514J.108 External review — expedited.

1. Notwithstanding section 514J.107, a covered person or the covered person's authorized representative may make an oral or written request to the commissioner for an expedited external review at the time the covered person or the covered person's authorized representative receives any of the following:

a. An adverse determination that involves a medical condition of the covered person for which the time frame for completion of an internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

b. A final adverse determination that involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

c. A final adverse determination that concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, and the covered person has not been discharged from a facility.

2. *a.* Upon receipt of a request for an expedited external review, the commissioner shall immediately send written notice of the request to the health carrier.

b. Immediately upon receipt of notice of a request for expedited external review, the health carrier shall complete a preliminary review of the request to determine whether the request meets the eligibility requirements for external review set forth in section 514J.107, subsection 3, and this section.

c. The health carrier shall then immediately issue a notice of initial determination informing the commissioner and the covered person or the covered person's authorized representative of its eligibility determination including a statement informing the covered person or the covered person's authorized representative of the right to appeal that determination to the commissioner.

d. The commissioner may specify by rule the form required for the health carrier's notice of initial determination and any supporting information to be included in the notice.

3. The commissioner may determine that a request is eligible for expedited external review, notwithstanding a health carrier's initial determination that the request is not eligible. In making a determination, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter. The commissioner shall make a determination pursuant to this subsection as expeditiously as possible.

4. *a.* Upon receipt of notice from a health carrier that a request is eligible for expedited external review or upon a determination by the commissioner that a request is eligible for expedited external review, the commissioner shall immediately assign an independent review organization from the list of approved independent review organizations maintained by the commissioner to conduct the expedited external review. The commissioner shall then immediately notify the health carrier and the covered person or the covered person's authorized representative of the name of the assigned independent review organization.

b. The assignment of an independent review organization shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns.

5. Upon receiving notice of the independent review organization assigned to conduct the expedited external review, the health carrier shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the independent review organization electronically or by telephone or facsimile or any other available expeditious method.

6. The independent review organization is not bound by any decisions or conclusions reached during the health carrier's internal grievance process. The independent review organization shall consider the documents and information provided by the health carrier,

and to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

a. The covered person's pertinent medical records.

b. The treating health care professional's recommendation.

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's authorized representative, or the covered person's treating physician or other health care professional.

d. The terms of coverage under the covered person's health benefit plan with the health carrier, to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

e. 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.

f. Any applicable clinical review criteria developed and used by the health carrier.

g. The opinion of the independent review organization's clinical reviewer after considering the information or documents described in paragraphs *"a"* through *"f"* to the extent the information or documents are available and the clinical reviewer considers them relevant.

7. *a.* As expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two hours after the date of receipt of an eligible request for expedited external review, the assigned independent review organization shall do all of the following:

(1) Make a decision to uphold or reverse the adverse determination or final adverse determination of the health carrier.

(2) Notify the covered person or the covered person's authorized representative, the health carrier, and the commissioner of its decision.

b. If the notice given by the independent review organization pursuant to paragraph *"a"* was not in writing, within forty-eight hours after providing that notice, the independent review organization shall provide written confirmation of the decision to the covered person or the covered person's authorized representative, the health carrier, and the commissioner that includes the information set forth in section 514J.107, subsection 13, paragraph *"b"*.

c. Upon receipt of the notice of decision by an independent review organization pursuant to paragraph *"a"* reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

2011 Acts, ch 101, §8; 2012 Acts, ch 1021, §99
Referred to in §514J.106, 514J.109