

**IMPLEMENTATION OF THE  
WISCONSIN INDEPENDENT REVIEW PROCESS**

Office of the Commissioner of Insurance  
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## INTRODUCTION

Wisconsin's independent review process provides consumers with the opportunity to resolve some coverage disputes through an independent review organization (IRO) that has no connection to their health plan. The health plan's coverage denial must be based on an adverse determination or an experimental treatment determination. The IRO has the authority to determine whether the health plan must provide coverage of the medical treatment or service.

The independent review process in Wisconsin is administered by the Office of the Commissioner of Insurance (OCI) under s. 632.835, Wis. Stat., and ch. Ins 18, Wis. Adm. Code.

### **The Independent Review Process**

Generally, in order to request an independent review, an insured or an insured's authorized representative must first complete the insurer's internal grievance process. All health benefit plans in Wisconsin are required to have a grievance process to resolve their insureds' complaints. The insured has the right to attend the grievance panel meeting or to participate by teleconference. Insurers must resolve most grievances within 30 days of the date that they initially receive the grievance.

If the grievance panel upholds the plan's adverse determination or experimental treatment determination, the letter explaining its decision must also include an explanation of the insured's right to request an independent review. The information provided must include an explanation of how to request the review and must include a current listing of IROs certified by OCI and the informational brochure developed by OCI. The insured chooses an IRO from the list provided and must submit the independent review request to the insurer within four months of the date of the grievance resolution letter. The insurer is required to notify OCI and the IRO chosen by the insured of the request within two business days and to forward all relevant material regarding the appeal to the IRO within five business days. The IRO is required to review the request to verify that it is eligible for an independent review and to determine whether the request is complete and whether the IRO has a potential conflict of interest. The IRO forwards the file to one or more of its peer reviewers, who must be an expert in treating the medical condition that is the subject of the review through current clinical experience. The IRO must notify the insurer and the insured of its decision within 30 business days of receiving all the information it needs to complete the review. Its decision is binding on both the insurer and the insured.

The requirement that the insured complete the grievance procedure before being eligible for an independent review does not apply in two situations. The grievance process may be bypassed if both the insurer and the insured agree. It may also be bypassed if the insured needs immediate medical treatment and the time required to complete the grievance process could jeopardize the life or health of the insured. If immediate medical treatment is necessary, the insured or his or her authorized representative sends the request for an expedited independent review to the IRO at the same time the request is sent to the insurer. If the IRO agrees that the review should be expedited, the insurer must submit the file to the IRO within one day of receiving the request and the IRO must complete its review within 72 hours of receiving all necessary information.

OCI is responsible for certifying and recertifying the IROs to verify that they have procedures to comply with all applicable Wisconsin insurance laws. It must maintain a current list of certified IROs, which is posted on OCI's Web site.

## Summary of IRO Reports

The IROs are required to submit an annual report to OCI for the prior calendar year's experience. Summaries of the reports showing the results by insurer for each year are posted on the OCI Web site.

The chart below indicates the total percent of insurers' decisions that were upheld and the total reversed in whole or in part by the IROs.

	<b>Total Reviews Completed</b>	<b>Upheld</b>	<b>Reversed</b>
2002	180	57.8%	42.2%
2003	176	65.3	34.7
2004	135	61.5	38.5
2005	115	66.9	33.1
2006	162	73.4	26.6

## Legislative History

The independent review process in Wisconsin was established by 1999 Wisconsin Act 155, which was signed into law on May 12, 2000. The law required all health benefit plans to develop internal grievance procedures and independent review procedures. It required OCI to promulgate rules for independent review, including application procedures for IROs, procedures and processes that IROs must follow, and standards addressing conflicts of interest by IROs. The administrative rules were effective December 1, 2001. The rule was amended effective January 1, 2005, to implement the statutory requirement that the minimum necessary cost of a procedure or service be adjusted annually to reflect changes in the consumer price index.

The independent review process was implemented June 15, 2002, after OCI had certified two IROs. There are currently six IROs certified to perform independent reviews in Wisconsin. Five provide reviews for all types of medical services; one is limited to reviews involving psychiatry, behavioral health or addictions treatment.

## PURPOSE AND SCOPE

Section 632.835 (2), Wis. Stat., requires an insurer to establish an independent review procedure whereby an insured under the health benefit plan, or his or her authorized representative, may request an independent review of an adverse determination or an experimental treatment determination.

In November 2006, a survey was conducted of 29 insurers to determine whether insurers have developed and implemented sufficient procedures to comply with all requirements in the law and regulation. The insurers were chosen from the top 50 writers according to the 2005 Group Accident & Health market share report. Surveys were sent to those insurers who market products in Wisconsin subject to the independent review law except for those insurers whose independent review process had recently been reviewed by OCI as part of a market conduct examination.

This report is limited to OCI's review of the insurers' responses to the survey, including copies of any written procedures. The results apply to policies and procedures in effect during 2006.

## FINDINGS

### Notice Procedures

Section 632.835 (2), Wis. Stat., requires an insurer to provide notice of the insured's right to obtain an independent review and to explain how to request the review each time it makes an adverse determination or an experimental treatment determination. In addition, s. Ins 18.11 (2), Wis. Adm. Code, details the information required in the notice.

The survey asked the company to describe how insureds are notified of the right to request an independent review. It also requested a copy of the written procedure which describes the process and copies of any standard letters, forms and attachments used. A review of the responses found that six companies provided notice procedures that appear sufficient to provide complete information to their insureds regarding the independent review process.

The notices provided by three companies did not clearly state that an insured or authorized representative must request the independent review within four months after the date that the insured receives notice of the disposition of his or her grievance. One company did not explain that the insured may bypass its internal grievance process if the IRO agrees that the insured's medical condition requires an expedited review or if both the insurer and the insured agree. Five companies did not include a current list of certified IROs. Three companies did not explain that the \$25 filing fee would be refunded if the insured prevailed in the review, either in whole or in part. Six companies did not include a copy of the informational brochure developed by OCI, or a form substantially similar to the OCI brochure, with its notice. The notices provided by two companies did not state that the IRO's decision is binding on both the insurer and the insured.

If a company does not provide a complete notice of the right to request an independent review each time it makes an adverse determination or an experimental treatment determination, its explanation of benefits form (EOBs) must state that the insured may have the right to request an independent review after the internal grievance process and may be entitled to an expedited independent review, per s. 632.835 (2) (bg) 2, Wis. Stat. The review of sample EOBs found that eight companies did not include all of the required information.

Seven companies maintained that they provided a complete notice with each adverse or experimental treatment determination. The scope of the survey did not include a review of an insurer's claims procedures. The review of the responses could not verify that these companies had procedures that would identify all claims that could result in an adverse or experimental treatment determination.

### Discussion:

The review found that insurers generally provided some notice of the right to request an independent review when the insurer made an adverse determination or an experimental treatment determination. However, in many cases the information provided was not complete and in some cases did not sufficiently explain the process.

## **Policy/Certificate Language**

Section 632.835 (2), Wis. Stat., requires an insurer to provide notice of the insured's right to obtain an independent review each time it makes an adverse determination or an experimental treatment determination. Subsection (bg) states that the insurer is not required to provide a complete notice with the initial determination if the health benefit plan contains a description of the process and if the insurer also includes a statement regarding the right to an independent review with the initial benefit determination notice. The description in the health benefit plan must include an explanation of the insured's right to an independent review, including the right to bypass the grievance process in certain situations; how to request the review; the time within which the review must be requested; and how to obtain a current listing of independent review organizations.

The survey asked insurers to provide a sample copy of the policy language describing the internal grievance and the independent review procedure. The responses for 26 insurers provided sample copies of policy provisions that included some description of the insured's right to request an independent review. A review of these provisions found that not all provisions included all of the required information.

An insured is not required to exhaust the internal grievance procedure before requesting an independent review if both the insurer and the insured agree or if the IRO determines that the insured's medical condition requires an expedited review. In four sample policy provisions, the insurer did not provide a correct explanation of the right to bypass the internal grievance process. One insurer's policy provision indicated that the insurer must agree to bypass the internal grievance process in all situations. One insurer's policy provision stated that the insured must specifically request an expedited review in the request sent to the insurer. One insurer's policy provision required a request for an expedited review to include a certification from an attending physician. One insurer's policy provision indicated that an expedited review was limited to appeals involving services provided in an urgent care facility or an emergency room.

Eight sample policy provisions provided an incomplete explanation of how the insured may obtain a current listing of IROs. Five provisions referred the insured to OCI for a current listing but did not explain that the insured may also obtain a listing from the insurer. Three provisions did not include any explanation of how the insured could obtain the listing.

Three insurers did not include any description of the independent review process in its policies and certificates. Two insurers maintained that this requirement did not apply to its policies because a complete notice was provided each time the insurer made an adverse determination or an experimental treatment determination. One insurer stated that it was in the process of preparing an amendment to policies subject to the independent review process.

### **Discussion:**

The review found that although insurers generally included an explanation of the independent review process in policies and certificates, some of the provisions were not complete or accurate. Most significantly, some policy provisions did not clearly explain the insured's right to bypass the grievance process in certain situations. An insured who believes that he or she needs an expedited independent review due to an urgent medical condition is required to send the review request to the IRO chosen by the insured at the same time he or she sends the request to the insurer. The IRO has the authority to determine whether the review should be expedited or whether the insured may be required to complete the internal grievance process. Policies and certificates should include an explanation of the independent review process that includes the information the insured needs to request an expedited review.

## Eligibility

Section 632.835 (2) (a), Wis. Stat., requires every insurer that issues a health benefit plan to establish a procedure whereby an insured or an insured's authorized representative may request and obtain an independent review of an adverse determination, as defined in sub. (1) (a), or an experimental treatment determination, as defined in sub (1) (b).

The survey asked insurers to define the claims and other benefit determinations that are considered eligible for independent review by the company. The review of the responses indicates that 17 companies use the statutory definitions in their policies and procedures. Nine companies indicated that eligible determinations are those that the insurer determines are not medically necessary or are experimental. Two companies used the statutory definitions in their policies and certificates, but their procedures referred to medical necessity and experimental determinations. One company's procedures appeared to limit the definition of an adverse determination to a denial of a request for an out-of-plan referral.

## Discussion:

The statutory definition of an adverse determination includes the insurer's reduction, denial or termination of coverage based on the insurer's determination that the treatment does not meet the health benefit plan's requirements for appropriateness, health care setting, level of care or effectiveness, in addition to the plan's requirements for medical necessity. The scope of the survey did not include a review of an insurer's claim or benefit denials. The examiners could not verify that insurers whose procedures appeared to limit the definition of an adverse determination to a medical necessity denial were accurately identifying all claims and benefits determinations that meet the statutory definition.

The survey also provided examples of five sample claims denials and, for each, asked the company if it would consider the example to be eligible for an independent review and requested an explanation of how the company made the determination.

This chart summarizes the insurer responses regarding the eligibility for the following:

- a. Request for coverage of eyelid surgery denied as cosmetic treatment;
- b. Request for coverage of a prescription medication denied as not on the formulary;
- c. Request for coverage of a FDA-approved medical device denied as investigational;
- d. Request for coverage of services of a non-plan provider denied as plan providers are available;
- e. Request for coverage of physical therapy services denied as being above the policy limits.

	a.	b.	c.	d.	e.
	Cosmetic	Formulary	Investigational	Non-plan Provider	Policy Limits
Eligible for IRO	13	6	25	6	2
Eligible if insured argues medical necessity	4	1	0	9	0
Not eligible -policy exclusion	10	8	1	3	24
Not eligible - benefit level issue	0	12	0	10	0
Not applicable to policies	2	2	3	1	3

## **Discussion:**

Cosmetic—The review found that 13 of the 29 insurers agreed that a denial based on the company's determination that the treatment was cosmetic would be eligible for an independent review. As noted in the chart, 10 insurers maintained that the denial would not be eligible because their policies contained an exclusion for cosmetic treatment. However, the surgery or other medical treatment determined to be cosmetic, such as eyelid surgery in the example, would generally be a covered benefit when the company determines that the treatment meets its clinical guidelines. An insured's appeal may then involve a dispute over whether the treatment is medically appropriate or whether it is solely a cosmetic treatment. A denial based on a cosmetic exclusion is an adverse determination eligible for independent review.

Formulary—Six insurers agreed that a denial of a non-formulary drug would be eligible for an independent review. Twelve insurers indicated that their policies have an open formulary and would cover a non-formulary drug at a lower benefit level. If the insurer has a process to consider covering a prescription at a higher benefit level based on the individual insured's medical condition, that process should include the insured's right to request an independent review.

Investigational—The majority of insurers, 25 of the 29, agreed that a determination that a medical device was investigational would meet the definition of an experimental treatment determination and be eligible for an independent review. A coverage denial based on the insurer's determination that the treatment was investigational, unproven, or any other similar term used by the insurer would be considered an experimental treatment determination.

Non-Plan Provider—Section Ins 18.10 (1), Wis. Adm. Code, states that an adverse determination includes the denial of a request for a referral for out-of-network services because the clinical expertise of the provider may be medically necessary for treatment and that expertise is not available in the insurer's provider network. Six insurers agreed that a coverage denial of services from a non-plan provider would be eligible for an independent review. Ten insurers maintained that their policies did not deny coverage of non-plan providers and that these services would be covered at a lower benefit level. If the insurer has a process to provide coverage of a non-plan provider at a higher benefit level because there are no participating providers with the necessary expertise, that process should include the insured's right to an independent review. In addition, nine insurers required the insured to argue that the expertise of the non-plan provider was medically necessary. However, an insured should not be required to include specific language in his or her coverage request in order to receive the statutory right to an independent review.

Policy Limits—Two insurers indicated that a coverage denial of services above the policy limits would be eligible for an independent review; the responses indicated that their policies do not include this type of benefit limitation. Generally, if a health benefit plan that contains benefit limits on specific services denies coverage of services above that limit, it is not making an adverse or experimental treatment determination. However, if the health benefit plan does not include this type of specific limitation, or if it would consider allowing additional services above the stated benefit limit when those services met the plan's medical criteria, a coverage denial would be an adverse determination eligible for an independent review.

## **Grievance Procedure**

The review also found that the six companies had a 2-level internal grievance process. One company indicated that it was in the process of moving to a 1-level grievance process and one company had modified its process to make the second level optional. However, four companies reported that the insured was required to complete both levels of the internal grievance process before the adverse or experimental treatment determination was eligible for an independent review.

**Discussion:**

Pursuant to s. 632.835 (2) (c), Wis. Stat., an insured may be required to exhaust the internal grievance procedure under s. 632.83, Wis. Stat., prior to requesting an independent review, except as provided in par. (d). Section Ins 18.03, Wis. Adm. Code, states that an insurer must generally resolve a grievance within 30 days. The statutes and regulations do not allow an insurer to require the insured to complete some additional process before being eligible to request an independent review.

**Process of Handling Request**

Section 632.835 (3), Wis. Stat., includes the requirements that an insurer must follow when it receives an independent review request from an insured or an authorized representative of an insured. The insurer must immediately notify the IRO selected by the insured and also notify OCI of its receipt of the request. Within five business days, the insurer is required to submit a file of all relevant documents related to the review request. If the IRO requests additional information, the insurer must submit the information requested or an explanation within five business days of the request. In addition, if the IRO determines that the review should be expedited, the insurer must submit the file within one day and respond to any request for additional information within two days.

The survey asked insurers to describe how a request for an independent review was handled, from the date that it received the request through the time the insurer had complied with the IRO's determination. The survey also requested a copy of any written procedures. All insurers provided a description of its process for handling a request. However, one insurer did not have any written procedures; it maintained that the requirements detailed in the statute were sufficient. Another insurer provided a copy of its general corporate procedures, which did not include a process to comply with Wisconsin-specific requirements.

The review of the responses found that not all procedures for handling independent review requests were complete. The procedures for four companies did not specify that OCI and the IRO selected by the insured must be notified within two business days, as required by s. Ins 18.11 (3), Wis. Adm. Code. In two of the cases, the procedure stated that the notice should be made "immediately," but did not define this term according to the administrative regulation. One insurer's procedure included the notice requirement but did not include a time period. One insurer had no notification process. Also, one insurer's notification procedure stated that the notice to OCI should include the name of the insured or the authorized representative. In its April 26, 2002, bulletin to insurers, OCI stated that the notice to OCI should not include any information that could identify the insured.

In addition, one company's procedures did not include a process for responding to an IRO's request for additional information, and one company did not have a procedure for handling an expedited review within the required timeframes.

**Discussion:**

The review found that insurers generally had established procedures to handle a request for an independent review from an insured or the insured's authorized representative. However, in some cases, the procedures did not explain how the insurer would comply with all requirements in the statute and regulation.

## **CONCLUSION**

The review of the survey responses indicates that insurers have generally established and implemented procedures whereby an insured under the health benefit plan, or his or her authorized representative, may request an independent review of an adverse determination or an experimental treatment determination. However, insurers do not all interpret and apply the requirements in the law in the same manner.

1. Insurers appear to be applying different standards in identifying claims and other benefit determinations as adverse determinations and experimental treatment determinations eligible for an independent review.
2. Insurers are not providing the notices of the right to request an independent review required by s. 632.835 (2), Wis. Stat., and s. Ins 18.11 (2), Wis. Adm. Code, in a consistent manner.

In order for the process to continue to be successful, consumers must be aware of all of their appeal rights. A clear, understandable notice from the insurer each time that the insurer makes an adverse determination or an experimental treatment determination is a critical step of the independent review process.

## **RECOMMENDATIONS**

1. OCI should provide additional training for insurers offering health benefit plans regarding the independent review laws and regulations.
2. OCI should continue to look for opportunities to educate Wisconsin consumers on their appeal rights.



# State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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## INSURER SURVEY OF INDEPENDENT REVIEW PROCESS

Please have an officer of the company respond in writing to the following questions on company stationary and provide the requested material applicable to the company's operations in Wisconsin. The officer must sign the response.

1. Provide the name of the department(s) responsible for participating in the grievance process and in the independent review process. Provide an organizational chart for each department.
2. Provide a sample copy of the policy language describing the grievance procedure and a sample copy of the policy language describing the independent review procedure. Indicate the most recent date(s) that the policy language was approved by OCI.
3. Provide a copy of the company's written procedures and guidelines used by company staff for the grievance process. Also provide copies of any templates or form letters used.
4. Provide a copy of the procedures and an explanation of the process for notifying grievants of the right to request an independent review.
5. Define the claims and other benefit determinations that are considered eligible for independent review by the company.

Also, indicate whether your company has denied an insured's request for an independent review based on the company's determination that it was not eligible. If so, indicate the number of cases and the reasons the cases were not eligible. Provide a copy of any written guidelines used in making the determination.

6. Indicate whether your company would consider each of the following an adverse determination or an experimental treatment determination eligible for an independent review, and provide an explanation of the company's determination in each case:
  - f. Request for coverage of eyelid surgery denied as cosmetic treatment;
  - g. Request for coverage of a prescription medication denied as not on the formulary;
  - h. Request for coverage of a FDA-approved medical device denied as investigational;
  - i. Request for coverage of services of a non-plan provider denied as plan providers are available;
  - j. Request for coverage of physical therapy services denied as being above the policy limits.
7. Indicate whether the company delegates any claim processing authority or other authority to make benefit determinations to another entity. If so, provide the name and address of each entity

and provide sample EOBs and benefit denial letters for each.

8. Describe how insureds are notified of the right to request an independent review, pursuant to s. Ins 18.11, Wis. Adm. Code. Provide a copy of the written procedure which describes this process and copies of any standard letters, forms and attachments used.
9. Describe how the company handles a request for an independent review, from the date that the company initially receives the request through the time that it has complied with the independent review organization's determination. Provide a copy of any procedures or program specifications regarding the independent review process.
10. Provide a copy of any training materials used by the company's customer service department to respond to inquiries from insureds regarding the independent review process. Include copies of any memos, "frequently answered questions" lists, scripts used by the customer service department, and any other material.
11. Provide the name of a contact person authorized to respond to any questions or requests for additional information. Provide the contact's phone number, email address, and mailing address.

## INSURANCE COMPANIES SURVEYED

Name of Company	City, State
Aetna Life Insurance Company	Hartford CT
AIG Life Insurance Company	Wilmington DE
American Medical Security Life Insurance Company	Green Bay WI
American Republic Insurance Company	Des Moines IA
Blue Cross Blue Shield of Wisconsin	West Allis WI
Compcare Health Services Insurance Corporation	West Allis WI
Dean Health Plan Inc	Madison WI
Federated Mutual Insurance Company	Owatonna MN
Golden Rule Insurance Company	Indianapolis IN
Group Health Cooperative of Eau Claire	Eau Claire WI
Group Health Cooperative of South Central Wisconsin	Madison WI
Health Tradition Health Plan	Onalaska WI
Humana Insurance Company	Green Bay WI
Medica Insurance Company	Minnetonka MN
Medical Associates Clinic Health Plan of Wisconsin	Dubuque IA
MercyCare HMO Inc	Janesville WI
Monumental Life Insurance Company	Cedar Rapids IA
Physicians Plus Insurance Corporation	Madison WI
Principal Life Insurance Company	Des Moines IA
Security Health Plan of Wisconsin Inc	Marshfield WI
Time Insurance Company	Milwaukee WI
Trustmark Life Insurance Company	Lake Forest IL
UniCARE Life & Health Insurance Company	Indianapolis IN
Union Security Insurance Company	Des Moines IA
United HealthCare Insurance Company	Hartford, CT
Unity Health Plans Insurance Corporation	Sauk City WI
WEA Insurance Corporation	Madison WI
Wisconsin Auto & Truck Dealers Insurance Corporation	Madison WI
WPS Health Plan Inc	Madison WI

# Fact Sheet on the Independent Review Process in Wisconsin

STATE OF WISCONSIN  
OFFICE OF THE COMMISSIONER OF INSURANCE

PI-203 (R 11/2007)

This fact sheet provides general information on the independent review process in Wisconsin. If you have specific questions on how it may apply to your situation, please contact your insurance company or the Office of the Commissioner of Insurance (OCI).

As with any other product or service, you may some day have questions or complaints about your health insurance plan. You may be able to resolve a complaint by contacting the health plan's customer service department. You can also file a written grievance with the insurer. All insurance companies offering health benefit plans in Wisconsin are required to have an internal grievance process to resolve any complaint you may have with the plan. You may, at any time, contact OCI with your question or problem.

If you are not satisfied with the outcome of your grievance, a new law provides you with an additional way to resolve some disputes involving medical decisions. You or your authorized representative may request that an Independent Review Organization (IRO) review your health plan's decision.

## **What is an independent review?**

The independent review process provides you with an opportunity to have medical professionals who have no connection to your health plan review your dispute. You choose the IRO from a list of review organizations certified by OCI. The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The clinical peer reviewer is generally a board-certified physician or other appropriate medical professional. The IRO has the authority to determine whether the treatment should be covered by your health plan.

## **Who conducts the independent reviews?**

The independent reviews are conducted by IROs that are certified by OCI. In order to be certified, the IRO must demonstrate that it is unbiased and that it has procedures to ensure that its clinical peer reviewers are qualified and independent.

## **What types of disputes can be decided through independent review?**

The dispute must involve a medical judgment. You can request an independent review whenever your health plan denies you coverage for treatment because it maintains that the treatment is not medically necessary or that it is experimental, including a denial of your request for out-of-network services when you believe that the clinical expertise of the out-of-network provider is medically necessary. The treatment must otherwise be a covered benefit under the insurance contract. Also, the total cost of the denied coverage must exceed \$282.

If you and your insurer disagree about whether or not your dispute is eligible for independent review, you may request that it be sent to the IRO. The IRO will decide if it has the authority to do the review.

## **What types of disputes are not eligible for independent review?**

No health benefit plan covers all medical expenses. You may not request an independent review if the requested treatment is not a covered benefit. For example, if your policy specifically excludes coverage of hearing aids, your request to have the insurer cover your hearing aid would not be eligible for independent review, even if you believed that the hearing aid was medically necessary. However, you would be able to ask the insurer to review its denial through its internal grievance process.

If you have coverage through Medicare, Medicaid, or another federal plan, or if you are covered through your employer's self-funded plan, you are not eligible to request the independent review described in this brochure. These plans generally have a different appeal process, which is explained in your member materials.

### **When can I request an independent review?**

Whenever your insurer bases its decision to deny coverage on a medical necessity or an experimental treatment determination, it must provide you with information on your appeal rights, including its internal grievance procedures and your right to request an independent review. It must also explain how you can obtain additional information on its internal grievance and independent review processes.

### **How do I request an independent review?**

In most cases, you will need to complete your health plan's internal grievance procedure. After you receive the insurer's final decision on your grievance, choose an IRO from the list provided by the insurer. Then send a written request for independent review to the insurance company.

Be sure to include:

- your name, address, and phone number,
- a check for \$25 payable to the IRO that you chose,
- an explanation of why you believe that the treatment should be covered,
- any additional information or documentation that supports your position,
- if someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative, and
- any other information requested by your insurer.

Your insurer should have provided you with a list of certified IROs and with detailed information on how to request a review with its written grievance decision.

If you have any problems with your insurance company in making your request, contact OCI at the address, phone number, or electronic mail address at the end of this fact sheet.

### **What if I need care now?**

Generally, you must complete your health plan's internal grievance procedure before requesting an independent review. However, you do not need to complete this process if both you and the insurer agree to proceed directly to independent review or if you need immediate medical care.

If you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize your life or health, you may ask to bypass the insurer's internal grievance process. When you obtained your coverage, your health plan should have provided you with written information explaining the independent review process. You can also call the health plan's toll-free telephone number to request information on the independent review process and to request a copy of the list of certified IROs. When you have the information you need, send your request to the IRO at the same time you send it to the insurer. The IRO will review your request and decide if an immediate review is needed. If so, it will review your dispute on an expedited basis. If the IRO decides that your health condition does not require its immediate review of your dispute, it will notify you that you must first complete the internal grievance process.

If you have any problems obtaining the information you need from your health plan, contact OCI at the address, phone number, or electronic mail address at the end of this fact sheet.

### **Is there a cost involved?**

Yes, you must pay a \$25 fee to the IRO. This fee will be refunded to you if the IRO resolves the dispute in your favor.

### **How long does the independent review process take?**

The insurer must send all relevant medical records and other documentation used in making its decision to the IRO within five business days. The IRO then has five business days to review the information and to request any additional information it may need from the insurer or from you. After it receives the information it needs, the IRO has thirty business days to make its decision.

If the IRO determines that this time period could jeopardize your life or health, the insurer must send its documentation within one day and the IRO then has two business days to request any additional

information. The IRO must make its decision within 72 hours after receiving all of the information it needs.

**How does the IRO make its decision?**

All of the documentation and other information provided by you and by the insurer is reviewed by a clinical peer reviewer who must be an expert in the treatment of your medical condition and knowledgeable about the recommended health care service. In reviewing a case involving medical necessity, the IRO and its reviewer are required to consider all of the documentation, including your medical records, your attending provider's recommendation, the terms of coverage of your health plan, the rationale for the insurer's prior decision, and any medical or scientific evidence. It must limit its decision on a case involving experimental treatment to whether the proposed treatment is experimental, based on independent research.

**Does my health plan have to abide by the decision?**

Yes, the decision of the IRO is binding.

**What if I have more questions?**

Your insurer's customer service department should be able to answer any questions you may have regarding the independent review process.

You may also contact OCI at the address, phone number, or electronic mail address below. OCI has a new brochure, *Consumer's Guide to Grievances and Complaints*, to help with the entire appeals process.

**For information on how to file insurance complaints, call:**

(608) 266-0103 (In Madison)  
or 1-800-236-8517 (Statewide)

**For your convenience a complaint form is included on OCI's Web site at:**

[http://oci.wi.gov/com\\_form.htm](http://oci.wi.gov/com_form.htm)

**Office of the Commissioner of Insurance**  
125 South Webster Street  
P.O. Box 7873  
Madison, Wisconsin 53707-7873  
E-mail: [ociinformation@wisconsin.gov](mailto:ociinformation@wisconsin.gov)



# State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

**Jim Doyle, Governor**  
**Sean Dilweg, Commissioner**

**Wisconsin.gov**

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## INDEPENDENT REVIEW ORGANIZATIONS CERTIFIED TO PERFORM INDEPENDENT REVIEWS IN WISCONSIN

If your health plan denies coverage of a service based on a medical necessity or experimental treatment determination, Wisconsin's independent review process may help you resolve your dispute. This process allows you to have a medical expert with no connection to your health plan review the health plan's decision. In most cases, you will first be required to complete your health plan's internal grievance process. If your health plan's internal grievance process results in an adverse determination, you may choose the Independent Review Organization (IRO) from the list on page 2 and send your request for an independent review to your health plan.

*The Fact Sheet on the Independent Review Process in Wisconsin* provides more information about this process. It can be found at [http://oci.wi.gov/pub\\_list/pi-203.htm](http://oci.wi.gov/pub_list/pi-203.htm). You can also contact OCI at the address above to request a copy.

Page 2 contains a listing of organizations, listed in alphabetical order, certified as IROs in Wisconsin.

Your health plan should provide you with information on your right to request an independent review in its written materials. You can also call the health plan at its toll-free number and request information on independent review.

Further questions may be directed to: [ocihmo@wisconsin.gov](mailto:ocihmo@wisconsin.gov)

## Independent Review Organizations Certified in Wisconsin

Name/Address	Phone/fax	Types of Reviews	Comments
<u>IPRO</u> 1979 Marcus Ave Lake Success, NY 11042-1002 www.ipro.org	800-227-3143  516-326-1034 (fax)	Comprehensive  All specialties available	Certified 5/19/03  No conflicts of interest reported  Contact: Terese Giorgio, ext. 223 or Charles Scott Smith, ext 544
<u>MAXIMUS - Center for Health Dispute Resolution</u> Eastgate Square 50 Square Dr Ste 210 Victor NY 14564-1099 www.healthappeal.com	(800) 356-8151  585-425-5296 (fax)	Comprehensive  All specialties available	Certified 10/01/02  No significant conflicts of interest reported  Contact: Lisa Maguire, Esq. or Lisa Gebbie, RN  Cover page should specify: <b>Not a Medicare Appeal</b>
<u>MCMC LLC</u> 5272 River Rd. Ste. 650 Bethesda, MD 20816-1405 www.mcmcllc.com	888-313-6267  301-652-1250 (fax)	Comprehensive  All specialties available	Certified 9/8/06  No significant conflicts of interest reported  Contact: Cindy Liu, 301-652-1818
<u>Medical Review Institute of America</u> 2875 S. Decker Lake Dr. Ste. 550 PO Box 25547 Salt Lake City, UT 84125-0547 www.mrioa.com	800-654-2422  801-261-3189 (fax)	Comprehensive  All specialties available	Certified 3/29/02  No significant conflicts of interest reported  Contact: Laura Daley, ext 415
<u>Permedion</u> 350 Worthington Rd. Ste. H Westerville, OH 43082-8325 www.permedion.com	800-473-0802  614-895-6784 (fax)	Comprehensive  All specialties available	Certified 3/29/02  No conflicts of interest reported  Contact: Sue Butterfield, ext. 3428
<u>Prest &amp; Associates</u> 2712 Marshall Court Ste. 1 Madison, WI 53705 www.prestmds.com	800-358-5129  608-232-9929 (fax)	Limited to: Psychiatry, Behavioral Health & Addictions Medicine	Certified 5/19/03  No significant conflicts of interest reported  Contact: Susan Prest or Jay Story

## Glossary of Terms

Adverse determination [s. 632.835 (1) (a), Wis. Stat., and s. Ins 18.10 (1), Wis. Adm. Code]—

A determination by or on behalf of an insurer that issues a health benefit plan to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed.
2. Based on the information provided, the treatment under subd. 1. does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
3. Based on the information provided, the insurer that issued the health benefit plan reduced, denied or terminated the treatment under subd. 1. or payment for the treatment under subd. 1.
4. Subject to sub. (5) (c), the amount of the reduction or the cost or expected cost of the denied or terminated treatment or payment exceeds, or will exceed during the course of the treatment, \$250.

This includes the denial of a request for a referral for out-of-network services when the insured requests health care services from a provider that does not participate in the insurer's provider network because the clinical expertise of the provider may be medically necessary for treatment of the insured's medical condition and that expertise is not available in the insurer's provider network.

Experimental treatment determination [s. 632.835 (1) (b), Wis. Stat., and s. Ins 18.10 (2), Wis. Adm. Code]—A determination by or on behalf of an insurer that issues a health benefit plan to which all of the following apply:

1. A proposed treatment has been reviewed.
2. Based on the information provided, the treatment under par. 1. is determined to be experimental under the terms of the health benefit plan.
3. Based on the information provided, the insurer that issued the health benefit plan denied the treatment under par. 1 or payment for the treatment under par. 1.
4. Pursuant to s. 632.835 (5) (c), Wis. Stat., the cost or expected cost of the denied treatment or payment exceeds, or will exceed during the course of the treatment, the amount published in accordance with s. Ins 18.105, Wis. Adm. Code.

Grievance [s. Ins 18.01 (4), Wis. Adm. Code]—Any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured.

Health benefit plan [s. 632.835 (1) (c), Wis. Stat., and s. Ins 18.10 (3), Wis. Adm. Code]—Has the meaning given in s. 632.745 (11), Wis. Stat., except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10, Wis. Stat., and includes Medicare supplement and replacement plans as defined in s. 600.03 (28p) and (28r), Wis. Stat., and s. Ins 3.39 (3) (v) and (w), Wis. Adm. Code. Health benefit plan includes Medicare cost and select plans but does not include Medicare Advantage plans.

Independent review [s. Ins 18.01 (6), Wis. Adm. Code]—A review conducted by a certified independent review organization.

Independent review organization [s. Ins 18.01 (5), Wis. Adm. Code]—An organization certified under s. 632.835 (4), Wis. Stat.