CHAPTER 514J

EXTERNAL REVIEW OF HEALTH CARE COVERAGE DECISIONS

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.

99 Acts, ch 41, §7, 22

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, or a denial of coverage for a service or treatment that has already been received and for which the enrollee has no financial liability.

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.

99 Acts, ch 41, §8, 22; 2007 Acts, ch 137, §11

514J.3 Exclusions.

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

99 Acts, ch 41, §9, 22; 2008 Acts, ch 1030, §1

514J.3A Notice.

When a claim is denied in whole or in part based on medical necessity, the carrier or organized delivery system shall provide a notice in writing to the enrollee of the internal appeal mechanism provided under the carrier or organized delivery system's plan or policy.

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.

2001 Acts, ch 69, §24

514J.4 External review request — fee.

1. 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.

2. 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.

99 Acts, ch 41, §10, 22; 2001 Acts, ch 69, §25

514J.5 Certification of request — 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 all of 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 or received.

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

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 plan or policy.

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 certification.

3. The carrier or organized delivery system has three business days from the date of receipt to contest the commissioner's certification decision. If the commissioner finds that the request for external review is not eligible for certification, the commissioner, within two business days of the date of the request, 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 certification.

If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the carrier or organized delivery system, the commissioner shall promptly notify the carrier or organized delivery system in writing of the reasons for upholding the certification.

99 Acts, ch 41, §11, 22; 2001 Acts, ch 69, §26; 2002 Acts, ch 1119, §69

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.

99 Acts, ch 41, §12, 22

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, or within three business days of receipt of the commissioner's denial of the carrier's or organized delivery system's contest of the certification of the request under section 514J.5, subsection 3, whichever is later, 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 in writing the enrollee, and the enrollee's treating health care provider, of the name, address, and telephone number of the independent review entity and of the enrollee's and treating health care provider's right to submit additional information.

c. Notify the selected independent review entity by facsimile that the carrier or organized delivery system has chosen it to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review.

d. Provide to the commissioner by facsimile a copy of the notices sent to the enrollee and to the selected independent review entity.

2. The independent review entity, within three business days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the enrollee and the carrier containing a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity shall, upon request from the carrier, the enrollee, or the enrollee's treating health care provider, disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner. If the independent review entity does not have a person who is an expert in the treatment of the medical condition under review and certified by the commissioner to conduct an independent review, the independent review entity may either decline the review request or may request from the commissioner additional time to have such an expert certified. The independent review entity shall notify the commissioner by facsimile of its choice between these options within three business days of receipt of the notice from the carrier or organized delivery system. The commissioner shall provide a notice to the enrollee and carrier or organized delivery system of the independent review entity's decision and of the commissioner's decision as to how to proceed with the external review process within three business days of receipt of the independent review entity's decision.

3. 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 or to the person selected as the reviewer by the independent review entity by notifying the commissioner and carrier or organized delivery system within ten days of the mailing of the notice by the independent review entity. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

4. The carrier or organized delivery system, within fifteen days of the mailing of the notice by the independent review entity, or within three business days of a receipt of notice by the

commissioner following an objection by the enrollee, whichever is later, shall do all of the following:

a. Provide to the independent review entity 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.

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

c. Provide to the commissioner a confirmation that the information required in paragraphs *"a"* and *"b"* has been provided to the independent review entity, including the date the information was provided.

5. The enrollee, or the enrollee's treating health care provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the carrier's or organized delivery system's evidence of coverage, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the ten-day period.

6. 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 4. The enrollee or the enrollee's treating health care provider shall provide the requested information to the independent review entity within five days after receipt of the notification requesting additional medical information. The independent review entity may decide whether it is reasonable to consider any information provided by the enrollee or the enrollee's treating health care provider after the five-day period. The independent review entity shall notify the commissioner and the carrier or organized delivery system of this request.

7. The independent review entity shall submit its external review decision as soon as possible, but not later than thirty days from the date the independent review entity received the information required under subsection 4 from the carrier or organized delivery system. The independent review entity, for good cause, may request an extension of time from the commissioner. The independent review entity's external review decision shall be mailed to the enrollee or the treating health care provider acting on behalf of the enrollee, the carrier or organized delivery system, and the commissioner.

8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws. Other than the sharing of information required by this chapter and the rules adopted pursuant to this chapter, the commissioner shall keep confidential the information obtained in the external review process pursuant to section 505.8, subsection 8.

9. If an enrollee dies before the completion of the external review process, the process shall continue to completion if there is potential liability of a carrier or organized delivery system to the estate of the enrollee.

10. *a.* If an enrollee who has already received a service or treatment under a plan requests external review of the plan's coverage decision and changes to another plan before the external review process is completed, the carrier or organized delivery system whose coverage was in effect at the time the service or treatment was received is responsible for completing the external review process.

b. If an enrollee who has not yet received service or treatment requests external review of a plan's coverage decision and then changes to another plan prior to receipt of the service or treatment and completion of the external review process, the external review process shall

begin anew with the enrollee's current carrier or organized delivery system. In this instance, the external review process shall be conducted in an expedited manner.

99 Acts, ch 41, §13, 22; 2001 Acts, ch 69, §27; 2002 Acts, ch 1119, §70 – 72; 2003 Acts, ch 91, §31; 2006 Acts, ch 1117, §65; 2010 Acts, ch 1121, §17

[T] Subsection 2 amended

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.

99 Acts, ch 41, §14, 22

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.

99 Acts, ch 41, §15, 22

514J.10 Reporting.

The commissioner shall prepare an annual report 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 the report by January 31 of each year.

99 Acts, ch 41, §16, 22; 2003 Acts, ch 91, §32

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.

99 Acts, ch 41, §17, 22

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.

99 Acts, ch 41, §18, 22

514J.13 Effect of external review decision.

1. The review decision by the independent review entity conducting the review is binding upon the carrier or organized delivery system. The external review process shall not be considered a contested case under chapter 17A, the Iowa administrative procedure Act.

2. 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 petition shall name the enrollee or the enrollee's treating health care provider as the petitioner. The respondent shall be the carrier or the organized delivery system. The petition shall not name the independent review entity as a party. The commissioner shall not be named as a

respondent unless the petitioner alleges action or inaction by the commissioner under the standards articulated in section 17A.19, subsection 10. Allegations against the commissioner under section 17A.19, subsection 10, must be stated with particularity. The commissioner may, upon motion, intervene in the judicial review proceeding. The findings of fact by the independent review entity conducting the review are conclusive and binding on appeal.

3. 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.

4. 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.

99 Acts, ch 41, §19, 22; 2003 Acts, ch 91, §33

514J.14 Rules.

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

99 Acts, ch 41, §20, 22

514J.15 Penalties.

A carrier who fails to comply with this chapter or with rules adopted pursuant to this chapter is subject to the penalties provided under chapter 507B.

2001 Acts, ch 69, §28