

CONFIDENTIAL

**Department of Health and Human Services and the Department of Labor  
Request for Information: Federal External Review Process**



**Submitted by:**

**Advanced Medical Reviews**



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## Executive Summary

Advanced Medical Reviews' (AMR) progressive technology and large, diverse physician network are a platform for a very efficient workflow. Founded in 1998, AMR has over a decade of experience as an Independent Review Organization. Clients range from large corporations to small businesses, in both the private and public sectors. At current staffing levels, AMR is capable of processing in excess of 500 requests per day.

Health plans, hospitals, third-party administrators and government agencies comprise the majority of AMR's client base. Standard service requests are among the following: medical necessity; experimental/investigational; pharmaceutical review; disability; workman's compensation; injury/illness assessment; and standard of care.

**The core of AMR's efforts centers on quality.** At each level of the organization, quality checks and balances are in place to guarantee superior reports. AMR is a paperless company. The proprietary web system is in its fourth generation of modification, continually updated to ensure the most secure, user-friendly and speediest components. The unique data mining capabilities allow users to generate customized reports and conduct extensive searches on all current and past reviews.

Customer service is available 24-hours a day, with multiple account coordinators in place during business hours to respond to requests immediately. Security assurance has been met with a HIPAA compliant web portal and staff training. Patient Health Information (PHI) is never compromised, and a score of 100% has been awarded on every URAC audit.

AMR employs a rigid credentialing policy for reviewers. As a result, cases are assessed by a network of over 1,800 experienced, board-certified physicians and professionals. Submitted cases undergo a five-stage QA, beginning with a reviewing coordinator's initial receipt and ending with a final quality check by one of four in-house medical directors.

Per URAC guidelines, AMR offers three turnaround time options: standard, expedited and rush. These are determined with each client at the time of contracting and cases will be processed per the client's requested time frame.



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## **1. What accreditation standards currently apply to IROs?**

IROs may apply to be accredited by URAC, an independent, nonprofit organization that aims to promote healthcare quality. URAC is nationally recognized as the leader of quality certifications and accredits several types of organizations. Many states and companies require their Independent Review Organization to hold a URAC accreditation, as URAC does employ a rigid and thorough assessment of a company's practice and procedure. During AMR's last onsite URAC audit, we were awarded a 100% for compliance. [www.urac.org](http://www.urac.org)

\*Please see **Attachment A**, AMR URAC Certification

IROs may also elect to be a member of NAIRO, the National Association of Independent Review Organizations. Although this group does not accredit IROs, it does aim to bring together the review process from state to state and protect the integrity of the peer review process. NAIRO keeps its members aware of legislative changes and news within the review industry. [www.nairo.org](http://www.nairo.org)

## **2. What credentialing standards do IROs require for medical and legal reviewers? Is credentialing required or voluntary?**

IROs that are a member of URAC will be subject to credentialing standards, as set by that organization. Advanced Medical Reviews (AMR) follows a strict credentialing protocol and maintains records of each reviewer's license, boards, DEA status, OIG status and current CV.

\*Please see **Attachment B**, AMR Reviewer Credentialing Policy

## **3. What procedures are currently used by IROs to assure that reviewers do not have conflicts of interest with disputing parties?**

AMR has multiple measures in place to avoid conflict of interest. When the case is dispatched to a reviewer, he/she must first sign off that no conflict of interest is present. Additionally, there are red prompts on the reviewer's portal instructing the reviewer to notify AMR staff if at any time they notice any information that presents conflict of interest. AMR staff checks for any of these flags during the QA process.

## **4. What are IROs' current capacity for performing reviews? Does staffing and the time necessary for performing a review differ based on the type of claim (e.g., medical necessity, experimental/investigational treatment, coverage issues, etc.)?**

The capabilities of each IRO differ. AMR has the capacity to process hundreds of reviews each day, as our reviewer network has over 1,800 physicians and our operations staff is well-equipped. The AMR review process is uniform regardless of review type; clients submit via our secure web portal, where they can track status, add information, retrieve completed cases and generate detailed reports. However, the turnaround time for each type of claim may differ. Clients may dictate the turnaround they would like for standard, expedited and rush cases during contract negotiation.

## Infrastructure

**5. Please describe the type of data collection systems that IROs currently use to conduct analyses, reporting, and tracking of appeals and grievances.**

Data collection and reporting again will differ with each IRO. AMR has a proprietary web system with extensive data mining and reporting capabilities. Our secure web portal allows for customizable submission sheets; these customized fields may capture any piece of data a client would like to see: review type, medical field, provider name, patient name, dates of birth, dates of service, turnaround time, facility, etc. Each of these fields is then available to be part of a customizable report. For example, a client may choose to generate a report for all female patients who saw provider x between a certain time period.

\*Please see **Attachment C**, AMR Reporting Capabilities

**6. Are the current data systems available in a secure, 508-compliant, web-based interactive structure?**

Yes, AMR's data is secure in a 508-compliant, web-based interactive structure.

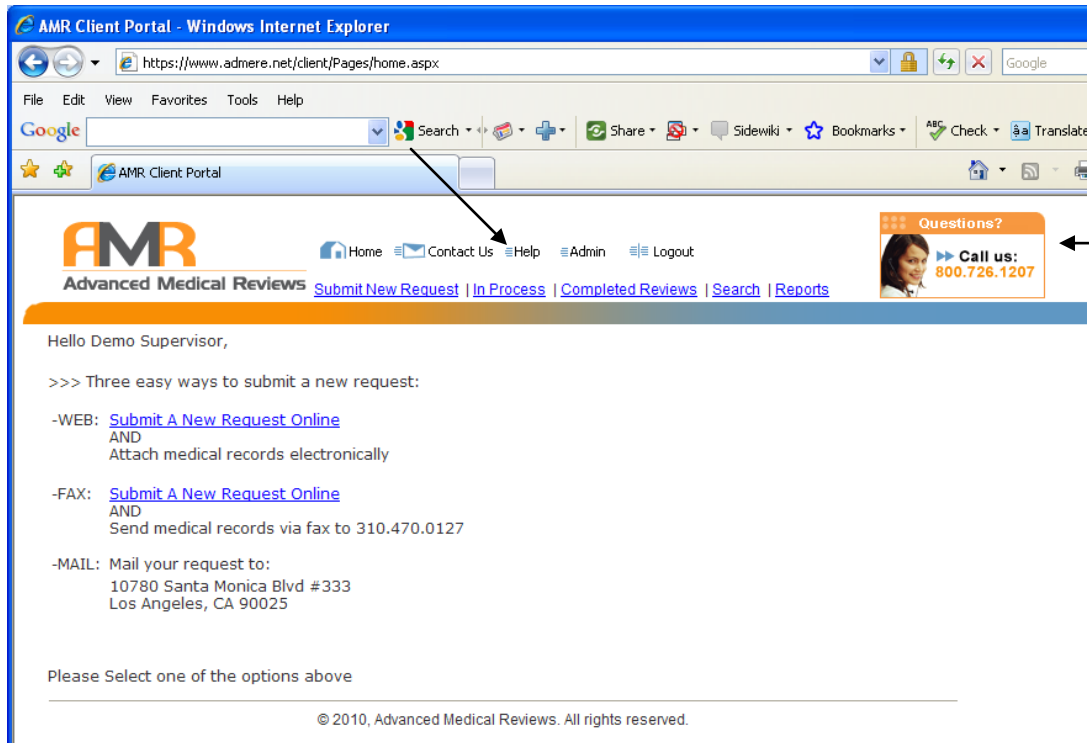
**7. What telecommunication systems and consumer technical support systems do IROs currently maintain for consumers (e.g., Web sites, 24-hour hotlines, helpdesk, and/or translation services for non-English speakers)?**

AMR has customer service available at all times, by telephone and web. Each staff member is fully trained before communicating with clients.

AMR has over twenty review coordinators who receive referrals, identify the appropriate reviewer, dispatch cases, liaise between clients and physicians and answer customer questions. Additionally, each client has an account manager who is their representative and main point of contact.

The coordinators and account manager are available via email and phone. The client's account manager is also available via cell phone. AMR's website has a Live Chat option that allows questions to be answered in real time online. Additionally, there is a Help feature in the web portal that has video options and written answers to frequently asked questions, as seen in the image below.

Clients have the option to call, email, web-chat, or search in the Help feature when addressing questions.



A client's staff may use the web to answer service questions by emailing an AMR staff member, communicating via web-chat or utilizing the Help feature.

All clients and submitters have a username and password that allows them to submit cases, access pending and completed cases, check the status of cases and create customizable reports. Once logged into our system, client staff members can obtain assignment status, check outcomes and generate reports from this view.

AMR's Independent Review Process can be broken into five stages; each of which can be easily monitored online.

**Stage 1 "Received":** Each review request is automatically date stamped upon receipt, and logged into a central database. Each review is also provided a specific due date (assigned by the submitter, or a default setting) to ensure that reviews are completed within the mandated timeframe.

**Stage 2 "In Process":** AMR's data entry team edits the requests, verifies that all new requests include all the mandatory items, and forwards the requests to a UR coordinator. The UR coordinator dispatches the request to a properly credentialed and matched reviewer. AMR's staff assures that each review is assigned to a reviewer in the appropriate specialty with the necessary experience.

**Stage 3 "Reviewer":** Our reviewers are instructed to incorporate both medical fact and health plan information in their determinations. In many cases, our reviewers are given specific medical plan inclusions and exclusions that they address in their rationales. Reviewers can submit completed reviews via a secure web system. The system will prompt the reviewer if the clinical history, decision, rationale, or clinical guidelines are missing.

**Stage 4 "Post Reviewer QA:** AMR's UR coordinators receive the completed review via the web application and ensure that the review contains all the essential components; as well as correct any spelling, punctuation or grammatical errors.

**Stage 5 "Final Medical QA":** Final level QA to assure the delivery of a high quality product from a medical perspective. Our medical directors work closely with our staff members and our clients' staff members to assure client satisfaction.

**8. What is a reasonable amount of time for a contractor to become fully operational (have all systems in place to conduct external reviews) after the date of a contract award? What resources would be necessary?**

The average time it takes clients to begin working with AMR after the date of a contract award is about seven to ten days, although this could be lesser or greater depending on each individual client. Once a contract is negotiated, AMR will arrange for a customization call with the appropriate staff to create a customized submission template.

The clients will also supply AMR with a list of all submitters and their contact information to build the client's database. A training call (or onsite visit) will be the next step. All individuals who will be accessing AMR's system will be trained. After this call, clients are ready to submit cases.

**9. What considerations must be taken into account to smoothly transition from the current Federal interim external review process to a possible new permanent Federal external review process?**

The main considerations for a smooth transition will be adequate timing for adjustments and clear statements detailing the new rules and regulations. Although AMR and many other IROs already have the workflows in place that make the new federal process a relatively seamless transition, there will need to be a comfortable time frame to communicate rules and regulations with clients, make additions to existing contracts, add additional users to accounts, update technology to include patient letters, train users, etc.

**10. Do IROs currently operate nationally or in limited geographic areas? Would IROs that currently serve local areas be able to expand their service areas to possibly include other geographic areas such as other States? Are there any State and/or local licensing requirements?**

AMR operates nationally. Our network of 1800+ reviewers exists on a national level, as we have physicians and allied health professionals in all 50 states. Additionally, we have clients in nearly all 50 states. The technology that AMR employs allows for access to our system from anywhere in the country.

Each state has varying requirements for IROs. For example, some states require reviewing physicians to be licensed in the same state as the provider, while others do not. AMR's compliance team maintains a database with each of these regulations to ensure we are following all protocol.

**11. Are there any special considerations HHS and/or DOL should be aware of in considering a specialized contract for urgent care appeals or for experimental and investigational treatments? Would such an approach have an impact on coordination?**

AMR currently reviews urgent care appeals and experimental and investigational treatments (E/I). A specialized contract is not necessary. IROs are already accustomed to handling urgent requests and most regularly accommodate client needs by completing reviews in less than 24 hours when required on an exception, based on criteria relating to clinical necessity basis. The 72-hour expedited timeframe allowed in PPACA and the NAIC Model Act is not onerous to IROs. In terms of E/I treatments, all IRO determinations are based on evidence-based findings and peer specialty reviewers are skilled at making these determinations. Some IROs and their clients may choose use a panel approach to E/I reviews and

make the final determination based on consensus, but this is largely defined by client needs and not by IRO choice.

**12. Please describe the difference in standard operating procedures and resources (time, cost, personnel) for appeals that involve only medical necessity and those that involve both medical necessity and coverage questions.**

This question will elicit a broad range of responses from IROs. Some NAIRO IROs utilize reviewers who are both MDs/clinicians and JDs to deal with these types of cases. However this combined licensure presents challenges of having a clinical peer that meets the minimum qualifications for a clinical reviewer as defined in the NAIC Uniform Model Act. These require that the clinical reviewer is an expert in the treatment of the covered person's medical condition and recommended service or treatment through recent or current actual clinical experience. Alternatively, two reviewers might be utilized: an appropriate clinician for the medical necessity issue and a legal professional for the coverage determination with the IROs developing a coordinated determination from those findings. In general, cost for cases that involve two different determinations on two different issues will be higher as they require both more peer reviewer resources as well as more internal IRO resources.

**13. What data are currently collected by IROs for tracking appeals and conducting analyses?**

Additionally, please see Question #5. AMR's system is customizable. Each client has the ability to create fields on their submission template that capture any piece of information they would like. Additionally, the following items are always captured:

- client name
- submitter name
- type of case
- review level
- provider specialty
- reviewer specialty
- reviewer name
- patient gender and name
- turnaround time

Clients have the ability to run reports off any combination of data elements that they would like. These reports may be scheduled or ad hoc.

**14. What steps are taken to ensure confidentiality and security protections of patient information?**

IROs are considered Business Associates under HIPAA regulations. As such IRO contracts incorporate BA agreements that apply HIPAA privacy and security standards to IROs just as they are applied to covered entities under the law. Each IRO has differing internal procedures for ensuring confidentiality and security, just as each client has differing requirements within their contracts. For the most part, IROs have very high security standards and some undergo specialized security audits or hold URAC accreditation in healthcare security. IRO employees as well as peer reviewers are all trained in HIPAA privacy and URAC also maintains a set of standards in their Core standards to ensure compliance with confidentiality requirements.



**15. Do IROs (or subcontractors) currently conduct evaluations of their operations? Do such evaluations include an assessment of how easy it is for consumers to access and use the external review process in a timely manner? Do evaluations result in quality improvement initiatives? If so, what are some examples of quality improvement initiatives undertaken by IROs?**

All NAIRO member IROs have quality improvement programs in place, and URAC accreditation assures IROs have quality programs that include committees, reporting, measurement, and at least two quality improvement plans in place at all times. This is the current URAC standard, which will likely change effective January, 2011, to be more focused on specific performance measures.

As mentioned above, most IRO business comes from plans and TPAs and not directly from consumers, but URAC also requires IROs to track any grievances related to access to services and to develop quality improvement projects around any issues related to access. Each IRO does its own evaluations and those will vary from company to company, but accredited IROs will all have a formal quality improvement program available for review. Some quality improvement initiatives undertaken by IROs include topics around consumer safety, turn-around-time improvement, accuracy of review products, peer reviewer consistency, and customer service improvements.

**16. What specific requirements should be applied to IROs to evaluate progress toward performance goals? What performance goals are the most appropriate?**

Performance goals need to be based on criteria that are easily measurable and reportable. The criteria should be objective and not subjective so it lends to quality measurement and improvement.

In regard to external appeals, performance goals could be based on turn-around times, consumer access to services, customer/consumer satisfaction (though satisfaction should measure service, access and response, not satisfaction with determinations), reviewer inter-rater reliability and quality/ thoroughness of review products.



**CERTIFICATE OF FULL ACCREDITATION**

*is awarded to*

*Advanced Medical Reviews*

*10780 Santa Monica Boulevard #333, Los Angeles, CA 90025*

*for compliance with*

*Independent Review Accreditation Program*

*pursuant to the*

**INDEPENDENT REVIEW ORGANIZATION STANDARDS, version 3.0**

*Effective from the 1st day of September 2008 through the 1st day of September 2011*

Alan P. Spielman  
President & CEO

Christine Leyden, RN, MSN  
Chief Accreditation Officer



**ACCREDITED**

**Independent Review  
Organization**

**Attachment A: URAC Certificate**

UR-AC accreditation is assigned to the organization and address named in this certificate and is not transferrable to subcontractors or other affiliated entities not accredited by UR-AC.

UR-AC accreditation is subject to the representations contained in the organization's application for accreditation. UR-AC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of UR-AC and shall be returned upon request.

## **Attachment B: Credentialing Policy**

All potential employees and contract provider reviewers sign a service agreement that includes provisions for credentialing requirements. Prior to AMR signing the contract, the provider will submit a copy of his/her license and DEA. Reviews are performed by individuals who have been thoroughly trained in the medical field and who are intimately involved with various medical programs, i.e. Medicaid and Medicare.

### Objective(s)

To establish selection criteria for AMR' reviewers.

### Definitions

- Board-Certified: A certification – approved by the American Board of Medical Specialties, the American Osteopathic Association
- License: A license or permit (or equivalent) to practice medicine or a health profession that is 1) issued by any state or jurisdiction in the United States; and 2) required for the performance of job functions.
- Practitioner – An individual person who is licensed to deliver health care services without supervision.
- Provider – Any person or entity that provides health care services. Includes both *practitioners* and *facilities*.
- Reviewer(s): The individual (or individuals) selected by AMR to consider a case.

### Policy Provisions

1. Selection Criteria
  - a. AMR must select the reviewer(s) for a case in accordance with AMR Policies and Procedures.
  - b. All reviewer(s) who are health care practitioners must have the following qualifications:
    - i. Active licensure;
    - ii. Recent experience or familiarity with current body of knowledge and medical practice;
    - iii. At least 5 years experience providing health care;
    - iv. If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.
    - v. If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery.
  - c. No reviewer may have a history of sanctions and/or disciplinary actions that cause the Medical Director and/or the Management Committee to believe that the reviewer's knowledge of medicine is insufficient to perform properly independent reviews.
2. Contracting with a provider

All potential employees and contract provider reviewers sign a service agreement that includes provisions for credentialing requirements.

- a. Prior to AMR signing the contract the provider will submit a copy of his/her license and DEA.
- b. If criteria described in section 2 meets AMR' credentialing requirements, the application will be approved and signed.

### 3. Credentialing Criteria

- a. AMR has contracted with a Credentials Verification Organization (CVO) 'Credentialing Solutions LLC' for use of its NCQA and URAC accredited credentialing services.
- b. Credentialing Solutions LLC uses the following sources for the provider data supplied by AMR:
  - i. Drug Enforcement Administration (DEA) Registration from the NTIS
  - ii. Provider State License Status and Sanctions, when available, from the data provided by the individual state licensing boards for specific provider types.
  - iii. KROLL Database
  - iv. Specialty Board Certification provided by Elsevier on behalf of the American Board of Medical Specialties (ABMS).
  - v. AMA: Education and other data provided by the American Medical Association (AMA) (under licensing agreement with AMA). This source is also a URAC approved source for education.
  - vi. Provider Medicare Sanctions as provided by the Office of the Inspector General, Health and Human Services ("DHHS").
  - vii. NPDB-HIPDB
- c. Credentialing Solutions LLC collects and provides updated information from the aforementioned sources on its Website, promptly after Credentialing Solutions LLC obtains it.

### 4. Credentialing Process

- a. Provider submits to AMR a copy of his/her medical license(s) and DEA.
- b. AMR' UR credentialing coordinator II (Suzanne Lieberman) submits the application record to Credentialing Solutions LLC for the following verifications:
  - i. -Board Certification issue date
  - ii. -Board Certification expiration date
  - iii. -Board Certification number
  - iv. -State License issue date
  - v. -State License expiration date
  - vi. -State License number
  - vii. -DEA issue date
  - viii. -DEA expiration date
  - ix. -DEA number

- x. -OIG
- xi. -NPDB
- xii. -HIPDB
- xiii. -Background SSN trace and criminal screening
- xiv. -Medical School
- xv. -Residency Programs
- xvi. -CV
- xvii. -Hours of practice
- xviii. -FAA
- xix. -TX ADL
- xx. -Trans/DOT
- xxi. -Academic privileges

- c. All results are forwarded to the Medical Director for review and recommendation to the Quality Committee.
- d. The Quality Committee will approve all initial and re-credentialed provider files.
- e. A written confirmation of approval or denial is sent to the potential employee or contracted consultant.
- f. AMR stores the credentialing data in a SQL database. Using the credentialing database, all data elements are being monitored.

#### 5. Re-credentialing

This process is repeated every year for all employed and contracted providers.

### **Attachment C: Reporting Capabilities**

AMR has a proprietary web system with extensive data mining and reporting capabilities. Our secure web portal allows for customizable submission sheets; these customized fields may capture any piece of data a client would like to see: review type, medical field, provider name, patient name, dates of birth, dates of service, turnaround time, facility, etc. Each of these fields is then available to be part of a customizable report. For example, a client may choose to generate a report for all female patients who saw provider x.

The screenshot shows the AMR Client Portal interface. At the top, there is a navigation bar with the AMR logo and links for Home, Contact Us, Help, Admin, and Logout. Below this is a search bar and a 'GO!' button. The main content area features a 'Select Basic Report Filter Options' section with dropdown menus for Date From (1/7/2009), Date To (3/3/2010), Specialty (- choose -), Submitter (- choose -), Review Type (- choose -), and Determination (- choose -). A 'GO!' button is next to these filters. Below the filters, it says 'Search Results: 5 Records' and provides a link to 'Export data to CSV file'. A table of records is displayed below, with columns for AMR #, Patient Name, Date Created, Reviewer Specialty, Submitter, Review Type, and Determination. A callout box on the right side of the screenshot highlights the filter options with the text: 'Basic Reporting Options, by Date, Specialty, Submitter, Review Type, and Determination'.

AMR #	Patient Name	Date Created	Reviewer Specialty	Submitter	Review Type	Determination
138235	Rupert Smith - Int Med & Psych Disability	8/14/2009 8:56:45 AM		Julio Smith		Non-Certified
138210	Nancy Smith Occ Med Disability	8/14/2009 8:04:11 AM		John Smith		Non-Certified
119173	Demo Case Do Not Process	4/16/2009 3:17:47 PM	Ophthalmology, Neuroophthalmology	HKCS Supervisor		
111126	THIRD PARTY REVIEW OF RESCISSIONS #2	2/18/2009 9:25:49 AM				
111124	THIRD PARTY REVIEW OF RESCISSIONS	2/18/2009 9:23:58 AM				

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The screenshot shows the 'Create a New Custom Report' page in the AMR Client Portal. The page is titled 'Create a New Custom Report' and features two main sections: 'Available Columns' and 'Visible Columns'. The 'Available Columns' list includes fields like 'Attach Prev Clinicals', 'Call to Provider Req', 'Date Completed', 'Date Created', 'Follow Specified Medical Guid', 'Medical Guideline Name', 'Previous AMR No.', 'Provider Name', 'Provider Phone', 'Provider Specialty', 'Question 02', and 'Question 03'. The 'Visible Columns' list includes 'Patient Name', 'Submitter Name', 'Due Date (Pacific Time)', 'Specialty', and 'Determination'. A 'Filter Details' section shows a filter for 'Determination = certified'. Below this, there are radio buttons for 'PRIVATE' and 'PUBLIC' custom reports, and a 'Save As A New Report' button. At the bottom, there is a table with 3 records and a 'Generate report using current settings' button.

**Available Columns:**

- Attach Prev Clinicals
- Call to Provider Req
- Date Completed
- Date Created
- Follow Specified Medical Guid
- Medical Guideline Name
- Previous AMR No.
- Provider Name
- Provider Phone
- Provider Specialty
- Question 02
- Question 03

**Visible Columns:**

- Patient Name
- Submitter Name
- Due Date (Pacific Time)
- Specialty
- Determination

**Filter Details:**

Field Name	Operator	Value
Determination	=	certified

**Filter Options:**

- This is a PRIVATE custom report (only viewable by you)
- This is a PUBLIC custom report (viewable by all users in your organization)

**Save under a new report name:**

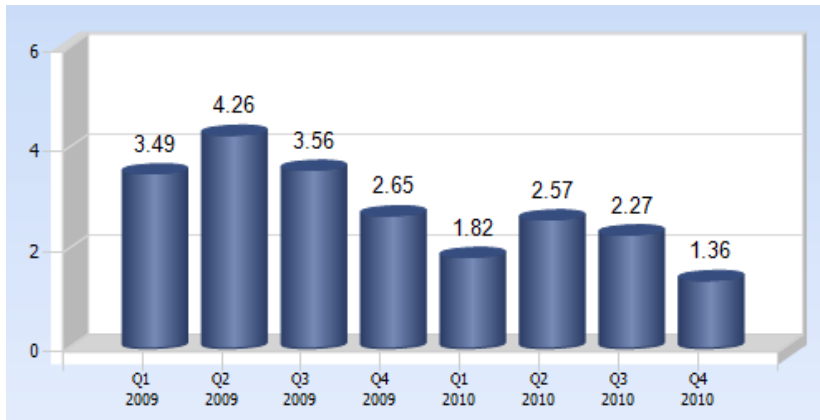
**Search Results:** 3 Records [Export data to CSV file](#)

AMR #	Patient Name	Submitter Name	Due Date (Pacific Time)	Specialty	Determination
67061	T. Doe - Neph Transplant	Jane Smith	6/5/2008 2:00:00 PM		Certified
49345	John Smith	John Smith	1/22/2011 2:00:00 PM		Certified
48928	Jim Jones	Jane Smith	12/31/2010 2:00:00 PM		Certified

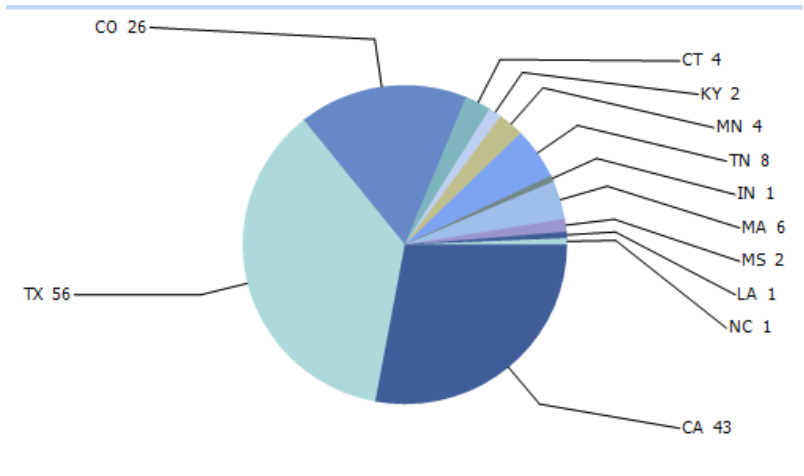
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Customize reports using any field from the Submission Template

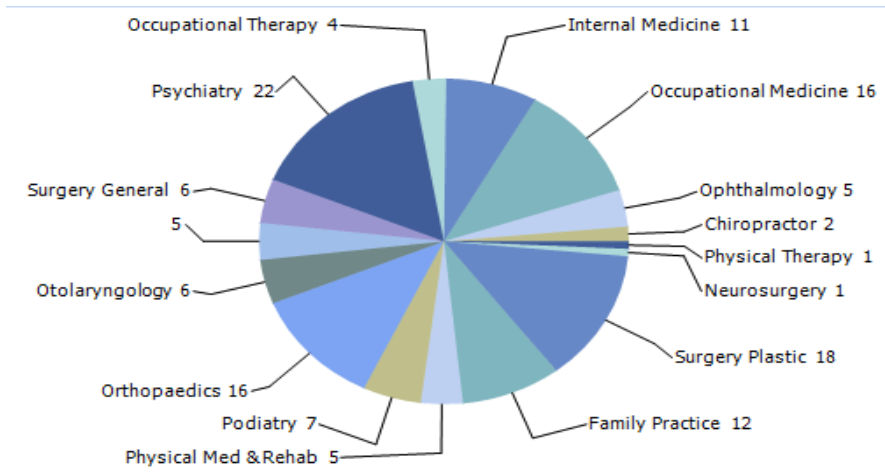
**Reporting Capabilities**



TAT by Quarter



Review Volume by Jurisdiction



Review Volume by Specialty