**State Corporation Commission**
**Bureau of Insurance – External Review**
**P.O. Box 1157**
**Richmond, VA 23218**
**Phone: 1-877-310-6560 Fax: (804) 371-9915**
**Email: externalreview@scc.virginia.gov**

# Independent Review Organization External Review Annual Report Form

## External Review Annual Summary for 20____.

**Due on April 1 for previous calendar year.**

Each independent review organization (IRO) shall submit an annual report with information in the aggregate on external reviews performed for Virginia only.

1. IRO name: _____

2. IRO license/certification no: _____

3. IRO address: _____

   City, State, Zip: _____

4. Name and title, email address, phone and fax number of the person completing this form:
   _____
   _____
   _____
   _____

5. Name and title of the person responsible for regulatory compliance and quality of external reviews:

   Name: _____Title: _____

6. Total number of requests for external review received from Virginia: _____

7. Number of standard external reviews: _____

8. Average number of days IRO required to reach a final decision in standard reviews: _____

9. Number of expedited reviews completed to a final decision: _____

10. Average number of hours IRO required to reach a final decision in expedited reviews: _____

11. Number of medical necessity reviews decided in favor of the health carrier: _____

Briefly list procedures denied: _____

12. Number of medical necessity reviews decided in favor of the covered person: _____

Briefly list the procedures approved: _____

_____

_____

_____

13. Number of experimental/investigational reviews decided in favor of the health carrier: _____

Briefly list procedures denied: _____

_____

_____

_____

_____

14. Number of experimental/investigational reviews decided in favor of the covered person: _____

Briefly list procedures approved: _____

_____

_____

_____

15. Number of reviews terminated as the result of a reconsideration by the health carrier: _____

16. Number of reviews terminated by the covered person: _____

17. Number of reviews declined due to possible conflict with:

Health carrier _____ Covered person _____ Health care provider _____

Describe possible conflicts(s) of interest: _____

18. Number of reviews declined due to other reasons not reflected in #17 above: _____

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