CHAPTER 514F

UTILIZATION AND COST CONTROL

Referred to in §87.4, 296.7, 331.301, 364.4, 505.28, 505.29, 514C.11, 514L.1, 669.14, 670.7

514F.1 Utilization and cost control review committees.

The licensing boards under chapters 148, 149, 151, and 152 shall establish utilization and cost control review committees of licensees under the respective chapters, selected from licensees who have practiced in Iowa for at least the previous five years, or shall accredit and designate other utilization and cost control organizations as utilization and cost control committees under this section, for the purposes of utilization review of the appropriateness of levels of treatment and of giving opinions as to the reasonableness of charges for diagnostic or treatment services of licensees. Persons governed by the various chapters of Title XIII, subtitle 1, of the Code and self-insurers for health care benefits to employees may utilize the services of the utilization and cost control review committees upon the payment of a reasonable fee for the services, to be determined by the respective boards. The respective boards under chapters 148, 149, 151, and 152 shall adopt rules necessary and proper for the administration of this section pursuant to chapter 17A. It is the intent of this general assembly that conduct of the utilization and cost control review committees authorized under this section shall be exempt from challenge under federal or state antitrust laws or other similar laws in regulation of trade or commerce.

86 Acts, ch 1180, §10; 87 Acts, ch 115, §63; 88 Acts, ch 1199, §6; 89 Acts, ch 164, §6; 90 Acts, ch 1233, §32; 2007 Acts, ch 10, §177; 2008 Acts, ch 1088, §135

514F.2 Utilization and cost control.

Nothing contained in the chapters of Title XIII, subtitle 1, of the Code shall be construed to prohibit or discourage insurers, nonprofit service corporations, health maintenance organizations, or self-insurers for health care benefits to employees from providing payments of benefits or providing care and treatment under capitated payment systems, prospective reimbursement rate systems, utilization control systems, incentive systems for the use of least restrictive and least costly levels of care, preferred provider contracts limiting choice of specific provider, or other systems, methods or organizations designed to contain costs without sacrificing care or treatment outcome, provided these systems do not limit or make optional payment or reimbursement for health care services on a basis solely related to the license under or the practices authorized by chapter 151 or on a basis that is dependent upon a method of classification, categorization, or description based upon differences in terminology used by different licensees under the chapters of Title IV, subtitle 3, of the Code in describing human ailments or their diagnosis or treatment.

86 Acts, ch 1180, §10

514F.3 Preferred providers.

The commissioner of insurance shall adopt rules for preferred provider contracts and organizations, both those that limit choice of specific provider and those that do not. The rules adopted shall include, but not be limited to, the following subjects: preferred provider arrangements and participation requirements, health benefit plans, and civil penalties.

88 Acts, ch 1112, §604

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. Tit. 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.

99 Acts, ch 41, §5; 2010 Acts, ch 1061, §180

514F.5 Experimental treatment review.

1. A carrier, as defined in section 513B.2, an organized delivery system authorized under 1993 Iowa Acts, ch. 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.

99 Acts, ch 41, §6

514F.6 Credentialing — retrospective payment.

1. The commissioner shall adopt rules to provide for the retrospective payment of clean claims for covered services provided by a physician, advanced registered nurse practitioner,

or physician assistant during the credentialing period, once the physician, advanced registered nurse practitioner, or physician assistant is credentialed.

2. For purposes of this section, *"physician"* means a licensed doctor of medicine and surgery or a licensed doctor of osteopathic medicine and surgery; *"advanced registered nurse practitioner"* means a licensed nurse who is also registered to practice in an advanced role, *"physician assistant"* means a person who is licensed to practice as a physician assistant under the supervision of one or more physicians; and *"credentialing period"* means the time period between the health insurer's receipt of a physician's, advanced registered nurse practitioner's, or physician assistant's application for credentialing and approval of that application by the health insurer. *"Credentialing"* means a process through which a health insurer makes a determination based on criteria established by the health insurer concerning whether a physician, advanced registered nurse practitioner, or physician assistant is eligible to provide health care services to an insured and to receive reimbursement for the health care services provided under an agreement entered into between the physician, advanced registered nurse practitioner, or physician assistant and the health insurer. *"Clean claim"* means the same as defined in section 507B.4A, subsection 2, paragraph *"b"*.

2008 Acts, ch 1123, §28; 2010 Acts, ch 1121, §16