MEDICAL CLAIMS REVIEW AGENT CHECKLIST
Refer to IC 27-8-16 & IAC 760:1-49 for all requirements

Complete entire checklist for a new application or only those sections changed since last renewal.
Fill in "Located" column with section and page number supporting the requirement.

***Company Name*____________________________** ***Date* ____________________**

STATUTE/REGULATION	*REQUIREMENTS*	*LOCATED*
Application IC 27-8-16-5 760:1-49-3	Complete application in its entirety. Include explanation for any "no" answers.	N/A
Fee IC 27-8-16-5.2 760: 1-46-3 & 11	$150.00 Initial application $100.00 Renewal application	N/A
Staffing 760: 1-49-3(d)(2) 760: 1-49-4(1)(G) 760: 1-49-4(1)(F)	Describe categories of personnel performing medical claims review by listing or organizational chart. Describe initial orientation and ongoing training procedures for reviewers. Describe methods used to determine if reviewers are licensed and have maintained appropriate licensing including action plan for addressing licensing issues.	
Certifications/Statements 760: 1-49-3(d)(1) 760: 1-49-3(d)(4) IC 27-8-16-11	Compliance - Include a certification of compliance with the provisions of IC 27-8-16. Compensation - Include a certification of compliance with the provisions of IC 27-8-16-11 regarding compensation. Compensation shall not be based on the amount the claim is reduced for payment.	
IC 27-8-16-6(b) & (c) 760: 1-49-3(e)	Material Changes - Include statement that the DOI will be notified of any material change in application information within 30 days after the change.	
IC 27-8-16-9 IC 27-8-16-7(6)	Physician Certification - Include a signed statement by a provider employed by the claim review agent verifying determinations are made by or determined by standards approved by a provider licensed in the same discipline as the provider rendering the service.	
Medical Claims Review Plan		
Plan Summary IC 27-8-16-7(9) 760: 1-49-4	Provide a summary of the medical claims review plan.	
Telephone Access IC 27-8-16-7(1)	Provide toll free number and hours of operation. Toll free access must be provided at least 40 hours per week during normal business hours.	
After hours 760: 1-49-3(d)(3) 760: 1-49-4(1)(C) 760: 1-49-7	Describe phone recording and response system for calls received after normal business hours. After hours calls, must be returned within 2 business day after receiving call.	
Complaints 760: 1-49-4(1)(E) 760: 1-49-9	Describe process for responding to complaints.	
Forms 760: 1-49-3(d)(4) 760: 1-49-4(1)(D)(i)	Provide samples of materials used to inform enrollees/providers of medical claim review requirements.	
Confidentiality IC 27-8-16-7(4) 760: 1-49-3(c)(2)	Describe procedures for protecting the confidentiality of medical records. Confidentiality procedures should comply with state and federal confidentiality laws.	

STATUTE/REGULATION	***REQUIREMENTS***	***LOCATED***
Specific Use 760:1-49-4(1)(H)(ii)	Acknowledge patient specific information shall be used only for purposes of the medical claims review process and only shared with necessary agencies.	
Identification 760: 1-49-8(b)	Acknowledge medical claims review agent will provide certification number and name when contacting provider or provider's office representative.	
Secure Access 760: 1-49-8(c)	Describe electronic and physical access to medical records. Records and patient-specific info are to be maintained in secure area with access limited to MCR personnel.	
Time Frame 760: 1-49-8	Describe time period for maintaining information obtained during medical claims review. Information generated and obtained during the medical claims review shall be maintained for at least 2 years for an adverse decision or if case is likely to be reopened.	
Screening Criteria IC 27-8-16-7(6) IC 27-8-16-8 760: 1-49-4 760: 1-49-4(2) 760: 1-49-4(3)	Describe written screening criteria and review procedures utilized in making MCR determinations. Screening criteria shall be periodically updated by medical providers and made available for inspection by the IDOI. Medical claims review agent decisions should be based on standards or guidelines developed from health care providers and approved by a physician holding a current license issued by a state licensing agency in the U.S.	
Decision Notification IC 27-8-16-7(7) IC 27-8-16-9.5	The determination notification to an enrollee should include an explanation of the factual basis for determination. If determination is based on data base criteria, the notification shall include the name and address of entity compiling data base, and if data base information was based on amounts charged for health care services performed outside Indiana. Notification should also include any percentile limiter applied.	
Appeals IC 27-8-16-8 760: 1-49-6	Describe appeals procedure. A written description of the appeals procedure shall be made available to an enrollee.	
IC 27-8-16-8(b)(1)	Appeal determination not to certify service as necessary or appropriate shall be made by provider licensed in same discipline as provider of record.	
IC 27-8-16-8(b)(2)	Appeal should be completed within 30 days after appeal is filed and all information necessary to complete appeal is received.	
IC 27-8-16-8(c)	If medical review determination results in limitation or reduction of benefits, notice of appeals procedure must be provided to the provider who rendered the services.	