

Bulletin 99

**CERTIFICATION OF
INDEPENDENT REVIEW ORGANIZATIONS**

October 7, 1999

This Bulletin is directed to all health maintenance organizations (HMOs) doing business in Indiana and to all organizations interested in acting as independent review organizations for the HMO external grievance procedures set forth in IC 27-13-10.1.

IC 27-13-10.1, as added by P.L. 133-1999, requires each HMO doing business in Indiana to establish and maintain an external grievance procedure for the resolution of grievances regarding adverse utilization review determinations, adverse determinations of medical necessity or determinations that a proposed service is experimental or investigational. The Department of Insurance (Department) is required to establish and maintain a process for annual certification of independent review organizations and to maintain a list of certified independent review organizations to be used by HMOs. This Bulletin sets forth the procedure for certification as an independent review organization (IRO).

Request for Certification as an Independent Review Organization

In order to be considered for certification, organizations must submit a Request for Certification to the Department, in duplicate. The Request must comply with all instructions contained in this Bulletin; incomplete requests will not be considered. A Request shall include the following information:

- ◆ Identifiable and specific responses to each criteria set forth in this Bulletin and IC 27-13-10.1;
- ◆ A statement certifying that all information included in the Request for Certification is accurate to the best of the Applicant's knowledge and belief and signed by the Applicant's chief executive officer or an individual authorized to act in such capacity for the Applicant;
- ◆ Consecutive page numbering and identification of sections.

Section 1 – Technical/Procedure

This section shall describe the organization's approach and plans for accomplishing the external grievance review process described in IC 27-13-10.1. The organization should describe the effort and skills necessary to complete the process. This section shall contain at least the following information:

- 1) A summary of the organization's case review process, which demonstrates an understanding of the law governing the external review process.
- 2) A description of how the work will be accomplished within each step of the case review process. Simple statements that a task will be completed or a reiteration of the criteria are not acceptable. The description should explain the process to be employed in reviewing an HMO's determination and include a flow chart depicting the process by which external review will proceed from the receipt of the request for review to the final decision. The

explanation should address the criteria used in the decision-making process and the systems and methods used to process case reviews, including the following:

- a) Process for providing a decision in the statutorily mandated amount of time.
 - b) Process for selecting and assigning reviewers to cases including the recruitment and contracting, credentialing, and assignment of appropriate specialists to cases.
 - c) Process for ensuring independence. Include any contract provisions with reviewers that require the contracted reviewer to review the case for potential conflicts of interest before accepting the assignment.
 - d) Process for maintaining the confidentiality of medical and treatment records and any other review materials during communication with parties involved in the review process and during “in house” communication.
 - e) Process for communication with parties involved in the review process. Include any requirements for the process that HMOs must follow when submitting the request for external review and the case file.
 - f) Process for requesting and receiving additional information from HMOs or other parties. Include any requirements that responses be submitted by a particular method (i.e. overnight mail, facsimile). Include whether the organization will recontact an HMO if information is not provided in a timely fashion and process for doing so.
 - g) Process for rendering and communicating decisions.
 - h) Process for maintaining written records pertaining to each case review and the retention schedule of those records.
- 3) A summary of any problems the organization might reasonably expect in the external review process, and anticipated solutions to those problems.
 - 4) A drafted format for the annual report to the Department required by IC 27-13-10.1-8(c)(3).
 - 5) A description of the statistics maintained by the IRO that will be made available to the Department on request.

Section 2 – Cost

This section shall contain all information related to fees to be charged by the organization to the HMO.

- 1) Fees charged for each review should be reasonable in relation to the work performed. Work performed should be broken down into the following review types:
 - a) preliminary review;
 - b) situations where full review is not necessary owing to reversal by the HMO of its adverse determination due to new information; and
 - c) full review.

- 2) If the fee structure is other than a flat, per case rate, provide the basis upon which it is determined and include the anticipated average cost per case.
- 3) A statement that all fee schedules submitted with the Request for Certification will not be increased during the one-year certification period.

Section 3 – Organizational Support and Experience

This section shall contain all pertinent information relating to the organization's personnel and experience that would substantiate its qualifications and capabilities to perform external reviews as described in IC 27-13-10.1. This section shall contain at least the following information.

- 1) Certification of incorporation or partnership and location of applicant's headquarters and offices in or nearest to Indiana.
- 2) Any organization requesting certification as an IRO must provide the following information about the organization and any parent corporation, subsidiary, or affiliate:
 - a) Name and address of each member of the board of directors;
 - b) Name and address of any owner, partner or any other person with 10% or more voting shares;
- 3) A chart illustrating the relationship among all affiliated entities.
- 4) An internal organizational chart that identifies key grievance review staff members and their responsibilities within the organization. It shall provide an estimate of the number, types, and functions of the personnel considered necessary to the administration and operation of the organization in Indiana with a separate job description detailing the roles of key persons. It shall describe the contractual and financial relationships between the organization and the clinical personnel who will be responsible for individual case reviews.
- 5) A list of personnel who may be assigned to individual case reviews. For each reviewer, the list shall include the name, professional license(s), board certification(s), and any history of disciplinary actions or sanctions that raise a substantial question as to the reviewer's physical, mental or professional competence or moral character, including loss of staff privileges, or restrictions on participation, taken or pending by any hospital, government or regulatory body.
- 6) A list of all managed care organizations, hospitals, health care facilities, and other health care providers with whom the organization maintains any health related business arrangements. This list shall include a brief description of the nature of any such arrangement.
- 7) A description of how the organization will:
 - a) Provide licensed review personnel who possess the appropriate training and qualifications in the medical subject area for which they will be conducting the review. Include the criteria to be used for the selection or rejection of review personnel.
 - b) Ensure the availability of appropriate personnel as needed for timely and efficient review.

- c) Ensure the neutrality and objectivity of all personnel conducting external reviews, including avoidance of conflicts of interest or the appearance of a conflict of interest.
- 8) A description of the organization's quality assurance program for case review.
- 9) Documentation which clearly shows the organization's experience in performing similar reviews. Describe the organization's experience in managed care utilization review, including an explanation of level(s) and scope of involvement in the utilization review process. The organization may also provide a list of references including entities for which the applicant has performed similar review under any state or federal external grievance review law.
- 10) A statement that the organization agrees to accept all eligible cases referred to it on the rotating basis required to be used by HMOs.
- 11) A statement that the Request for Certification designates agreement to comply with IC 27-13-10.1.
- 12) A list of all professional designations and/or licenses held by the organization and a brief explanation of all credentials held by the organization from other states and credentialing organizations.
- 13) A description of any disciplinary actions or sanctions taken or ongoing against the organization in the preceding ten (10) years.

Department Review

The Department may:

- ◆ Approve any number of entities for certification as IROs;
- ◆ Reject any request for certification or recertification if determined by the Commissioner to be necessary, appropriate, or in the best interests of HMOs and their enrollees;
- ◆ Suspend, revoke or otherwise sanction an organization's IRO certification if the Commissioner determines that the organization is not in substantial compliance with the information provided in the organization's request for certification, any applicable law, or any regulation or other guidance issued by the Commissioner;
- ◆ Request that an organization alter its activities to be consistent with any applicable law or any regulation or other guidance issued by the Commissioner;
- ◆ Deny or reassign a request for external review if the Commissioner has reason to believe that such an assignment would result in or create the appearance of a conflict of interest or if the Commissioner determines that the organization cannot or has not conducted the review in accordance with the statute.

Timelines

The IRO Certification List will be effective January 1, 2000. In order to be considered for certification and inclusion on the January 1, 2000 list, Requests for Certification must be delivered to the Department on or before December 1, 1999. The period of certification will be

one (1) year. The IRO Certification List will be published on the Department website: www.state.in.us/idoi.

There will be a six (6) month update of the IRO Certification List on June 1, 2000. Any organization that wishes to be considered for certification and inclusion on the June 1, 2000 list must deliver a Request for Certification to the Department by May 1, 2000. Organizations added to the June 1, 2000 list must reapply for the 2001 certification period.

Beginning January 1, 2001, IRO certification and/or re-certification will be performed on an annual basis. Requests for certification or re-certification must be delivered to the Department on or before December 1 of each year.

Submission of Request for Certification

Requests for Certification and any questions may be submitted by mail or electronically.

Mail: Deputy Commissioner, Health Issues
Indiana Department of Insurance
311 W. Washington, Suite 300
Indianapolis, IN 46204-2787

Fax: (317) 232-5251

Electronic: doi@doi.state.in.us Requests submitted electronically must be a Microsoft Word document.

Sally McCarty, Commissioner