Office of the Montana State Auditor
CSI
Commissioner of Securities & Insurance

Matt M. Rosendale
Commissioner of Securities & Insurance
Montana State Auditor
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INDEPENDENT REVIEW ORGANIZATION

RENEWAL FORM

This form is for entities seeking renewal of their two-year certification to serve in Montana as an independent review organization (IRO). Pursuant to MCA § 33-32-416, an IRO must obtain the approval of the Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI) to perform external review services. Please complete this form and attach any required documentation. The CSI will contact your entity if we require any additional information. If you have any questions, please contact David Dachs at: marketconduct@mt.gov or (406) 444-9722.

INSTRUCTIONS:
This form can be filled out and saved in Adobe Acrobat Reader. To download the lastest version of Adobe Reader for free, go to: http://get.adobe.com/reader/. To submit this renewal form, please go to: www.csimt.gov/IROsubmit.

Please submit this form, and any changes to the following documentation:

☐ Documentation of Accreditation

☐ Statement of disciplinary action, sanction, or consent agreement or other settlement by or with any hospital, government agency, government unit, or regulatory body

☐ Statement identifying the areas of expertise for which the applicant provides independent review, and the number of reviewers meeting the qualification requirements of MCA § 33-32-417 within each respective area of expertise

☐ Fee Schedule

☐ Copies of policies and procedures governing all aspects of both the standard external review process and the expedited external review process

☐ Document summarizing, for each policy or procedure, the aspect or aspects of external review processes that the policy or procedure governs

INDEPENDENT REVIEW ORGANIZATION

DEMOGRAPHIC INFORMATION

Business Name:_____

Tax Identification Number:_____

BUSINESS CONTACT INFORMATION

Mailing Address:_____

City/State/Zip:_____

Street Address:_____

City/State/Zip:_____

Business Telephone Number:_____ Business Fax Number:_____

COMPLIANCE CONTACT INFORMATION

Name: _____ Title:_____

Telephone:_____ Email:_____

ACCREDITATION

Were there any changes to your organization's previously reported accreditation: ☐ Yes ☐ No

If yes, what changes? _____

_____

Please include documentation of any changes to your accreditation.

APPLICANT/REVIEWER QUALIFICATIONS

Does the applicant perform independent external reviews in other states? ☐ Yes ☐ No

If yes, in what states?

IN THE PAST TWO YEARS:

Has a state ever denied or withdrawn approval for the applicant to perform independent external reviews?

☐ Yes ☐ No

Has the applicant ever lost or been threatened with losing accreditation to perform independent external reviews?

☐ Yes ☐ No

Has the applicant or any clinical reviewer associated with the applicant been subject to any disciplinary action, sanction, or consent agreement or other settlement by or with any hospital, government agency, government unit, or regulatory body?

If yes, please attach a statement providing details.

Please attach a document identifying any changes to the areas of expertise for which the applicant provides independent review, or the number of reviewers meeting the qualification requirements of MCA § 33-32-417 within each respective area of expertise.

FINANCIAL CONFLICT OF INTEREST

Is the applicant related in any way, directly or indirectly, to a health plan, health insurance issuer, trade association of health plans, or trade association of health care providers? "Related" includes but is not limited to being owned or controlled by, or being a subsidiary of; owning or exercising control over; or being owned by the same holding company as the other party.

☐ Yes ☐ No

Please provide a copy of the applicant's fee schedule, if it has changed in the past two years.

Please identify all health plans or health insurance issuers for which the applicant currently provides external reviews.

EXTERNAL REVIEW HOTLINE

Does the applicant maintain a toll-free telephone service to receive information related to external reviews on a 24-hour-a-day, 7 day-a-week basis?

☐ Yes ☐ No

If yes, is the service capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other-than-normal business hours?

☐ Yes ☐ No

If yes, provide telephone number: _____

POLICIES AND PROCEDURES

Montana Code Annotated § 33-32-417 requires an independent review organization to establish and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process.

Please attach copies of any changes to your organization's policies and procedures governing all aspects of both the standard external review process and the expedited external review process.

For any changes, please attach a document summarizing, for each policy or procedure, the aspect or aspects of external review processes that the policy or procedure governs.

RENEWAL FORM ATTESTATION AND CERTIFICATION

Applicant has received accreditation as an independent review organization by _____accrediting body to conduct independent external reviews. Applicant certifies that it will notify the Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI) if accreditation is lost with this accrediting body. Applicant acknowledges that the CSI may terminate this license if the applicant loses accreditation or no longer satisfies the minimum requirements for licensure.

Applicant acknowledges that payment of any fees associated with any external reviews conducted to Montana Code Annotated Title 33, Chapter 32 are the sole responsibility of the health insurance issuer whose decision is being reviewed.

Applicant understands that it has no recourse against the CSI or the State of Montana to the extent that any health insurance issuer fails to pay any medical reviewer fees. Applicant authorizes the CSI to verify information with any federal, state, or local government agency, insurance company, or accrediting organization.

Applicant acknowledges and represents that it understands and will comply with Montana's insurance laws, including applicable administrative rules. Applicant further agrees to maintain and provide to the CSI the information set out in MCA § 33-32-421.

I hereby certify that, under penalty of perjury, I am the person named below and know the contents of this application, and that all of the information submitted in this application and the attachments are true and complete. I attest that I have the authority and capacity to execute this certification on behalf of Applicant. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license denial or revocation and may subject me to civil or criminal penalties.

Name of Applicant: _____

Electronic Signature of Officer or Representative of Applicant: _____

Printed name: _____Title: _____

Date: _____

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