514G.110 Independent review of benefit trigger determinations.

1. *Request.* An insured may file a written request for independent review of a benefit trigger determination with the commissioner after the internal appeal process has been exhausted. The request shall be filed within sixty days after the insured receives written notice of the insurer's internal appeal decision.

2. *Fee.* A request for independent review shall 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 insured prevails in the independent review process.

3. *Eligibility for review.* The commissioner shall certify that the request is eligible for independent review if all of the following criteria are satisfied:

a. The insured was covered by a long-term care insurance policy issued by the insurer at the time the benefit trigger determination was made.

b. The sole reason for requesting an independent review is to review the insurer's determination that the benefit trigger was not met.

c. The insured has exhausted all internal appeal procedures provided under the insured's long-term care insurance policy.

d. The written request for independent review was filed by the insured within sixty days from the date of receipt of the insurer's internal appeal decision.

4. *Notice of eligibility.* The commissioner shall provide written notice regarding eligibility of a request for independent review to the insured and the insurer within two business days from the date of receipt of the request.

a. If the commissioner decides that the request is not eligible for independent review, the written notice shall indicate the reasons for that decision.

b. If the commissioner certifies that the request is eligible for independent review, the insurer may appeal that certification by filing a written notice of appeal with the commissioner within three business days from the date of receipt of the notice of certification. If upon further review, the commissioner upholds the certification, the commissioner shall promptly notify the insured and the insurer in writing of the reasons for that decision.

5. *Qualifications of independent review entities.* The commissioner shall maintain a list of qualified independent review entities that are certified by the commissioner. Independent review entities shall be recertified by the commissioner every two years in order to remain on the list. In order to be certified, an independent review entity shall meet all of the following criteria:

a. Have on staff, or contract with, a qualified, licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment who can conduct an independent review.

(1) In order to be qualified, a licensed health care professional who is a physician shall hold a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

(2) In order to be qualified, a licensed health care professional who is not a physician shall hold a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

b. Ensure that any licensed health care professional who conducts an independent review has no history of disciplinary actions or sanctions, including but not limited to the loss of staff privileges or any participation restrictions taken or pending by any hospital or state or federal government regulatory agency.

c. Ensure that the independent review entity or any of its employees, agents, or licensed health care professionals utilized does not receive compensation of any type that is dependent on the outcome of a review.

d. Ensure that the independent review entity or any of its employees, agents, or licensed health care professionals utilized are not in any manner related to, employed by, or affiliated with the insured or with a person who previously provided medical care to the insured.

e. Ensure that an independent review entity or any of its employees, agents, or licensed health care professionals utilized is not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insurer is a member.

f. Have a quality assurance program on file with the commissioner that ensures the timeliness and quality of reviews performed, the qualifications and independence of the licensed health care professionals who perform the reviews, and the confidentiality of the review process.

g. Have on staff or contract with a licensed health care practitioner, as defined in section 514G.103, subsection 3, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

6. *Independent review process.* The independent review process shall be conducted as follows:

a. Within three business days of receiving a notice from the commissioner of the certification of a request for independent review or receipt of a denial of an insurer's appeal from such a certification, the insurer shall do all of the following:

(1) Select an independent review entity from the list certified by the commissioner and notify the insured in writing of the name, address, and telephone number of the independent review entity selected. The independent review entity selected shall utilize a licensed health care professional with qualifications appropriate to the benefit trigger determination that is under review.

(2) Notify the independent review entity that it has been selected to conduct an independent review of a benefit trigger determination and provide sufficient descriptive information to enable the independent review entity to provide licensed health care professionals who will be qualified to conduct the review.

(3) Provide the commissioner with a copy of the notices sent to the insured and to the independent review entity selected.

b. Within three business days of receiving a notice from an insurer that it has been selected to conduct an independent review, the independent review entity shall do one of the following:

(1) Accept its selection as the independent review entity, designate a qualified licensed health care professional to perform the independent review, and provide notice of that designation to the insured and the insurer, including a brief description of the health care professional's qualifications and the reasons that person is qualified to determine whether the insured's benefit trigger has been met. A copy of this notice shall be sent to the commissioner via facsimile. The independent review entity is not required to disclose the name of the health care professional selected.

(2) Decline its selection as the independent review entity or, if the independent review entity does not have a licensed health care professional who is qualified to conduct the independent review available, request additional time from the commissioner to have a qualified licensed health care professional certified, and provide notice to the insured, the insurer, and the commissioner. The commissioner shall notify the review entity, the insured, and the insurer of how to proceed within three business days of receipt of such notice from the independent review entity.

c. An insured may object to the independent review entity selected by the insurer or to the licensed health care professional designated by the independent review entity to conduct the review by filing a notice of objection along with reasons for the objection, with the commissioner within ten days of receipt of a notice sent by the independent review entity pursuant to paragraph *"b"*. The commissioner shall consider the insured's objection and shall notify the insured, the insurer, and the independent review entity of the commissioner's decision to sustain or deny the objection within two business days of receipt of the objection.

d. Within five business days of receiving a notice from the independent review entity accepting its selection or within five business days of receiving a denial of an objection to the review entity selected, whichever is later, the insured may submit any information or documentation in support of the insured's claim to both the independent review entity and the insurer.

e. Within fifteen days of receiving a notice from the independent review entity accepting its selection or within three business days of receipt of a denial of an objection to the independent review entity selected, whichever is later, an insurer shall do all of the following:

(1) Provide the independent review entity with any information submitted to the insurer

by the insured in support of the insured's internal appeal of the insurer's benefit trigger determination.

(2) Provide the independent review entity with any other relevant documents used by the insurer in making its benefit trigger determination.

(3) Provide the insured and the commissioner with confirmation that the information required under subparagraphs (1) and (2) has been provided to the independent review entity, including the date the information was provided.

f. The independent review entity shall not commence its review until fifteen days after the selection of the independent review entity is final including the resolution of any objection made pursuant to paragraph "*c*". During this time period, the insurer may consider any information provided by the insured pursuant to paragraph "*d*" and overturn or affirm the insurer's benefit trigger determination based on such information. If the insurer overturns its benefit trigger determination, the independent review process shall immediately cease.

g. In conducting a review, the independent review entity shall consider only the information and documentation provided to the independent review entity pursuant to paragraphs "*d*" and "*e*".

h. The independent review entity shall submit its decision as soon as possible, but not later than thirty days from the date the independent review entity receives the information required under paragraphs "*d*" and "*e*", whichever is received later. The decision shall include a description of the basis for the decision and the date of the benefit trigger determination to which the decision relates. The independent review entity, for good cause, may request an extension of time from the commissioner to file its decision. A copy of the decision shall be mailed to the insured, the insurer, and the commissioner.

i. All medical records submitted for use by the independent review entity shall be maintained as confidential records as required by applicable state and federal laws. The commissioner shall keep all information obtained during the independent review process confidential pursuant to section 505.8, subsection 8, except that the commissioner may share some information obtained as provided under section 505.8, subsection 8, and as required by this chapter and rules adopted pursuant to this chapter.

j. If an insured dies before completion of the independent review, the review shall continue to completion if there is potential liability of an insurer to the estate of the insured or to a provider for rendering qualified long-term care services to the insured.

7. *Costs.* All reasonable fees and costs of the independent review entity incurred in conducting an independent review under this section shall be paid by the insurer.

8. *Immunity.* An independent review entity that conducts a review under this section is not liable for damages arising from determinations made during the review. Immunity does not apply to any act or omission made by an independent review entity in bad faith or that involves gross negligence.

9. *Effect of independent review decision.*

a. The review decision by the independent review entity conducting the review is binding on the insurer.

b. The independent review process set forth in this section shall not be considered a contested case under chapter 17A.

c. An insured may appeal the review decision by the independent review entity conducting the review by filing a petition for judicial review in the district court in the county in which the insured resides. The petition for judicial review shall be filed within fifteen business days after the issuance of the review decision. The petition shall name the insured as the petitioner and the insurer as the respondent. The petitioner shall not name the independent review entity as a party. The commissioner shall not be named as a respondent unless the insured alleges action or inaction by the commissioner under the standards articulated under section 17A.19, subsection 10. Allegations made against the commissioner under section 17A.19, subsection 10, must be stated with particularity. The commissioner may, upon motion, intervene in a judicial review proceeding brought pursuant to this paragraph. The findings of fact by the independent review entity conducting the review are conclusive and binding on appeal.

d. An insurer shall not be subject to any penalties, sanctions, or damages for complying

in good faith with a review decision rendered by an independent review entity pursuant to this section.

e. Nothing contained in this section or in section 514G.109 shall be construed to limit the right of an insurer to assert any rights an insurer may have under a long-term care insurance policy related to:

(1) An insured's misrepresentation.

(2) Changes in the insured's benefit eligibility.

(3) Terms, conditions, and exclusions contained in the policy, other than failure to meet the benefit trigger.

f. The requirements of this section and section 514G.109 are not applicable to a group long-term care insurance policy that is governed by the federal Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. §100 et seq.

g. The provisions of this section and section 514G.109 are in lieu of and supersede any other third-party review requirement contained in chapter 514J or in any other provision of law.

h. The insured may bring an action in the district court in the county in which the insured resides to enforce the review decision of the independent review entity conducting the review or the decision of the court on appeal.

10. *Receipt of notice.* Notice required by this section shall be deemed received within five days after the date of mailing.

2008 Acts, ch 1175, §11, 18; 2011 Acts, ch 34, §118

Referred to in **§514G.103**, **§514G.109**