INDEPENDENT REVIEW ORGANIZATION (IRO)
ONLINE REQUEST FORM
SYSTEM PROCEDURES

The IRO Online System has been developed to efficiently assist Utilization Review Agents (URA) and Payors/Carriers in requesting a review by an Independent Review Organization.

TABLE OF CONTENTS

Required Information and Definitions

The following information will be required for data entry:

What type of insurance or health care plan?

Type 1 – Health Care Plan (Non-Workers' Compensation)
Type 2 – Certified Workers' Compensation Health Care Network Plan
Type 3 – Workers' Compensation Non-Network Plan

Signed authorization for the release of medical information to the assigned IRO for health only.

Section I - Name of Party Requesting IRO.

- Self, (patient or injured employee) Party acting on behalf of patient or injured employee, Provider that received adverse determination or other physician or health care provider.)

Section II – Provider That Received the Adverse Determination

- Physician/Doctor or other health care provider/practitioner who requested/provided the services that are being denied and who received the initial denial review and/or reconsideration or appeal denial as applicable.

Section III – Additional Physicians or Health Care Providers

- Additional physicians or other health care providers who provided care to the patient and may have medical records relevant to the review.

Section IV – Patient Information

- Patient/Injured Employee for whom health care services are being requested or provided.

Section V – Payor Information

- An insurer writing health insurance policies
- Any preferred provider organization, health maintenance organization, self-insurance plan or
- Any other person or entity which provides, offers to provide, or administers hospital, outpatient, medical or other health benefits to persons treated by a health care provider in this state pursuant to any policy, plan, or contract.

Section VI – Utilization Review Agent (URA) Type 1 Health Care Plan

- An entity is certified by the TDI as a utilization review agent and conducts the review of services that are being denied.

Section VI - Workers' Compensation Health Care Network Type 2

- An entity certified by TDI as a Workers' Compensation Health Care Network as defined by Chapter 1305.04 (16)

Section VII – Additional URA Reviewers

- Additional physicians or other health care providers who participated in the review/determination of the Utilization Review.

Section VIII- Denial Information

- A determination by a utilization review agent that the health care services furnished or proposed to be furnished to an enrollee/injured employee are not medically necessary.
- Current Procedural Terminology (CPT codes)
- International Classification of Diseases (ICD-9 codes)

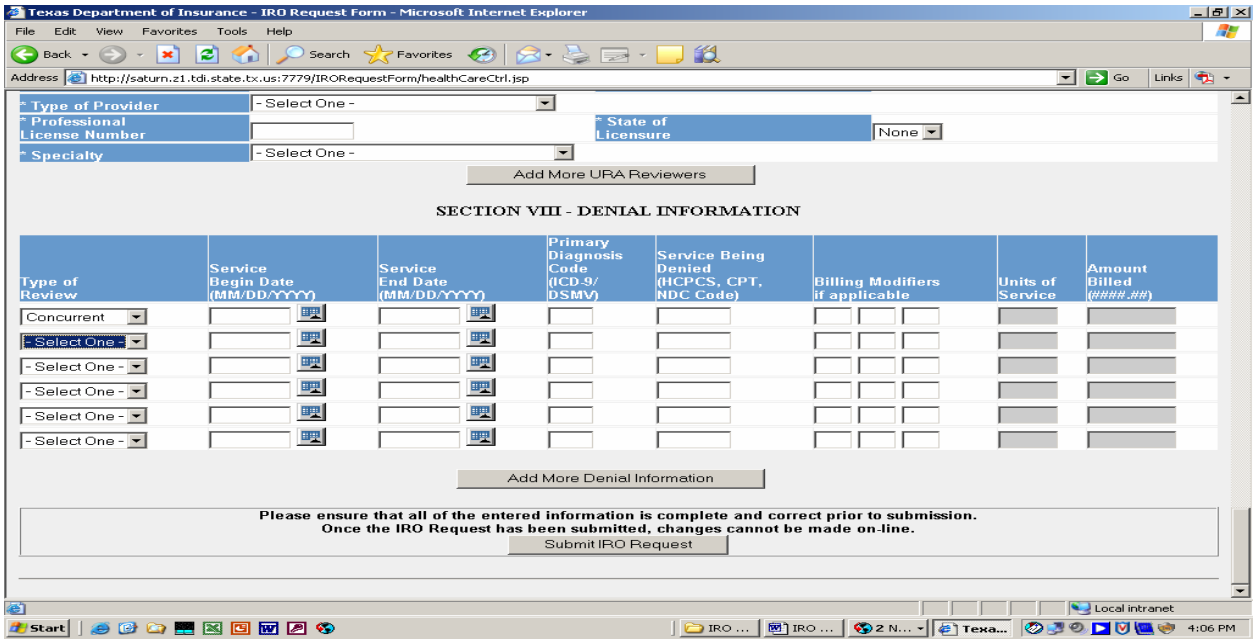
The fields located in Section VIII – Denial Information are mandatory fields and should be completed to the extent of the information you have related to the request.

M = Mandatory
O = Optional

	Retrospective	Concurrent	Prospective
Begin Date	**M**	**M**	**O**
End Date	**O**	**O**	**O**
ICD-9	**M**	**O**	**O**
HCPCS/CPT	**M**	**O**	**O**
Modifiers	**O**	**O**	**O**
Units	**O**	**O**	**O**
Amount	**M**	**O**	**O**
Date of Injury	**M**	**M**	**M**
Claim Number	**O**	**O**	**O**

Retrospective is Not Applicable to Health as well as Units, Amount, Date of Injury and Claim Number.

EXAMPLE OF REQUIRED FIELDS



Overview of Independent Review Organization (IRO) Plan Types

The following instructions have been provided to assist all users in navigating through the online system. **You must have access to the internet to use this system.**

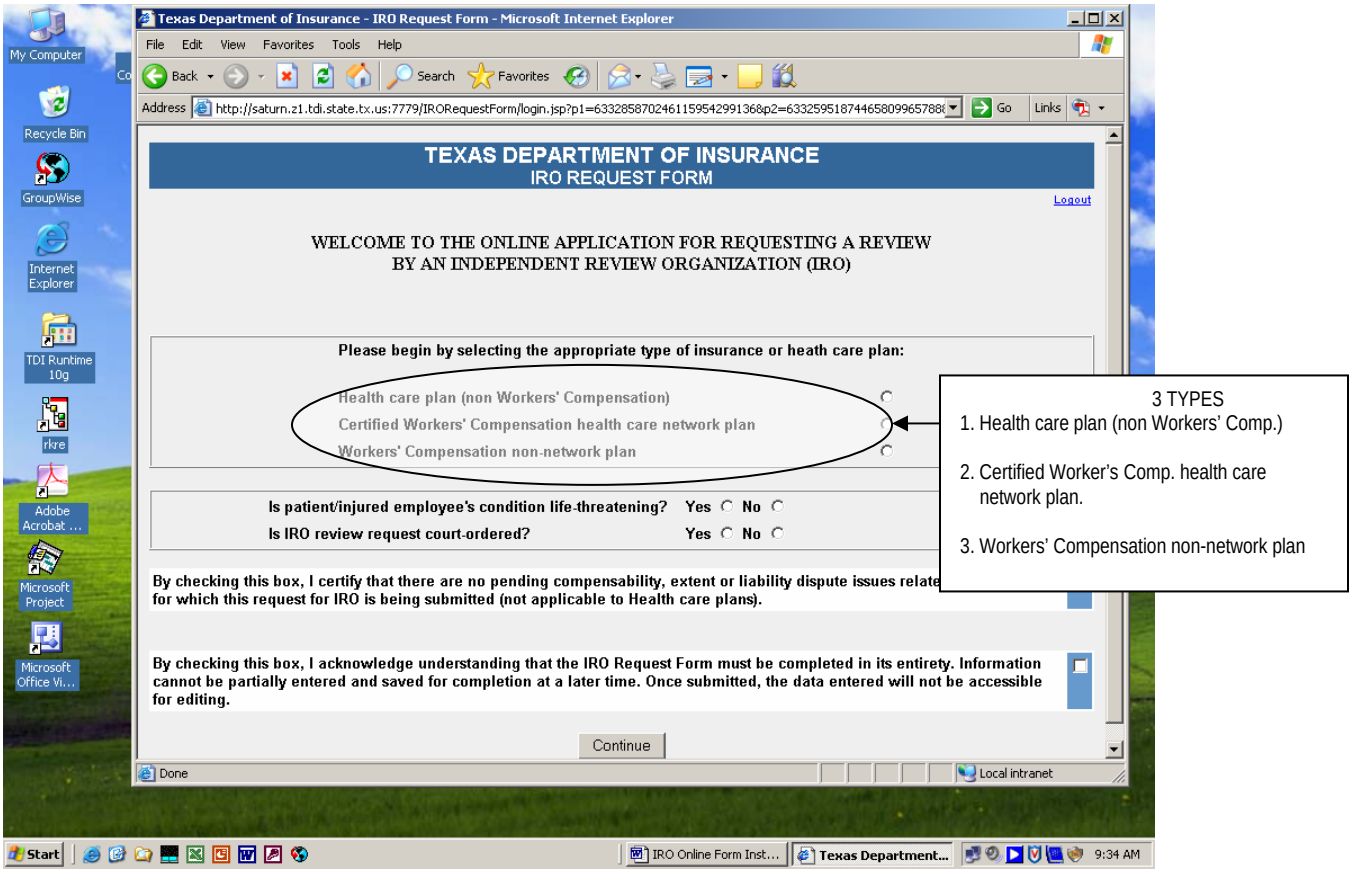
All required fields throughout the IRO Online Request Form will have an <u>asterisk</u> (*) to indicate the field is <u>required.</u> This information must be entered in it's entirety for the system to allow you to submit your request.

There are 3 different types of IRO Request that may be submitted via the internet online form.

Type 1 - Health Care Plan (Non-Workers' Compensation)

Type 2 - Certified Workers' Compensation Health Care Network Plan

Type 3 - Workers' Compensation Non-Network Plan



Type 1 Health Care Plan Non-Workers' Compensation

Welcome to the Online Application For Requesting A Review By An Independent Review Organization (IRO) System.

Instructions for Type 1- Health Care Plan (Non-Workers' Compensation)

***You can click in the text, boxes, circles and fields through out the system. The system has been designed to accommodate the American Disability Act.**

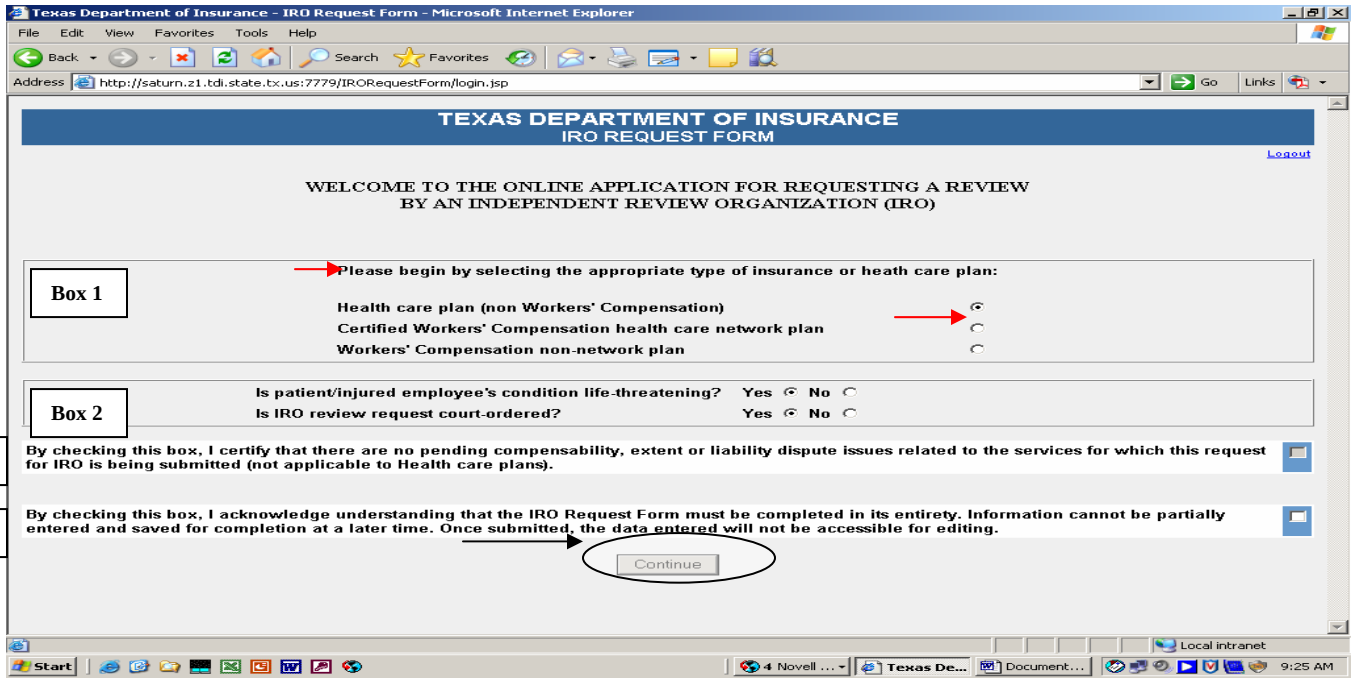
Begin by selecting the appropriate type of insurance or health care plan. Click in the **circle or the words** next to the plan you are choosing as shown in Box 1 on the screen below.

You will also be required to answer the questions found in Box 2 by clicking in the **Yes** or **No circles** as shown below.

Box 3 will automatically gray as this box is used in conjunction with the Type 2 Certified Workers' Compensation Health Care Network Plan and Type 3 Workers' Compensation Non-Network Plan.

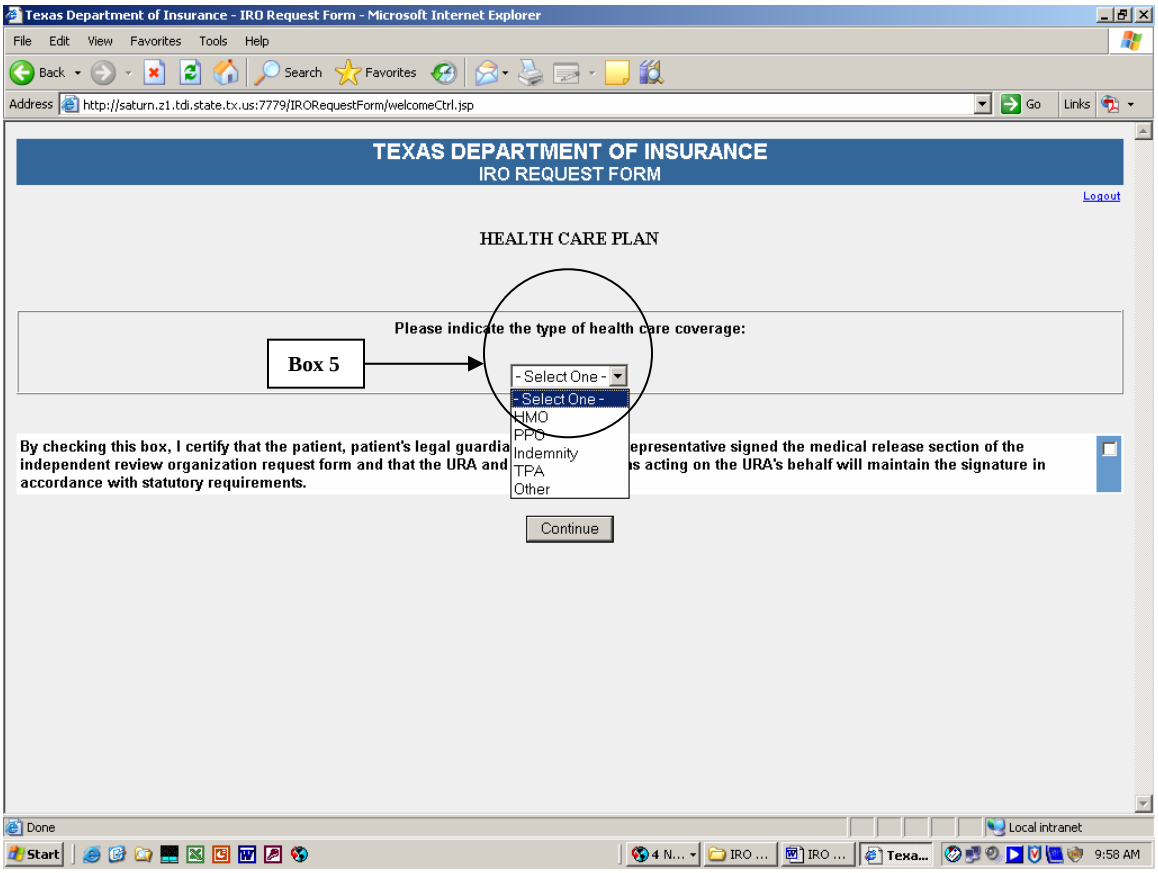
Click on the box found in Box 4 to check that you acknowledge and understand the IRO Request Form must be completed in its entirety. The information can not be partially completed or saved for completion at a later time.

Click **Continue** to continue entering your information.



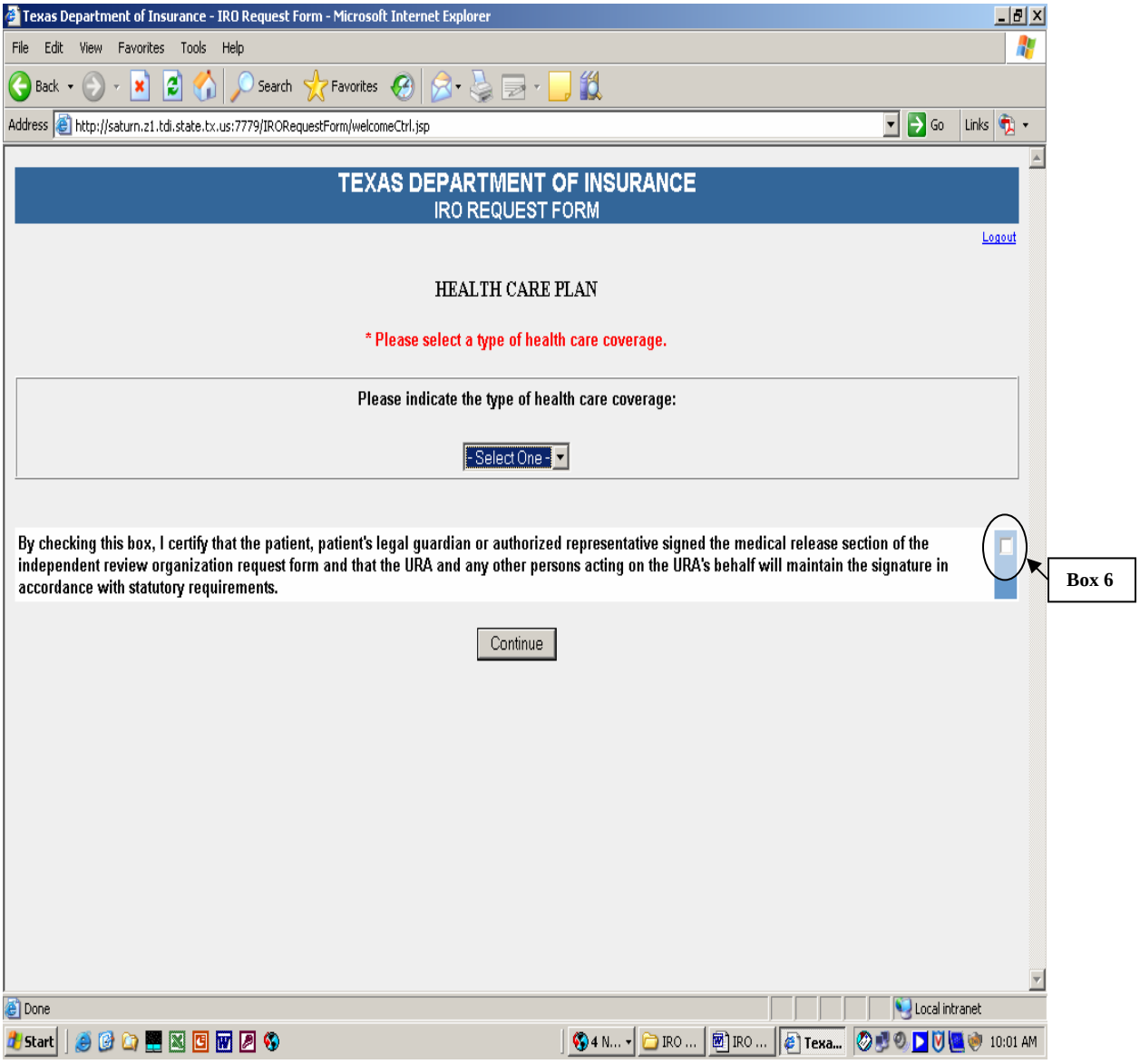
Indicate the type of health care coverage.

Select one type of Health Care Coverage as shown in Box 5 below, by using the **drop down box** located in Box 5.



You must **click** on the box located in Box 6 to check that you certify the patient, patient's legal guardian or authorized representative signed the medical release section of the independent review organization request form and that the URA and any other persons acting on the URA's behalf will maintain the signature in accordance with statutory requirements.

Click Continue to continue entering your information.



All required fields throughout the IRO Online Request Form will have an asterisk (*) to indicate the field is required. This information must be entered in its entirety for the system to allow you to submit your request.

Use your tab key to navigate through the document form beginning in Section I.
If you fail to complete the required fields you will receive this message at point of submittal.

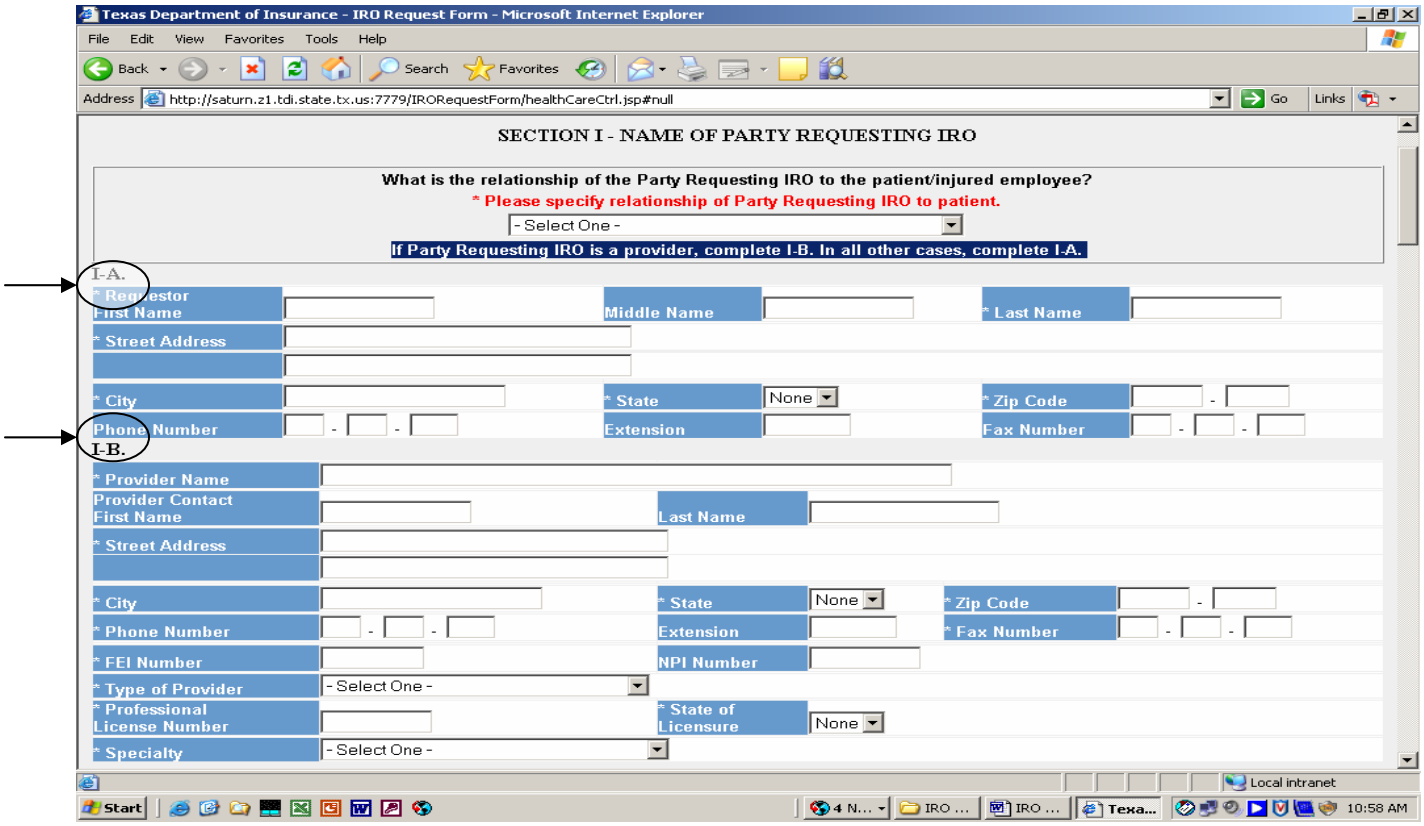
If you use a mouse errors may not be indicated until all data is entered and the submit button is selected.

You can use your mouse to click in fields you may have inadvertently placed incorrect information in, or to complete information that has been inadvertently left out.

SECTION I – NAME OF PARTY REQUESTING IRO

Information that is not required should be submitted allowing for a more complete request.

Please choose from the **drop down** box (self, party acting on behalf of patient or provider that received adverse determination or other physician or health care provider). **What is the relationship of the Party Requesting IRO to the patient/injured employee?**



If Party Requesting IRO is a provider, **complete I-B**. In all other cases, **complete I-A**.

Please enter the following information in Section I, **I-A**:

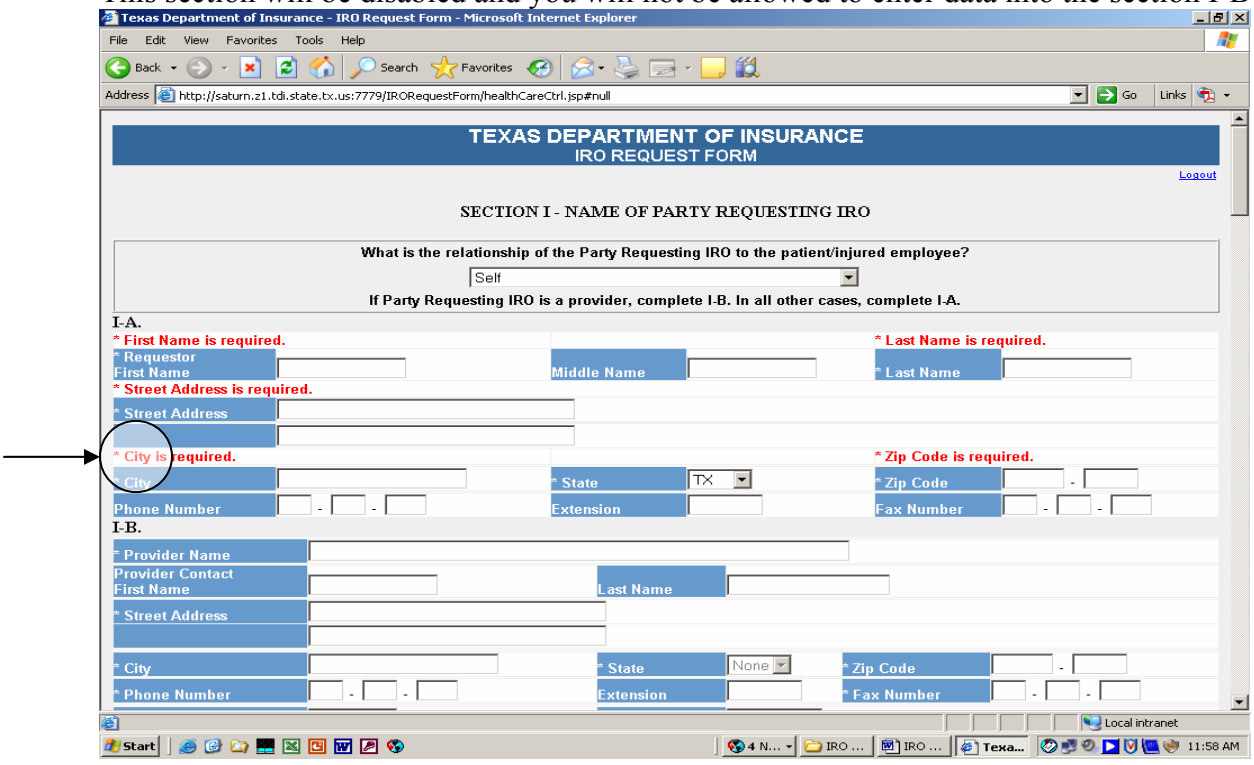
Requestor is self or party acting on behalf of patient.

The fields that must be completed are listed below:

*Requestor First Name
*Last Name
*Street Address
*City
*State and Zip Code

If you inadvertently tab or click in a disabled section in error you may loose your cursor. Click your mouse in a field outside of the disabled area to view position of cursor.

If you are completing section I-A you do not have to complete section I-B.
This section will be disabled and you will not be allowed to enter data into the section I-B fields.



If Party Requesting IRO is a provider, **complete I-B.**

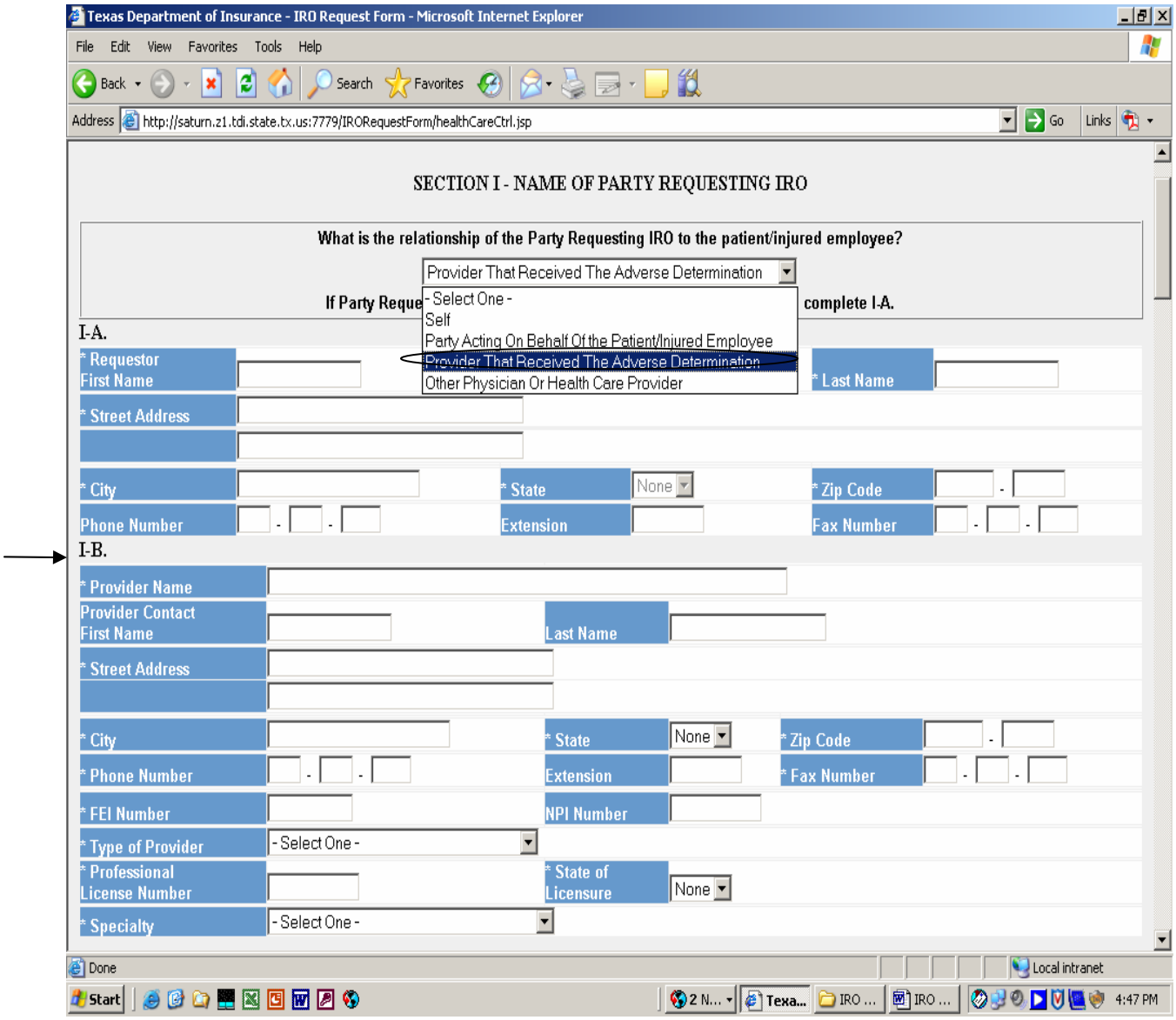
Choose from the **drop down** box (provider that received adverse determination or other physician or health care provider) in Section I – Name of Party Requesting IRO.

Enter the following information in Section I, **I-B**:

The fields that must be completed are listed below:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty

Information that is not required should be submitted, allowing for a more complete application.



SECTION II – PROVIDER THAT RECEIVED THE ADVERSE DETERMINATION

Once you have entered the Fax Number located in Section I, I-A press your tab key to continue to SECTION II.

Pressing the **tab key** will take you to the 1st question in Section II.

Is the provider that received the adverse determination the same as the party requesting the IRO? Yes or No

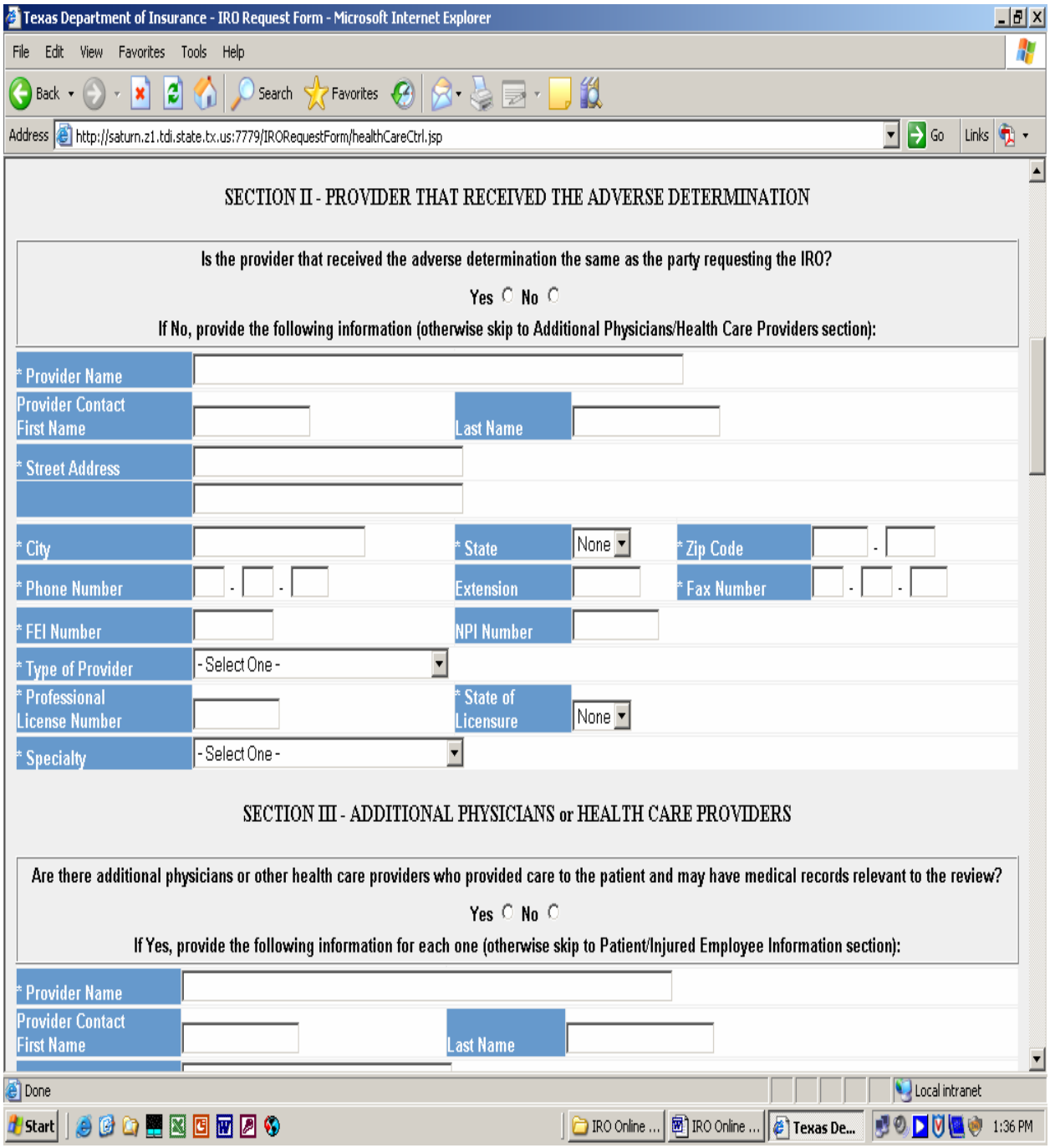
If **Yes** go to **Section III – Additional Physicians or Health Care Providers**.

If you have chosen Self or Party acting on behalf of the patient or injured employee located in Section I, you must **click** on **No** when answering the question above.

If you choose No the following fields must be completed:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number
*Type of Provider
*Professional License
*State of Licensure
*Specialty

Information that is not required should be submitted, allowing for a more complete application.



SECTION III – ADDITIONAL PHYSICIANS or HEALTH CARE PROVIDERS

Click on **Yes** or **No** to the question below.

Are there additional physicians or other health care providers who provided care to the patient and who may have medical records relevant to the review?

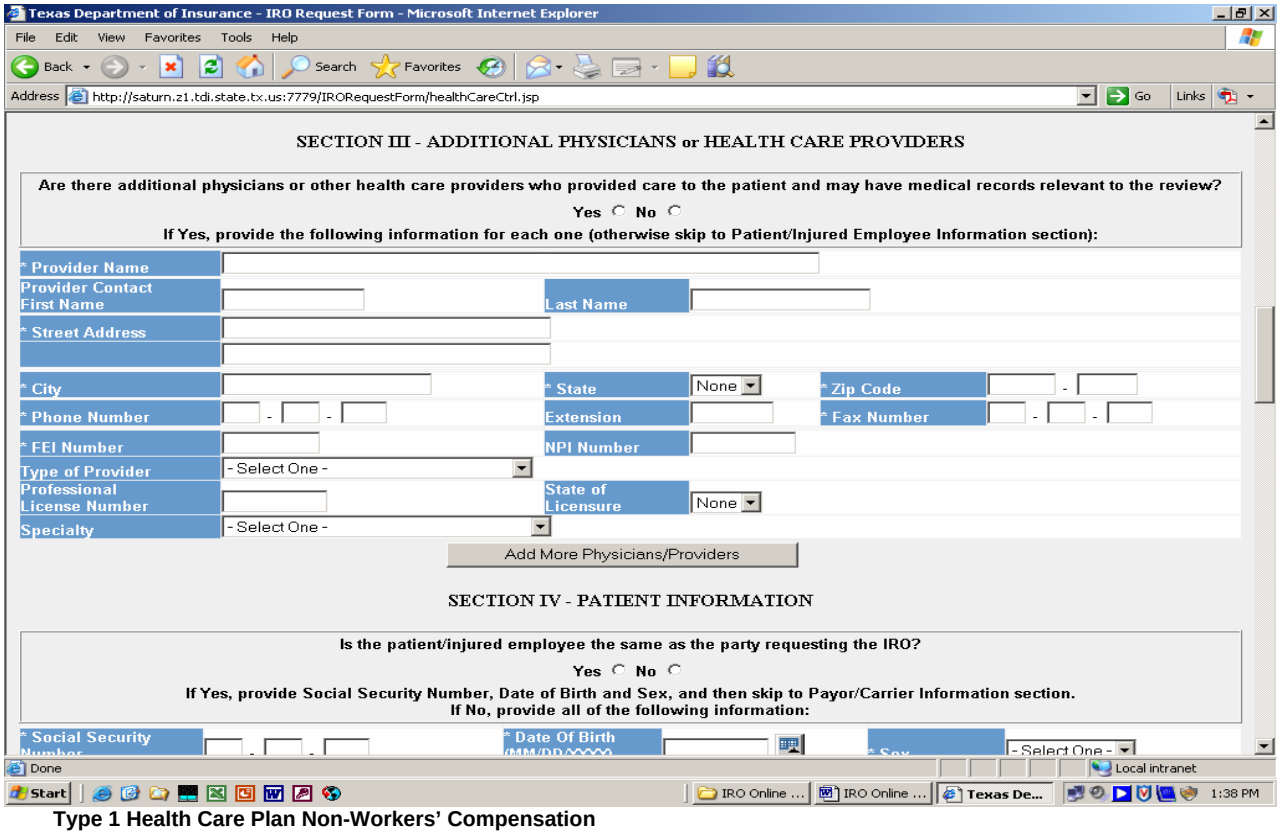
If **Yes** the following fields must be completed in Section III:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number

If **No** go to **Section IV Patient Information**.

If you have more than 1 physician or provider **click** on the **Add More Physicians/Provider** button located at the end of Section III.

Information that is not required should be submitted, allowing for a more complete application.



SECTION IV – PATIENT INFORMATION

Click on **Yes** or **No** to the question below.

Is the patient the same as the party requesting the IRO?

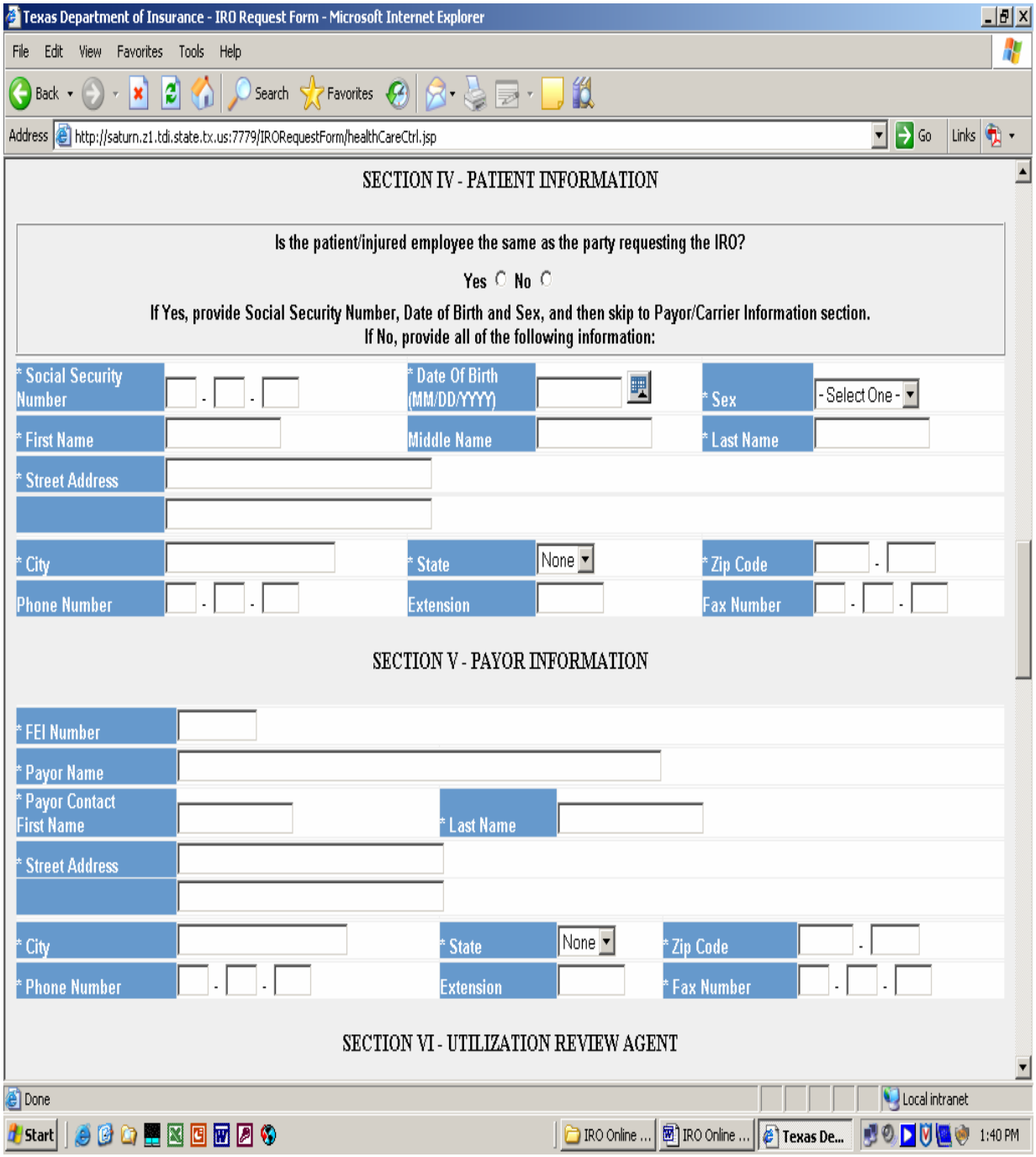
If **Yes** the following fields must be completed in Section III:

*Social Security
*Date of Birth
*Sex

If **No** the following fields must be completed in Section III:

*Social Security
*Date of Birth
*Sex
*Patient's First Name
*Patient's Last Name
*Street Address
*City
*State
*Zip Code

Information that is not required should be submitted, allowing for a more complete application.

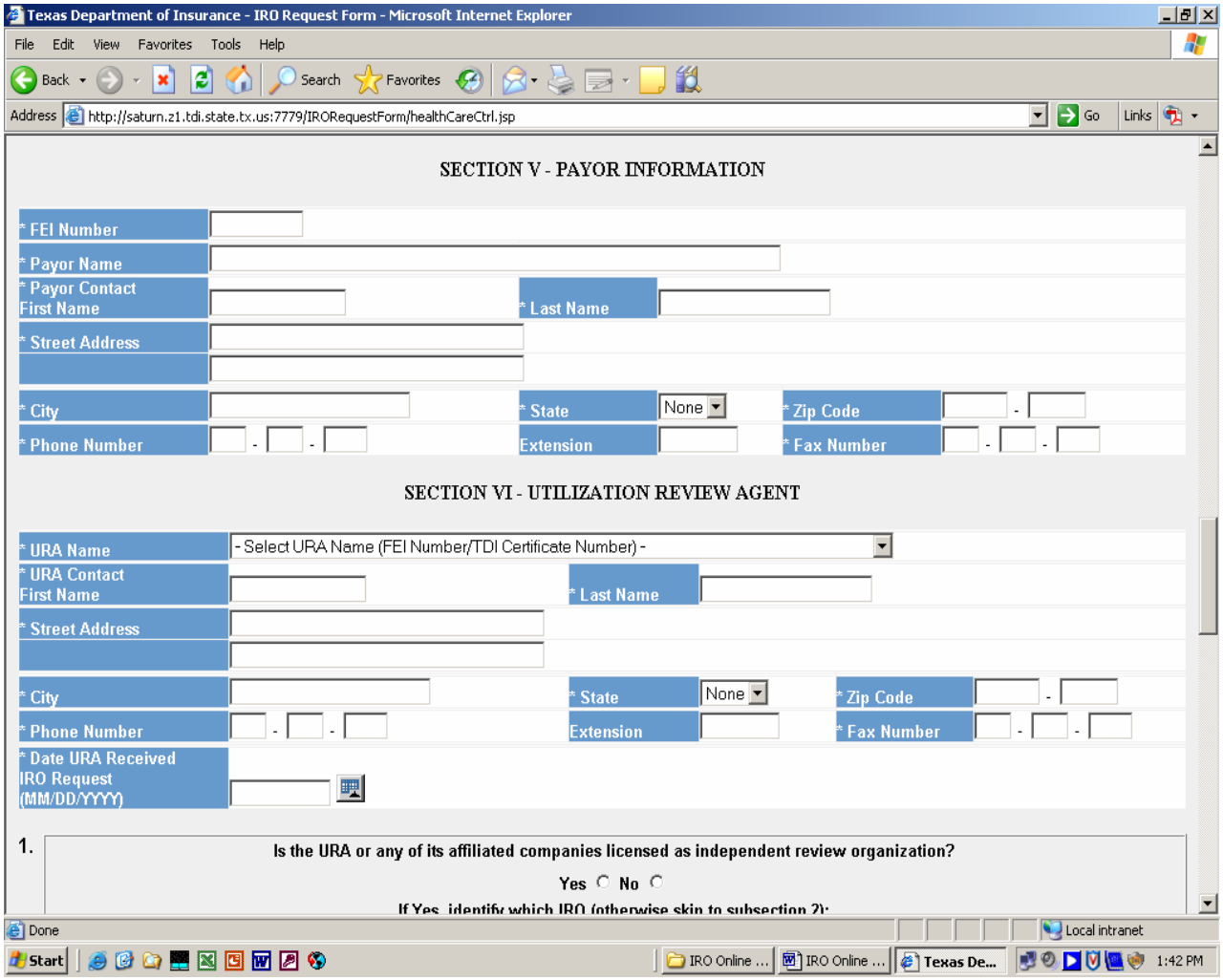


SECTION V – PAYOR INFORMATION

The following fields must be completed in Section V:

*FEI Number
*Payor Name
*Payor Contact First Name
*Payor Contact Last Name
*Street Address
*City
*State
*Zip Code
*Phone Number
*Fax Number

Information that is not required should be submitted, allowing for a more complete application.



SECTION VI – UTILIZATION REVIEW AGENT

The following fields must be completed in Section VI:

*URA Name
*URA Contact First Name
*URA Contact Last Name
*Street Address
*City
*State
*Zip Code
*Phone Number
*Fax Number
*Date URA Received IRO Request

Information that is not required should be submitted, allowing for a more complete application.

Please answer the question below by **clicking** **Yes** or **No**.

Is the URA or any of its affiliated companies licensed as independent review organizations? Yes or No?

If **Yes** identify which IRO by choosing the appropriate IRO company name from the **drop down** box located below the question.

Provide the following information for the physician or health care provider who performed the initial adverse determination review:

*Provider Name
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty

Please answer the question below by **clicking** **Yes** or **No**.

Was a reconsideration or appeal of the adverse determination conducted? Yes or No

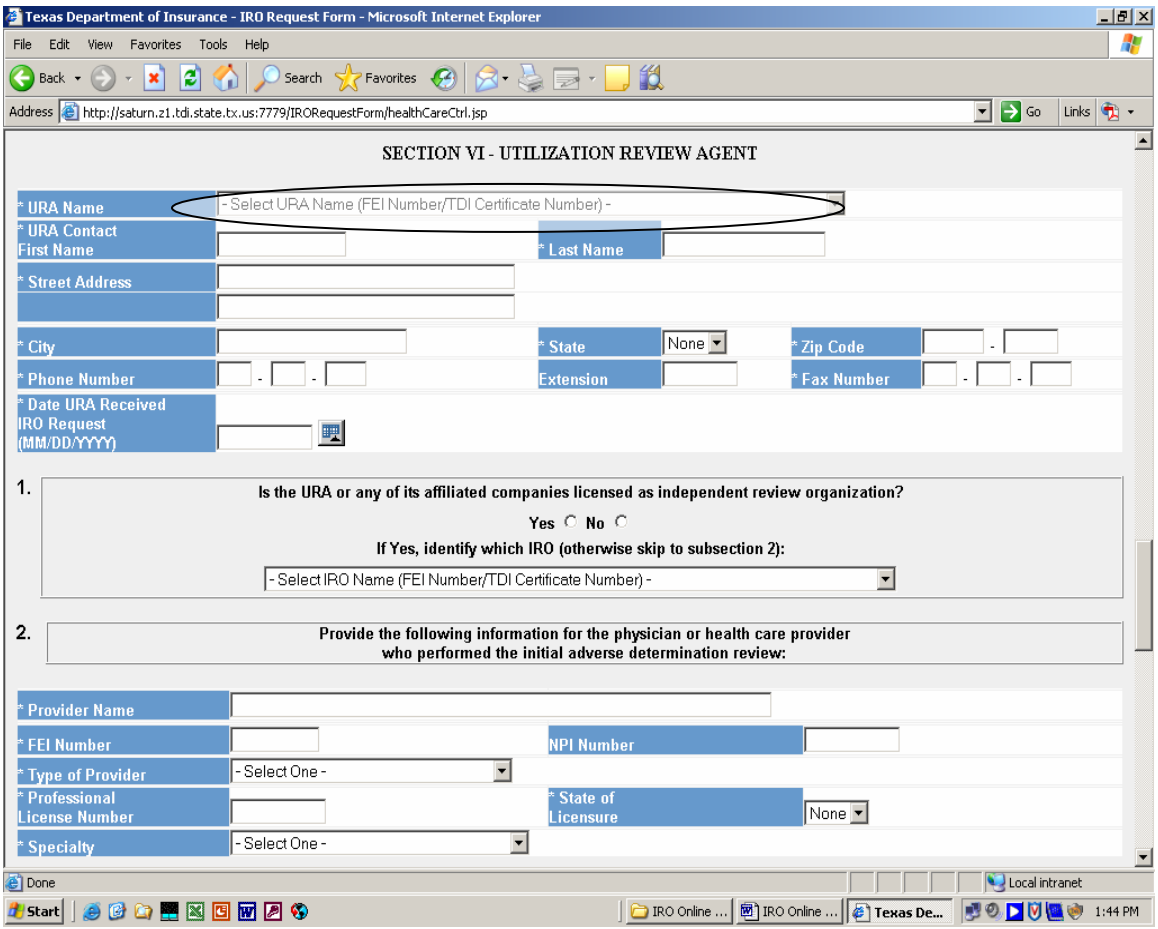
If **Yes** provide the following information:

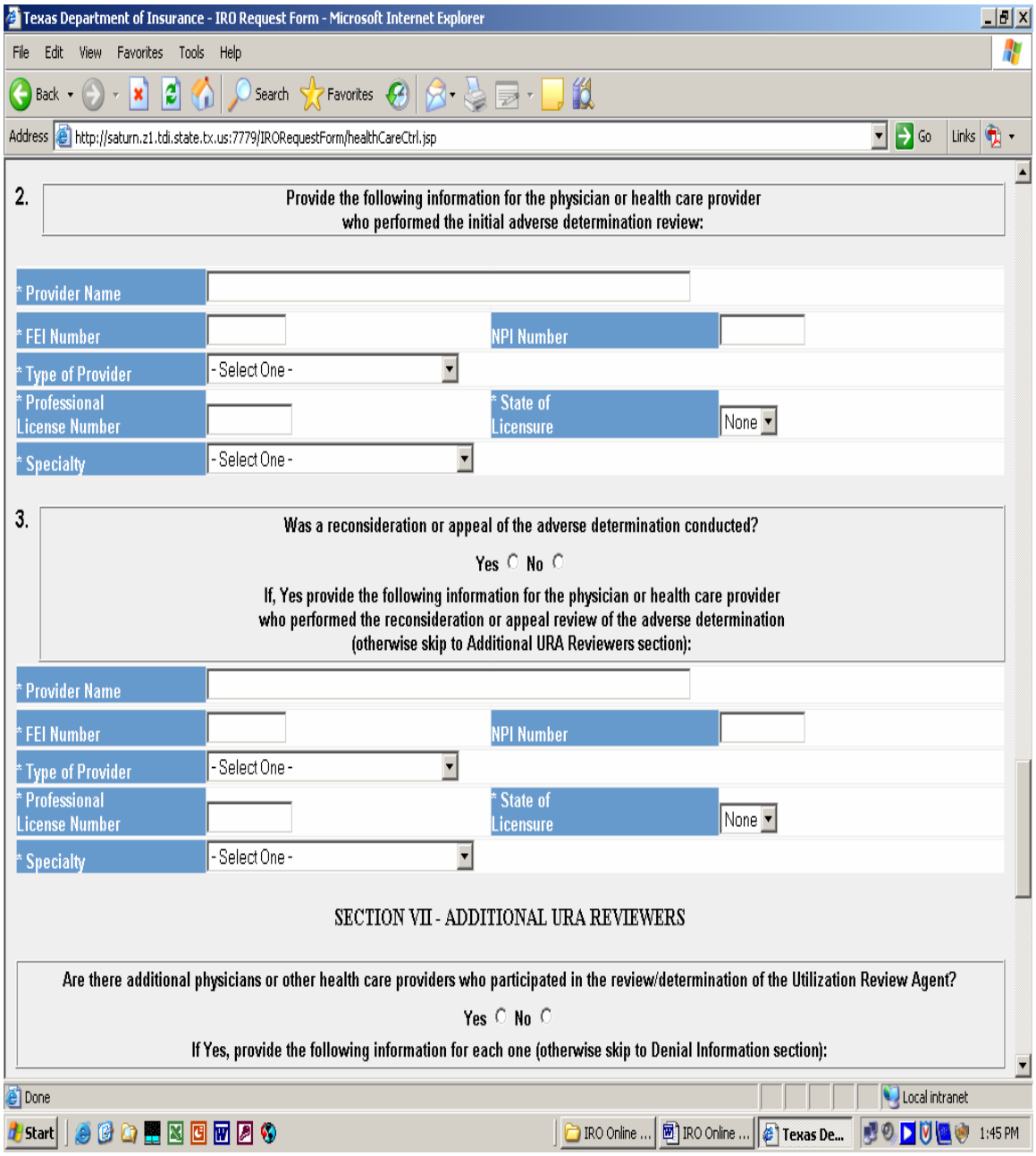
*Provider Name
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty

If **No** go to **Section VII – Additional URA Reviewers**.

Information that is not required should be submitted, allowing for a more complete application.

If you chose No you do not have to provide the information listed above. Tab to Section VII .




Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address http://saturn.z1.tdi.state.tx.us:7779/IRORequestForm/healthCareCtrl.jsp
Go Links
2.
Provide the following information for the physician or health care provider who performed the initial adverse determination review:
* Provider Name
* FEI Number
NPI Number
* Type of Provider
- Select One -
* Professional License Number
* State of Licensure
None
* Specialty
- Select One -
3.
Was a reconsideration or appeal of the adverse determination conducted?
Yes No
If, Yes provide the following information for the physician or health care provider who performed the reconsideration or appeal review of the adverse determination (otherwise skip to Additional URA Reviewers section):
* Provider Name
* FEI Number
NPI Number
* Type of Provider
- Select One -
* Professional License Number
* State of Licensure
None
* Specialty
- Select One -
SECTION VII - ADDITIONAL URA REVIEWERS
Are there additional physicians or other health care providers who participated in the review/determination of the Utilization Review Agent?
Yes No
If Yes, provide the following information for each one (otherwise skip to Denial Information section):
Done
Local intranet
Start
IRO Online ...
IRO Online ...
Texas De...
1:45 PM

SECTION VII – ADDITIONAL URA REVIEWERS

Click on **Yes** or **No** to the question below.

Are there additional physicians or other health care providers who participated in the review/determination of the utilization review agent? **Yes** or **No**

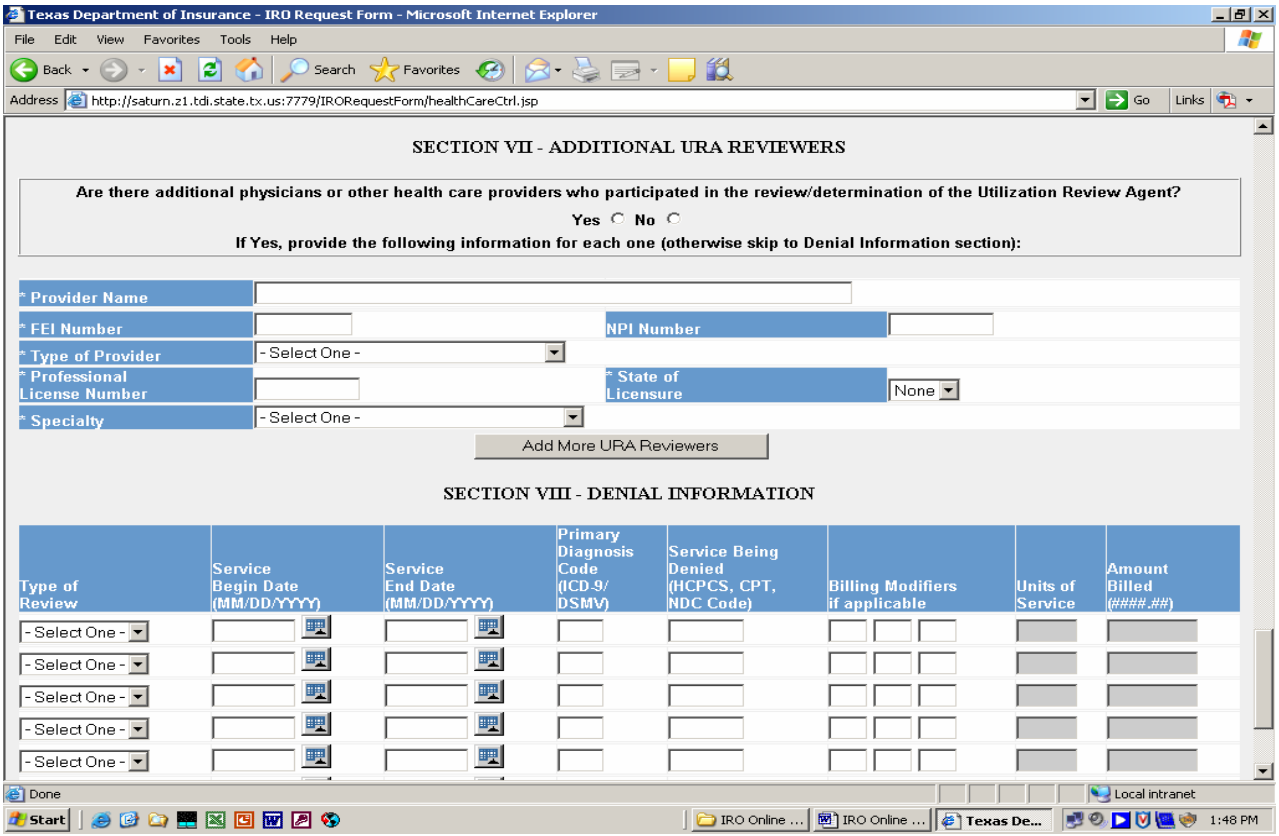
If **Yes** the following fields must be completed in Section VII:

*Provider Name
*Type of Provider
*Professional Licensure Number
*State of Licensure
*Specialty

If **No** go to **Section VIII- Denial Information.**

Information that is not required should be submitted, allowing for a more complete application.

If you have more than 1 URA Reviewer **click** on the **Add More URA Reviewers** button located at the end of Section VII.



SECTION VIII- DENIAL INFORMATION

The fields located in Section VIII – Denial Information must be completed to the extent of the information you have related to the request.

Click on the type of review **drop down** box and choose **Prospective** or **Concurrent** and enter the following information in fields provided:

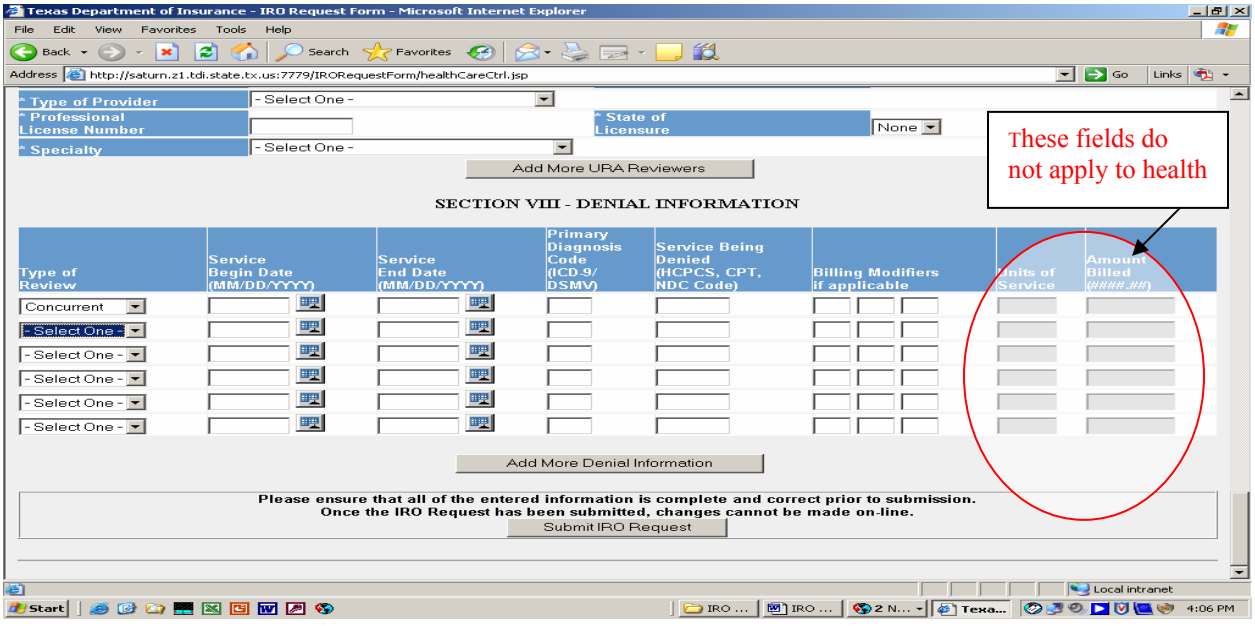
Type of Review
Service Begin Date (MM/DD/YYYY)
Service End Date (MM/DD/YYYY)
Primary Diagnosis Code (ICD-9/DSMV)
Service Being Denied (HCPCS, CPT, NDC Code)
Billing Modifiers if applicable

If you have additional denial information that needs to be entered for the request click on the **Add More Denial Information button** at the bottom of the screen shown below.

Ensure that all of the entered information is complete and correct prior to submission. Once the IRO Request has been submitted, changes cannot be made on-line.

If you have not entered all of the required information and **click** on the **Submit IRO Request** button you will receive the following error message:

*** There are problems with the information that you entered (see above). Please correct these problems and resubmit your request. The problems will be displayed in red.**



CONFIRMAITON OF RECEIPT OF A REQUEST FOR A REVIEW BY AN IRO

Once you have completed the IRO Request Form and your submission was successful you must print the Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) by selecting the Print Confirmation and Company Request for IRO button below. Select Yes if the form printed successfully and select the logout button.

FAX the signed Confirmation of Receipt to:

Texas Department of Insurance
Health and WC Network Certification & QA
Fax Number 512-490-1011

Example:

Texas Department of Insurance
Health and WC Network Certification & QA, Mail Code 103-6A
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-322-4266 telephone • 512-490-1011 fax • www.tdi.state.tx.us

CONFIRMAITON OF RECEIPT OF A REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

Your submission was successful.

Print and sign this page for inclusion with the documents to be submitted to TDI.

Print Confirmation and Company Request for IRO

Did the confirmation page and attached Company Request for IRO form print successfully?
Yes○ or No ○
If Yes, logout of application. If No, try reprinting.

Logout

The IRO case number is #

My signature confirms online submission of a request for a review by an independent review organization. I understand the submission was successful and the case will be assigned for review by an independent review organization upon the Department's receipt of the following documents:

1. Adverse determination letter
2. Appeal/reconsideration resolution letter as applicable
3. Patient/Injured Employee IRO request form
4. Company Request for IRO form (report attached to this confirmation page)

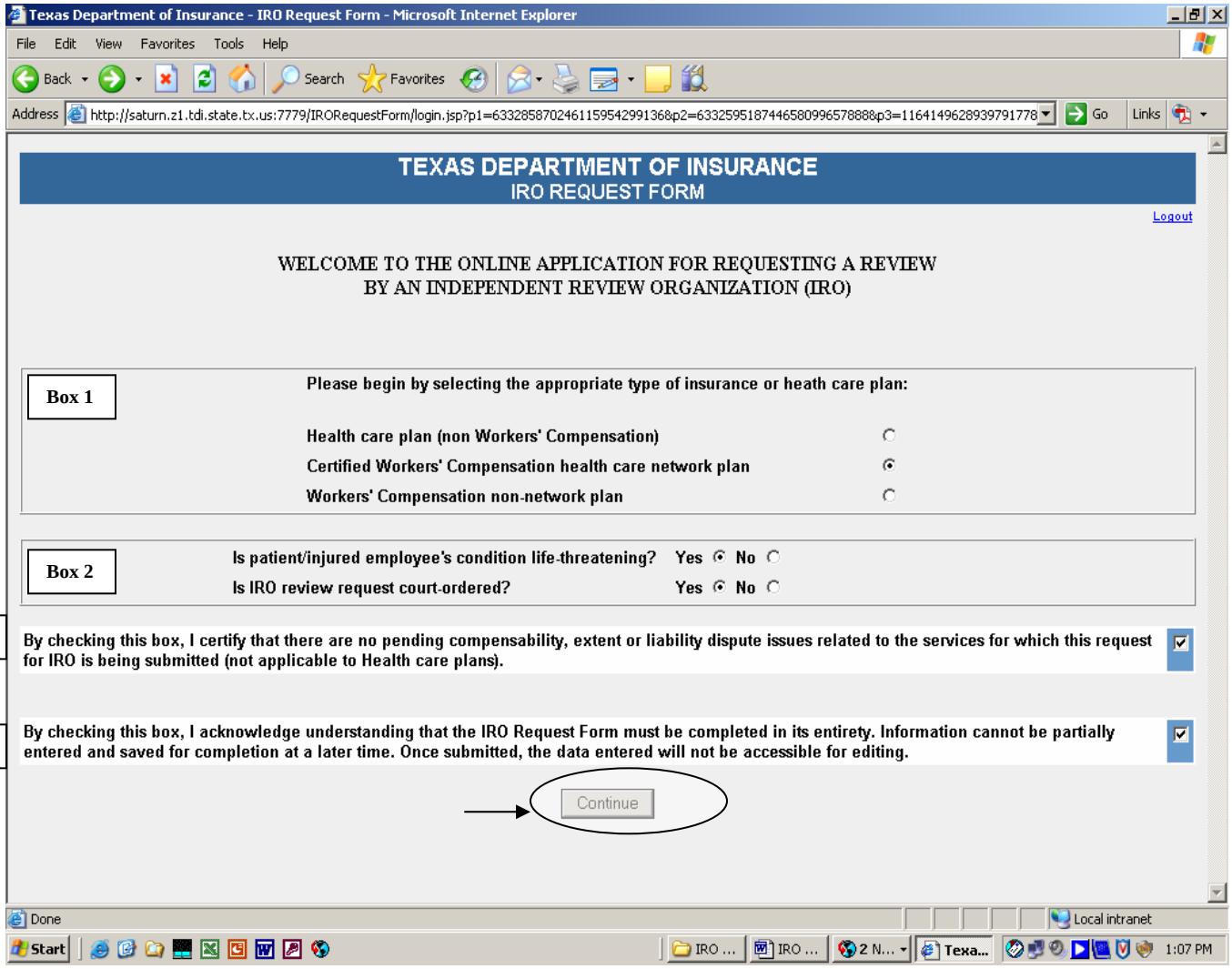
Type 2 Certified Workers' Compensation Health Care Network Plan

Begin by selecting the appropriate type of insurance or health care plan. Click in the **circle** next to the plan you are choosing as shown in Box 1 on the screen below.

You will also be required to answer the questions found in Box 2 by clicking in the **Yes** or **No circles** as shown below.

Click on the box found in Box 4 to check that you acknowledge and understand the IRO Request Form must be completed in its entirety. The information can not be partially completed or saved for completion at a later time.

Click **Continue** to continue entering your information.

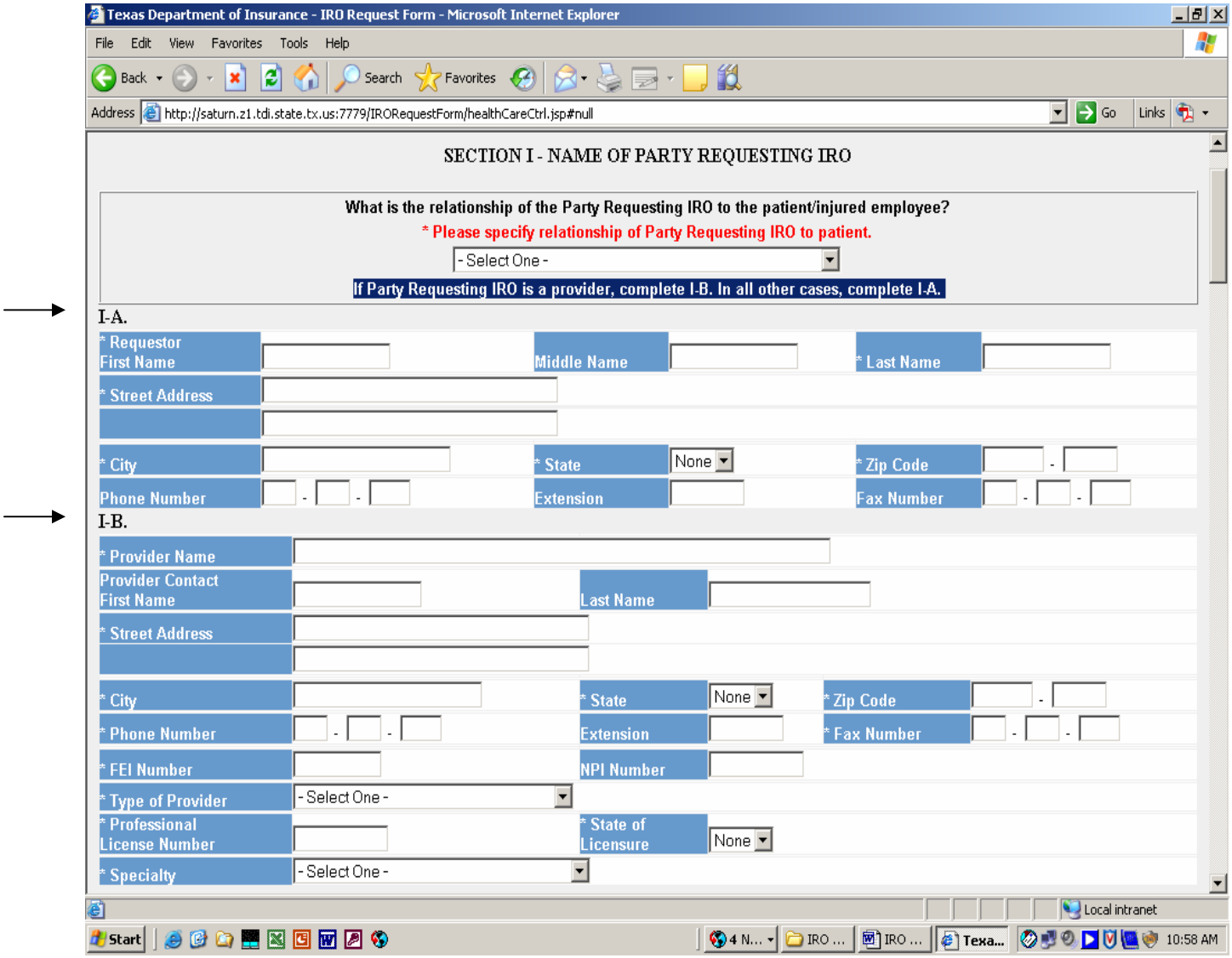


SECTION I – NAME OF PARTY REQUESTING IRO

What is the relationship of the Party Requesting IRO to the patient/injured employee?

Please choose from the **drop down** box (self, party acting on behalf of patient or injured employee provider that received adverse determination or other physician or health care provider).

If Party Requesting IRO is a provider, complete I-B. In all other cases, complete I-A.



If you are completing section I-A you do not have to complete section I-B.
This section will be disabled and you will not be allowed to enter data into the section I-B fields.

Please enter the following information in Section I:

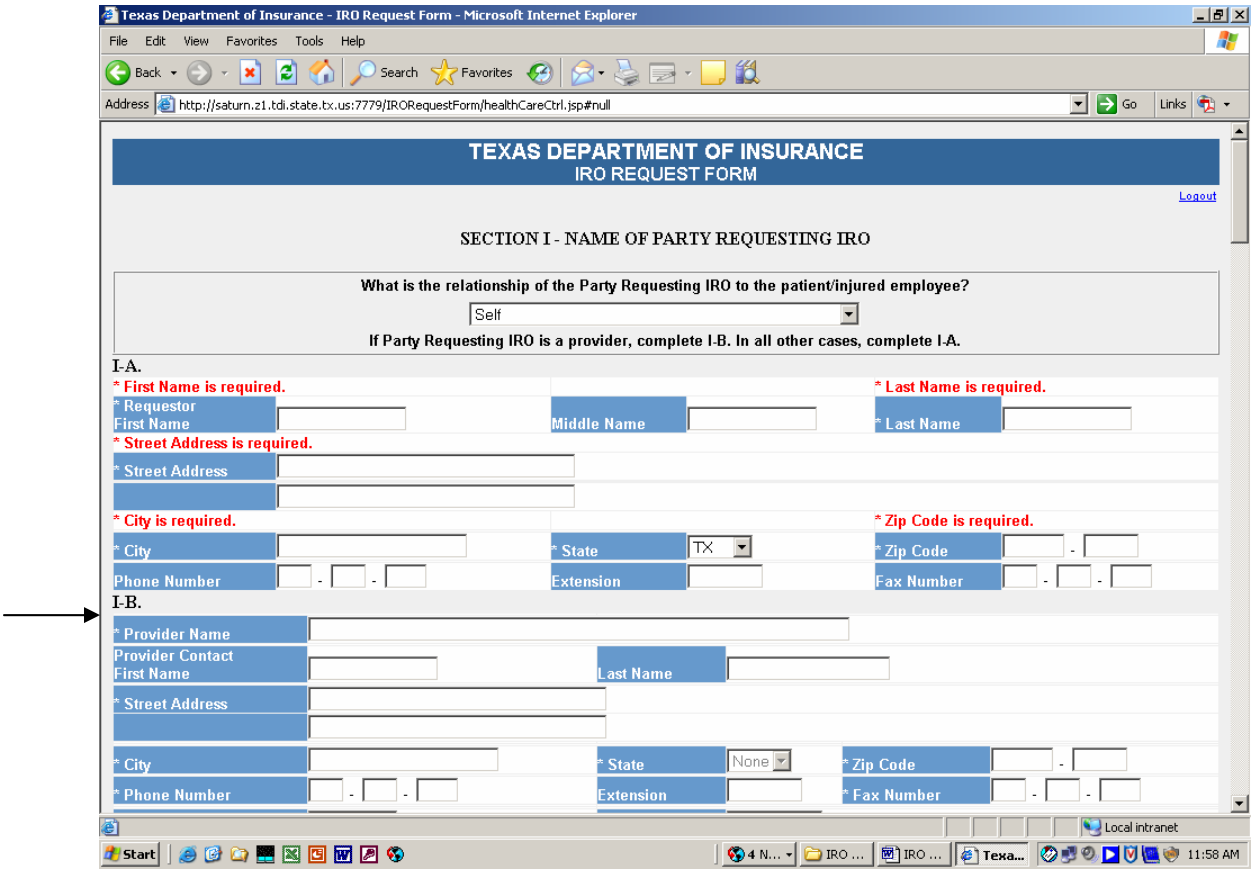
I-A

Requestor is self or party acting on behalf of patient or injured employee.

The fields that must be completed are listed below:

*Requestor First Name
*Last Name
*Street Address
*City
*State and Zip Code

Information that is not required should be submitted, allowing for a more complete application.



If you are completing section I-A you do not have to complete section I-B.
This section will be disabled and you will not be allowed to enter data into the section I-B fields.

If Party Requesting IRO is a provider, **complete I-B.**

Please choose from the **drop down** box (provider that received adverse determination or other physician or health care provider) in Section I – Name of Party Requesting IRO.

If Party Requesting IRO is a provider, complete **I-B**. In all other cases, complete I-A.

Please enter the following information in Section I:

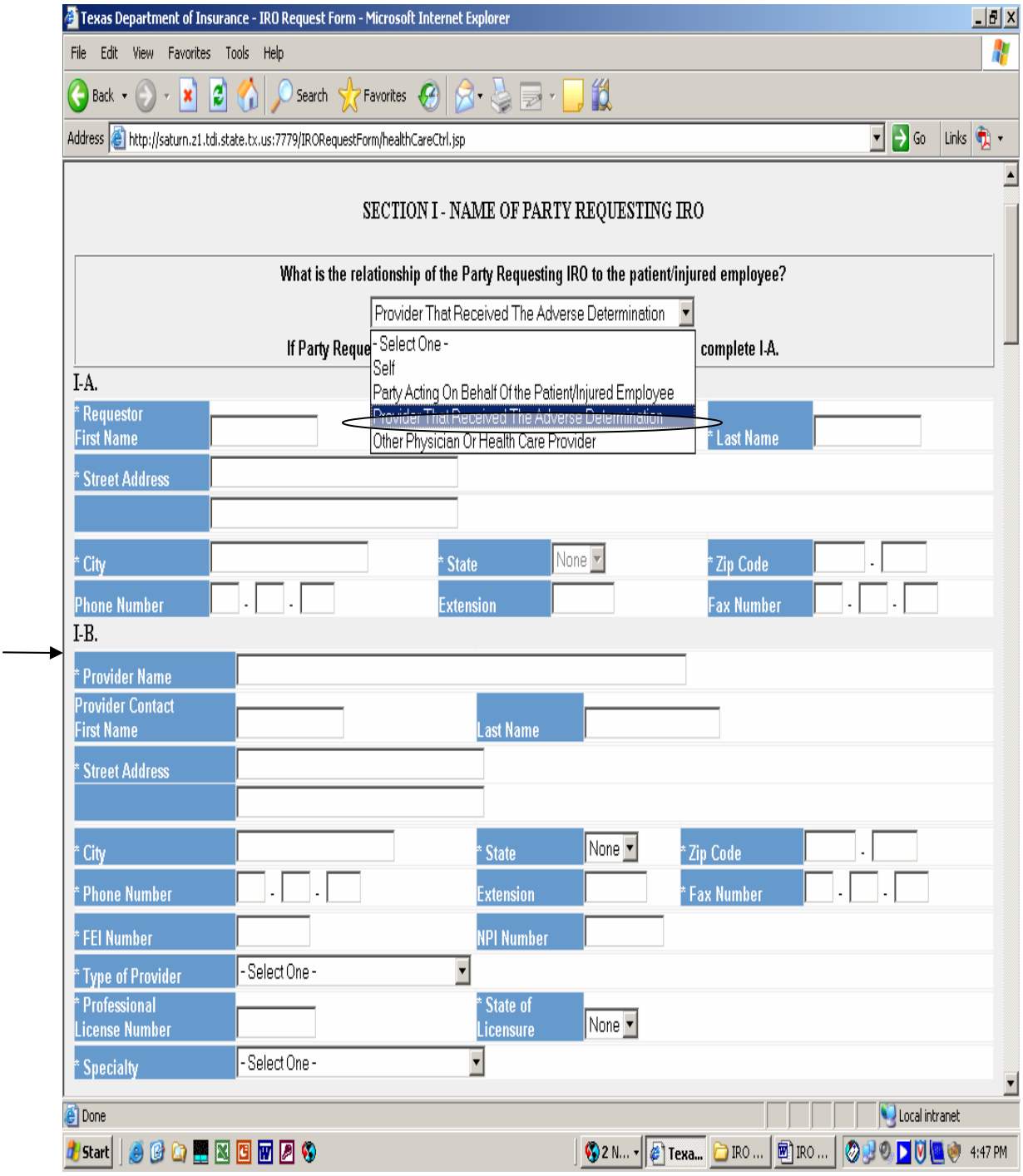
I-B

Requestor is provider that received adverse determination or other physician or health care provider.

The fields that must be completed are listed below:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty

Information that is not required should be submitted, allowing for a more complete request.



SECTION II – PROVIDER THAT RECEIVED THE ADVERSE DETERMINATION

Once you have entered the Fax Number located in Section I, I-A press your tab key to continue to SECTION II.

Pressing the **tab key** will take you to the 1st question in Section II.

Click on **Yes** or **No** when answering the question below.

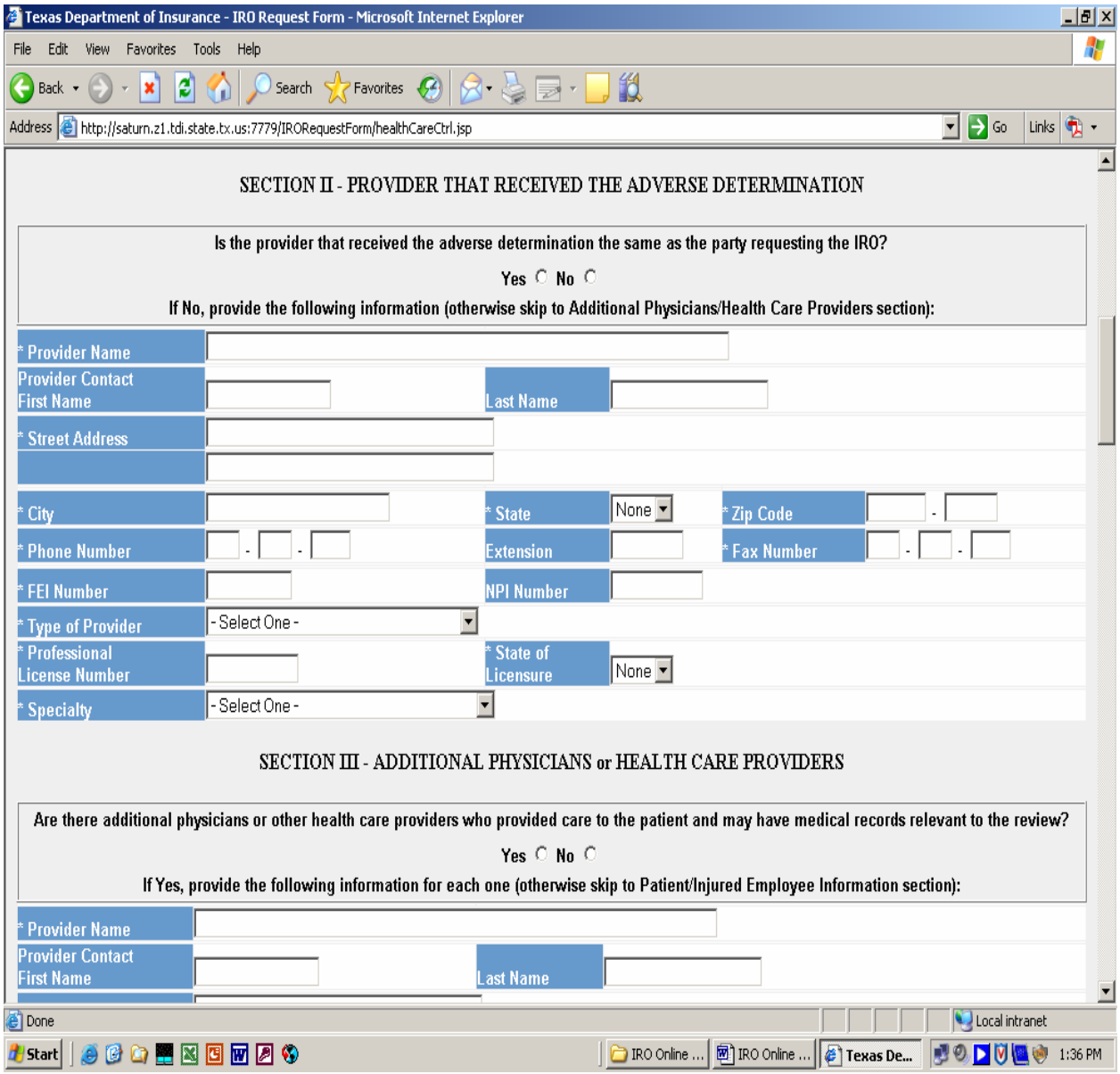
If you have chosen Self or Party acting on behalf of the patient or injured employee located in Section I, you must **click** on **No** when answering the question below.

Is the provider that received the adverse determination the same as the party requesting the IRO? Yes or No

The following fields must be completed in Section II:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number
*Type of Provider
*Professional License
*State of Licensure
*Specialty

Information that is not required should be submitted, allowing for a more complete request.



SECTION III – ADDITIONAL PHYSICIANS or HEALTH CARE PROVIDERS

Click on **Yes** or **No** to the question below.

Are there additional physicians or other health care providers who provided care to the patient and may have medical records relevant to the review?

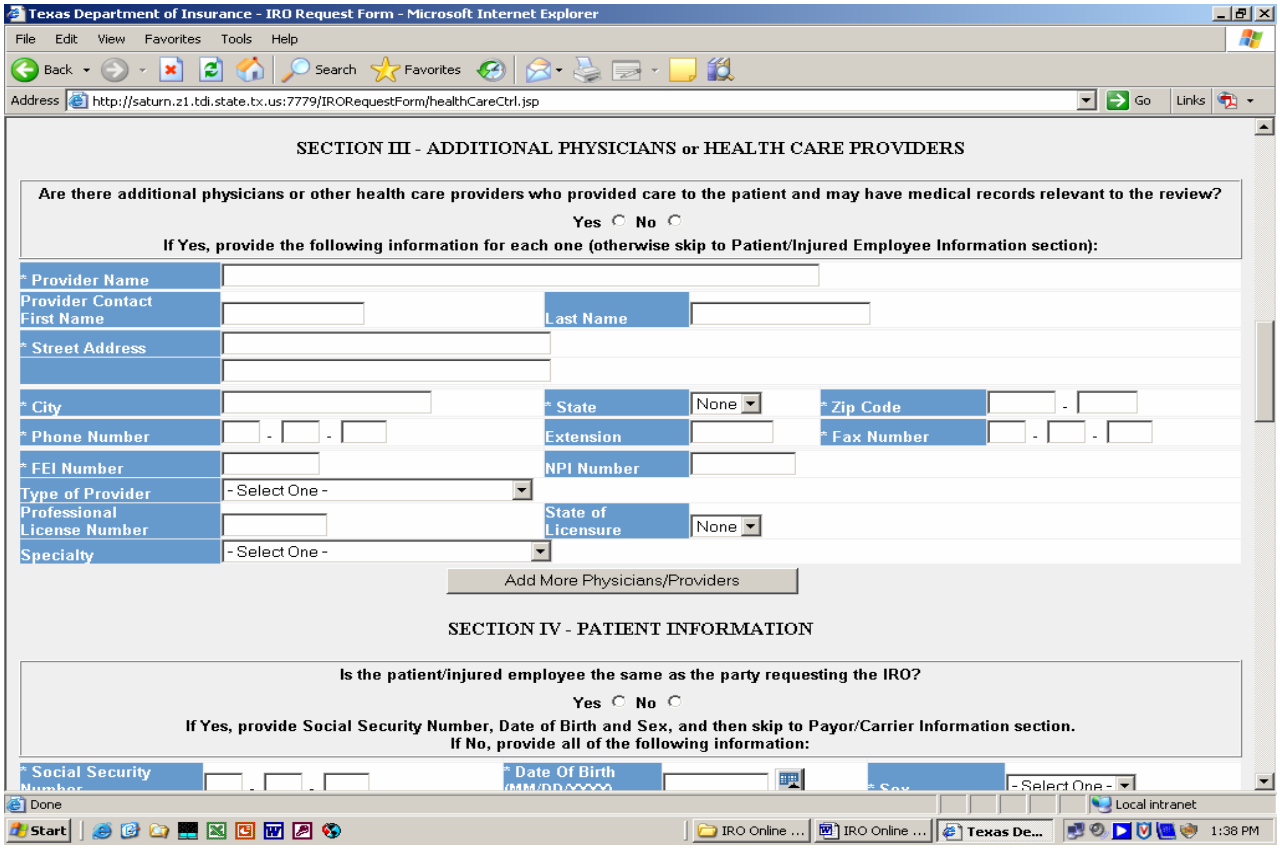
If **Yes** the following fields must be completed in Section III:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number

If **No** go to Section IV – Injured Employee Information

If you have more than 1 medical physician **click** on the **Add More Physicians/Provider** button located at the end of Section III.

Information that is not required should be submitted, allowing for a more complete request.



SECTION IV – INJURED EMPLOYEE INFORMATION

Click on **Yes** or **No** to the question below.

Is the patient the same as the party requesting the IRO?

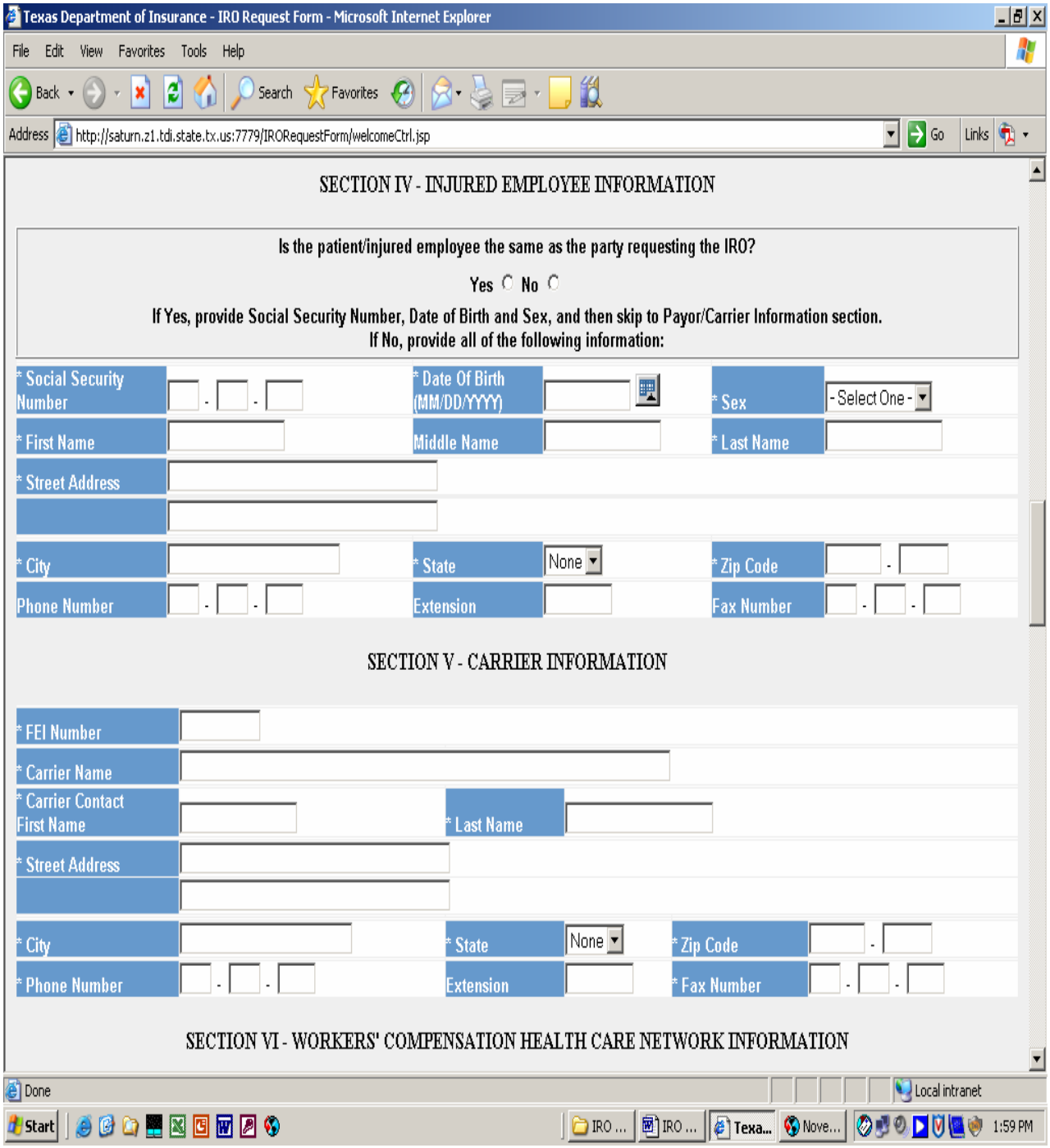
If **Yes** the following fields must be completed in Section III:

*Social Security
*Date of Birth
*Sex

If **No** the following fields must be completed in Section III:

*Social Security
*Date of Birth
*Sex
*Injured Employee First Name
*Last Name
*Street Address
*City
*State
*Zip Code

Information that is not required should be submitted, allowing for a more complete request.

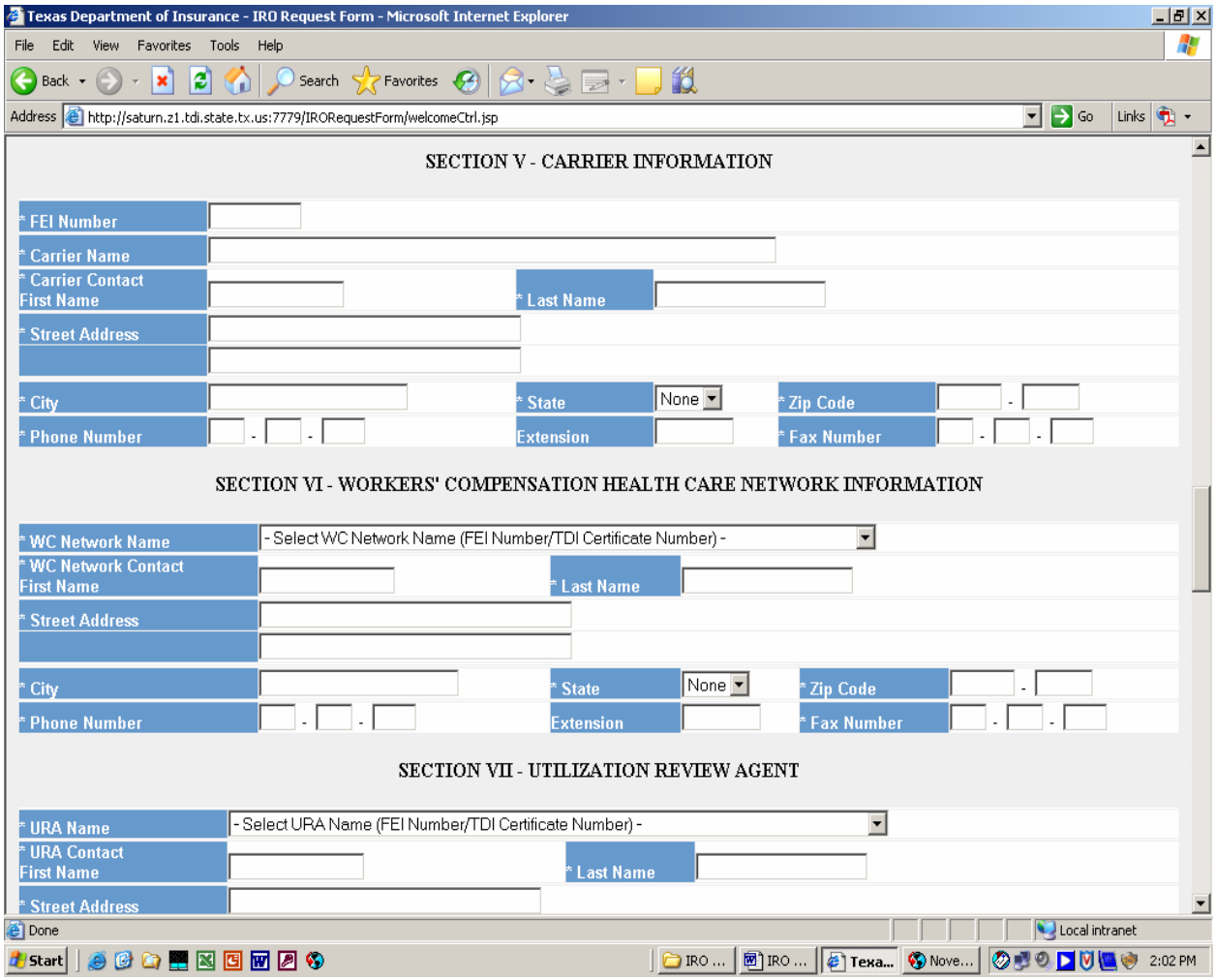


SECTION V – CARRIER INFORMATION

The following fields must be completed in Section V:

*FEI Number
*Carrier Name
*Carrier Contact First Name
*Carrier Contact Last Name
*Street Address
*City
*State
*Zip Code
*Phone Number
*Fax Number

Information that is not required should be submitted, allowing for a more complete request.

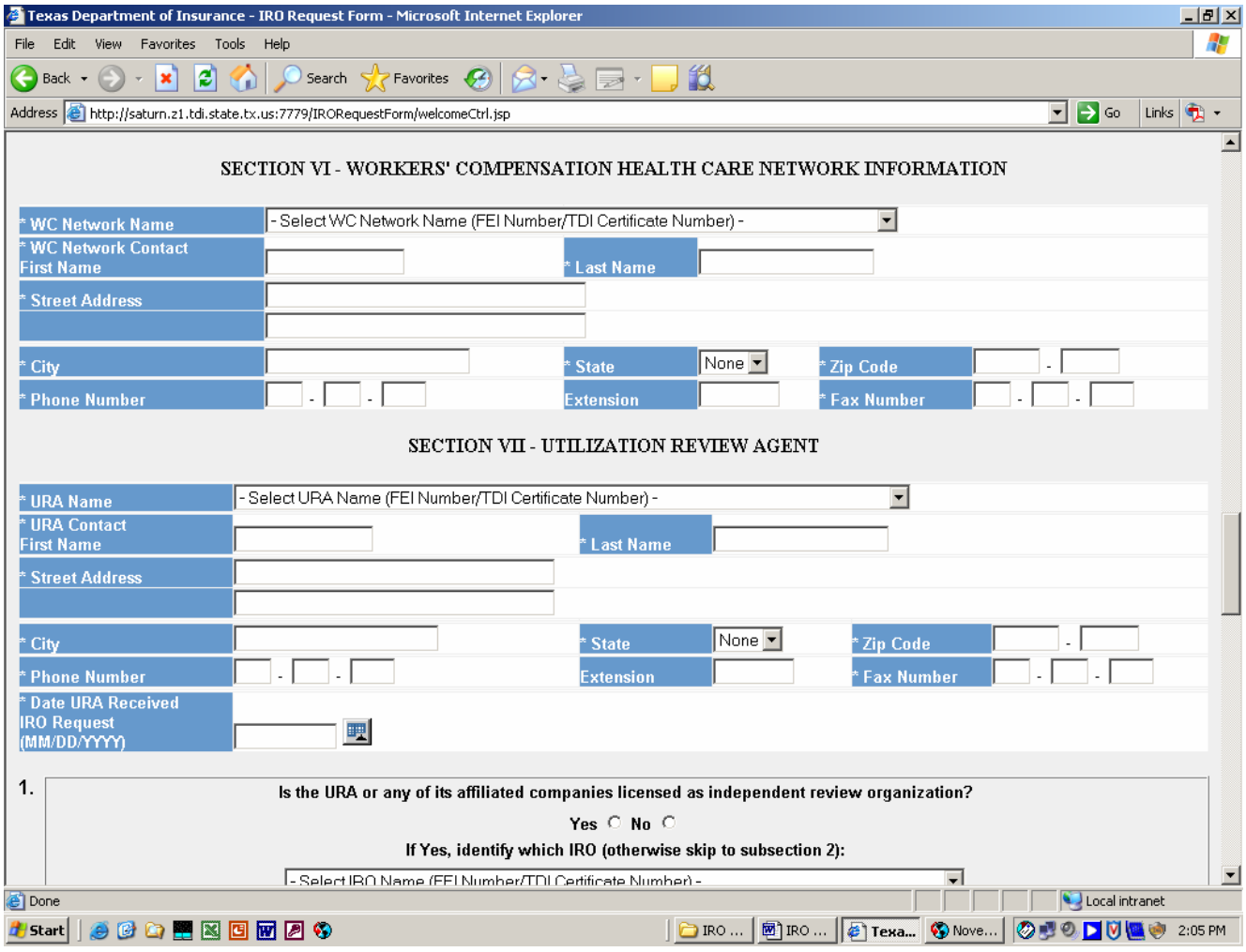


SECTION VI – WOREKERS' COMPENSATION HEALTH CARE NETWORK INFORMATION

The following fields must be completed in Section VI:

*WC Network Name
*WC Network Contact First Name
*WC Network Contact Last Name
*Street Address
*City
*State
*Zip Code
*Phone Number
*Fax Number

Information that is not required should be submitted, allowing for a more complete request.



SECTION VII – UTILIZATION REVIEW AGENT

The following fields must be completed in Section VII:

*URA Name
*URA Contact First Name
*URA Contact Last Name
*Street Address
*City
*State
*Zip Code
*Phone Number
*Fax Number
*Date URA Received IRO Request

Information that is not required should be submitted, allowing for a more complete application.

Is the URA or any of its affiliated companies licensed as independent review organizations? Yes or No?

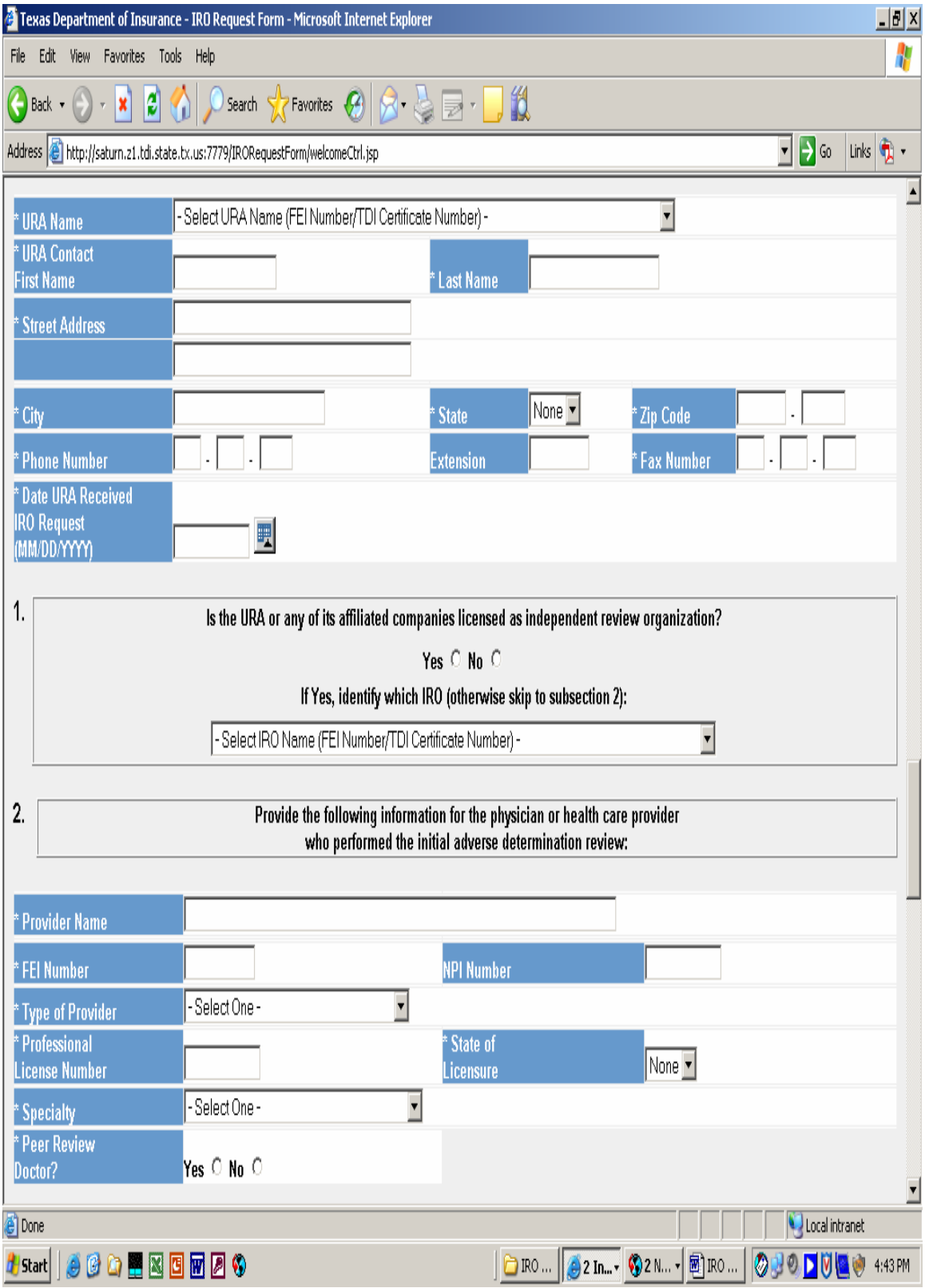
Please answer the question below by **clicking Yes** or **No**.

If **Yes** identify which IRO by choosing the appropriate IRO company name from the **drop down** box located below the question.

Provide the following information for the physician or health care provider who preformed the initial adverse determination review:

*Provider Name
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty
*Peer Review Doctor Yes or No

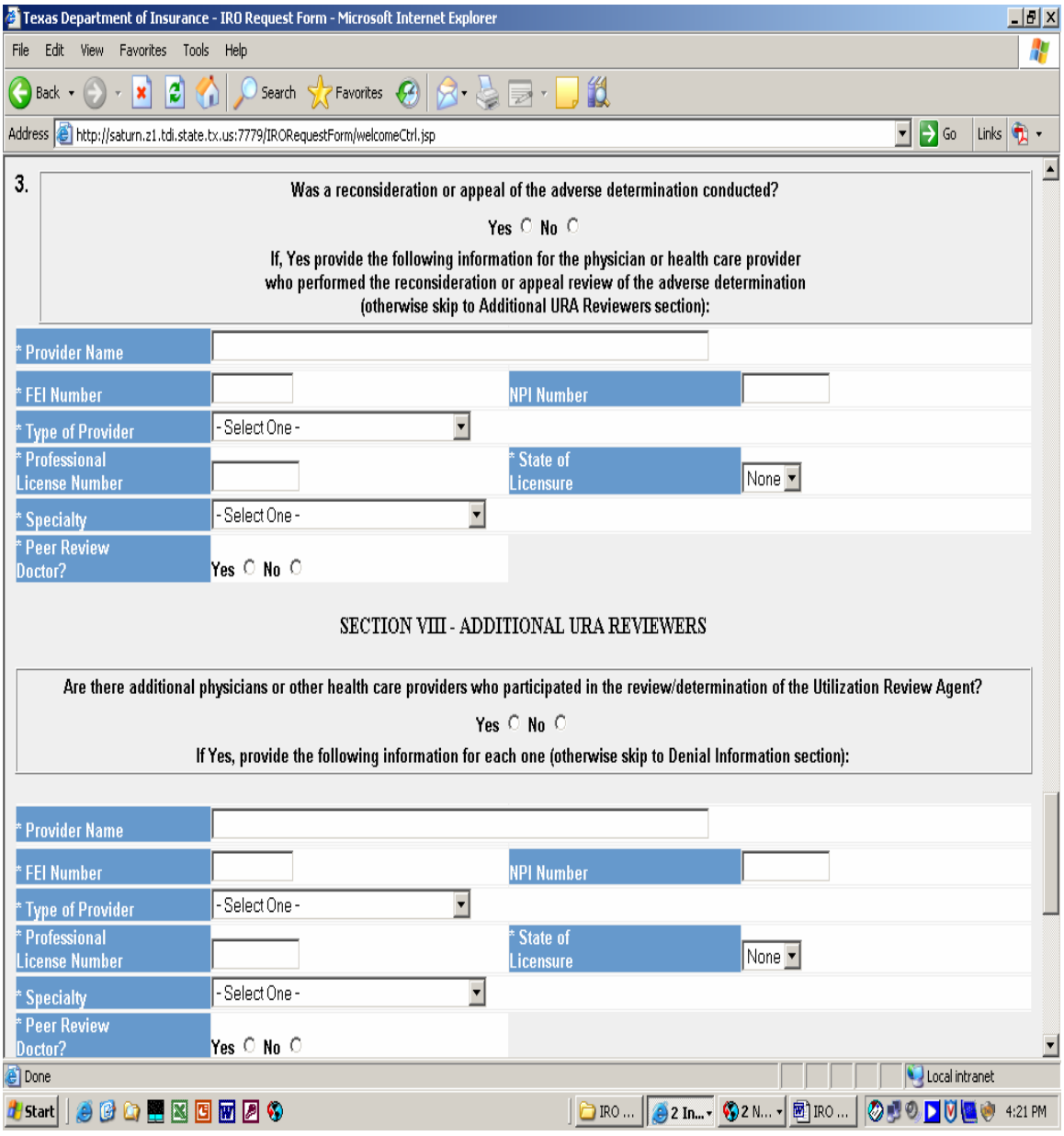
Example: Section – VII Utilization Review Agent



Example: Section VII - Utilization Review Agent

Was a reconsideration or appeal of the adverse determination conducted? Yes or No

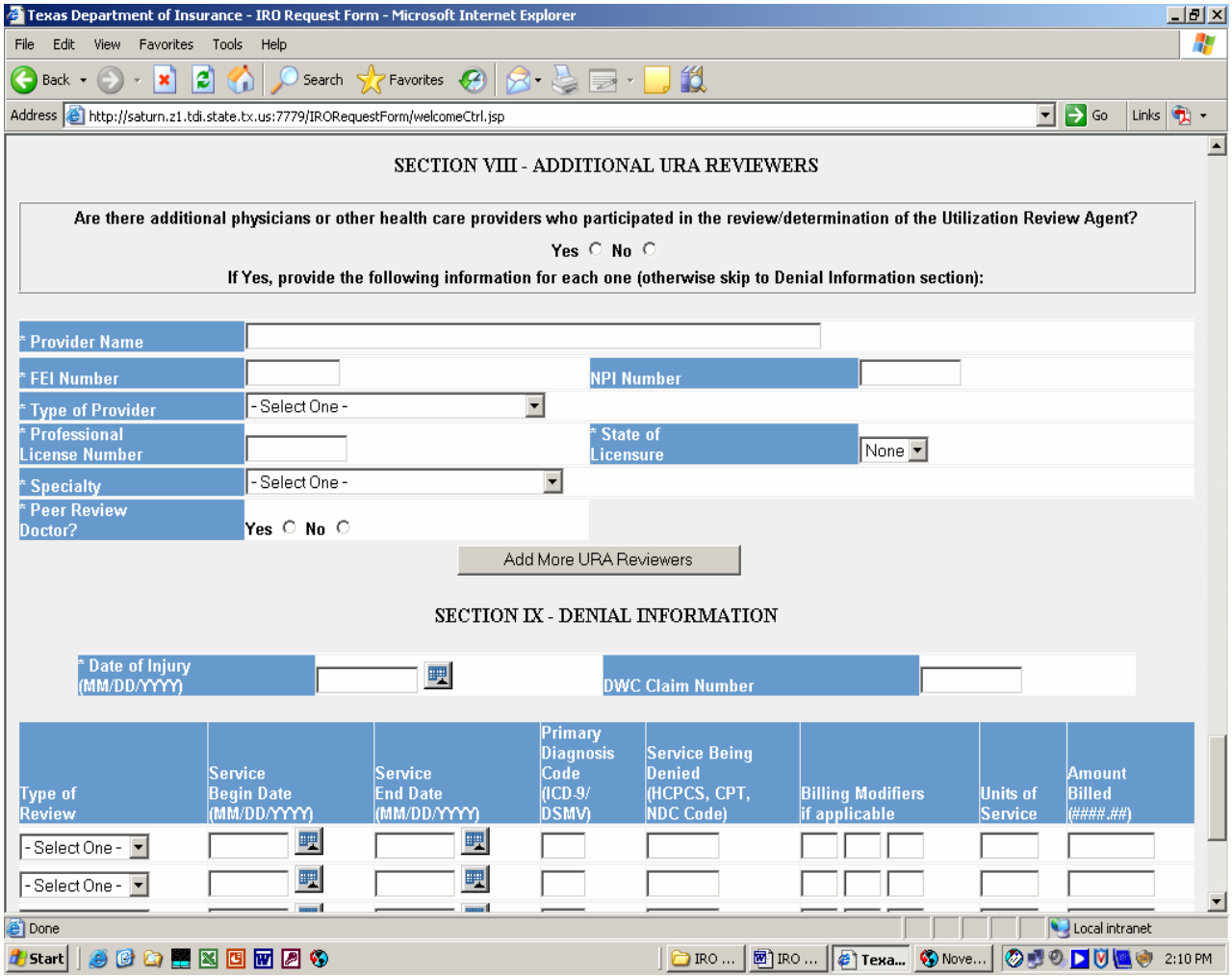
If **No** go to **Section VIII – Additional URA Reviewers.**



If **Yes** provide the following information:

*Provider Name
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty
*Peer Review Doctor? Yes or No

Information that is not required should be submitted, allowing for a more complete application.



SECTION VIII – ADDITIONAL URA REVIEWERS

Click on **Yes** or **No** to the question below.

Are there additional physicians or other health care providers who participated in the review/determination of the utilization review agent? Yes or No

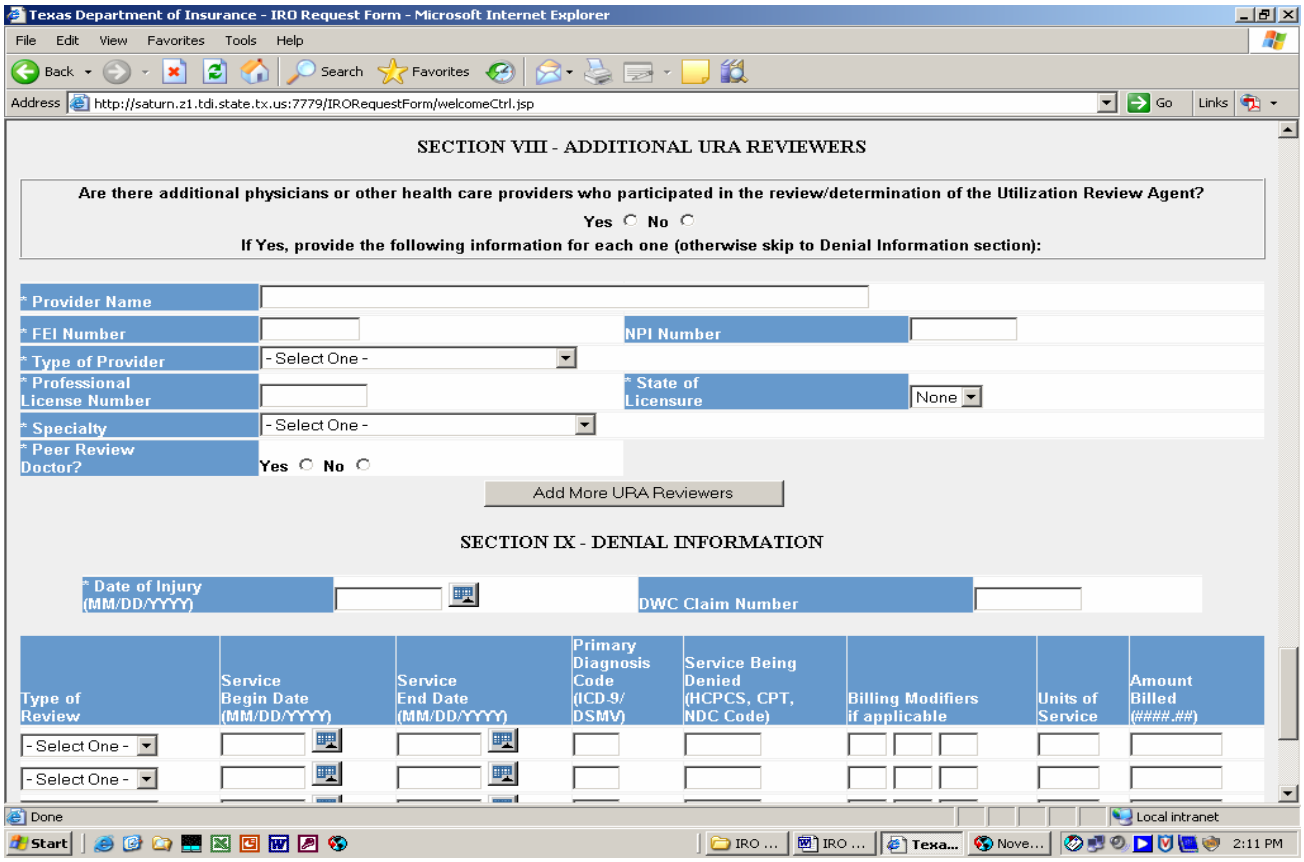
If **Yes** the following fields must be completed in Section VIII:

*Provider Name
*Type of Provider
*Professional Licensure Number
*State of Licensure
*Specialty

If **No** go to **Section IX- Denial Information**:

Information that is not required should be submitted, allowing for a more complete application.

If you have more than 1 URA Reviewer **click** on the **Add More URA Reviewers** button located at the end of Section VIII.



SECTION IX- DENIAL INFORMATION

The fields located in Section IX – Denial Information must be completed to the extent of the information you have related to the request.

Click on the type of review **drop down** box and choose **Prospective**, **Concurrent** or **Retrospective** and enter the following information in fields provided:

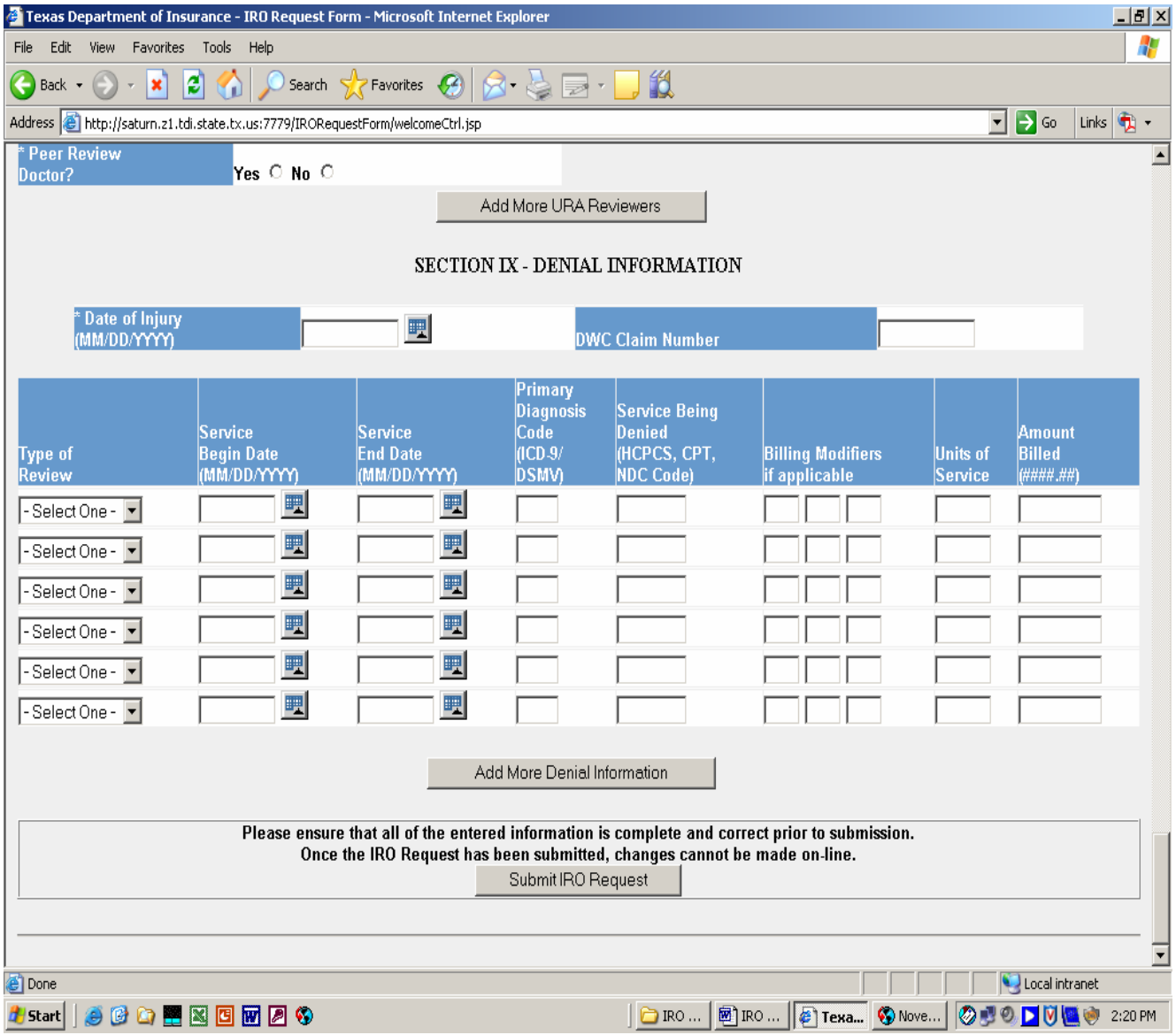
Date of Injury (MM/DD/YYY)
DWC Claim Number
Type of Review
Service Begin Date (MM/DD/YYYY)
Service End Date (MM/DD/YYYY)
Primary Diagnosis Code (ICD-9/DSMV)
Service Being Denied (HCPCS, CPT, NDC Code)
Billing Modifiers if applicable
Units of Service
Amount Billed (do not put numeric amount in field with out decimal 10000)
***add decimal information Example: 100.00**

If you have additional Denial Information click on the **Add More Denial Information button** at the bottom of the screen shown below.

Ensure that all of the entered information is complete and correct prior to submission. Once the IRO Request has been submitted, changes cannot be made on-line.

If you have not entered all of the required information and **click** on the **Submit IRO Request** button you will receive the following error message:

*** There are problems with the information that you entered (see above). Please correct these problems and resubmit your request.**



CONFIRMATION OF RECEIPT OF A REQUEST FOR A REVIEW BY AN IRO

Once you have completed the IRO Request Form and your submission was successful you must print the Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) by selecting the Print Confirmation and Company Request for IRO button below. Select Yes if the form printed successfully and select the logout button.

Fax the signed Confirmation of Receipt to:

Texas Department of Insurance
Health and WC Network Certification & QA
Fax Number 512-490-1011

Example:

Texas Department of Insurance
Health and WC Network Certification & QA, Mail Code 103-6A
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-322-4266 telephone • 512-490-1011 fax • www.tdi.state.tx.us

CONFIRMAITON OF RECEIPT OF A REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

Your submission was successful.

Print and sign this page for inclusion with the documents to be submitted to TDI.

Print Confirmation and Company Request for IRO

Did the confirmation page and attached Company Request for IRO form print successfully?
Yes ○ or No ○
If Yes, logout of application. If No, try reprinting.

Logout

The IRO case number is #

My signature confirms online submission of a request for a review by an independent review organization. I understand the submission was successful and the case will be assigned for review by an independent review organization upon the Department's receipt of the following documents:

5. Adverse determination letter
6. Appeal/reconsideration resolution letter as applicable
7. Patient/Injured Employee IRO request form
8. Company Request for IRO form (report attached to this confirmation page)

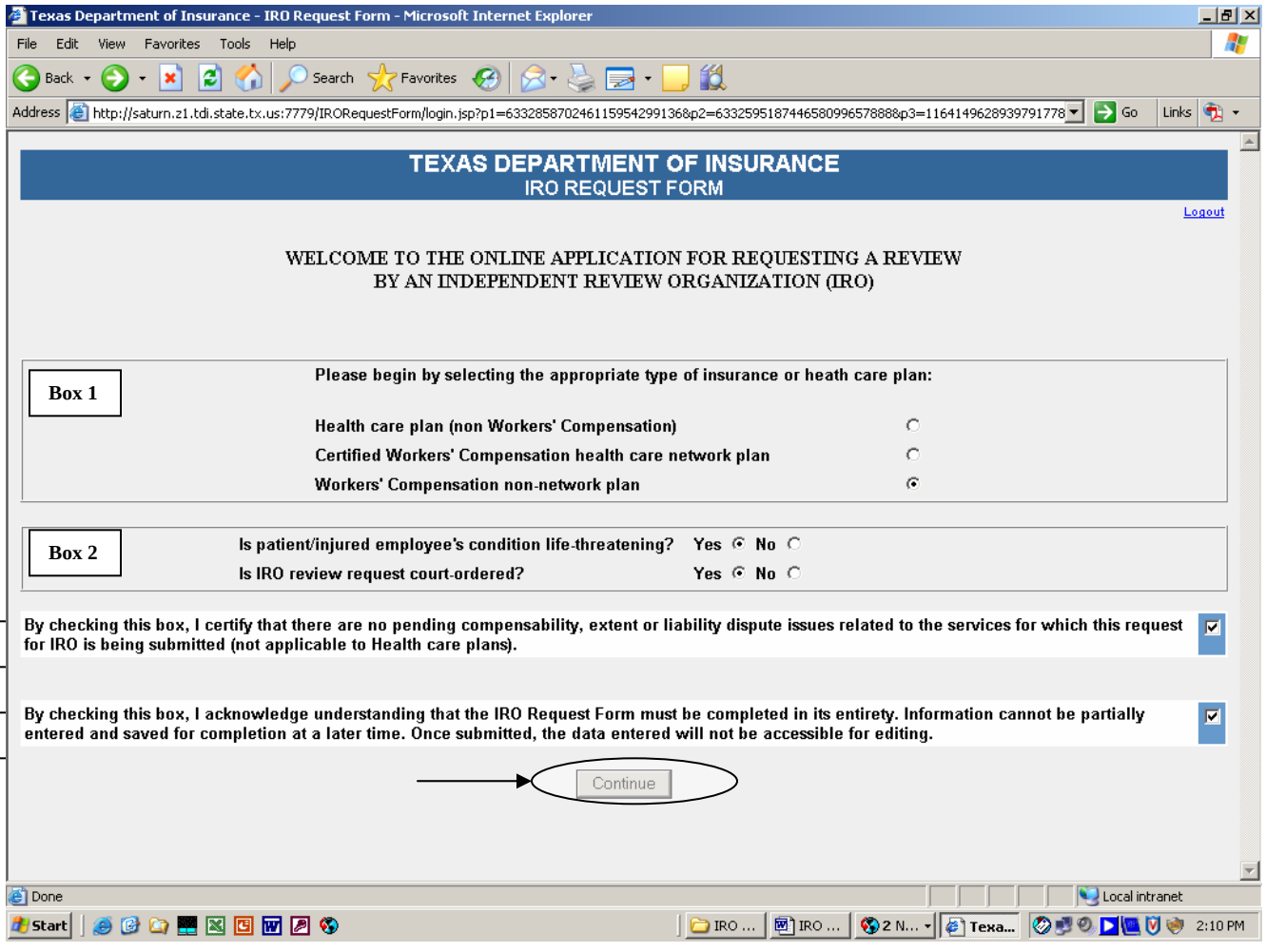
Type 3 Workers' Compensation Non-Network Plan

Begin by selecting the appropriate type of insurance or health care plan. Click in the **circle** next to the plan you are choosing as shown in Box 1 on the screen below.

You will also be required to answer the questions found in Box 2 by clicking in the **Yes** or **No circles** as shown below.

Click on the box found in Box 4 to check that you acknowledge and understand the IRO Request Form must be completed in its entirety. The information can not be partially completed or saved for completion at a later time.

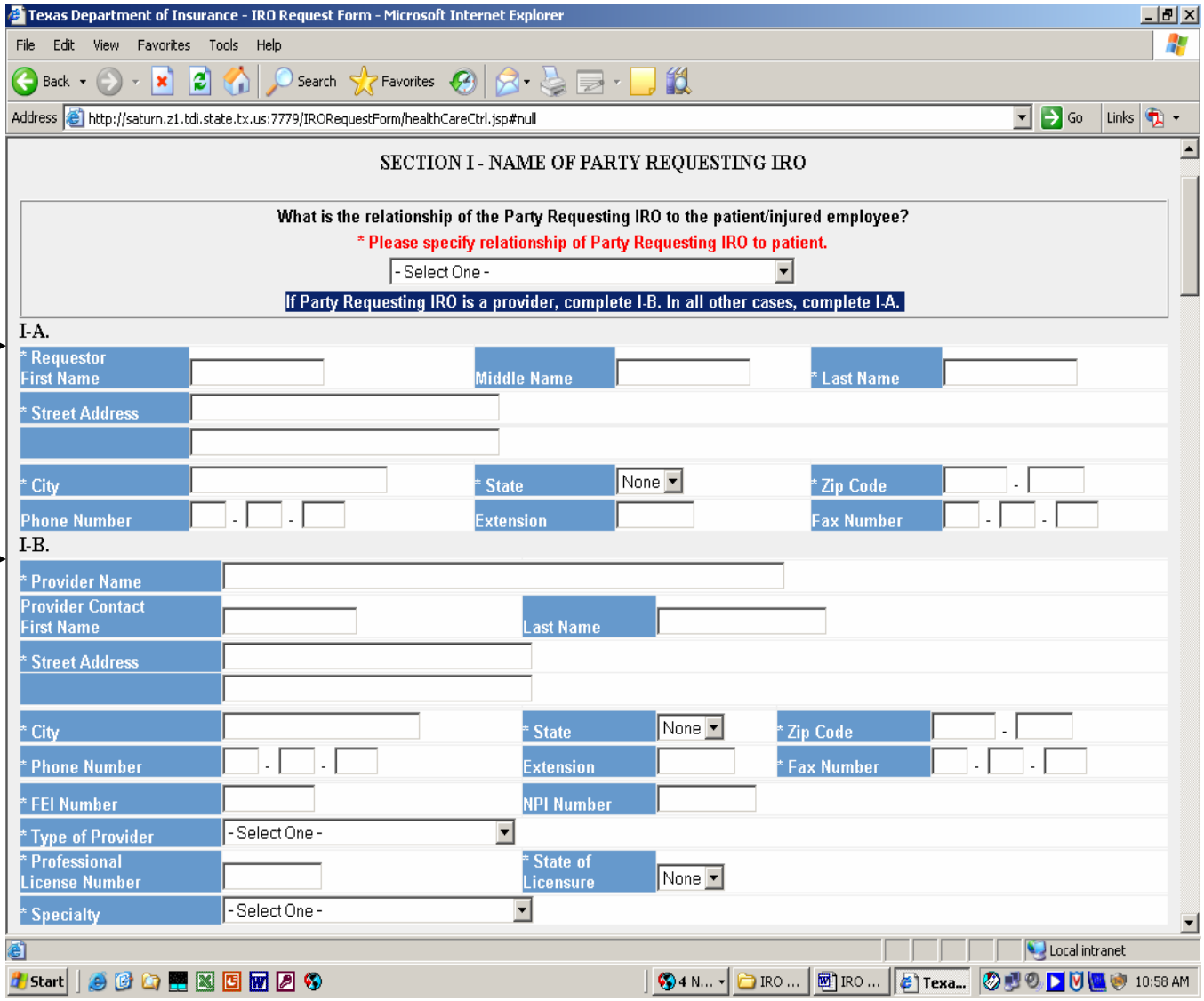
Click **Continue** to continue entering your information.



SECTION I – NAME OF PARTY REQUESTING IRO

Choose from the **drop down** box (self, party acting on behalf of patient or injured employee provider that received adverse determination or other physician or health care provider). **What is the relationship of the Party Requesting IRO to the patient/injured employee?**

If Party Requesting IRO is a provider, **complete I-B**. In all other cases, **complete I-A**.



If you are completing section I-A you do not have to complete section I-B.
This section will be disabled and you will not be allowed to enter data into the section I-B fields.

Enter the following information in Section I:

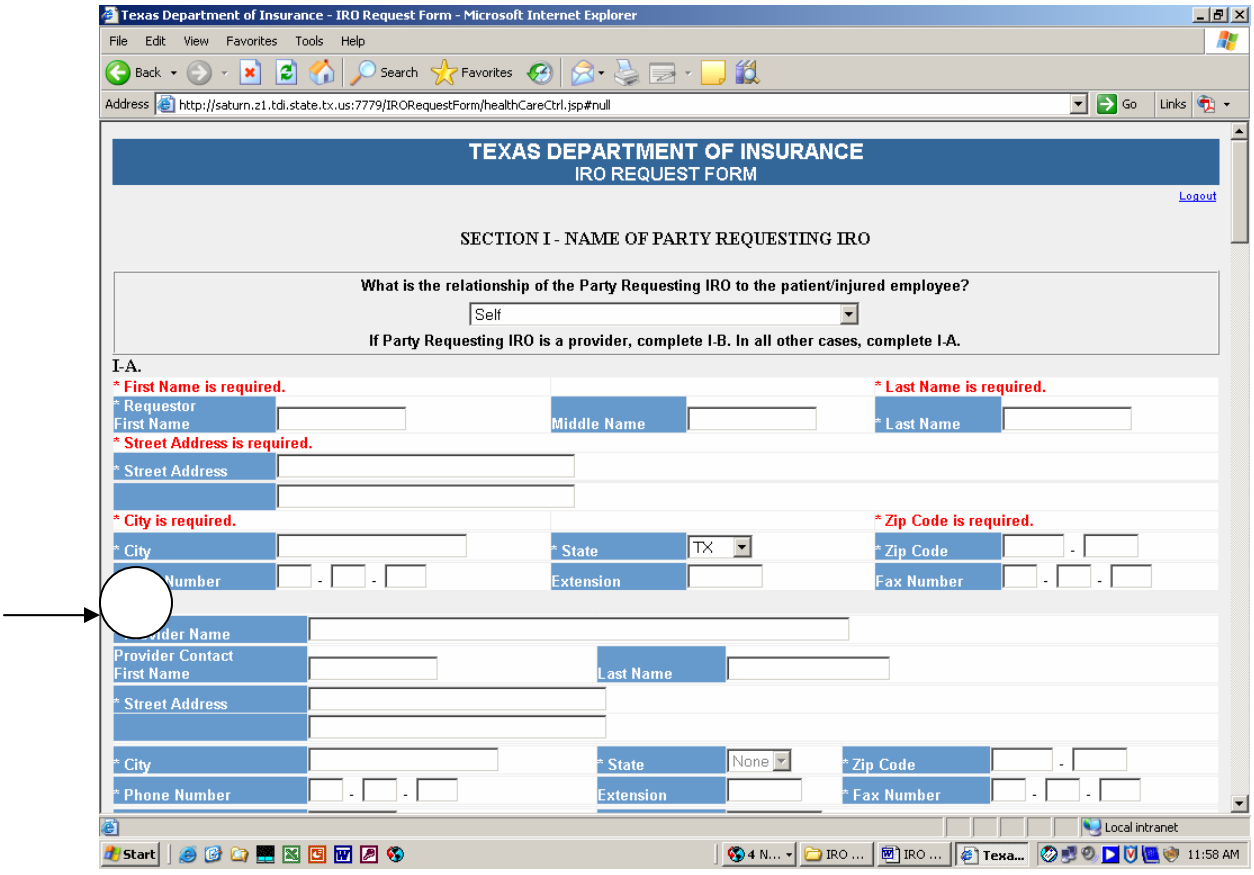
I-A

Requestor is self or party acting on behalf of patient or injured employee.

The fields that must be completed are listed below:

*Requestor First Name
*Last Name
*Street Address
*City
*State and Zip Code

Information that is not required should be submitted, allowing for a more complete application.



If you are completing section I-A you do not have to complete section I-B.
This section will be disabled and you will not be allowed to enter data into the section I-B fields.

If Party Requesting IRO is a provider, **complete I-B.**

Choose from the **drop down** box (provider that received adverse determination or other physician or health care provider) in Section I – Name of Party Requesting IRO.

If Party Requesting IRO is a provider, complete **I-B**. In all other cases, complete I-A.

Please enter the following information in Section I:

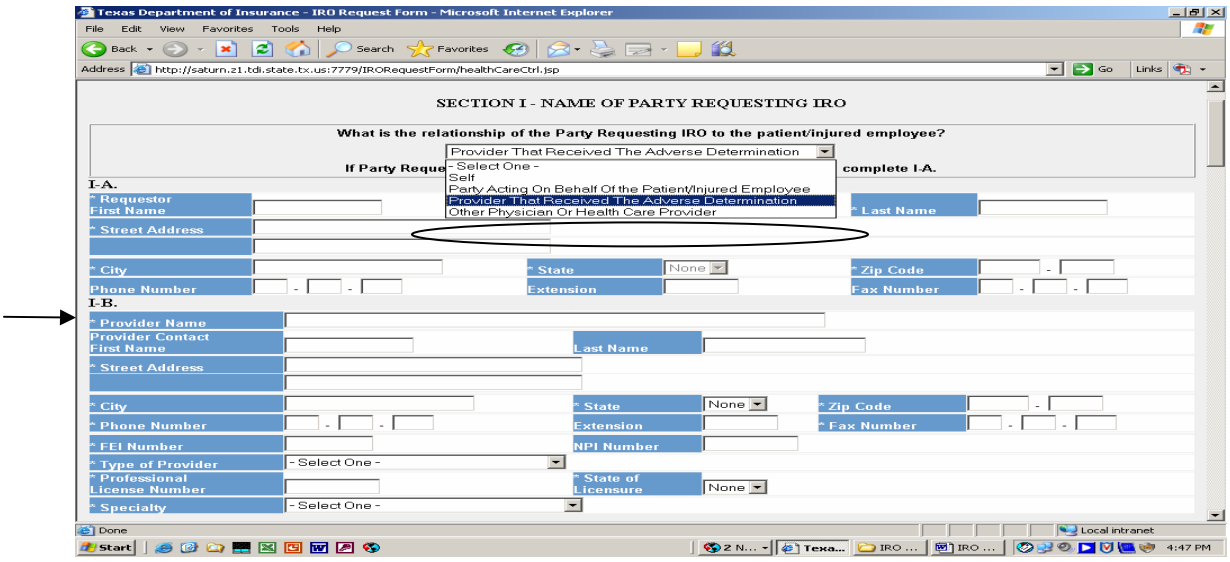
I-B

Requestor is provider that received adverse determination other physician or health care provider.

The fields that must be completed are listed below:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty

Information that is not required should be submitted, allowing for a more complete application.



SECTION II – PROVIDER THAT RECEIVED THE ADVERSE DETERMINATION

Once you have entered the Fax Number located in Section I, I-A press your tab key to continue to SECTION II.

Pressing the **tab key** will take you to the 1st question in Section II.

Click on **Yes** or **No** when answering the question below.

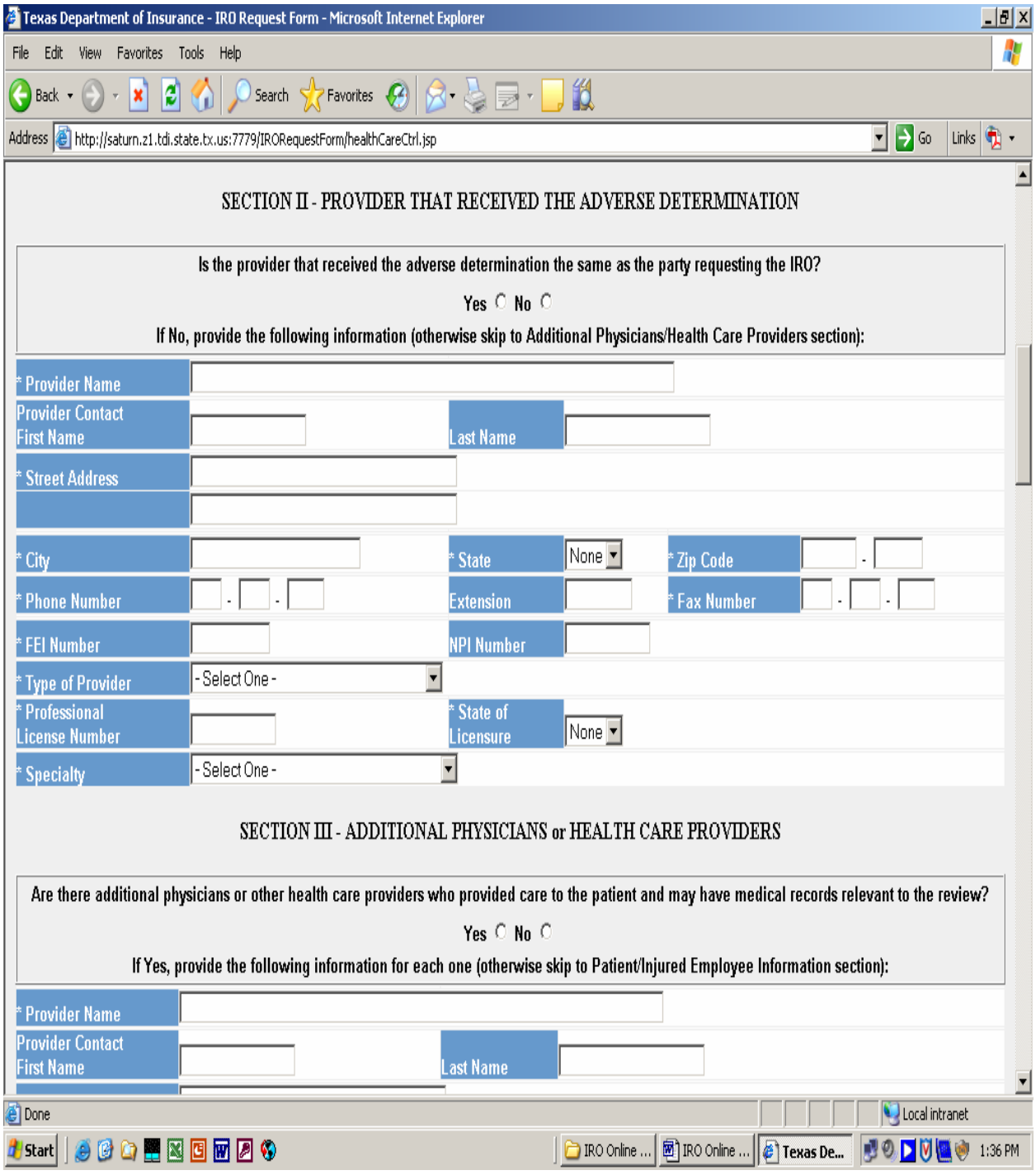
If you have chosen Self or Party acting on behalf of the patient or injured employee located in Section I, you must **click** on **No** when answering the question below.

Is the provider that received the adverse determination the same as the party requesting the IRO? Yes or No

The following fields must be completed in Section II:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number
*Type of Provider
*Professional License
*State of Licensure
*Specialty

Information that is not required should be submitted, allowing for a more complete application.



SECTION III – ADDITIONAL PHYSICIANS or HEALTH CARE PROVIDERS

Click on **Yes** or **No** to the question below.

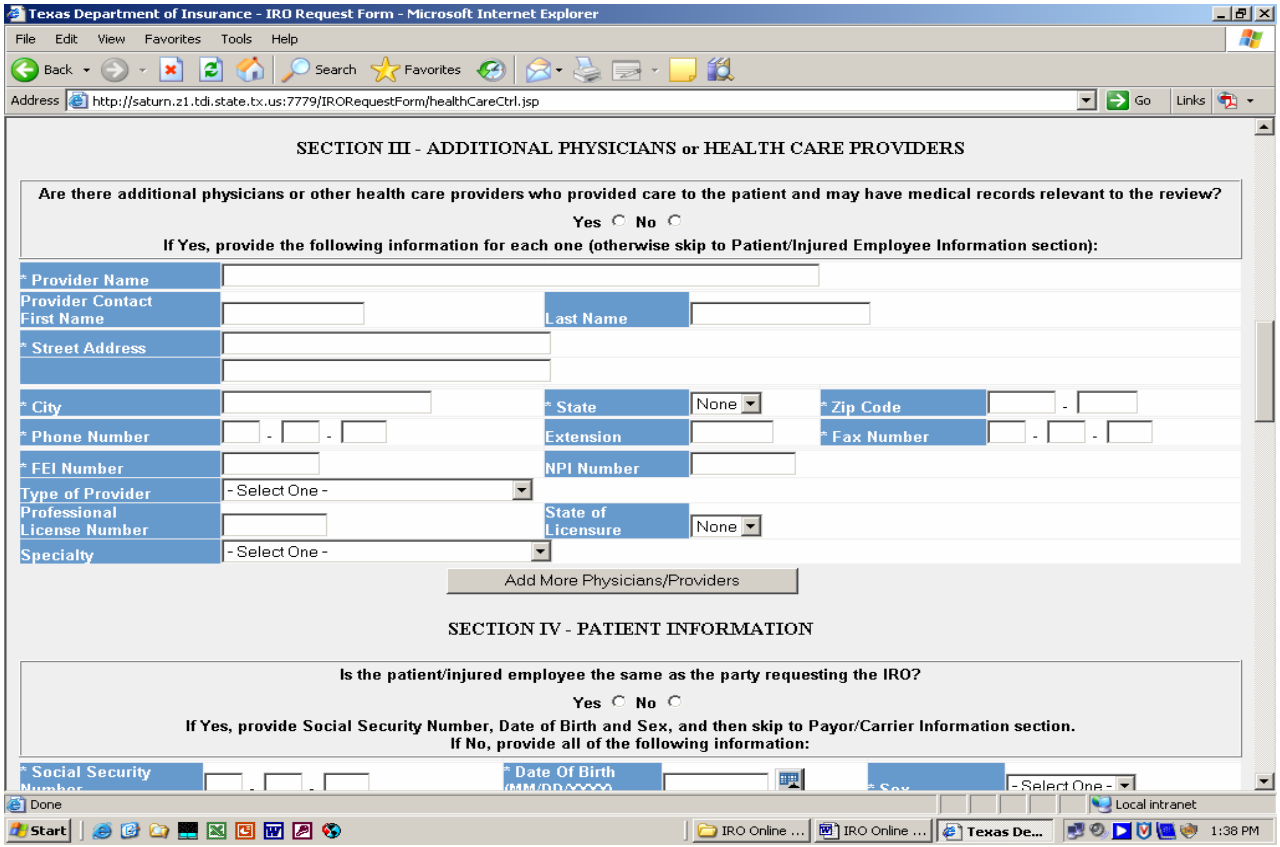
Are there additional physicians or other health care providers who provided care to the patient and may have medical records relevant to the review?

If **Yes** the following fields must be completed in Section III:

*Provider Name
*Street Address
*City
*State and Zip Code
*Phone Number
*Fax Number

If you have more than 1 medical physician **click** on the **Add More Physicians/Provider** button located at the end of Section III.

Information that is not required should be submitted, allowing for a more complete application.



SECTION IV – INJURED EMPLOYEE INFORMATION

Click on **Yes** or **No** to the question below.

Is the patient the same as the party requesting the IRO?

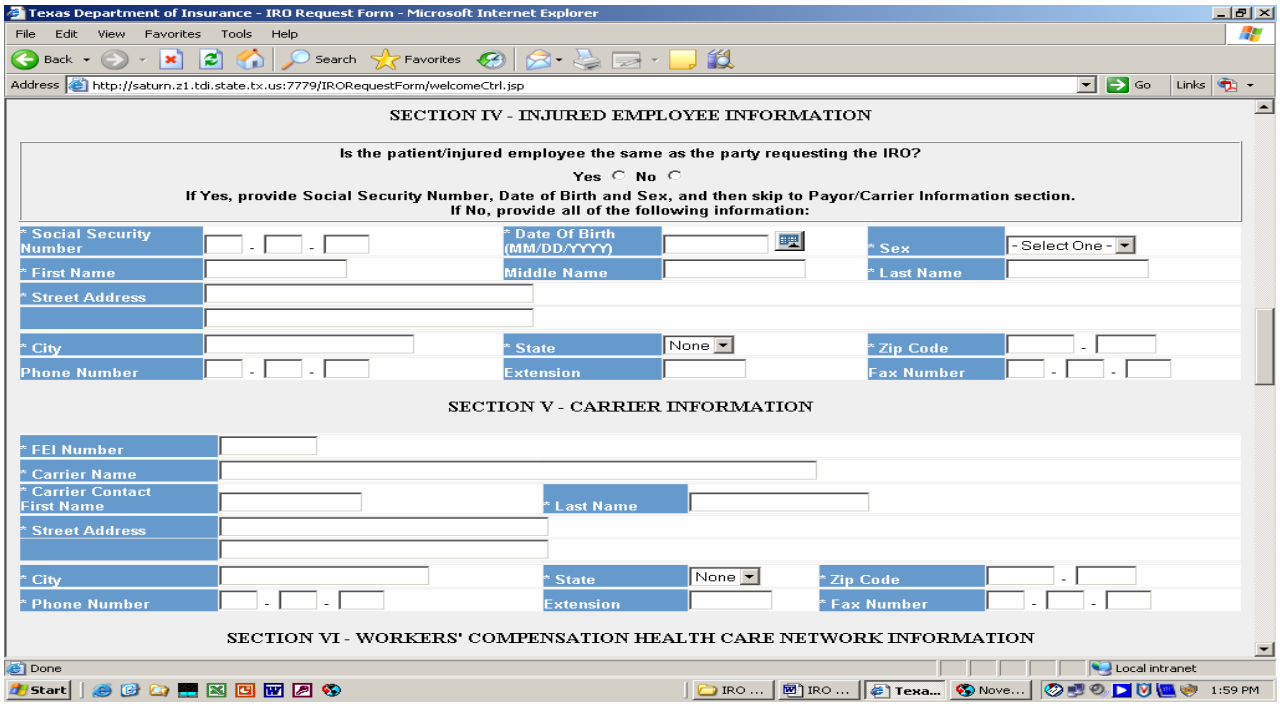
If **Yes** the following fields must be completed in Section III:

*Social Security
*Date of Birth
*Sex

If **No** the following fields must be completed in Section III:

*Social Security
*Date of Birth
*Sex
*Injured Employee First Name
*Last Name
*Street Address
*City
*State
*Zip Code

Information that is not required should be submitted, allowing for a more complete application.

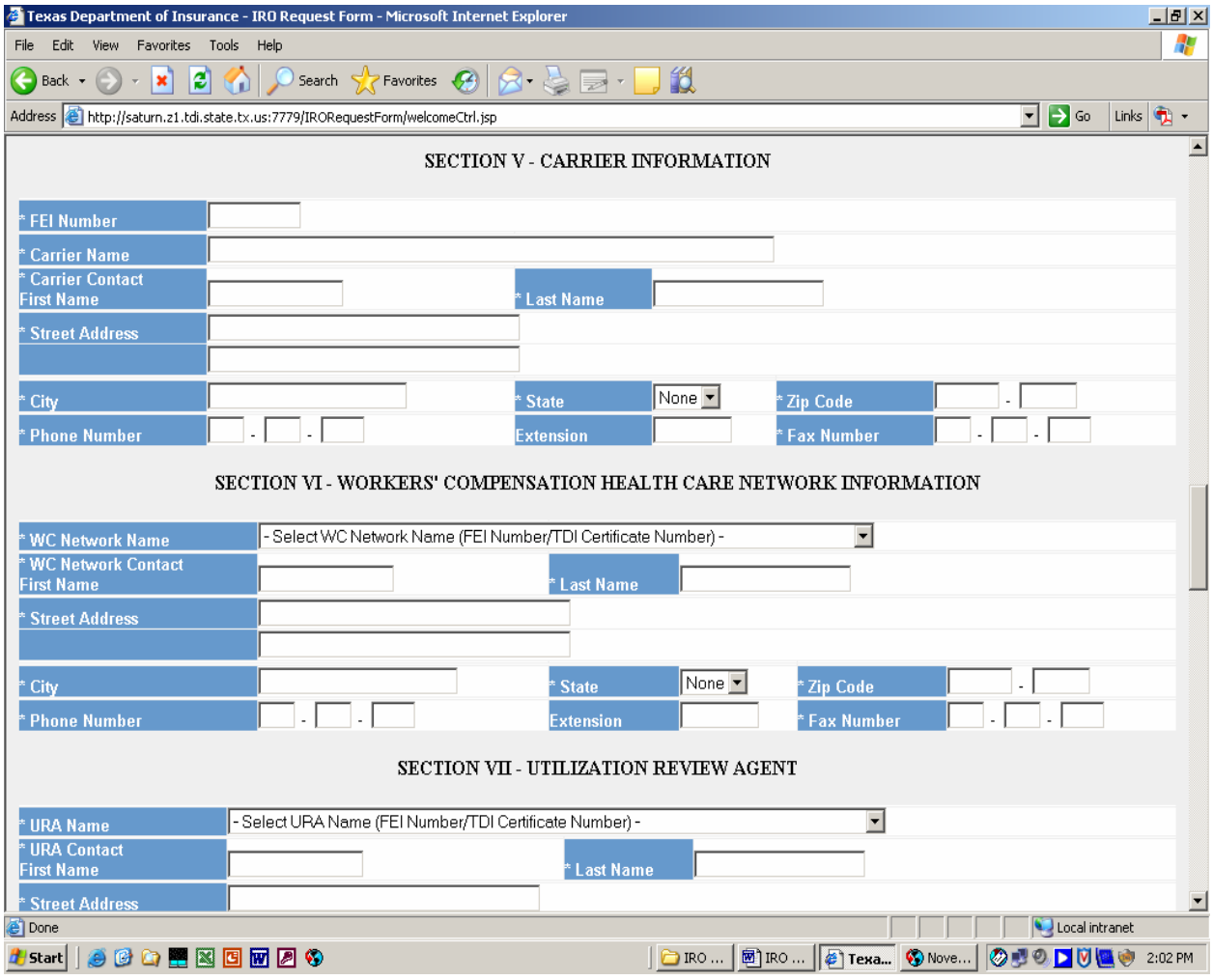


SECTION V – CARRIER INFORMATION

The following fields must be completed in Section V:

*FEI Number
*Carrier Name
*Carrier Contact First Name
*Carrier Contact Last Name
*Street Address
*City
*State
*Zip Code
*Phone Number
*Fax Number

Information that is not required should be submitted, allowing for a more complete application.



SECTION VI – UTILIZATION REVIEW AGENT

The following fields must be completed in Section VI:

*URA Name
*URA Contact First Name
*URA Contact Last Name
*Street Address
*City
*State
*Zip Code
*Phone Number
*Fax Number
*Date URA Received IRO Request

Information that is not required should be submitted, allowing for a more complete application.

Is the URA or any of its affiliated companies licensed as independent review organizations? Yes or No?

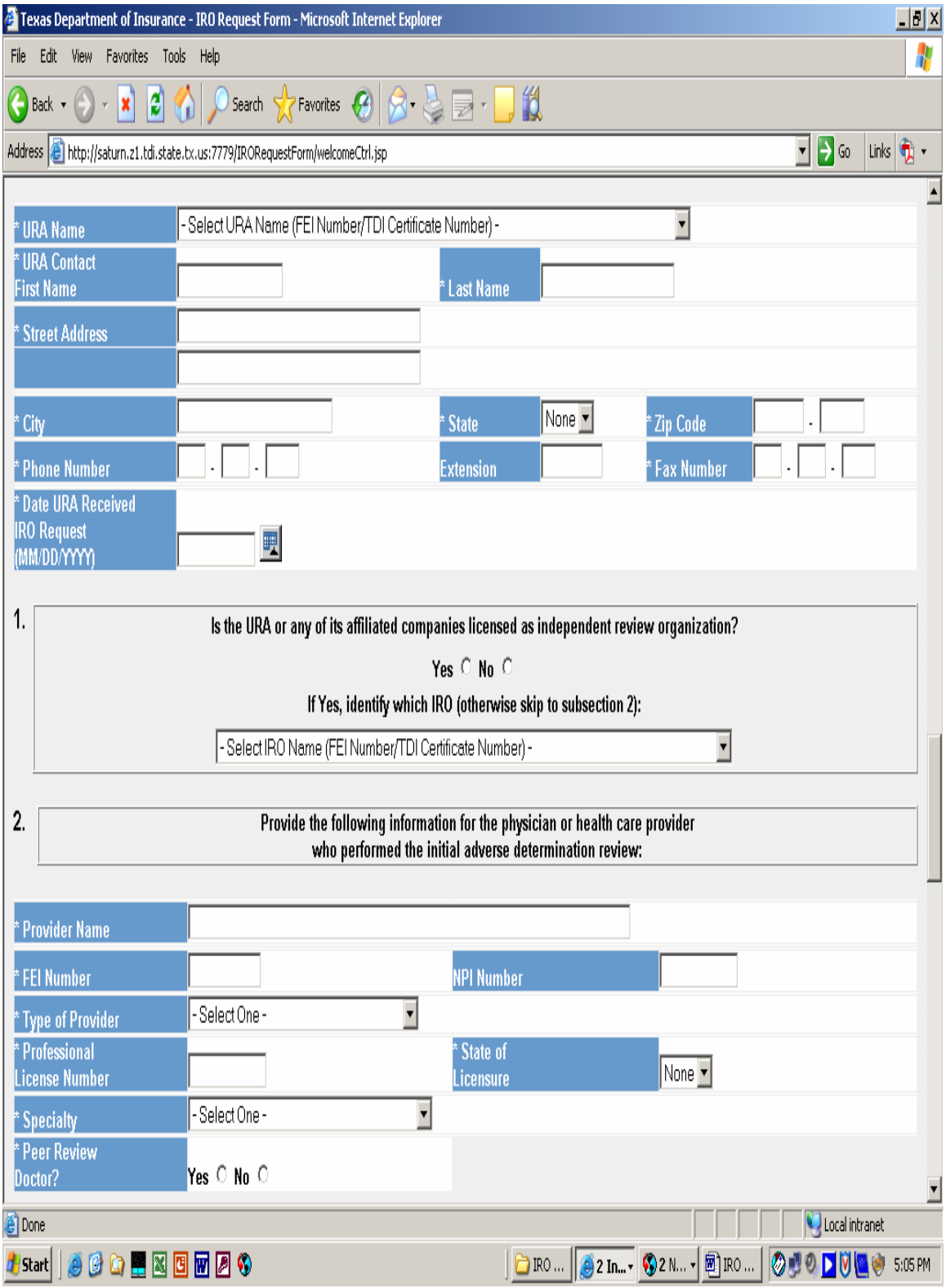
Answer the question below by **clicking** **Yes** or **No**.

If **Yes** identify which IRO by choosing the appropriate IRO company name from the **drop down** box located below the question.

Provide the following information for the physician or health care provider who preformed the initial adverse determination review:

*Provider Name
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty
*Peer Review Doctor Yes or No

Example: Section – VI Utilization Review Agent



Example: Section VI - Utilization Review Agent

Was a reconsideration or appeal of the adverse determination conducted? Yes or No

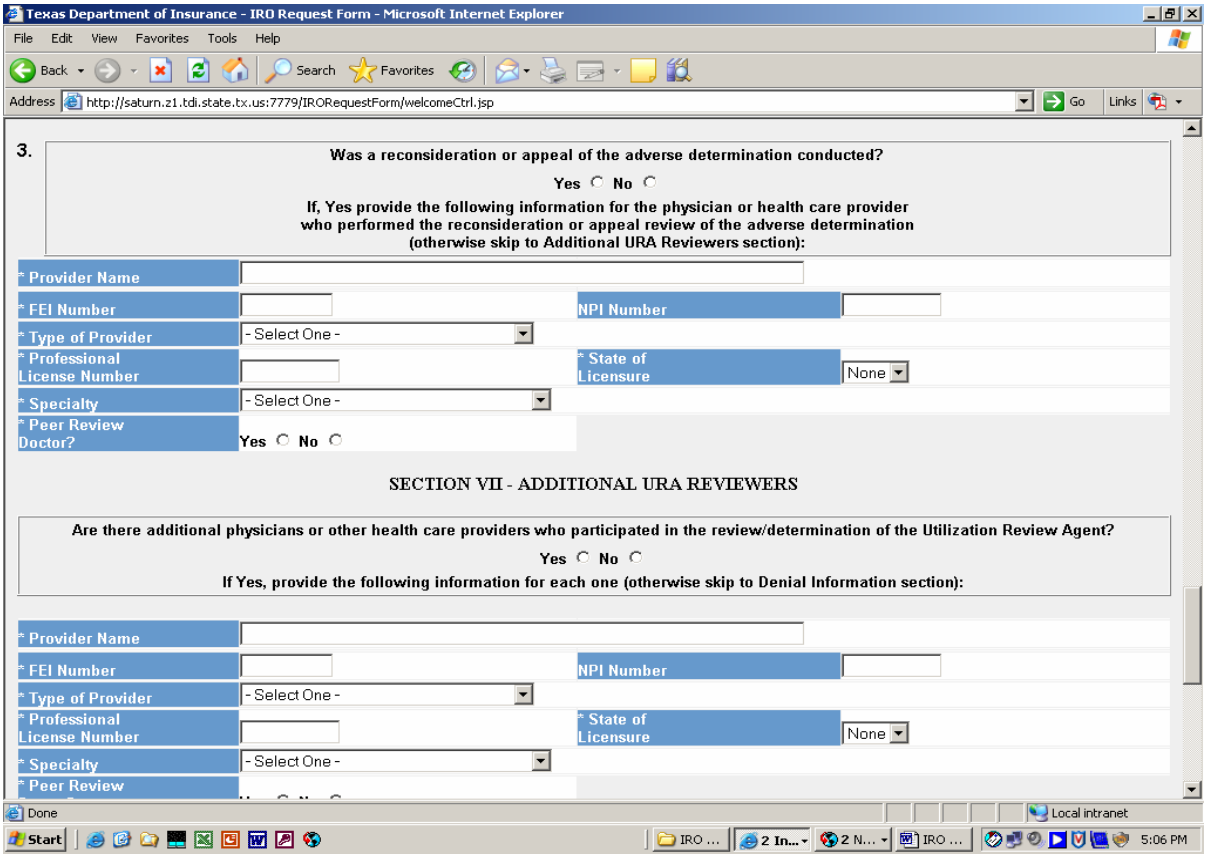
Answer the question below by **clicking Yes** or **No**.

If **Yes** provide the following information:

*Provider Name
*Type of Provider
*Professional License Number
*State of Licensure
*Specialty
*Peer Review Doctor? Yes or No

Information that is not required should be submitted, allowing for a more complete application.

If **No** you do not have to provide the information listed above. Tab to Section VI .



SECTION VII – ADDITIONAL URA REVIEWERS

Click on **Yes** or **No** to the question below.

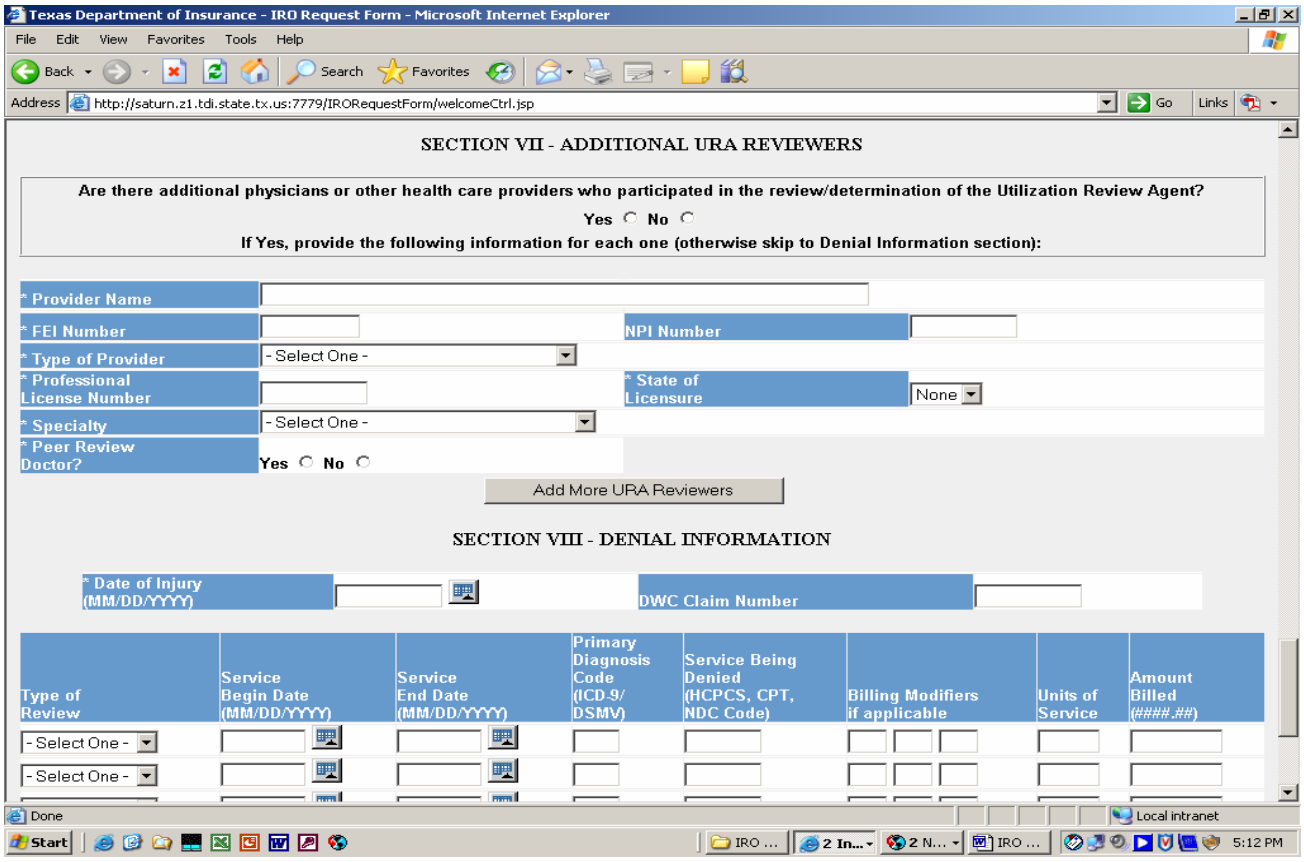
Are there additional physicians or other health care providers who participated in the review/determination of the utilization review agent? Yes or No

If **Yes** the following fields must be completed in Section VII:

*Provider Name
*Type of Provider
*Professional Licensure Number
*State of Licensure
*Specialty

Information that is not required should be submitted, allowing for a more complete application.

If you have more than 1 URA Reviewer **click** on the **Add More URA Reviewers** button located at the end of Section VII.



SECTION VIII - DENIAL INFORMATION

The fields located in Section VIII – Denial Information are not required fields and should be completed to the extent of the information you have related to the request.

Click on the type of review **drop down** box and choose **Prospective**, **Concurrent** or **Retrospective** and enter the following information in fields provided:

Date of Injury (MM/DD/YYY)
DWC Claim Number
Type of Review
Service Begin Date (MM/DD/YYYY)
Service End Date (MM/DD/YYYY)
Primary Diagnosis Code (ICD-9/DSMV)
Service Being Denied (HCPCS, CPT, NDC Code)
Billing Modifiers if applicable
Units of Service
Amount Billed (do not put numeric amount in field with out decimal 10000)
***add decimal information Example: 100.00**

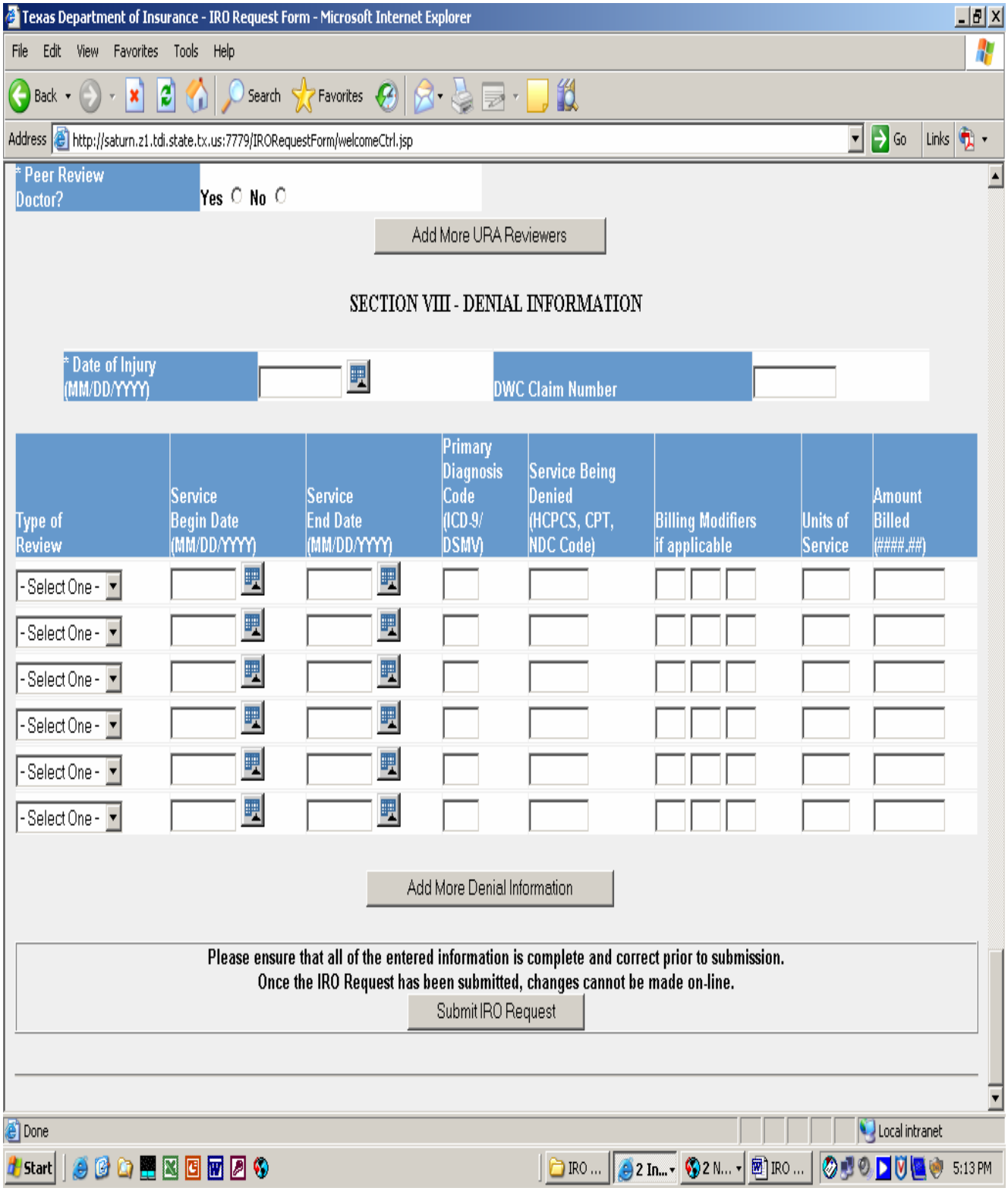
If you have additional denial information click on the **Add More Denial Information button** at the bottom of the screen shown below.

Ensure that all of the entered information is complete and correct prior to submission. Once the IRO Request has been submitted, changes cannot be made on-line.

If you have not entered all of the required information and **click** on the **Submit IRO Request** button you will receive the following error message:

*** There are problems with the information that you entered (see above). Please correct these problems and resubmit your request.**

Example: Denial Information



CONFIRMATION OF RECEIPT OF A REQUEST FOR A REVIEW BY AN IRO

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Fax the signed Confirmation of Receipt to:

Texas Department of Insurance
Health and WC Network Certification & QA
Fax Number 512-490-1011

Example:

Texas Department of Insurance
Health and WC Network Certification & QA, Mail Code 103-6A
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-322-4266 telephone • 512-490-1011 fax • www.tdi.state.tx.us

CONFIRMAITON OF RECEIPT OF A REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

Your submission was successful.

Print and sign this page for inclusion with the documents to be submitted to TDI.

Print Confirmation and Company Request for IRO

Did the confirmation page and attached Company Request for IRO form print successfully?
Yes○ or No ○
If Yes, logout of application. If No, try reprinting.

Logout

The IRO case number is #

My signature confirms online submission of a request for a review by an independent review organization. I understand the submission was successful and the case will be assigned for review by an independent review organization upon the Department's receipt of the following documents:

9. Adverse determination letter
10. Appeal/reconsideration resolution letter as applicable
11. Patient/Injured Employee IRO request form
12. Company Request for IRO form (report attached to this confirmation page)