TDI | Texas Department of Insurance

LHL009 | 0522

Request for a Review by an Independent Review Organization (IRO)

Instructions to patient, person acting on behalf or representative of patient / employee, and provider

This form is being provided to you because your request for health care services has been denied as not medically necessary by your insurance carrier. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier (company). This is called an independent review by an Independent Review Organization or "IRO." You, your health care provider, or someone acting on your behalf or representative may file this form.

To request an independent review of your case, you must take the following action

- Complete the Request for a Review by an IRO form (TDI form LHL009).
- Sign the form so the IRO can receive your medical records. (A signature is not required for Workers' Compensation cases).
- Return the completed form to the company that is denying your request for health care services as soon as possible. Do not return this form to the Texas Department of Insurance (TDI). For Workers' Compensation cases, you must return this form within 45 calendar days.
    - Carrier instructions: Complete the "Company or URA That Denied Services" Section on page 4.
    - Note to patients: The company address and/or fax number can be found on the denial letter.
- The company will forward your request for an independent review to TDI. Once TDI receives the request from the company, TDI will assign your case to an IRO. You will receive a letter from TDI identifying the IRO to whom your case has been assigned.
- There is no cost to you for the independent review. Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective independent review will be required to pay the IRO fee prior to the IRO beginningits review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.

The timeframes for an IRO's decision are as follows:

Coverage Types	Health	Workers' Compensation Network (WCN)	Workers' Compensation Non-Network (WC)
Life threatening	3 days	8 days	8 days
Denial of prescription drugs or intravenous infusions - Concurrent	3 days	NA	NA
Denial of an exception request to a prescription drug step therapy protocol - Preauthorization	3 days	NA	NA
Non-life-threatening Preauthorization / Concurrent	20 days	20 days	20 days
Retrospective	20 days	30 days from receipt of fee*	30 days from receipt of fee**

*Carrier pays the fee.

**Requestor pays the fee; however, if the requestor is an injured employee, carrier pays the fee.

Request information

Today's date (MM/DD/YYYY) _____ Name of requestor _____

Relationship to the patient or injured employee: (check one)

- ☐ Self (complete page 3, item A)
- ☐ Person acting on behalf of patient or injured employee (complete page 3, items A and C)
- ☐ Provider acting on behalf of patient or injured employee (complete page 3, items A and B)
- ☐ Provider that received the denial (complete page 3, item A)
- ☐ Sub claimant (Workers' Compensation only) (complete page 3, items A and C)

Applies to health and workers' compensation cases:

1. Is the condition life-threatening?

   ☐ Yes ☐ No

2. Is the review ordered by a Court? (This question does not apply if services have been received)

   ☐ Yes ☐ No

Applies to health cases **only**:

1. Is this a denial of prescription drugs or intravenous infusions for which you are already receiving benefits?

   ☐ Yes ☐ No

2. Is this a denial of an exception request to a prescription drug step therapy protocol?

   ☐ Yes ☐ No

Denied services - describe the health care services that are being denied and include dates only if services have been performed:

_____

_____

_____

_____

Patient / injured employee information

Health plan or claim identification number _____

(Usually found on the patient's ID card for health plans. The number identifies the patient to the insurance carrier. Enter the DWC claim number for workers' compensation cases.)

Date of birth (MM/DD/YYYY) _____ Sex _____

Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Email _____

A. Provider that received the denial

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

B. Provider acting on patient's / injured employee's behalf if applicable

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

C. Person acting on patient's / injured employee's behalf if applicable

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Release

The release must be signed by the patient, or his or her parent or legal guardian. Not required for Workers' Compensation cases.

I, _____ (Print name), ☐ the patient, ☐ parent, or ☐ patient's legal guardian **(select one)**, authorize the release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed _____ Date (MM/DD/YYYY) _____

Note: For chemical dependency or mental health treatment, list the providers to which this release applies:

_____

_____

_____

Company or Utilization Review Agent that denied services

This section to be completed **only** by the company or URA that denied services. The person requesting the independent review should submit this form to the company given in this section.

Name of Company _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Questions

For information about the independent review process, please call TDI at 1-866-554-4926, option 2. Reminder to return this from to the company that is denying your request for health care services. Do not return this form to the Texas Department of Insurance.

Your rights

You can request information we have about you by emailing OpenRecords@tdi.texas.gov or writing to: Public Information Coordinator, Texas Department of Insurance, P.O. Box 12030 (mail code GC-ORO) Austin, Texas 78711-2030. You also have the right to ask that we fix information we have about you that is wrong. To ask for a correction, send (1) your name, mailing address, and your phone number, (2) details about what needs to be fixed, and (3) the reason or proof showing why the information is wrong. Send this by email to RecordCorrections@tdi.texas.gov or by mail to: Record Correction Request, Texas Department of Insurance, P.O. Box 12030 (mail code CO-AAL-CC), Austin, Texas 78711-2030.