514F.8 Prior authorizations — reimbursement.

1. For purposes of this section:

a. *"Covered person"* means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

b. *"Facility"* means the same as defined in section 514J.102.

c. *"Health benefit plan"* means the same as defined in section 514J.102.

d. *"Health care professional"* means the same as defined in section 514J.102.

e. *"Health care provider"* means a health care professional or a facility.

f. *"Health care services"* means services provided by a health care provider for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease. *"Health care services"* includes the provision of durable medical equipment. *"Health care services"* does not include prescription drugs or dental care services as that term is defined in section 514J.102.

g. *"Health carrier"* means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, 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. *"Health carrier"* does not include the department of health and human services, or a managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

h. *"Prior authorization"* means a determination by a utilization review organization that a specific health care service proposed by a health care provider for a covered person is medically necessary or medically appropriate, and the determination is made prior to the provision of the health care service to the covered person, and, if applicable, includes a utilization review organization's requirement that a covered person or a health care provider notify the utilization review organization prior to receiving or providing a specific health care service.

i. *"Utilization review"* means the same as defined in section 514F.4, subsection 3.

j. *"Utilization review organization"* means an entity that performs utilization review, including a health carrier that meets the requirements established for accreditation set by the utilization review accreditation commission or the national committee on quality assurance and that performs utilization review for the health carrier's health benefit plans.

2. *a.* A utilization review organization shall provide a determination to a request for prior authorization from a health care provider as follows:

(1) Within forty-eight hours after receipt for urgent requests.

(2) Within ten calendar days after receipt for nonurgent requests.

(3) Within fifteen calendar days after receipt for nonurgent requests if there are complex or unique circumstances or the utilization review organization is experiencing an unusually high volume of prior authorization requests.

b. Within twenty-four hours after receipt of a prior authorization request, the utilization review organization shall notify the health care provider of, or make available to the health care provider, a receipt for the request for prior authorization.

c. A utilization review organization shall conduct an annual review and submit the findings in a report to the commissioner pursuant to the reporting procedures and deadlines established by the commissioner. The commissioner shall publish, within sixty calendar days of receipt, the report on a publicly accessible internet site. The annual report shall include all of the following:

(1) The total number of, and percentage of, urgent prior authorization requests that the utilization review organization approved, aggregated for all health care services and items.

(2) The total number of, and percentage of, urgent prior authorization requests that the utilization review organization denied, aggregated for all health care services or items.

(3) The total number of, and percentage of, nonurgent prior authorization requests that the utilization review organization approved, aggregated for all health care services or items.

(4) The total number of, and percentage of, nonurgent prior authorization requests that the utilization review organization denied, aggregated for all health care services or items.

(5) The total number of, and percentage of, nonurgent prior authorization requests that were complex or involved unique circumstances that the utilization review organization approved, aggregated for all health care services or items.

(6) The average and median time that elapsed between the submission of a prior authorization request and a determination by the utilization review organization for the prior authorization request, aggregated for all health care services or items.

(7) The average and median time that elapsed between the submission of an urgent prior authorization request and a determination by the utilization review organization for the urgent prior authorization request, aggregated for all health care services or items.

(8) The average and median time that elapsed between the submission of a nonurgent prior authorization request and a determination by the utilization review organization for the nonurgent prior authorization request, aggregated for all health care services or items.

3. *a.* A utilization review organization shall not revoke, or impose a limitation, condition, or restriction on, a prior authorization after the date on which a health care provider provides a health care service to a covered person per the prior authorization.

b. A health carrier shall reimburse a health care provider at the contracted reimbursement rate for a health care service provided by the health care provider to a covered person per a prior authorization.

c. Paragraphs "*a*" and "*b*" shall not apply in any of the following circumstances:

(1) The health care provider or the covered person committed fraud, waste, or abuse.

(2) The health care provider or the covered person provided inaccurate information that the utilization review organization relied on for the utilization review organization's prior authorization determination.

(3) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the health care service was no longer a benefit covered by the covered person's health benefit plan.

(4) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the health care provider was no longer contracted with the health carrier that provides the covered person's health benefit plan.

(5) The health care provider failed to meet the health carrier's requirements related to timely filing of claims for submission of a claim for the health care service provided by the health care provider to the covered person per the prior authorization.

(6) Due to coordination of benefits, the health carrier does not have liability for a claim for the health care service provided by the health care provider to the covered person per a prior authorization.

(7) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the covered person was no longer a participant in the health benefit plan in which the covered person participated on the date that the prior authorization was received by the health care provider.

4. *a.* A utilization review organization shall, at least annually, review all health care services for which the health benefit plan requires prior authorization and shall eliminate prior authorization requirements for health care services for which prior authorization requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality, or reduce health care spending, to a degree sufficient to justify the health benefit plan's administrative costs to require the prior authorization.

b. A utilization review organization shall submit an annual report containing the findings of the review conducted under paragraph "*a*" to the commissioner pursuant to the reporting procedures and deadlines established by the commissioner. The commission shall publish, within sixty days of receipt, the report on a publicly accessible internet site. The annual report shall include all of the following:

(1) The total number of prior authorizations the utilization review organization evaluated as part of the annual review.

(2) The number of prior authorizations the utilization review organization eliminated as a result of the annual review, and the reason for the elimination.

(3) A list of prior authorizations that had at least eighty percent of requests approved in the previous twelve months for a specific health care service covered by a health benefit plan, but which prior authorizations were retained due to medical or scientific evidence, as defined in section 514J.102, that justified continuing such requirement.

(4) The total number of prior authorization requests submitted in the previous twelve months for each eliminated prior authorization, and the total number of health care providers that submitted a request for prior authorization in the previous twelve months for each eliminated prior authorization requirement.

(5) For each health care service for which prior authorization was eliminated under subparagraph (2), the report shall include data regarding any increase or decrease of ten percent or greater in the average number of claims submitted per health care provider for that health care service compared to the twelve months immediately preceding the elimination of the prior authorization.

5. A prior authorization for a specific health care service for a covered person shall be valid for the specific health care service for not less than ninety days from the date that the covered person's health care provider receives the prior authorization from a utilization review organization, provided that during the ninety days the covered person remains a participant in the same health benefit plan in which the covered person participated on the date the prior authorization was received by the health care provider.

6. Complaints regarding a utilization review organization's compliance with this chapter may be directed to the insurance division. The insurance division shall notify a utilization review organization of all complaints regarding the utilization review organization's noncompliance with this chapter. All complaints received pursuant to this subsection shall not be considered public records for purposes of chapter 22.

7. The commissioner may adopt rules pursuant to chapter 17A as necessary to administer this chapter.

2022 Acts, ch 1056, §1, 2; 2023 Acts, ch 19, §1204; 2025 Acts, ch 108, §1; 2025 Acts, ch 159, §16

NEW subsection 2 and former subsection 2 renumbered as 3
NEW subsection 4 and former subsection 3 renumbered as 5
NEW subsection 6 and former subsection 4 renumbered as 7