

**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.

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## Required Information and Definitions

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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
<b>Begin Date</b>	M	M	O
<b>End Date</b>	O	O	O
<b>ICD-9</b>	M	O	O
<b>HCPCS/CPT</b>	M	O	O
<b>Modifiers</b>	O	O	O
<b>Units</b>	O	O	O
<b>Amount</b>	M	O	O
<b>Date of Injury</b>	M	M	M
<b>Claim Number</b>	O	O	O

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

### EXAMPLE OF REQUIRED FIELDS

The screenshot shows a web browser window titled "Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer". The address bar shows "http://saturn.z1.tdi.state.tx.us:7779/IROResultForm/healthCareCtrl.jsp". The form includes fields for "Type of Provider", "Professional License Number", "Specialty", and "State of Licensure". Below these is a section titled "SECTION VIII - DENIAL INFORMATION" which contains a table with the following columns: "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", and "Amount Billed (#####)". The table has five rows, with the first row set to "Concurrent". Below the table is a "Submit IRO Request" button and a warning message: "Please 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."

## 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 asterisk (\*) to indicate the field is required. 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**

**TEXAS DEPARTMENT OF INSURANCE**  
IRO REQUEST FORM [Logout](#)

WELCOME TO THE ONLINE APPLICATION FOR REQUESTING A REVIEW  
BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

Please begin by selecting the appropriate type of insurance or health care plan:

- Health care plan (non Workers' Compensation)
- Certified Workers' Compensation health care network plan
- Workers' Compensation non-network plan

Is patient/injured employee's condition life-threatening? Yes  No

Is IRO review request court-ordered? Yes  No

By checking this box, I certify that there are no pending compensability, extent or liability dispute issues related to this request for IRO review (not applicable to Health care plans).

By checking this box, I acknowledge understanding that the IRO Request Form must be completed in its entirety. Information cannot be partially entered and saved for completion at a later time. Once submitted, the data entered will not be accessible for editing.

3 TYPES

1. Health care plan (non Workers' Comp.)
2. Certified Worker's Comp. health care network plan.
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.

## Type 1 Health Care Plan Non-Workers' Compensation

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.

The screenshot shows a web browser window titled "Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer". The address bar shows "http://saturday.z1.tdi.state.tx.us:7779/IRORequestForm/welcomeCtrl.jsp". The main content area is titled "TEXAS DEPARTMENT OF INSURANCE IRO REQUEST FORM" and "HEALTH CARE PLAN". A "Logout" link is visible in the top right. The instruction "Please indicate the type of health care coverage:" is followed by a form field labeled "Box 5". A dropdown menu is open, showing options: "- Select One -", "HMO", "PPO", "Indemnity", "TPA", and "Other". A "Continue" button is located below the dropdown. Below the form field, there is a certification statement: "By checking this box, I certify that the patient, patient's legal guardian, independent review organization request form and that the URA and accordance with statutory requirements." followed by a checkbox and the text "representative signed the medical release section of the is acting on the URA's behalf will maintain the signature in". The Windows taskbar at the bottom shows the Start button, several application icons, and the system tray with the time "9:58 AM".



## Type 1 Health Care Plan Non-Workers' Compensation

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.

Address <http://saturn.z1.tdi.state.tx.us:7779/IRORquestForm/welcomeCtrl.jsp>

**TEXAS DEPARTMENT OF INSURANCE**  
IRO REQUEST FORM

[Logout](#)

**HEALTH CARE PLAN**

\* Please select a type of health care coverage.

Please indicate the type of health care coverage:

- Select One -

By checking this box, I certify that 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.

Continue

Done

Local intranet

Start

4 N... IRO ... IRO ... Tewa...

10:01 AM

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?**

The screenshot shows a web browser window with the URL <http://saturn.z1.tdi.state.tx.us:7779/IRORequestForm/healthCareCtrl.jsp#null>. The page title is "Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer". The form content is as follows:

**SECTION I - NAME OF PARTY REQUESTING IRO**

What is the relationship of the Party Requesting IRO to the patient/injured employee?  
*\* Please specify relationship of Party Requesting IRO to patient.*  
- Select One -  
If Party Requesting IRO is a provider, complete I-B. In all other cases, complete I-A.

**I-A.**

\* Requestor First Name  Middle Name  \* Last Name   
\* Street Address   
\* City  \* State  \* Zip Code  -   
\* Phone Number  -  -  Extension  Fax Number  -  -

**I-B.**

\* Provider Name   
\* Provider Contact First Name  Last Name   
\* Street Address   
\* City  \* State  \* Zip Code  -   
\* Phone Number  -  -  Extension  Fax Number  -  -   
\* FEI Number  NPI Number   
\* Type of Provider   
\* Professional License Number  \* State of Licensure   
\* Specialty

**Type 1 Health Care Plan Non-Workers' Compensation  
Section I**

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

**Type 1 Health Care Plan Non-Workers' Compensation  
Section I**

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

**SECTION I - NAME OF PARTY REQUESTING IRO**

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

If Party Requesting IRO is a Provider That Received The Adverse Determination, complete I-A.

**I-A.**

\* Requestor First Name  \* Last Name

\* Street Address

\* City  \* State  \* Zip Code  -

Phone Number  -  -  Extension  Fax Number  -  -

**I-B.**

\* Provider Name

Provider Contact First Name  Last Name

\* Street Address

\* City  \* State  \* Zip Code  -

\* Phone Number  -  -  Extension  \* Fax Number  -  -

\* FEI Number  NPI Number

\* Type of Provider

\* Professional License Number  \* State of Licensure

\* Specialty

**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 1<sup>st</sup> 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

**Type 1 Health Care Plan Non-Workers' Compensation  
Section II**

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

**SECTION II - PROVIDER THAT RECEIVED THE ADVERSE DETERMINATION**

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

If No, provide the following information (otherwise skip to Additional Physicians/Health Care Providers section):

* Provider Name	<input type="text"/>		
Provider Contact	<input type="text"/>	Last Name	<input type="text"/>
* Street Address	<input type="text"/>		
* City	<input type="text"/>	* State	None <input type="text"/>
* Phone Number	<input type="text"/> - <input type="text"/> - <input type="text"/>	Extension	<input type="text"/>
* FEI Number	<input type="text"/>	NPI Number	<input type="text"/>
* Type of Provider	- Select One - <input type="text"/>		
* Professional License Number	<input type="text"/>	* State of Licensure	None <input type="text"/>
* Specialty	- Select One - <input type="text"/>		

**SECTION III - ADDITIONAL PHYSICIANS or HEALTH CARE PROVIDERS**

Are there additional physicians or other health care providers who provided care to the patient and may have medical records relevant to the review?  
Yes  No

If Yes, provide the following information for each one (otherwise skip to Patient/Injured Employee Information section):

* Provider Name	<input type="text"/>		
Provider Contact	<input type="text"/>	Last Name	<input type="text"/>

**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

**Type 1 Health Care Plan Non-Workers' Compensation  
Section IV**

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

**SECTION IV - PATIENT INFORMATION**

Is the patient/injured employee the same as the party requesting the IRO?  
Yes  No

If Yes, provide Social Security Number, Date of Birth and Sex, and then skip to Payor/Carrier Information section.  
If No, provide all of the following information:

* Social Security Number	<input type="text"/>	* Date Of Birth (MM/DD/YYYY)	<input type="text"/>	* Sex	- Select One -
* First Name	<input type="text"/>	Middle Name	<input type="text"/>	* Last Name	<input type="text"/>
* Street Address	<input type="text"/>				
* City	<input type="text"/>	* State	None	* Zip Code	<input type="text"/>
Phone Number	<input type="text"/>	Extension	<input type="text"/>	Fax Number	<input type="text"/>

**SECTION V - PAYOR INFORMATION**

* FEI Number	<input type="text"/>				
* Payor Name	<input type="text"/>				
* Payor Contact First Name	<input type="text"/>	* Last Name	<input type="text"/>		
* Street Address	<input type="text"/>				
* City	<input type="text"/>	* State	None	* Zip Code	<input type="text"/>
* Phone Number	<input type="text"/>	Extension	<input type="text"/>	* Fax Number	<input type="text"/>

**SECTION VI - UTILIZATION REVIEW AGENT**

## **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 V - PAYOR INFORMATION

\* FEI Number

\* Payor Name

\* Payor Contact First Name

\* Payor Contact Last Name

\* Street Address

\* City

\* State

\* Zip Code

\* Phone Number

\* Extension

\* Fax Number

SECTION VI - UTILIZATION REVIEW AGENT

\* URA Name

\* URA Contact First Name

\* URA Contact Last Name

\* Street Address

\* City

\* State

\* Zip Code

\* Phone Number

\* Extension

\* Fax Number

\* Date URA Received IRO Request (MM/DD/YYYY)

1. Is the URA or any of its affiliated companies licensed as independent review organization?

Yes  No

If Yes, identify which IRO (otherwise skip to subsection 2):

**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 .

SECTION VI - UTILIZATION REVIEW AGENT

\* URA Name - Select URA Name (FEI Number/TDI Certificate Number) -

\* URA Contact First Name \* Last Name

\* Street Address

\* City \* State None \* Zip Code

\* Phone Number \* Extension \* Fax Number

\* Date URA Received IRO Request (MM/DD/YYYY)

1. Is the URA or any of its affiliated companies licensed as independent review organization?  
Yes  No   
If Yes, identify which IRO (otherwise skip to subsection 2):  
- Select IRO Name (FEI Number/TDI Certificate Number) -

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 -

**Type 1 Health Care Plan Non-Workers' Compensation  
Section VI**

**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):

**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.**

The screenshot shows the 'SECTION VIII - DENIAL INFORMATION' section of the IRO Request Form. It contains a table with the following columns: 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, and Amount Billed (####.##). The 'Units of Service' and 'Amount Billed' columns are circled in red, and a callout box points to them with the text 'These fields do not apply to health'. Below the table is an 'Add More Denial Information' button and a warning message: 'Please 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.' A 'Submit IRO Request' button is also present.



## 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](http://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.

**TEXAS DEPARTMENT OF INSURANCE**  
IRO REQUEST FORM

Logout

WELCOME TO THE ONLINE APPLICATION FOR REQUESTING A REVIEW  
BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

**Box 1** Please begin by selecting the appropriate type of insurance or health care plan:

Health care plan (non Workers' Compensation)

Certified Workers' Compensation health care network plan

Workers' Compensation non-network plan

**Box 2** Is patient/injured employee's condition life-threatening? Yes  No

Is IRO review request court-ordered? Yes  No

**Box 3** By checking this box, I certify that there are no pending compensability, extent or liability dispute issues related to the services for which this request for IRO is being submitted (not applicable to Health care plans).

**Box 4** By checking this box, I acknowledge understanding that the IRO Request Form must be completed in its entirety. Information cannot be partially entered and saved for completion at a later time. Once submitted, the data entered will not be accessible for editing.

Continue

## **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.**

SECTION I - NAME OF PARTY REQUESTING IRO

What is the relationship of the Party Requesting IRO to the patient/injured employee?  
**\* Please specify relationship of Party Requesting IRO to patient.**

- Select One -

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

**I-A.**

\* Requestor First Name  Middle Name  \* Last Name

\* Street Address

\* City  \* State  \* Zip Code  -

Phone Number  -  -  Extension  Fax Number  -  -

**I-B.**

\* Provider Name

Provider Contact First Name  Last Name

\* Street Address

\* City  \* State  \* Zip Code  -

\* Phone Number  -  -  Extension  \* Fax Number  -  -

\* FEI Number  NPI Number

\* Type of Provider

\* Professional License Number  \* State of Licensure

\* Specialty

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.

**Type 2 Certified Workers' Compensation Health Care Network Plan  
Section I**

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.

TEXAS DEPARTMENT OF INSURANCE  
IRO REQUEST FORM

SECTION I - NAME OF PARTY REQUESTING IRO

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

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

**I-A.**

\* First Name is required. \* Last Name is required.

Requestor First Name Middle Name Last Name

\* Street Address is required.

Street Address

\* City is required. \* Zip Code is required.

City State TX Zip Code

Phone Number Extension Fax Number

**I-B.**

\* Provider Name

Provider Contact First Name Last Name

\* Street Address

\* City \* State None \* Zip Code

\* Phone Number Extension Fax Number

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

**Type 2 Certified Workers' Compensation Health Care Network Plan  
Section I**

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

**SECTION I - NAME OF PARTY REQUESTING IRO**

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

If Party Requesting IRO is a Provider, please complete I.A.

**I.A.**

\* Requestor First Name  \* Last Name

\* Street Address

\* City  \* State  None \* Zip Code  -

Phone Number  -  -  Extension  Fax Number  -  -

**I-B.**

\* Provider Name

Provider Contact First Name  Last Name

\* Street Address

\* City  \* State  None \* Zip Code  -

\* Phone Number  -  -  Extension  Fax Number  -  -

\* FEI Number  NPI Number

\* Type of Provider  -Select One-

\* Professional License Number  \* State of Licensure  None

\* Specialty  -Select One-

**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 1<sup>st</sup> 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

**Type 2 Certified Workers' Compensation Health Care Network Plan  
Section II**

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

**SECTION II - PROVIDER THAT RECEIVED THE ADVERSE DETERMINATION**

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

If No, provide the following information (otherwise skip to Additional Physicians/Health Care Providers section):

* Provider Name	<input type="text"/>		
Provider Contact	<input type="text"/>	Last Name	<input type="text"/>
* Street Address	<input type="text"/>		
* City	<input type="text"/>	* State	None <input type="text"/>
* Phone Number	<input type="text"/> - <input type="text"/> - <input type="text"/>	Extension	<input type="text"/>
* FEI Number	<input type="text"/>	* Zip Code	<input type="text"/> - <input type="text"/>
* Type of Provider	- Select One - <input type="text"/>		
* Professional License Number	<input type="text"/>	* Fax Number	<input type="text"/> - <input type="text"/> - <input type="text"/>
* Specialty	- Select One - <input type="text"/>		
	NPI Number	<input type="text"/>	
	* State of Licensure	None <input type="text"/>	

**SECTION III - ADDITIONAL PHYSICIANS or HEALTH CARE PROVIDERS**

Are there additional physicians or other health care providers who provided care to the patient and may have medical records relevant to the review?  
Yes  No

If Yes, provide the following information for each one (otherwise skip to Patient/Injured Employee Information section):

* Provider Name	<input type="text"/>		
Provider Contact	<input type="text"/>	Last Name	<input type="text"/>



**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

**Type 2 Certified Workers' Compensation Health Care Network Plan  
Section IV**

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

**SECTION IV - INJURED EMPLOYEE INFORMATION**

Is the patient/injured employee the same as the party requesting the IRO?  
Yes  No

If Yes, provide Social Security Number, Date of Birth and Sex, and then skip to Payor/Carrier Information section.  
If No, provide all of the following information:

* Social Security Number	<input type="text"/> - <input type="text"/> - <input type="text"/>	* Date Of Birth (MM/DD/YYYY)	<input type="text"/>	* Sex	- Select One -
* First Name	<input type="text"/>	Middle Name	<input type="text"/>	* Last Name	<input type="text"/>
* Street Address	<input type="text"/>				
* City	<input type="text"/>	* State	None	* Zip Code	<input type="text"/> - <input type="text"/>
Phone Number	<input type="text"/> - <input type="text"/> - <input type="text"/>	Extension	<input type="text"/>	Fax Number	<input type="text"/> - <input type="text"/> - <input type="text"/>

**SECTION V - CARRIER INFORMATION**

* FEI Number	<input type="text"/>				
* Carrier Name	<input type="text"/>				
* Carrier Contact First Name	<input type="text"/>	* Last Name	<input type="text"/>		
* Street Address	<input type="text"/>				
* City	<input type="text"/>	* State	None	* Zip Code	<input type="text"/> - <input type="text"/>
* Phone Number	<input type="text"/> - <input type="text"/> - <input type="text"/>	Extension	<input type="text"/>	* Fax Number	<input type="text"/> - <input type="text"/> - <input type="text"/>

**SECTION VI - WORKERS' COMPENSATION HEALTH CARE NETWORK INFORMATION**

## **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.

The screenshot shows a web browser window titled "Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer". The address bar shows "http://saturn.z1.tdi.state.tx.us:7779/IROResultForm/welcomeCtrl.jsp". The main content area is titled "SECTION V - CARRIER INFORMATION" and contains the following fields:

- \* FEI Number
- \* Carrier Name
- \* Carrier Contact First Name
- \* Last Name
- \* Street Address
- \* City
- \* State (dropdown menu, currently set to "None")
- \* Zip Code
- \* Phone Number
- Extension
- \* Fax Number

Below this is "SECTION VI - WORKERS' COMPENSATION HEALTH CARE NETWORK INFORMATION" with fields:

- \* WC Network Name (dropdown menu, currently set to "- Select WC Network Name (FEI Number/TDI Certificate Number) -")
- \* WC Network Contact First Name
- \* Last Name
- \* Street Address
- \* City
- \* State (dropdown menu, currently set to "None")
- \* Zip Code
- \* Phone Number
- Extension
- \* Fax Number

Finally, "SECTION VII - UTILIZATION REVIEW AGENT" has fields:

- \* URA Name (dropdown menu, currently set to "- Select URA Name (FEI Number/TDI Certificate Number) -")
- \* URA Contact First Name
- \* Last Name
- \* Street Address

The browser's taskbar at the bottom shows the Start button, several application icons, and the system tray with the time "2:02 PM".

## **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 VI - WORKERS' COMPENSATION HEALTH CARE NETWORK INFORMATION**

\* WC Network Name - Select WC Network Name (FEI Number/TDI Certificate Number) -  
\* WC Network Contact First Name Last Name  
\* Street Address  
\* City \* State None \* Zip Code  
\* Phone Number Extension \* Fax Number

**SECTION VII - UTILIZATION REVIEW AGENT**

\* URA Name - Select URA Name (FEI Number/TDI Certificate Number) -  
\* URA Contact First Name Last Name  
\* Street Address  
\* City \* State None \* Zip Code  
\* Phone Number Extension \* Fax Number  
\* Date URA Received IRO Request (MM/DD/YYYY)

1. Is the URA or any of its affiliated companies licensed as independent review organization?  
Yes  No   
If Yes, identify which IRO (otherwise skip to subsection 2):  
- Select IRO Name (FEI Number/TDI Certificate Number) -

## **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**

Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer

Address: http://satum.z1.tdi.state.tx.us:7779/IRORequestForm/welcomeCtrl.jsp

\* URA Name: - Select URA Name (FEI Number/TDI Certificate Number) -

\* URA Contact  
First Name: [ ] \* Last Name: [ ]

\* Street Address: [ ]

\* City: [ ] \* State: None \* Zip Code: [ ] - [ ]

\* Phone Number: [ ] - [ ] - [ ] Extension: [ ] \* Fax Number: [ ] - [ ] - [ ]

\* Date URA Received IRO Request (MM/DD/YYYY): [ ]

1. Is the URA or any of its affiliated companies licensed as independent review organization?  
Yes  No   
If Yes, identify which IRO (otherwise skip to subsection 2):  
- Select IRO Name (FEI Number/TDI Certificate Number) -

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 -

\* Peer Review Doctor? Yes  No

**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**.

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	<input type="text"/>		
* FEI Number	<input type="text"/>	* NPI Number	<input type="text"/>
* Type of Provider	- Select One -		
* Professional License Number	<input type="text"/>	* State of Licensure	None
* Specialty	- Select One -		
* Peer Review Doctor?	Yes <input type="radio"/> No <input type="radio"/>		

**SECTION VIII - 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):

* Provider Name	<input type="text"/>		
* FEI Number	<input type="text"/>	* NPI Number	<input type="text"/>
* Type of Provider	- Select One -		
* Professional License Number	<input type="text"/>	* State of Licensure	None
* Specialty	- Select One -		
* Peer Review Doctor?	Yes <input type="radio"/> No <input type="radio"/>		



**Type 2 Certified Workers' Compensation Health Care Network Plan  
Section VII**

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**

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):

* Provider Name	<input type="text"/>		
* FEI Number	<input type="text"/>	NPI Number	<input type="text"/>
* Type of Provider	- Select One -		
* Professional License Number	<input type="text"/>	* State of Licensure	None
* Specialty	- Select One -		
* Peer Review Doctor?	Yes <input type="radio"/> No <input type="radio"/>		

**SECTION IX - DENIAL INFORMATION**

* Date of Injury (MM/DD/YYYY)	<input type="text"/>	DWC Claim Number	<input type="text"/>
-------------------------------	----------------------	------------------	----------------------

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 (####.##)
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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/YYYY)

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.**

Peer Review Doctor? Yes  No

Add More URA Reviewers

**SECTION IX - DENIAL INFORMATION**

\* Date of Injury (MM/DD/YYYY)   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 (####.##)
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add More Denial Information

Please 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.

Submit IRO 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](http://www.tdi.state.tx.us)

### CONFIRMATION 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.

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.

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.

**Box 1** Please begin by selecting the appropriate type of insurance or health care plan:

Health care plan (non Workers' Compensation)

Certified Workers' Compensation health care network plan

Workers' Compensation non-network plan

**Box 2** Is patient/injured employee's condition life-threatening? Yes  No

Is IRO review request court-ordered? Yes  No

**Box 3** By checking this box, I certify that there are no pending compensability, extent or liability dispute issues related to the services for which this request for IRO is being submitted (not applicable to Health care plans).

**Box 4** By checking this box, I acknowledge understanding that the IRO Request Form must be completed in its entirety. Information cannot be partially entered and saved for completion at a later time. Once submitted, the data entered will not be accessible for editing.

Continue

## **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**.

SECTION I - NAME OF PARTY REQUESTING IRO

What is the relationship of the Party Requesting IRO to the patient/injured employee?  
**\* Please specify relationship of Party Requesting IRO to patient.**

- Select One -

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

**I-A.**

\* Requestor First Name  Middle Name  \* Last Name

\* Street Address

\* City  \* State  \* Zip Code  -

Phone Number  -  -  Extension  Fax Number  -  -

**I-B.**

\* Provider Name

Provider Contact First Name  Last Name

\* Street Address

\* City  \* State  \* Zip Code  -

\* Phone Number  -  -  Extension  \* Fax Number  -  -

\* FEI Number  NPI Number

\* Type of Provider

\* Professional License Number  \* State of Licensure

\* Specialty

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.



**Type 3 Workers' Compensation Health Non-Network Plan  
Section I**

---

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.

The screenshot shows a web browser window displaying the 'Texas Department of Insurance - IRO Request Form'. The page title is 'SECTION I - NAME OF PARTY REQUESTING IRO'. The form asks 'What is the relationship of the Party Requesting IRO to the patient/injured employee?' and provides two options: 'I-A. Requestor' and 'I-B. Provider'. The 'I-B' section is highlighted with a blue background. A dropdown menu is open above the 'I-A' section, showing options: 'Provider That Received The Adverse Determination', 'Self', 'Party Acting On Behalf Of the Patient/Injured Employee', 'Provider That Received The Adverse Determination', and 'Other Physician Or Health Care Provider'. The 'I-B' section includes fields for Provider Name, Provider Contact (First Name, Last Name), Street Address, City, State, Zip Code, Phone Number, Extension, Fax Number, FEI Number, NPI Number, Type of Provider, Professional License Number, State of Licensure, and Specialty. An arrow points to the 'I-B' section.

**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 1<sup>st</sup> 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

**Type 3 Workers' Compensation Health Non-Network Plan  
Section II**

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

The screenshot shows a Microsoft Internet Explorer browser window displaying the Texas Department of Insurance's IRO Request Form. The address bar shows the URL: <http://saturn.z1.tdi.state.tx.us:7779/IRORequestForm/healthCareCtrl.jsp>.

**SECTION II - PROVIDER THAT RECEIVED THE ADVERSE DETERMINATION**

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

If No, provide the following information (otherwise skip to Additional Physicians/Health Care Providers section):

* Provider Name	<input type="text"/>		
Provider Contact		Last Name	<input type="text"/>
First Name	<input type="text"/>		
* Street Address	<input type="text"/>		
	<input type="text"/>		
* City	<input type="text"/>	* State	None <input type="text"/>
		* Zip Code	<input type="text"/> - <input type="text"/>
* Phone Number	<input type="text"/> - <input type="text"/> - <input type="text"/>	Extension	<input type="text"/>
		* Fax Number	<input type="text"/> - <input type="text"/> - <input type="text"/>
* FEI Number	<input type="text"/>	NPI Number	<input type="text"/>
* Type of Provider	- Select One - <input type="text"/>		
* Professional License Number	<input type="text"/>	* State of Licensure	None <input type="text"/>
* Specialty	- Select One - <input type="text"/>		

**SECTION III - ADDITIONAL PHYSICIANS or HEALTH CARE PROVIDERS**

Are there additional physicians or other health care providers who provided care to the patient and may have medical records relevant to the review?  
Yes  No

If Yes, provide the following information for each one (otherwise skip to Patient/Injured Employee Information section):

* Provider Name	<input type="text"/>		
Provider Contact		Last Name	<input type="text"/>
First Name	<input type="text"/>		

### **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 IV - INJURED EMPLOYEE INFORMATION

Is the patient/injured employee the same as the party requesting the IRO?  
Yes  No

If Yes, provide Social Security Number, Date of Birth and Sex, and then skip to Payor/Carrier Information section.  
If No, provide all of the following information:

\* Social Security Number [ ] - [ ] - [ ] \* Date Of Birth (MM/DD/YYYY) [ ] [ ] [ ] [ ] \* Sex - Select One - [v]  
\* First Name [ ] \* Middle Name [ ] \* Last Name [ ]  
\* Street Address [ ]  
\* City [ ] \* State [ None v ] \* Zip Code [ ] - [ ]  
Phone Number [ ] - [ ] - [ ] Extension [ ] Fax Number [ ] - [ ] - [ ]

SECTION V - CARRIER INFORMATION

\* FEI Number [ ]  
\* Carrier Name [ ]  
\* Carrier Contact First Name [ ] \* Last Name [ ]  
\* Street Address [ ]  
\* City [ ] \* State [ None v ] \* Zip Code [ ] - [ ]  
\* Phone Number [ ] - [ ] - [ ] Extension [ ] Fax Number [ ] - [ ] - [ ]

SECTION VI - WORKERS' COMPENSATION HEALTH CARE NETWORK INFORMATION

## **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.

The screenshot shows a web browser window titled "Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer". The address bar shows "http://saturn.z1.tdi.state.tx.us:7779/IROResultForm/welcomeCtrl.jsp". The main content area is titled "SECTION V - CARRIER INFORMATION" and contains the following fields:

- \* FEI Number
- \* Carrier Name
- \* Carrier Contact First Name
- \* Carrier Contact Last Name
- \* Street Address
- \* City
- \* State (dropdown menu, currently set to "None")
- \* Zip Code
- \* Phone Number
- \* Extension
- \* Fax Number

Below this section is "SECTION VI - WORKERS' COMPENSATION HEALTH CARE NETWORK INFORMATION" with the following fields:

- \* WC Network Name (dropdown menu, currently set to "- Select WC Network Name (FEI Number/TDI Certificate Number) -")
- \* WC Network Contact First Name
- \* WC Network Contact Last Name
- \* Street Address
- \* City
- \* State (dropdown menu, currently set to "None")
- \* Zip Code
- \* Phone Number
- \* Extension
- \* Fax Number

Below that is "SECTION VII - UTILIZATION REVIEW AGENT" with the following fields:

- \* URA Name (dropdown menu, currently set to "- Select URA Name (FEI Number/TDI Certificate Number) -")
- \* URA Contact First Name
- \* URA Contact Last Name
- \* Street Address

The browser's taskbar at the bottom shows the Start button, several application icons, and the system tray with the time "2:02 PM".

## **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 performed 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**

Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address <http://saturn.z1.tdi.state.tx.us:7779/IRORequestForm/welcomeCtrl.jsp> Go Links

\* URA Name - Select URA Name (FEI Number/TDI Certificate Number) -

\* URA Contact  
First Name  \* Last Name

\* Street Address

\* City  \* State None  \* Zip Code  -

\* Phone Number  -  -  Extension  \* Fax Number  -  -

\* Date URA Received IRO Request (MM/DD/YYYY)

1. Is the URA or any of its affiliated companies licensed as independent review organization?  
Yes  No   
If Yes, identify which IRO (otherwise skip to subsection 2):  
- Select IRO Name (FEI Number/TDI Certificate Number) -

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 -

\* Peer Review Doctor? Yes  No

Done Local intranet

Start IRO ... 2 In... 2 N... IRO ... 5:05 PM



**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 .

The screenshot shows a web browser window with the address <http://saturn.z1.tdi.state.tx.us:7779/IRDRequestForm/welcomeCtrl.jsp>. The form content is as follows:

**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	<input type="text"/>		
* FEI Number	<input type="text"/>	NPI Number	<input type="text"/>
* Type of Provider	- Select One -		
* Professional License Number	<input type="text"/>	* State of Licensure	None
* Specialty	- Select One -		
* Peer Review Doctor?	Yes <input type="radio"/> No <input type="radio"/>		

**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):

* Provider Name	<input type="text"/>		
* FEI Number	<input type="text"/>	NPI Number	<input type="text"/>
* Type of Provider	- Select One -		
* Professional License Number	<input type="text"/>	* State of Licensure	None
* Specialty	- Select One -		
* Peer Review	<input type="radio"/> Yes <input type="radio"/> No		

## **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 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):

\* Provider Name   
\* FEI Number  NPI Number   
\* Type of Provider - Select One -  
\* Professional License Number  \* State of Licensure None  
\* Specialty - Select One -  
\* Peer Review Doctor? Yes  No

Add More URA Reviewers

**SECTION VIII - DENIAL INFORMATION**

\* Date of Injury (MM/DD/YYYY)  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 (###.##)
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## **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/YYYY)  
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

Texas Department of Insurance - IRO Request Form - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address http://saturn.z1.tdi.state.tx.us:7779/IRORequestForm/welcomeCtrl.jsp

\* Peer Review Doctor? Yes  No

Add More URA Reviewers

**SECTION VIII - DENIAL INFORMATION**

\* Date of Injury (MM/DD/YYYY)   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 (####.##)
- Select One -	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
- Select One -	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/> <input type="button" value="Calendar"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>

Add More Denial Information

Please 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.

Submit IRO Request

Done Local intranet

Start IRO ... 2 In... 2 N... IRO ... 5:13 PM

## 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](http://www.tdi.state.tx.us)

### CONFIRMATION 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)