

The organization completes an assessment of the information necessary to appropriately manage a case.

RP 1-1: Initial Case Assessment

Upon accepting a case from a referring entity, the organization identifies:

a. The specific question or issue to be resolved by the review process [4]

b. Whether the case relates to medical necessity and medical appropriateness, experimental or investigational treatment, an administrative or legal issue, an independent medical review or a combination of these categories [4]

c. Whether the case is expedited or not [4]

d. Applicable jurisdictional law or regulation as well as contract requirements, including: [4]

   i. The information that must be taken into consideration as part of reviewing the case

   ii. The process, including time frame, for securing additional information if it should be determined that case documentation is incomplete

   iii. Time frames applicable to steps in the review process, including communication of the determination

   iv. Identification of the parties to receive notification of the determination

Standard RP 2: Additional Information and Time Frames

The organization's processes support the timely review and documentation of cases and the acceptance of additional information when available.

RP 2-1: Review of Additional Information

The organization implements mechanisms:

a. To request and accept any additional information that may assist in rendering a determination [4]

RP 2-2: Expedited Review Process

The organization:

a. Provides for an expedited review process that is available in cases for which the time frame for completion of a non-expedited review would seriously jeopardize the life or health of a covered person, or the covered person's ability to regain maximum function. [8]

Standard RP 3: Information Used for Case Review

The organization establishes a written policy that addresses the information used to conduct reviews.

RP 3-1: Medical Necessity/Appropriateness Case Processing

Processing a case regarding medical necessity and appropriateness requires that the organization and its reviewer(s) consider information pertinent to the case:

a. Which includes the following as available, unless otherwise prohibited by jurisdictional regulation: [8]
   i. The covered person's medical records
   ii. The attending provider's recommendation
   iii. Information submitted to the organization by the referring entity, covered person or attending provider
   iv. Information accumulated regarding the case prior to its referral for review, including rationale for prior review determinations
   v. Clinical review criteria and/or medical policy developed and used by the insurance issuer or group health plan
   vi. Medical or scientific evidence or guidelines
   vii. The terms of coverage under the covered person's health benefit plan, if applicable

RP 3-2: Experimental/Investigational Case Processing

Processing a case regarding the experimental or investigational nature of a proposed treatment requires that the organization and its reviewer(s) consider the following, unless otherwise prohibited by jurisdictional law or regulation:

a. Medical Necessity/Appropriateness Case Processing evidence in addition to the following: [4]
   i. Whether the recommended health care service or treatment has been approved by the Federal Food and Drug Administration, if applicable, for the condition
   ii. Whether medical or scientific evidence or evidence-based clinical practice guidelines or criteria demonstrating that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments
   iii. The terms of coverage under the covered person's health benefit plan, if applicable

RP 3-3: Benefit Coverage/Rescission/Legal Case Processing
Processing a case regarding administrative or legal issues is comprehensive.

a. The organization and its reviewer(s) consider: [4]
    i. All information necessary to render a decision, such as applicable health benefit plan contract and other relevant health benefit plan materials and documents
    ii. Applicable jurisdictional law or regulation

Standard RP 4: Notice and Final Record

The decision notice and final record contain all the information necessary to clearly communicate the determination and comprehensively document the case.

RP 4-1: Decision Notice
The organization's:

a. Notice for Internal and/or External Review to the referring entity of the determination includes: [8]
    i. A description of the issue to be resolved
    ii. A description of the qualifications of the reviewer(s)
    iii. Documentation of peer-to-peer conversation attempts and contacts, if required
    iv. A clinical rationale or explanation for the determination
    v. Citations for supporting evidence or references per the organization's policy