

INDIANA INDEPENDENT REVIEW ORGANIZATION CHECKLIST

Fill in "Located" column with section and page location documenting that you meet the requirement.

Return checklist with application.

IC 27-13-10.1 (HMO)

IC 27-8-29 (INSURERS)

Company Name _____

Date _____

CRITERIA	CRITERIA SPECIFICS	LOCATED	Dept Use Only	
			YES	NO
Application	Completed - are there explanations for any boxes checked "no"	N/A		
	Contact name and telephone	N/A		
	EIN or FIN	N/A		
	Signed	N/A		
Fee	\$250.00 Initial application or \$200.00 for renewal application			
Staffing IC 27-13-10.1-8(c)(1)(A) or IC 27-8-29-19(c)(1)(A)	Review professionals assigned must be board certified in the specialty in which the insured's proposed service would be provided			
IC 27-13-10.1-8(c)(1)(B) or IC 27-8-29-19(c)(1)(B)	Review professionals assigned must be knowledgeable about proposed service through actual clinical experience			
IC 27-13-10.1-8(c)(1)(C) or IC 27-8-29-19(c)(1)(C)	Review professionals assigned must hold an unlimited license to practice in a state of the United States			
IC 27-13-10.1-8(c)(1)(D) or IC 27-8-29-19(c)(1)(D) or	Review professionals assigned must have no history of disciplinary actions or sanctions including: loss of staff privileges, or restriction on participation			
Quality IC 27-13-10.1-8(c)(2)(A) or IC 27-8-29-19(c)(2)(A)	The IRO must have a quality assurance mechanism to ensure the timeliness and quality of reviews			
IC 27-13-10.1-8(c)(2)(B) or IC 27-8-29-19(c)(2)(B)	The IRO must have a quality assurance mechanism to ensure the qualifications and independence of medical review professionals			
IC 27-13-10.1-8(c)(2)(C) or IC 27-8-29-19(c)(2)(C)	The IRO must have a quality assurance mechanism to ensure the confidentiality of medical records and other review materials			
IC 27-13-10.1-8(c)(2)(D) or IC 27-8-29-19(c)(2)(D)	The IRO must have a quality assurance mechanism to ensure the satisfaction of covered insureds with the procedures utilized by the IRO, including the use of covered individual satisfaction surveys			
Certifications Bulletin 193	Signed statement certifying that all information included in the request for Certification is accurate to the best of the Applicant's knowledge and belief (must be signed by CEO or an individual authorized to act in such capacity)			
Bulletin 193 Section 3-10	A statement that the organization agrees to accept all eligible cases referred to it on a rotating basis required to be used by insurers.			
Bulletin 193 Section 3-11	A statement that the organization accepts the rotational assignment procedure.			
Bulletin 193 Section 3-12	A statement that the Request for a Certification designates agreement to comply with IC 27-13-10.1 or IC 27-8-29.			
Bulletin 193 Section 3-13	A list of all professional designations and/or licenses held by the organization and a brief explanation of all credentials held by the organization from other states and credentialing organizations			
Required Time-Frames IC 27-13-10.1-4(a)(1)	For an expedited appeal filed under section 2(a)(2)(A) of this chapter, within seventy-two (72) hours after the appeal is filed make a determination			
IC 27-8-29-15(a)(1)	For an expedited appeal filed under section 13(a)(2)(A) of this chapter, within seventy-two (72) hours after the external grievance is filed make a determination			

IC 27-13-10.1-4(a)(2)	For a standard appeal filed under section 2(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed make a determination			
IC 27-8-29-15(a)(2)	For a standard external grievance filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the external grievance is filed make a determination			
Notifications				
IC 27-13-10.1-4(c)(1)	For an expedited appeal, notify the HMO and enrollee of the determination with seventy-two (72) hours after the appeal is filed			
IC 27-8-29-15(d)(1)	For an expedited external grievance, notify the insurer and covered individual within seventy-two (72) hours after the appeal is filed			
IC 27-13-10.1-4(a)(2)	For a standard appeal, notify the HMO and enrollee of the determination within seventy-two (72) hours after making the determination			
IC 27-8-29-15(d)(2)	For a standard grievance, notify the insurer and the covered individual with seventy-two (72) hours after making the determination			