



**Matt M. Rosendale**  
Commissioner of Securities & Insurance  
Montana State Auditor  
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Phone: 406.444.2040 or 800.332.6148  
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## INDEPENDENT REVIEW ORGANIZATION APPLICATION

This application is for entities seeking approval 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. To apply, please complete this form and attach the required documentation. CSI will contact your entity with its determination regarding the application. Questions? Please contact Nick Mazanec, CSI Attorney, at [nmazanec@mt.gov](mailto:nmazanec@mt.gov) or (406) 444-0385.

### INSTRUCTIONS:

This form can be filled out and saved in Adobe Acrobat Reader. To download the latest version of Adobe Reader for free, go to <http://get.adobe.com/reader/>. To submit this application, please go to [www.csimt.gov/IROsubmit](http://www.csimt.gov/IROsubmit)

Please submit the following documentation:

- |   |   |
|---|---|
| <input type="checkbox"/> This application   | <input type="checkbox"/> Fee Schedule   |
| <input type="checkbox"/> Documentation of Accreditation   | <input type="checkbox"/> Copies of policies and procedures governing all aspects of both the standard external review process and the expedited external review process |
| <input type="checkbox"/> Statement of disciplinary action, sanction, or consent agreement or other settlement by or with any hospital, government agency, government unit, or regulatory body   | <input type="checkbox"/> Document summarizing, for each policy or procedure, the aspect or aspects of external review processes that the policy or procedure governs    |
| <input type="checkbox"/> 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 |   |

## 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

Is the applicant currently accredited to perform independent reviews:  Yes  No

If yes, with what accrediting body? \_\_\_\_\_

How long has the applicant been accredited? \_\_\_\_\_

***Please include documentation of accreditation.***

## APPLICANT/REVIEWER QUALIFICATIONS

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

If yes, in what states?

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 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.***

## 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.***

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 policies and procedures governing all aspects of both the standard external review process and the expedited external review process.***

***Please attach a document summarizing, for each policy or procedure, the aspect or aspects of external review processes that the policy or procedure governs.***

**APPLICANT 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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