CHAPTER 40

TAKING OF MUSKRATS BY COLONY TRAPS

S.F. 265

AN ACT relating to the taking of muskrats by colony trap.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. Section 481A.92, unnumbered paragraph 1, Code 1999, is amended to read as follows:

~~Except as otherwise provided in this chapter a~~ A person shall not use or attempt to use colony traps in taking, capturing, trapping, or killing any game or fur-bearing animals except muskrats as determined by rule of the commission. Box traps capable of capturing more than one game or fur-bearing animal at each setting are prohibited. A valid hunting license is required for box trapping cottontail rabbits and squirrels. All traps and snares used for the taking of fur-bearing animals shall have a metal tag attached plainly labeled with the user's name and address. All traps and snares, except those which are placed entirely under water, shall be checked at least once every twenty-four hours. Officers appointed by the department may confiscate such traps and snares found in use that are not properly labeled or checked.

Approved April 21, 1999

CHAPTER 41

HEALTH CARE SERVICE AND TREATMENT COVERAGE

S.F. 276

AN ACT relating to health care service and treatment coverage by providing for continuity of care, discussion and advocacy of treatment options, coverage of emergency room services, utilization review requirements, and an external review process, and providing an effective date.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. NEW SECTION. 514C.14 CONTINUITY OF CARE — PREGNANCY.

1. Except as provided under subsection 2 or 3, a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, which terminates its contract with a participating health care provider, shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

2. A covered person who makes an involuntary change in health plans may request that the new health plan cover the services of the covered person's physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Continuation of such coverage shall continue through postpartum care related to the child birth and delivery. Payment for covered

benefits and benefit level shall be according to the terms and conditions of the new health plan contract.

3. A carrier, organized delivery system, or plan established under chapter 509A, which terminates the contract of a participating health care provider for cause shall not be liable to pay for health care services provided by the health care provider to a covered person following the date of termination.

Sec. 2. NEW SECTION. 514C.15 TREATMENT OPTIONS.

A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan established pursuant to chapter 509A for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, doing either of the following:

1. Discussing treatment options with a covered individual, notwithstanding the carrier's, organized delivery system's, or plan's position on such treatment option.

2. Advocating on behalf of a covered individual within a review or grievance process established by the carrier, organized delivery system, or chapter 509A plan, or established by a person contracting with the carrier, organized delivery system, or chapter 509A plan.

Sec. 3. NEW SECTION. 514C.16 EMERGENCY ROOM SERVICES.

1. A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan established pursuant to chapter 509A for public employees, which provides coverage for emergency services, is responsible for charges for emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. Coverage for emergency services is subject to the terms and conditions of the health benefit plan or contract.

2. Prior authorization for emergency services shall not be required. All services necessary to evaluate and stabilize an emergency medical condition shall be considered covered emergency services.

3. For purposes of this section, unless the context otherwise requires:

a. "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(2) Serious impairment to bodily function.

(3) Serious dysfunction of a bodily organ or part.

b. "Emergency services" means covered inpatient and outpatient health care services that are furnished by a health care provider who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition.

Sec. 4. NEW SECTION. 514C.17 CONTINUITY OF CARE — TERMINAL ILLNESS.

1. Except as provided under subsection 2 or 3, if a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, terminates its contract with a participating health care provider, a covered individual who is undergoing a specified course of treatment for a terminal illness or a related condition, with the recommendation of the covered individual's treating physician licensed under chapter 148, 150, or 150A, may continue to receive coverage for treatment received from the covered individual's physician for the terminal illness or a related condition, for a period of up to ninety days. Payment for covered benefits and benefit level shall be according to the terms and conditions of the contract.

2. A covered person who makes a change in health plans involuntarily may request that the new health plan cover services of the covered person's treating physician licensed under chapter 148, 150, or 150A, who is not a participating health care provider under the new health plan, if the covered person is undergoing a specified course of treatment for a terminal illness or a related condition. Continuation of such coverage shall continue for up to ninety days. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

3. Notwithstanding subsections 1 and 2, a carrier, organized delivery system, or plan established under chapter 509A which terminates the contract of a participating health care provider for cause shall not be required to cover health care services provided by the health care provider to a covered person following the date of termination.

Sec. 5. NEW SECTION. 514F.4 UTILIZATION REVIEW REQUIREMENTS.

1. A third-party payor which provides health benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third-party who does not meet the requirements established for accreditation by the utilization review accreditation commission, national committee on quality assurance, or another national accreditation entity recognized and approved by the commissioner.

2. This section does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under any of the following:

a. Title XVIII of the federal Social Security Act.

b. The civilian health and medical program of the uniformed services.

c. Any other federal employee health benefit plan.

3. For purposes of this section, unless the context otherwise requires:

a. "Third-party payor" means:

(1) An insurer subject to chapter 509 or 514A.

(2) A health service corporation subject to chapter 514.

(3) A health maintenance organization subject to chapter 514B.

(4) A preferred provider arrangement.

(5) A multiple employer welfare arrangement.

(6) A third-party administrator.

(7) A fraternal benefit society.

(8) A plan established pursuant to chapter 509A for public employees.

(9) Any other benefit program providing payment, reimbursement, or indemnification for health care costs for an enrollee or an enrollee's eligible dependents.

b. "Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness, and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. Such evaluation does not apply to requests by an individual or provider for a clarification, guarantee, or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically stated, verification of benefits, preauthorization, or a prospective or concurrent utilization review program or process shall not be construed as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.

Sec. 6. NEW SECTION. 514F.5 EXPERIMENTAL TREATMENT REVIEW.

1. A carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, that limits coverage for experimental medical treatment, drugs, or devices, shall develop and implement a procedure to evaluate experimental medical treatments and shall submit a description of the procedure to the division of insurance. The procedure shall be in writing and must describe the process used to determine whether the carrier, organized

delivery system, or chapter 509A plan will provide coverage for new medical technologies and new uses of existing technologies. The procedure, at a minimum, shall require a review of information from appropriate government regulatory agencies and published scientific literature concerning new medical technologies, new uses of existing technologies, and the use of external experts in making decisions. A carrier, organized delivery system, or chapter 509A plan shall include appropriately licensed or qualified professionals in the evaluation process. The procedure shall provide a process for a person covered under a plan or contract to request a review of a denial of coverage because the proposed treatment is experimental. A review of a particular treatment need not be reviewed more than once a year.

2. A carrier, organized delivery system, or chapter 509A plan that limits coverage for experimental treatment, drugs, or devices shall clearly disclose such limitations in a contract, policy, or certificate of coverage.

Sec. 7. NEW SECTION. 514J.1 LEGISLATIVE INTENT.

It is the intent of the general assembly to provide a mechanism for the appeal of a denial of coverage based on medical necessity.

Sec. 8. NEW SECTION. 514J.2 DEFINITIONS.

1. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services.

2. "Commissioner" means the commissioner of insurance.

3. "Coverage decision" means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

4. "Enrollee" means an individual, or an eligible dependent, who receives health care benefits coverage through a carrier or organized delivery system.

5. "Independent review entity" means a reviewer or entity, certified by the commissioner pursuant to section 514J.6.

6. "Organized delivery system" means an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health, and performing utilization review.

Sec. 9. NEW SECTION. 514J.3 EXCLUSIONS.

This chapter does not apply to a hospital confinement indemnity, credit, dental, vision, long-term care, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile medical payment insurance.

Sec. 10. NEW SECTION. 514J.4 EXTERNAL REVIEW REQUEST.

1. At the time of a coverage decision, the carrier or organized delivery system shall notify the enrollee in writing of the right to have the coverage decision reviewed under the external review process.

2. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may file a written request for external review of the coverage decision with the commissioner. The request must be filed within sixty days of the receipt of the coverage decision. However, the enrollee's treating health care provider does not have a duty to request external review.

3. The request for external review must be accompanied by a twenty-five dollar filing fee. The commissioner may waive the filing fee for good cause. The filing fee shall be refunded if the enrollee prevails in the external review process.

Sec. 11. NEW SECTION. 514J.5 ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed service or treatment does not meet the definition of medical necessity as defined in the enrollee's evidence of coverage.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's contract.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the decision.

3. The carrier or organized delivery system has three business days to contest the eligibility of the request for external review with the commissioner. If the commissioner finds that the request for external review is not eligible for full review, the commissioner, within two business days, shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for full review.

Sec. 12. NEW SECTION. 514J.6 INDEPENDENT REVIEW ENTITIES.

1. The commissioner shall solicit names of independent review entities from carriers, organized delivery systems, and medical and health care professional associations.

2. Independent review entities include, but are not limited to, the following:

a. Medical peer review organizations.

b. Nationally recognized health experts or institutions.

3. The commissioner shall certify independent review entities to conduct external reviews. An individual who conducts an external review as or as part of a certified independent review entity shall be a health care professional and satisfy both of the following requirements:

a. Hold a current unrestricted license to practice medicine or a health profession in the United States. A health care professional who is a physician shall also hold a current certification by a recognized American medical specialty board. A health care professional who is not a physician shall also hold a current certification by such professional's respective specialty board.

b. Have no history of disciplinary actions or sanctions, including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

4. Each independent review entity shall have a quality assurance program on file with the commissioner that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

5. The commissioner shall certify independent review entities every two years.

Sec. 13. NEW SECTION. 514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, shall do all of the following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under

review. The independent review entity shall not be a subsidiary of, or owned or controlled by the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and phone number of the independent review entity and of the enrollee's and treating health care provider's right to submit additional information. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the independent review entity selected by the carrier or organized delivery system by notifying the commissioner within three business days of the receipt of notice from the carrier or organized delivery system. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection, to select an independent review entity, and to provide the notice required by this subsection to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

c. Provide any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

d. Provide any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

2. The enrollee, or the enrollee's treating health care provider, may provide any information submitted in support of the internal review, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the final notification of the independent review entity's selection to provide this information. Failure to provide the information within ten days shall be ground for rejection of consideration of the information by the independent review entity.

3. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 1. The requested information shall be submitted within five days. Failure to provide the information shall be ground for rejection of consideration of the information by the independent review entity. The carrier or organized delivery system shall be notified of this request.

4. The independent review entity shall submit its decision as soon as possible, but not more than thirty days from the independent review entity's receipt of the request for review. The decision shall be mailed to the enrollee, or the treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system.

5. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 14. NEW SECTION. 514J.8 EXPEDITED REVIEW.

An expedited review shall be conducted within seventy-two hours of notification to the commissioner if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

Sec. 15. NEW SECTION. 514J.9 FUNDING.

All reasonable fees and costs of the independent review entity in conducting an external review shall be paid by the carrier or organized delivery system.

Sec. 16. NEW SECTION. 514J.10 REPORTING.

Each carrier and organized delivery system shall file an annual report with the commissioner containing all of the following:

1. The number of external reviews requested.
2. The number of the external reviews certified by the commissioner.
3. The number of coverage decisions which were upheld by an independent review entity.

The commissioner shall prepare a report by January 31 of each year.

Sec. 17. NEW SECTION. 514J.11 IMMUNITY.

An independent review entity conducting a review under this chapter is not liable for damages arising from determinations made under the review process. This does not apply to any act or omission by the independent review entity made in bad faith or involving gross negligence.

Sec. 18. NEW SECTION. 514J.12 STANDARD OF REVIEW.

Review by the independent review entity is de novo. The standard of review to be used by an independent review entity shall be whether the health care service or treatment denied by the carrier or organized delivery system was medically necessary as defined by the enrollee's evidence of coverage subject to Iowa law and consistent with clinical standards of medical practice. The independent review entity shall take into consideration factors identified in the review record that impact the delivery of or describe the standard of care for the medical service or treatment under review. The medical service or treatment recommended by the enrollee's treating health care provider shall be upheld upon review so long as it is found to be medically necessary and consistent with clinical standards of medical practice.

Sec. 19. NEW SECTION. 514J.13 EFFECT OF EXTERNAL REVIEW DECISION.

The review decision by the independent review entity conducting the review is binding upon the carrier or organized delivery system. The enrollee or the enrollee's treating health care provider acting on behalf of the enrollee may appeal the review decision by the independent review entity conducting the review by filing a petition for judicial review either in Polk county district court or in the district court in the county in which the enrollee resides. The petition for judicial review must be filed within fifteen business days after the issuance of the review decision. The findings of fact by the independent review entity conducting the review are conclusive and binding on appeal. The carrier or organized delivery system shall follow and comply with the review decision of the independent review entity conducting the review, or the decision of the court on appeal. The carrier or organized delivery system and the enrollee's treating health care provider shall not be subject to any penalties, sanctions, or award of damages for following and complying in good faith with the review decision of the independent review entity conducting the review or decision of the court on appeal. The enrollee or the enrollee's treating health care provider may bring an action in Polk county district court or in the district court in the county in which the enrollee resides to enforce the review decision of the independent review entity conducting the review or the decision of the court on appeal.

Sec. 20. NEW SECTION. 514J.14 RULES.

The commissioner shall adopt rules pursuant to chapter 17A as are necessary to administer this chapter.

Sec. 21. NEW SECTION. 514K.1 HEALTH CARE PLAN DISCLOSURES — INFORMATION TO ENROLLEES.

1. A health maintenance organization, an organized delivery system, or an insurer using a preferred provider arrangement shall provide to each of its enrollees at the time of enrollment, and shall make available to each prospective enrollee upon request, written information as required by rules adopted by the commissioner and the director of public health. The information required by rule shall include, but not be limited to, all of the following:

a. A description of the plan's benefits and exclusions.

b. Enrollee cost-sharing requirements.

c. A list of participating providers.

d. Disclosure of the existence of any drug formularies used and, upon request, information about the specific drugs included in the formulary.

e. An explanation for accessing emergency care services.

f. Any policies addressing investigational or experimental treatments.
g. The methodologies used to compensate providers.
h. Performance measures as determined by the commissioner and the director.
i. Information on how to access internal and external grievance procedures.

2. The commissioner and the director shall annually publish a consumer guide providing a comparison by plan on performance measures, network composition, and other key information to enable consumers to better understand plan differences.

Sec. 22. EFFECTIVE DATE. Sections 7 through 20 of this Act, which create new chapter 514J, take effect January 1, 2000.

Approved April 21, 1999

CHAPTER 42

PHYSICIAN ASSISTANTS AND ADVANCED REGISTERED NURSE PRACTITIONERS — HOSPITAL CLINICAL PRIVILEGES

S.F. 277

AN ACT relating to hospital clinical privileges of a physician assistant or advanced registered nurse practitioner.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. Section 135B.7, unnumbered paragraph 2, Code 1999, is amended to read as follows:

The rules shall state that a hospital shall not deny clinical privileges to physicians and surgeons, podiatric physicians, osteopaths, osteopathic surgeons, dentists, ~~or~~ certified health service providers in psychology, physician assistants, or advanced registered nurse practitioners licensed under chapter 148, 148C, 149, 150, 150A, 152, or 153, or section 154B.7, solely by reason of the license held by the practitioner or solely by reason of the school or institution in which the practitioner received medical schooling or postgraduate training if the medical schooling or postgraduate training was accredited by an organization recognized by the council on postsecondary accreditation or an accrediting group recognized by the United States department of education. A hospital may establish procedures for interaction between a patient and a practitioner. ~~Nothing in the~~ The rules shall not prohibit a hospital from limiting, restricting, or revoking clinical privileges of a practitioner for violation of hospital rules, regulations, or procedures established under this paragraph, when applied in good faith and in a nondiscriminatory manner. ~~Nothing in this~~ This paragraph shall not require a hospital to expand the hospital's current scope of service delivery solely to offer the services of a class of providers not currently providing services at the hospital. ~~Nothing in this~~ This section shall not be construed to require a hospital to establish rules which are inconsistent with the scope of practice established for licensure of practitioners to whom this paragraph applies. This section shall not be construed to authorize the denial of clinical privileges to a practitioner or class of practitioners solely because a hospital has as employees of the hospital identically licensed practitioners providing the same or similar services.

Approved April 21, 1999