NAIRO

National Association of Independent Review Organizations

Understanding the Vital Role, Challenges, and Opportunities of Independent Medical Review Services

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I. Introduction

Purpose of This Paper

The purpose of this white paper is manifold. First, the paper seeks to give voice to the National Association of Independent Review Organization's (NAIRO) identification of relevant issues from the perspective of all stakeholders – including independent review organizations (IROs), health plans, and consumers. NAIRO is comprised of many of the thought leaders in this industry.

Second, the paper illustrates that to protect the overall integrity, consistency, and accuracy of independent medical review processes, the use of an accredited IRO is paramount. Accredited IROs adhere to specific, rigorous standards of practice, which promote a review process that is fair and transparent. Indeed, lawmakers placed such importance on the adherence to these standards of practice that the use of accredited IROs is mandated under the Patient Protection and Affordable Care Act (ACA) of 2010.

In so doing, NAIRO will foster a greater understanding of the often-complex independent medical review process. NAIRO also will develop a roadmap aimed to dispel negative perceptions of independent medical review functions and, accordingly, will issue a series of strategies aimed to help IROs avoid and overcome barriers standing in the way of fully maximizing the contributions to better healthcare made by the independent medical review process.

Mission of NAIRO

NAIRO is comprised of the majority of URAC-accredited IROs. NAIRO has more than 35 member organizations and is dedicated to protecting the integrity of the independent medical and utilization review processes. Utilizing the expertise of thousands of board-certified clinicians at a national level, NAIRO members embrace an evidence-based approach to independent medical peer review in a continuous effort to help resolve coverage disputes between enrollees and their health plans.

A Brief History of IROs

For decades, health insurance regulators have helped resolve disputes between patients and their health plans. With the rise of managed care in the latter half of the 20th century, many patient appeals have revolved around the language of a patient's health plan to deny or limit coverage. Most often, denials or limitations of coverage pertain to judgments about medical necessity or appropriateness of care.

Not long after managed care came to the fore, many states began to pass legislation requiring independent medical review (originally called external review) of adverse healthcare benefit decisions made by commercial health plans.[1] The ACA, passed in 2010, added to the laws, policies, and scope of independent medical review. Together, these distinct mandates, arriving from state and federal levels,

[1] Independent medical review processes trace back to 1978, when Michigan became the first state to enact an IRO law. Kaiser Report, March 2000, Revised. By March 2000, 33 states had enacted IRO laws. May 2002.

seek to ensure that the final decisions about an individual's care are made on the basis of sound medical judgment rather than being driven by financial or business considerations.

In 1978, Michigan became the first state to establish a system for independent medical review. Medicare established an independent medical review program in 1985. Since that time, state-mandated independent medical review has grown considerably, and today the vast majority of states plus the District of Columbia mandate and regulate independent external review.

Other forces contributed to the rise and spread of independent medical review as well. In 2000, the National Committee on Quality Assurance (NCQA), an organization that accredits health plans, expanded its accreditation standards to require that plans make the independent medical review process available when a health plan issues a medical necessity denial.

In 2002, a Supreme Court decision opened the door to more extensive state regulation of health maintenance organizations (HMOs). The 2002 case *Rush Prudential HMO vs. Moran* posed to the court the following question: Did Rush Prudential, a fully insured Employee Retirement Income Security Act (ERISA) health benefit plan, have to comply with state law and submit to independent medical review? More specifically, was Rush Prudential required by law to act in accordance with the Illinois HMO Act, a separate piece of legislation that required binding independent medical review when an HMO disagrees with the decision of a patient's physician that a treatment is medically necessary? The answer, in short, was "yes." The Court ruled that the Illinois HMO Act was not preempted by ERISA, and this decision led to the presumption that the majority of state laws requiring independent medical review of benefit denials can be enforced against HMOs. (Note: This decision does not apply to self-insured groups/plans.)

In 2010, the ACA significantly elevated the concept of independent medical reviews of adverse benefit decisions. The ACA made clear that state laws relating to internal and external independent medical review, as it applies to fully insured health plans, will not be pre-empted by ERISA. Further, the ACA requires all states to either substantially conform their independent medical review laws to the National Association of Insurance Commissioners (NAIC) Uniform Health Carrier External Review Model Act or elect to use a federally mandated process. In either case, states are required to adhere to strict, standardized rules for independent medical review.[2]

The ACA also stipulated that all self-insured group health plans and health insurance issuers are required to contract with three IROs to review appeals for members who have exhausted all internal appeal levels available to them. While health plans are allowed to conduct first- and second-level appeals internally, many health plans have turned to IROs to perform these internal reviews as well. Ultimately, the ACA has been a driver of uniformity and transparency in the review and appeals process.

Independent medical review has continued to grow and expand beyond the passage of the ACA into areas such as workers' compensation, disability, and now surprise billing following the passage of the No Surprises Act (NSA) of 2020, which is described in greater detail below.

[2] At least one state, Idaho, is now allowing single employer self-funded plans to Opt-In, in writing, to using the State IRO program instead of the Federal IRO program. (Rule 2021-5)-Effective January 2022.

II. Brief Overview of the Review Process

Defining Internal and External Appeal Options

In the course of receiving medical treatment, a healthcare consumer may encounter a denied claim, which occurs when a particular service (a test or treatment, for example) is not covered by the consumer's health plan. When a consumer's claim is denied, he or she has the option to file an appeal. In general, there are three steps in an appeals process:

1) A first level internal appeal.
2) A second level internal appeal. (There may be one or two levels of internal appeal, depending on the plan type and design.)
3) A third level external appeal.

The third level appeal is the only step that must occur on an external basis, meaning it is completed by an organization other than the health plan — which is where the term external review comes from.

External review often occurs after a health plan's internal appeals process has been exhausted, although many leading health plans retain IROs at the internal appeal level as well. The role of the IRO during the external review process is to act as an objective arbiter and determine — based on evidence-based medicine, clinical review criteria, and regulatory requirements — whether the services in question are medically necessary, or in the case of administrative appeals, whether the services in question meet the criteria for coverage under the health insurance plan, based on plan language.

Recently, the healthcare industry has witnessed an increase in the number of administrative external appeals, which don't require medical judgment, but instead demand legal review of policies, procedures, and applicable law to ensure a health plan is properly applying legal provisions to healthcare denials. As a result, the need for an IRO is greater than ever because the IRO ensures an independent medical review of payer practices and decisions in a healthcare landscape that is rapidly changing.

While the review decisions are not binding (the enrollee has the ability to challenge the determination) at the internal-review level, external appeals are by design binding decisions.

Clinical reviewers include board-certified or licensed physicians, physician advisors, allied clinicians, and other healthcare professionals and legal specialists.

Depending on whether a consumer is insured under a fully insured or self-funded healthcare plan, different laws regulate the appeal process. For fully insured plans, individual states regulate external appeals. Each state may have its own process or may use the federal-run process. Most states use their own state-run process. For self-funded plans, ERISA under the Department of Labor (DOL) regulates external appeals. (See the chart, below, for some of the main differences between self-insured and fully insured plans.)

Differences Between Plans

Question	Fully Insured	Self-Funded
Who makes coverage decisions on the internal appeals process?	The health plan provider.	Third-party administrator (TPA) working on behalf of the employer offering the self-funded plan.
Who conducts internal appeals?	Often, they are conducted by the clinical reviewers or staff employed by the health insurance provider or an IRO.	Clinical reviewers working for a third-party administrator or an IRO.
Who regulates external appeals?	These are regulated by a state insurance commissioner.	Regulated by ERISA under the U.S. Department of Labor.
Who conducts external appeals?	• State Process: An IRO approved by the state insurance commission. • Federal Process (when the state's process does not conform with NAIC): An IRO accredited by URAC and contracted directly with the health plan.	IROs contracted by the health plan and accredited by URAC.
What does it cost a patient to make an appeal?	There is no cost for internal appeals. Some states have a minimal charge for external appeals that can be refunded if the appeal is successful.	There is no cost for internal or external appeals.
Where can consumers go to find out about the appeals process?	Resources include the consumer's human resources department, plan document, customer service desk or website; or state insurance commission office or website.	Employee Benefits Security Administration (DOL-EBSA) website.

III. Current Challenges Facing Independent Medical Review for Consumers and Payers

Independent medical review providers face ongoing challenges in their collective effort to provide fair and impartial medical review. Some challenges, such as an underutilization of medical review, affect the business side of the independent medical review process. Others, including a perceived conflict of interest and lack of awareness of reviewer qualifications, pertain instead to the quality of independent medical reviews.

In this section, we address the primary challenges faced in the independent medical review industry.

Underutilized External Review Services

Challenge #1: Underutilized External Review Services	Affects Payers	Affects Consumers
Lack of understanding of the role of IROs	✔	✔
Lack of consumer knowledge of external appeal rights and process		✔
Implementation challenges	✔	✔
Lack of confidence in independent medical review	✔	✔

While the scope and role of independent medical review has grown significantly over the past five years, few consumers utilize this process. For example, a study conducted by AHIP found that, on average, less than one out of every 10,000 eligible individuals requested an external review of their denied health claim.

Legislation, such as the ACA, has gone to great lengths to solidify the important role of external review within the healthcare system. Additionally, financial regulations in the insurance market — perhaps most visible in the medical loss ratio (MLR) provision of the ACA — are increasingly shifting review operations to IROs, which specialize in such services.

Yet challenges remain. Consumer knowledge of the right to external appeal lags. General understanding of the role and function of IROs is underwhelming. And consumer confidence is low. Yet the independent medical review process provides the consumer with an easily accessible "check and balance" process to ensure their claim is properly determined. As a result, further promotion of the IRO process is necessary to educate consumers regarding their vital rights. Furthermore, the independent medical review process can save time and expense for the consumer, the health plan, and the health system overall.

Amid this challenging backdrop, NAIRO continues to work diligently to expand the knowledge base of consumers and to ensure its member organizations are able to lead the industry to a stronger future.

For consumers, NAIRO applauds the consumer protections that emerged from the ACA and other laws. As an industry thought leader, through white papers and our annual Educational Symposium, NAIRO promotes the continued education among both consumers and health plans so that all stakeholders can take advantage of the benefits of independent medical review.

Additionally, NAIRO members offer expanded services to both health plans and consumers. As part of internal and external review, today's URAC-accredited IROs are equipped to deliver three types of independent medical review services:

- Retrospective reviews, conducted after treatment or services are provided to a patient.
- Concurrent reviews, which take place during a hospital stay or course of treatment.
- Prospective reviews, also known as pre-certification reviews or prior authorizations, which occur before a patient is admitted or receives treatment.

By adapting to the new needs of the market, the versatility of many leading IROs brings added strength to the independent medical review process, ensuring that health plans and consumers have a trusted partner when the need for independent medical review arises.

Steps to Ensure a Quality Review

Challenge #2: Ensuring a Quality Report	Affects Payers	Affects Consumers
Stakeholders concern that IRO reports are not complete	✔	✔
When reviewers are not in the same or similar specialty that typically manages the issue under review or otherwise not qualified to perform the review	✔	✔

Some of these quality challenges can be tied to obtaining sufficient case records. Documentation is the key to a quality report that fairly and accurately represents the issue under external review. Once sufficient documentation is received and evaluated, the rules and regulations related to creating the review report are quite comprehensive. For example, the NAIC Model Act requires an IRO to return a written decision on the adverse determination to the patient, the patient's representative (if applicable), the health plan and the insurance commissioner within 45 days of the review submission for standard reviews, and within 72 hours for expedited reviews. Some states may require these decisions in shorter timeframes. Be sure to check with your respective Insurance Department to confirm these various timeframes.

To reach an evidence-based decision, the IRO must consider certain elements of a case, including the following items (to the extent the information and documents are available), according to the NAIC Model Act:

- The covered person's medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;
- The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the IRO's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and
- The opinion of the independent review organization's clinical reviewer or reviewers after considering the case elements listed directly above.

When issuing a final notice, the IRO is required to include significant elements of the case, including:

- An overview or general description of the reason leading to the request for the external review;
- The date the IRO received the assignment to conduct the external review;
- The date the external review was conducted;
- The date of the IRO's decision;
- The principal reason/s for the IRO's decision, including which evidence-based standards were used to render the decision, if applicable;
- The rationale for its decision; and
- References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

One challenge is that each state may vary its requirements slightly since the Model Act is a minimum requirement. Thus, the lack of uniformity creates a potentially burdensome process. URAC accreditation standards (and the state laws that follow the Model Act, as required by the ACA) require IROs to provide the clinical reviewer's qualifications in the determination notice as well as specific citations to supporting evidence or references that the reviewer used to make the determination.

To address the challenges of reviewer qualifications, multiple URAC accreditation standards underscore the importance of having experts render often complex medical recommendations.

URAC standards require that a clinical reviewer holds confirmed expertise on the topic under review. The standards also require that IROs independently verify the reviewer's stated qualifications to guarantee that the reviewer's credentials and experience are up to date. At a minimum, accreditation standards require that clinical reviewers:

- Hold a current, non-restricted licensure or certification for clinical practice in a state of the United States;
- Have at least five years of experience providing direct clinical care to patients;
- Are clinical peers (meaning the reviewer is in the same licensure category and same or similar specialty as the treating provider); and
- Have professional experience in the area of practice "that typically manages the medical condition, procedure, treatment, or issue under review."[3]

Importantly, accreditation standards also require that clinical reviewers are knowledgeable on the trends of current practice, stating that reviewers of external review cases must have experience providing direct clinical care to patients within the past three years.[4]

Further, the URAC standards require that IROs utilize primary source verification for the reviewer's licensure or certification and board certification status, if applicable. IROs must collect information regarding direct clinical care experience, including the date/s and length of the experience. The standards also require IROs to verify disciplinary action or sanctions against the medical professional. The NAIC Model Act stipulates that IROs may not use reviewers who have a history of sanctions or disciplinary action.

[3] URAC standards, IR-COI 1-3, 1-4
[4] URAC IRO Standards, IR-RCQ 1-6

Experimental and Investigational Reviews

Challenge #3: Performing Experimental and Investigational Reviews	Affects Payers	Affects Consumers
Health plan's terms of coverage vary	✔	✔
State regulations and coverage vary	✔	✔
Medical necessity vs. experimental treatment	✔	✔

Many therapies often involve complex and cutting-edge treatment options. When such advanced treatments are requested, disputes regarding the appropriateness and necessity can be commonplace between payers and plan participants.

Each case requires an in-depth review of plan provisions, evidence-based findings that demonstrate the effectiveness of the treatment under review and the unique case-specific issue and history of the member in question. Certain treatments may be considered appropriate in some cases and not indicated in others, depending on all factors under review.

If a health plan denies coverage for a given service or treatment as experimental/investigational, the patient has the right to appeal the denied claim. When this situation occurs, IROs step in to assess the claim and determine if the services in question meet the criteria for coverage under the health insurance plan.

When IROs consider appeals of experimental/investigational cases, they follow a legal framework that considers several factors. Specifically, IROs and their clinical reviewers assess two factors:

- **FDA approval**. Clinical reviewers assess whether the recommended service or treatment has been approved by the FDA for the patient's condition.
- **Evidence-based standards and/or medical or scientific evidence**. Also, clinical reviewers will study the evidence to see if "the expected benefits of the recommended or requested healthcare service or treatment is more likely than not to be beneficial to the covered person than any available standard healthcare services or treatment and the adverse risks of the recommended or requested healthcare service or treatment would not be substantially increased over those of available standard healthcare services or treatments," according to the NAIC Model Act.

With the expertise of clinical reviewers and specialized knowledge of healthcare services, accredited IROs are equipped to make evidence-based decisions about these types of appeals.

More specifically, accredited IROs offer:

- **Deep expertise and experience**. IROs have immediate access to physicians and allied healthcare practitioners who are at the vanguard of medical treatments and services. Accredited IROs provide expertise in experimental and investigational reviews and are up to date on the accepted standards of care.
- **Large panels of clinical reviewers**. IROs feature expansive reviewer panels of hundreds to thousands of experts, who can provide access to all recognized specialties and sub-specialties.

- **Affiliations to leading research and knowledge centers**. Many IRO reviewers are affiliated with or have relationships with medical centers of excellence and research hospitals, which links them to the latest knowledge and resources of accepted medical practices and treatments.
- **Advanced, ongoing education and training**. The training and credentialing programs for IROs are designed to ensure the use of reviewers who are knowledgeable about the most current peer-reviewed literature and evidence-based medicine.

The Perception of Organizational and Reviewer Conflict of Interest

Challenge #4: Minimizing Conflict of Interest	Affects Payers	Affects Consumers
Perceived conflict of interest	✔	✔

Accredited IROs adhere to several standards and guidelines intended to avoid issues of conflict of interest, including guidance within the Model Act and URAC accreditation standards.

Organizational Conflict of Interest

The Model Act states that IROs must act as separate business entities from health plans.[5] Specifically, the Act stipulates that IROs "may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of healthcare providers."

Further, URAC accreditation standards mandate certain requirements for review organizations that provide both internal and external review services. To comply with URAC's conflict-of-interest standards, if required by the state they are doing business in, IROs must disclose the names of the organizations for which it provides internal review. This information must be provided even if the IRO has non-disclosure agreements with its internal review clients. For external reviews, "the referring entity [generally the state] has the opportunity to forward these cases to a different organization for external review if a conflict is determined."[6]

Reviewer Conflict of Interest

Of particular concern for conflict-of-interest issues is the role of the reviewer, who provides a decision on the claims appeal. Both the NAIC Model Act and URAC standards address reviewer conflict-of-interest requirements.

URAC standards stipulate that the reviewer:

[5] Section 13, C
[6] URAC standards, IR-COI 1-7(a, ii)

- Will not receive compensation for the review decision dependent on the outcome of the case;
- Was not involved in the specific case in question; and
- Has neither professional, familial, or financial ties with any involved parties (the consumer, health plan, treatment facility, etc.) that could be considered leading to a conflict.[7]

The standards also require accredited IROs to assign a different reviewer, who has had no previous involvement with the case, for each level of review. Each assigned reviewer must complete a rigorous internal conflict-of-interest check, based on the factors stated above, before accepting a case, and are required to submit a signed attestation stating no conflicts of interest exist in accordance with URAC standards.[8]

Mental Health Parity

Challenge #5: Mental Health Parity	Affects Payers	Affects Consumers
Understanding federal and state mental health parity laws and coverage	✔	✔

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the ACA to also apply to individual health insurance coverage. HHS has jurisdiction over public sector group health plans (referred to as "non-federal governmental plans"), while the Departments of Labor and the Treasury have jurisdiction over private group health plans.[9]

Generally, health plans that must follow federal parity laws include:

- Group health plans for employers with 51 or more employees.
- Most group health plans for employers with 50 or fewer employees unless they have been "grandfathered," which means it was created before the federal parity laws went into effect.
- The Federal Employees Health Benefits Program.
- Medicaid Managed Care Plans (MCO).
- State Children's Health Insurance Programs (S-CHIP).
- Some state and local government health plans.
- Any health plans purchased through the Health Insurance Marketplaces.
- Most individual and group health plans purchased outside the Health Insurance Marketplaces unless "grandfathered."

Conversely, health plans that do not have to follow federal health parity include:

[7] URAC standards, IR-COI 1-2
[8] URAC standards, IR-COI 1-2, 1-3, 1-4
[9] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

- Medicare (except for Medicare's cost-sharing for outpatient mental health services do comply with parity).
- Medicaid fee-for-service plans.
- "Grandfathered" individual and group health plans that were created and purchased before March 23, 2010.
- Self-insured non-Federal governmental plans that have 50 or fewer employees.
- Self-insured small private employers that have 50 or fewer employees.
- Plans who received an exemption based on increase of costs related to parity.
- Large, self-funded non-federal governmental employers that opt-out of the requirements of MHPAEA.

At the state level, two significant challenges remain:

- To ensure effective implementation of federal parity regulation.
- To fill gaps in mental health and substance use coverage with strong state laws to the extent possible.

If the state's parity law is more stringent than the MHPAEA, the health insurance plans regulated in that state must follow those laws. Federal parity replaces state law in cases where the state's law does not require equal coverage.

In January 2022, The Departments of Labor, Health and Human Services and the Treasury issued their 2022 Report to Congress on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The report included information that "suggests health plans and health insurance issuers are failing to deliver parity for mental health and substance-use disorder benefits to those they cover. The report also highlights the departments' recent emphasis on greater MHPAEA enforcement in addition to guidance to correct those failures and makes recommendations to strengthen MHPAEA's consumer protections and enhance the departments' enforcement abilities."[10]

President Biden's 2022 State of the Union addressed a federal effort to confront escalating mental health issues including a refocus on mental health coverage parity. The United States is facing what the White House calls an "unprecedented mental health crisis." Accelerated by the COVID-19 pandemic and the resulting worry, isolation, and depression, mental health issues today impact every two out of five adults and an increasing number of children and adolescents. In addition to solutions aimed at expanding the supply of mental health providers in shortage areas and investing in training programs, the Biden administration seeks to "expand and strengthen" mental health parity by advancing additional terms of coverage to health plans.

No Surprises Act and Independent Dispute Resolution

Effective January 1, 2022, the No Surprises Act (NSA) ushered in sweeping changes to the dispute-resolution process between healthcare providers and payers, establishing a "baseball-style" arbitration system in which an independent arbiter settles payment differences for out-of-network (OON) charges.

[10] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf

The federal independent dispute resolution (IDR) process, which generally applies to group health plans, health insurance issuers offering group or individual health insurance coverage and Federal Employees Health Benefits (FEHB) carriers, includes the certification of IDR entities to make payment determinations.

To date, 10 IDR entities have gained certification from the Departments of the Treasury, Labor, and Health and Human Services (the Departments), with each of the 10 entities approved to operate in all states in which the federal process applies. Under the NSA, patients are required to pay "no more than in-network cost-sharing amounts" in situations where the patient receives emergency services, certain non-emergency services furnished by an OON (out-of-network) provider at in-network healthcare facilities, or air ambulance services furnished by OON providers of air ambulance services, according to federal guidance from the Departments.

"In such cases, the individual's health plan often does not cover the full amount of the OON charges, and the OON provider, facility or provider of air ambulance services then bills the patient for the outstanding amount (also known as balance billing)," the Departments state. "Prior to the NSA, the patient would often be responsible for paying these balance bills."

As of January 1, the NSA protections kickstart an IDR process in situations where payments are under dispute. In general, the following timeline shows how the IDR process may play out:

- After services are rendered, the plan must make an initial payment or a denial of payment within 30 calendar days.
- If either the plan or the provider believes the payment is not appropriate, either party has 30 days from the time of the payment or denial to notify the other party that it would like to negotiate the payment terms or the denial.
- Once notified, the parties enter a 30-day open negotiation period.
- If terms are not agreed upon, either party can initiate dispute resolution through the federal IDR process. The 30-day open negotiation period must conclude before the federal IDR process is available.
- The federal IDR process must be initiated within four business days from the close of the 30-day open negotiation period.

The provisions of the NSA, including the federal arbitration process for settling disputed claims, add a significant new wrinkle to the healthcare payment environment. But similarities in the federal IDR process to other forms of dispute resolution in the medical review field provide longtime leaders in the space — accredited IROs — the opportunity to deliver.

NAIRO members, which hold URAC accreditation, have a more than 20-year track record of providing unbiased medical opinions as trusted independent clinical experts and are independently verified by a third party to ensure quality. Accredited IROs have the necessary resources and expertise, supported by clinical, coding, and legal experts, to adequately fulfill the federal IDR process, as well as state-specific dispute resolution reviews.

With years of experience providing similar arbitration support in cases of internal and external review, utilization review and workers' compensation utilization management, accredited IROs are well-positioned to take the lead in NSA-related and state-specific dispute resolutions. They hold proven case

management tools and workflow systems. In addition, accredited IROs serving as IDR entities offer the following advantages:

- **Ensure quality and reliability**. Accredited IROs are independent entities that possess the necessary expertise and organizational resources.
- **Offer transparency and reduce the potential for conflict of interest**. Accredited IROs consistently render accurate and timely decisions in a transparent manner. As independent review entities, they have no interest in the outcome of the arbitration decision.
- **Understand the complexity of the IDR process**. They utilize highly qualified and specialized clinical, coding and legal reviewers to ensure complete, accurate decisions. Accredited IROs consider the medical necessity of care during the review to ensure patients only receive clinically appropriate services.
- **Qualified and credentialed expertise**. Accredited IROs maintain formal credentialing programs to ensure that all clinical, coding, and legal staff are appropriately licensed, credentialed and board-certified, as applicable.

For more information, please visit https://cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Federal-Independent-Dispute-Resolution-Process-Guidance-for-Certified-IDR-Entities.pdf.

State Surprise Billing Laws. To date, 33 states have some sort of consumer protections in place. According to the Georgetown University Center for Health Insurance Reform, 18 of those states have comprehensive safeguards against surprise bills while 15 have a more limited approach. The Georgetown experts assessed states on the comprehensiveness of their laws based on the following indicators:

- Extends protections in both emergency department and in-network hospital settings.
- Applies laws to all types of insurance, including health maintenance organizations and preferred provider organizations.
- Protects consumers by holding them harmless from costs above their cost-sharing requirement and prohibiting providers from balance billing.
- Adopts a state-specific payment standard or process for resolving payment disputes between providers and health insurers.[11]

IV. NAIRO's Efforts to Achieve a Fair, Impartial Review Process

As a leader in delivering greater transparency and impartial appeals decisions to the independent medical review process, NAIRO is engaged in continuous efforts to streamline and improve the independent medical review process for its constituents and stakeholders, including health plans and consumers.

NAIRO is engaged with legislative leaders on a state level in jurisdictions throughout the country. NAIRO's Legislative and Regulatory Committee, comprised of more than a dozen leaders in independent medical review, keeps tabs on state laws and pending legislation that will have an impact on the industry. The driving goal of the Legislative and Regulatory Committee is to ensure that laws governing

[11] https://www.ncsl.org/research/health/surprise-and-balance-billing-state-policy-options.aspx.

the independent medical review process adhere to quality standards that meet measures of excellence, and to monitor conflicting legislative language that could negatively impact the review process.

Additionally, NAIRO collaborates with federal agencies, such as the Department of Labor (DOL), CMS, and other industry leaders, such as NAIC, to ensure healthcare quality standards are met throughout the length of the medical review process. Leaders from NAIRO also are in active and ready contact with the accreditation bodies that issue the quality standards that govern much of the internal and external review processes. For example, NAIRO, as part of a stakeholder working group, recently collaborated with CMS to help create the NSA IDR process.

V. Summary

The future of independent medical review is bright. The recent and ongoing strengthening of the independent medical review process, including the inclusion of surprise billing IDR and the expansion of workers' compensation independent medical review, has served the industry well.

Yet challenges to a fully optimized system remain, and recognition among stakeholders about the significant and important role of IROs is something that the independent medical review industry continues to cultivate. As this paper details at length, NAIRO continues to identify the current issues and barriers that can prevent an effective and meaningful independent medical review process for all stakeholders.

Under the leadership of NAIRO, accredited IROs and other NAIRO member organizations are taking proactive steps to resolve and mitigate these issues and barriers. NAIRO and its members stand willing to collaborate with all stakeholders of the independent medical review process to ensure a fair, balanced, and effective system for all parties involved.

For further information on the independent medical review process and organizations that provide these services, visit NAIRO online at www.nairo.org.

Understanding the Vital Role, Challenges and Opportunities of Independent Medical Review Services was produced, researched, and written by members of NAIRO's Legislative and Regulatory Committee. Originally published July 2016; revised July 2022. To learn more about NAIRO and its member organizations, visit www.nairo.org.