VERMONT

Department of Financial Regulation
Insurance Division

MENTAL HEALTH REVIEW AGENTS
ANNUAL LICENSE RENEWAL APPLICATION

This application includes the annual renewal and data filing requirements specified under Rule H-2011-01 for mental health review agents licensing. License renewal applications are due back to the Department annually, no later than **September 15.**

1. Please complete the following information, attaching any necessary documents, and email them to Paige Coolbeth, Insurance Division, at: paige.coolbeth@vermont.gov

2. Mail the annual $200.00 license renewal fee to the attention of: Paige Coolbeth, Insurance Division, Department of Financial Regulation, 89 Main Street, Montpelier, VT 05620-3101. Checks should be made payable to the State of Vermont.

Please complete the following information:

Date: _____

Licensee Name: _____

VT License No: _____

Business Address: _____
Street Address

_____
City, State & Zip Code

Contact Name: _____

Contact Title: _____

Contact Address (if different from above): _____

Contact Telephone Number: _____

Email Address: _____

PART 1: DISCLOSURE OF MATERIAL CHANGES

Please submit only those documents, described in Rule H-2011-01, Section 6(A) below, in which material changes have occurred over the course of the previous calendar year. Please check all boxes that apply.

Document Submission Requirements*	Submission Includes
Change in business name or address, business license, contact name or information	☐
Change to organization chart	☐
Change to officers and directors of review agent, including names and medical license numbers of corporate medical director(s) and Vermont-licensed physicians making denial decisions for service reviews and grievances	☐
Disclose all regulatory actions, lawsuits, arbitrations, or criminal proceedings (briefly describe action or proceeding and resolution) - see Part 3 of this application	☐
Changes to staff licensure types/status, qualifications, or compensation structure	☐
Changes in NCQA or URAC accreditation	☐
Changes to written policies and procedures for performing service review or grievance determinations	☐
Changes to clinical review criteria. See Part 4 of this application	☐
Changes to training and evaluation of service review staff	☐
Changes to liability insurance coverage in effect	☐

***** *Please identify changes to submitted documents by using highlighting, underlining or other easily recognizable notations.*

PART 2: REQUIRED DATA SUBMISSION

Licensed Mental Health Review Agents are required to submit data outlined in this section for the **prior calendar year**, except for licensed review agents that are also required to submit the same data to the Department under Rule H-2009-03.

Covered Lives	Number
Provide the total number of fully-insured and self-insured covered lives (nationwide) for which the review agent is responsible to preform mental health service reviews and grievances.	
Provide the number of fully-insured Vermont covered lives for which the review agent is responsible to preform mental health service reviews and grievances.	
Provide the number of self-insured Vermont covered lives for which the review agent is responsible to preform mental health service reviews and grievances.	

Mental Health Reviews	Number	Percent
Number of reviews for Vermont lives completed during the prior calendar year		
Number and percentage of reviews for Vermont lives in which benefits were granted as requested		
Number and percentage of reviews for Vermont lives in which benefits were denied		
Number and percentage of reviews for Vermont lives in which benefits were reduced or changed from initial service request or length of service		
Number and percentage of reviews for Vermont lives that involved denials or reduction of care decisions		

Grievance Data	Initial decision was reversed	Initial decision was upheld	Average number of days to final decision
Number of appeals for Vermont lives in which care/treatment was denied as not medically necessary			
Number of appeals for Vermont lives in which the requested care/treatment was not covered by contract			
Other (please specify):			

Grievance History *(Attach additional pages if more space is needed)*	
Provide General Reason(s) for Complaint	**Provide Complaint Resolution(s)**

PART 3: REQUIRED LITIGATION HISTORY AND REGULATORY ACTIONS

Complete litigation history and enforcement actions taken against the review agent or the review agent's medical director in any state, not just for Vermont, during the prior calendar year. The following example provides the information required to complete this section, while not breaching confidentiality requirements.

Case Summary Example:

Case Number: 12344567-06
Date of Initiation: November 9, 2008
Venue: Civil Court
Issue/Allegation: Alleged improper non-certification for medical necessity (days of care for alcohol dependency treatment)
Outcome: Settled in the amount of $$ by the health benefits plan on behalf of itself and [Mental Health UR Agent]

Litigation History and Regulatory Enforcement Actions *(Attach additional pages if more space is needed)*
Docket/Case Number: Date of Initiation: Venue: Issue/Allegation: Outcome:

PART 4: REQUIRED ATTESTATION

The following statement must be signed by an authorized officer of the organization, notarized and submitted as part of the renewal application.

*(Insert Officer's Name andTitle)*_____ attests that I am authorized to sign this attestation and that the service review criteria and standards are periodically evaluated (at least annually) and updated with appropriate involvement from mental health providers. Such service review criteria and standards must be compatible with established principles and standards of mental health care. As indicated below, the review criteria are either adopted from already accepted, commercially available sources, or developed by the applicant, based on scientific evidence. That the information provided herein is true and accurate and that no material items have been omitted.

The review criteria have been:

1. Developed by the review agent based on scientific evidence: Yes ☐ No ☐

List all criteria below:

- _____
- _____
- _____

2. Adopted from[1] accepted, commercially available sources: Yes ☐ No ☐

List all sources below:

- _____
- _____
- _____

ATTESTED BY:

Review Agent Officer Name (*please print*)	Notary Name (*please print*)
Review Agent Officer Signature	Notary Signature
Review Agent Officer Title	Notary Commission Expires on:
Dated	Dated

[1] "Adopted from" includes use of commercially available service review standards and criteria with minor non-material modifications.