

**APPLICATION FOR  
RECERTIFICATION AS AN  
INDEPENDENT REVIEW  
ORGANIZATION**



State of Wisconsin  
Office of the Commissioner of Insurance  
P.O. Box 7873  
Madison, Wisconsin 53707-7873  
(608) 266-3585  
E-Mail: [ociinformation@wisconsin.gov](mailto:ociinformation@wisconsin.gov)  
Web Address: [oci.wi.gov](http://oci.wi.gov)

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All independent review organizations certified to conduct independent reviews in Wisconsin must be recertified on a biennial basis by the Office of the Commissioner of Insurance (OCI).

This packet summarizes the procedures for recertifying Independent Review Organizations (IRO) in Wisconsin under s. 632.835, Wis. Stat. Applicants should carefully review all requirements for performing and licensing of independent review organizations as delineated in s. 632.835, Wis. Stat., and ch. Ins 18, Wis. Adm. Code.

The following documents must be completed and returned with the application for recertification:

1. Application for Certification as an Independent Review Organization
2. Conflict of Interest Statement
3. Certification of Impartiality of Marketing Practices
4. Biographical sketches for all directors, officers, executives, owners, and the medical director (or clinical director)(only required for individuals appointed or employed after most recent certification date)

In addition to the items included in this packet, the application should include a letter of transmittal with an index using the identification system in this letter. An explanation for the omission of any material should accompany the application.

A statutory fee of \$100 must be filed with the application for recertification

Please file the materials identified below with OCI in the following order:

**I. Organizational Structure:**

- A. Description of any changes to the IRO's organizational structure; include two copies of any modifications made to the articles of incorporation, articles of organization and bylaws or operating agreement for the IRO, holding company or parent company.
- B. Current organizational chart.
- C. Current list and description of the scope and relationship of all agreements between the IRO and insurance companies, claims administrators, health care services entities, health care providers and management service organizations. Indicate the percentage of business the work from the insurers represents and the percent change from date of application.

**II. Regulatory Compliance Program:**

- A. Description of any changes to the previously submitted regulatory compliance program.
- B. Copy of the current list of affiliations that may represent potential conflicts of interest as described in s. 632.835 (6), Wis. Stat.

### **III. Quality Assurance Plan:**

- A. Description of any changes to the previously submitted quality assurance plan.
- B. Copy of the IRO's most recent review of its quality assurance program or the most recent report of its quality assurance program that was presented to its management.
- C. Summary of complaints received regarding the IRO's review procedures or its decisions in Wisconsin review cases. The summary should include, at a minimum, the source of the complaint (consumer, health care provider or insurer), the reason for the complaint, and an indication of any remedial action taken and if the complaint resulted in changes to the IRO's review procedures. The summary should include all complaints received directly from consumers, health care providers and insurers, but does not need to include complaints received from the OCI.
- D. Summary of complaints regarding the IRO's independent review activities in other states. For each state that the IRO is licensed or certified as an independent review entity, indicate the number of complaints regarding the independent review procedures, and the number of complaints regarding IRO decisions. If a state took any disciplinary or other administrative action against the IRO, provide a copy of the notice of hearing and other documents describing the problem, a copy of the stipulation, order or agreement and an explanation of the corrective steps taken as a result of the order.

### **IV. Peer Reviewers:**

- A. Description of any changes to previously submitted procedures for credentialing, recredentialing, and training clinical peer reviewers, matching reviewers to specific cases, and monitoring performance on an ongoing basis.
- B. Description of procedures to monitor the performance of peer reviewers and to ensure that decisions are consistent with the IRO's standards and with the standards listed in s. 632.835 (3m), Wis. Stat. The response should include a copy of any written oversight procedures.

### **V. Procedures for Handling Independent Review Requests:**

- A. Description of all aspects of the independent review process for Wisconsin insureds from receipt of the independent review request through notification of determination. Highlight any changes made to previously submitted procedures.
- B. Description of procedures to ensure that the peer reviewer has a complete file of all information necessary to consider the case. Highlight any changes made to previously submitted procedures.

### **VI. Financial Statement:**

Submit two copies of the audited financial statement for the IRO's most recently completed fiscal year, prepared on a generally accepted accounting basis including: assets, liabilities, and net worth; the results of operations; and the changes in net worth for the fiscal year on the accrual basis.

### **VII. Fee Schedule:**

Section 632.835 (4) (ap), Wis. Stat., requires an IRO to establish reasonable fees that it will charge for independent reviews and to submit its fee schedule to the Commissioner for approval. An IRO may not change any fees approved by the Commissioner more than one time per year and shall submit any proposed fee changes to the Commissioner for approval.

Submit fee schedule in following format:

|   | <b>Standard Review</b> | <b>Expedited Review</b> |
|---|------------------------|-------------------------|
| High Complexity - adverse determination                   |                        |                         |
| Moderately Complex – adverse determination                |                        |                         |
| Low Complexity – adverse determination                    |                        |                         |
| High Complexity – experimental treatment determination    |                        |                         |
| Moderately Complex – experimental treatment determination |                        |                         |
| Low Complexity – experimental treatment determination     |                        |                         |
| Review Terminated – insurer voluntarily reverses decision |                        |                         |

**Definitions of Categories:**

High Complexity: highly technical reviews involving terminally or seriously ill individuals, complex diagnoses or controversial medical treatment; more than one peer reviewer

Moderately Complex: reviews involving appropriateness of specific treatment plan; less complex, but requires review of medical literature; generally one peer reviewer

Low Complexity: reviews involving site of care, duration of care, cosmetic or custodial care versus medical necessity, physical, occupational or speech therapies

Review Terminated: insurer voluntarily reverses its decision

The Office will conduct a review of all submitted documents and other material and it may request clarification or additional documents prior to rendering its determination on recertification.

Questions about the certification process should be addressed to:

Barbara Belling  
 Managed Care Specialist  
 (608) 264-6224

**APPLICATION FOR  
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ORGANIZATION**



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(608) 266-3585

Ref: s. 632.835, Wis. Stat.

New Certification       Renewal

**Company Information**

|                                 |      |                         |         |
|---------------------------------|------|-------------------------|---------|
| Legal Name                      |      | Federal Employer ID No. |         |
| DBA/Trade Name                  |      |                         |         |
| Business Address                | City | State                   | Zip + 4 |
| Mailing Address                 | City | State                   | Zip + 4 |
| Telephone                       | Fax  | E-mail Address          |         |
| Name of Chief Executive Officer |      |                         |         |
| Contact Person                  |      | Telephone               |         |

Type of Organization

Corporation     
  Partnership     
  Sole Proprietorship     
  LLC     
  LLP

Other (list) \_\_\_\_\_

Type of Reviews

Comprehensive     
  List Exceptions \_\_\_\_\_

Limited     
  List Type Offered \_\_\_\_\_

List all states in which your company is licensed or certified as an independent review entity and indicate the date you received such license or certification:

  
  
  

\_\_\_\_\_ (IRO) hereby applies for certification as an independent review organization in Wisconsin. The undersigned attests to the accuracy of this application.

|                                    |      |
|------------------------------------|------|
| Signature of CEO/Officer and Title | Date |
|------------------------------------|------|

Subscribed and sworn before me, a Notary Public, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

(SEAL)

My commission expires: \_\_\_\_\_

**CONFLICT OF INTEREST STATEMENT**



State of Wisconsin  
Office of the Commissioner of Insurance  
125 South Webster Street  
P. O. Box 7873  
Madison, WI 53707-7873  
(608) 266-3585

Ref: s. 632.835, Wis. Stat.

Name of Independent Review Organization

Under s. 632.835 (6) (a), Wis. Stat., an Independent Review Organization (IRO) may not be affiliated with any of the following:

1. A health benefit plan.
2. A national, state or local trade association of health benefit plans, or an affiliate of any such association.
3. A national, state or local trade association of health care providers, or an affiliate of any such association.

Under s. 632.835 (6) (b), Wis. Stat., an IRO appointed to conduct an independent review and a clinical peer reviewer assigned by an IRO to conduct an independent review may not have a material professional, familial or financial interest with any of the following:

1. The insurer that issued the health benefit plan that is the subject of the independent review.
2. Any officer, director or management employee of the insurer that issued the health benefit plan that is the subject of the independent review.
3. The health care provider that recommended or provided the health care service or treatment that is the subject of the independent review, or the health care provider's medical group or independent practice association.
4. The facility at which the health care service or treatment that is the subject of the independent review was or would be provided.
5. The developer or manufacturer of the principal procedure, equipment, drug or device that is the subject of the independent review.
6. The insured or his or her authorized representative.

I, \_\_\_\_\_ (CEO/Officer), hereby certify that I have authority to bind and obligate the company by filing this application. I further certify, pursuant to s. 632.835 (6), Wis. Stat., that, \_\_\_\_\_ (IRO) is not affiliated with any of the entities listed in subsection s. 632.835 (6) (a), Wis. Stat., and will comply with subsection s. 632.835 (6) (b), Wis. Stat., in accepting independent review requests.

| Signature of CEO/Officer | Title | Date |
|--------------------------|-------|------|
|                          |       |      |

**CERTIFICATION OF  
IMPARTIALITY OF  
MARKETING PRACTICES**



State of Wisconsin  
Office of the Commissioner of Insurance  
125 South Webster Street  
P. O. Box 7873  
Madison, WI 53707-7873  
(608) 266-3585

Ref: s. 632.835, Wis. Stat.

Name of Independent Review Organization

I hereby certify that, as an officer of the above company, I have the authority to bind and obligate the company by filing this certification. I further certify, pursuant to s. Ins 18.12 (8), Wis. Adm. Code, that, to the best of my knowledge, information and belief, the company has established and maintains procedures to ensure that it is unbiased, and that:

1. It does not provide incentives of any kind, including financial incentives, to providers or consumers as inducements for selection as the independent review organization.
2. It does not directly or indirectly receive any compensation, in any form, related to a review, other than the compensation permitted under s. Ins 18.18, Wis. Adm. Code, and s. 632.835, Wis. Stat.
3. It does not promote, to providers, consumers or insurers any of the following:
  - a. A pattern of favorable results or a pattern of favorable results on a particular treatment or subject.
  - b. An association with a class of providers, consumers or insurers.
  - c. A bias favorable to a class of providers, consumers or insurers.

|                 |           |
|-----------------|-----------|
| Name and Title  | Date      |
| Company Address | Telephone |

**BIOGRAPHICAL FORM**



State of Wisconsin  
 Office of the Commissioner of Insurance  
 125 South Webster Street  
 P. O. Box 7873  
 Madison, WI 53707-7873  
 (608) 266-3585

Ref: s. 632.835, Wis. Stat.

To be filled out by all directors, officers, executives, owners, and the medical or clinical director

**Personal information:**

|                                       |       |         |                           |       |         |
|---------------------------------------|-------|---------|---------------------------|-------|---------|
| Name                                  |       |         | Date of Birth             |       |         |
| Street Address (residence)            |       |         | Business Name and Address |       |         |
| City                                  | State | Zip + 4 | City                      | State | Zip + 4 |
| Telephone                             |       |         | Telephone                 |       |         |
| Current or Proposed Position with IRO |       |         |                           |       |         |

**Individual employment history (last 10 years):**

| Name and Address of Employer | Type of Business | Title of Position and Main Responsibilities | Starting Date | Termination Date | Reason for Termination |
|------------------------------|------------------|---|---------------|------------------|------------------------|
|                              |                  |   |               |                  |                        |

**License history:**

| Type of License | Date Received | Name and Address of Institution Granting License | Expiration Date |
|-----------------|---------------|--|-----------------|
|                 |               |  |                 |

**Education history:**

| Name of Institution | Address | Dates of Attendance | Degree | Date Received |
|---------------------|---------|---------------------|--------|---------------|
|                     |         |                     |        |               |

**History of any legal actions:**

1. Have you ever changed your name or used an alias?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Have you ever been convicted of a felony?

Yes \_\_\_\_\_ No \_\_\_\_\_

3. Are there any criminal actions pending against you?

Yes \_\_\_\_\_ No \_\_\_\_\_

4. Have you ever been named as a defendant in any criminal or civil action in which fraud or breach of fiscal responsibility was an issue?

Yes \_\_\_\_\_ No \_\_\_\_\_

5. Have you ever been an owner, officer, trustee, management employee or controlling stockholder of an entity that, while you occupied any such position: suffered the suspension or revocation of its certificate of authority or license to do business in any state, or was denied a certificate of authority, license or contract to do business in any state?

Yes \_\_\_\_\_ No \_\_\_\_\_

Attach a complete explanation for any "yes" answers.

**Affiliation with other health care organizations:**

For this section, affiliation includes serving as an officer, director, member of the management staff, stockholder of 10% or more of stocks or key advisor for health care operation.

1. For the past 10 years, have you owned or operated or been affiliated with any health care or health related operations?

Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes," list the name(s) and address(es) of health care operation, your affiliation dates, the nature of the affiliation, the agency that licenses the health care operation, and the license number.

2. Are/were these health care operations in compliance with applicable laws and regulations during your affiliation?

Yes \_\_\_\_\_ No \_\_\_\_\_

If “no,” provide a complete explanation of each violation, including the nature of the violation, the name and address of the agency enforcing the violation, the steps taken by the health care operation to remedy the violation, and indicate whether any suspension, revocation or accreditation has since been restored.

**Personal financial involvement:**

1. Financial support for the proposed IRO

Do you intend to provide capital for use in owning, organizing or operating the proposed IRO?

Yes \_\_\_\_\_ No \_\_\_\_\_

If “yes,” provide the following:

- Personal financial statement
- Percent and value of the business you control
- Any additional information pertinent to determination of either the applicant’s financial capabilities or the project’s feasibility

2. Transactions with the proposed IRO or holding company

For this section, transaction is any business transaction of \$500 or more that during any one fiscal year, represents 5% of the total annual operating expenses of any of the parties to the transaction. Transactions include any sale or leasing of any property but do not include salaries paid to employees for services provided in the normal course of their employment.

Have any transactions involving money, extension of credit, liens, notes, bonds or mortgages occurred or are such transactions anticipated between the proposed IRO and you or any of your relatives or between the holding company and you or any of your relatives?

Yes \_\_\_\_\_ No \_\_\_\_\_

If “yes,” provide information on the transaction, including the parties to the transaction, the type of transaction, the value of the transaction (dollar value and percent of operating costs), the percent interest rate, the reason for the transaction, and the method of repayment.