Notice of Rescission of Preauthorization Exemption and Right to Request an Independent Review

Important information and instructions

Date of notice: ________________

Unless you request an appeal to an independent review organization (IRO) as set forth below, the preauthorization exemption for ________________________ will be rescinded effective ___________.
Health care service Date

- This form is being provided to you because we have determined that you no longer qualify for a preauthorization exemption. A preauthorization exemption may be rescinded if less than 90 percent of claims meet the issuer's medical necessity screening criteria.
- This notice includes a listing of claims that were randomly selected to be retrospectively reviewed for the purposes of evaluating continued eligibility for preauthorization exemption, the determination of whether each claim met the issuer's screening criteria, and an explanation for each claim that did not meet the issuer's screening criteria.
- You can now request that your preauthorization exemption be reviewed, at no cost to you, by a health care provider who is totally independent of the issuer. This is called an independent review by an IRO.
- To request an independent review of your preauthorization exemption, you must return this completed form to the issuer at the address listed below before the recission effective date listed on this notice. Make a copy of this form for your records and remember do not return this form to the Texas Department of Insurance (TDI).

Issuer information

Name of issuer ____

Address of issuer ____

City ___________________________ State ____________ ZIP __________

Phone __________________________ FAX _____________

Email ____

The issuer will forward your request for an independent review to TDI. Once TDI receives the request from the issuer, 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. The IRO must make a determination within 30 days.

Sample Information Used to Make the Determination to Rescind the Exemption

Total number of claims eligible to be evaluated: _______ Number of claims in random sample: _______

Claims randomly sampled and retrospectively reviewed to evaluate preauthorization exemption:

Claim	Did the claim meet the issuer's screening criteria?	**If no, explain (in chart or attachments):** - Principal reason claim did not meet screening criteria - Clinical basis for determination - Description of sources for screening criteria - Professional specialty of reviewer
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Percent of reviewed claims that met the issuer's screening criteria: _________.

Request for a Review by an IRO

Name of physician or provider ______________________________

Federal tax identification number ______________________________

Address ______________________________

City ______________________________ State ______________ ZIP ____________

Phone ______________________________ FAX ______________

Email ______________________________

Please indicate if you would like an IRO to review a separate random sample of claims, in addition to the issuer's random sample of claims. A separate random sample is available only if, based on the total number of claims eligible to be evaluated, there are at least five additional claims that were not included in the issuer's random sample.

☐ Review issuer's random sample

☐ Review the issuer's random sample and a separate random sample of claims, if available

Signature

Physician or Provider ______________________ Date ______________________

Date Received by Issuer ______________________

Questions

For information about the independent review process, please call TDI at 866-554-4926, Option 2 or email MCQA@TDI.Texas.gov.