CHAPTER 76
EXTERNAL REVIEW

191—76.1(514J) Purpose. This chapter is intended to implement 2011 Iowa Code Supplement chapter 514J and the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148 as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, which amends the Public Health Service Act and adopts, in part, new 42 U.S.C. Section 300gg-19. These rules address issues which are unique to the external review process in this state and provide a uniform process for covered persons of health carriers providing health insurance coverage or the covered persons' authorized representatives to request and receive an external review of adverse determinations and final adverse determinations as defined in 2011 Iowa Code Supplement sections 514J.102(1) and 514J.102(18) and as referenced in 2011 Iowa Code Supplement section 514J.109(1). Health carriers defined in 2011 Iowa Code Supplement section 514J.102(23), and included in paragraph 76.2(2)*"c"* are subject to these rules.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.2(514J) Applicable law and definitions.

76.2(1) The rules contained in this chapter shall apply to any health benefit plan as defined in 2011 Iowa Code Supplement section 514J.102(19) other than those excluded under 2011 Iowa Code Supplement section 514J.103(2), for any plan that is offered or issued by a health carrier as defined in 2011 Iowa Code Supplement section 514J.102(23), if the plan was issued in Iowa, and if the external review request is filed with the commissioner on or after July 1, 2011.

76.2(2) For purposes of this chapter, the definitions in 2011 Iowa Code Supplement chapter 514J shall apply. In addition:

a. For purposes of applying the exemption in 2011 Iowa Code Supplement section 514J.103(2)*"b,"* "Medicare supplement policy of insurance" shall mean the same as "Medicare supplement policy" as defined in rule 191—37.3(514D).

b. For purposes of this chapter, the definition of "adverse determination" in 2011 Iowa Code Supplement section 514J.102 shall include experimental or investigational treatment adverse determinations, as set forth in 2011 Iowa Code Supplement section 514J.109.

c. For purposes of this chapter, the definition of "health carrier" may include an employer self-funded plan if the employer chooses to opt in to comply with these rules.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.3(514J) Disclosure requirements. The description of external review procedures required by 2011 Iowa Code Supplement section 514J.116 shall be in the form of Appendix A or substantially similar language approved by the commissioner.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.4(514J) External review request.

76.4(1) Except for requests for expedited review, the covered person or the covered person's authorized representative shall submit a written request for external review (completed Appendix B) to the commissioner by personal delivery, by mail, by fax or by electronic transmission, including a copy of the health carrier's written notice containing the final adverse determination, within the time periods specified in 2011 Iowa Code Supplement section 514J.107(1) or 514J.109(1), as applicable. The request form and notice shall be submitted to the commissioner at Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319; fax (515)281-3059; or e-mail iid.marketregulation@iid.iowa.gov.

76.4(2) Requests for expedited review may be made orally, and the commissioner may require submission of additional documentation such as physician certifications or medical information releases as is deemed practicable under the time constraints.

76.4(3) There is no charge or fee for submitting a request for external review.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.5(514J) Communication between covered person, health carrier, independent review organization and the commissioner.

76.5(1) Notices or other communications required by 2011 Iowa Code Supplement chapter 514J between the commissioner, the health carrier and the independent review organization shall be by e-mail or facsimile, unless otherwise specified, and shall be documented to prove transmission and receipt of the communication.

76.5(2) Notices or other communications required by 2011 Iowa Code Supplement chapter 514J from the commissioner, the health carrier or the independent review organization to the covered person shall be by e-mail, facsimile or overnight mail, and shall be documented to prove transmission and receipt of the communication.

76.5(3) The covered person or covered person's representative may provide notifications and communications to the health carrier, independent review organization and the commissioner as required by 2011 Iowa Code Supplement chapter 514J by e-mail, facsimile or overnight mail, but also may do so by first-class mail or personal delivery.

76.5(4) Any time periods or deadlines specified in 2011 Iowa Code Supplement chapter 514J shall commence upon receipt of the notice or communication and cease upon the transmission of the subsequent notice or communication.

[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.6(514J) Assignment of independent review organization by the commissioner.

76.6(1) The assignment by the commissioner of an independent review organization pursuant to 2011 Iowa Code Supplement chapter 514J shall be by rotation among approved independent review organizations.

76.6(2) Upon assignment by the commissioner of an independent review organization, in addition to providing notice to the health carrier and the covered person or covered person's representative as required by 2011 Iowa Code Supplement chapter 514J, the commissioner shall provide notice of the assignment to the independent review organization.

76.6(3) Within two business days of receipt by the independent review organization of notice from the commissioner pursuant to subrule 76.6(2), the independent review organization shall make a determination of its ability to perform the external review and advise the commissioner if the independent review organization is unable to perform the review due to conflict of interest or due to lack of expertise or qualification for the particular subject matter of the review.

[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.7(514J) Decision notification. The independent review organization shall immediately provide a copy of a draft of the decision to the commissioner for review. The commissioner shall review the draft of the decision to verify that the independent review organization has included in its draft of the decision the requirements set forth in 2011 Iowa Code Supplement section 514J.107, 514J.108, or 514J.109. The commissioner shall make any suggestions for changes to make the draft of the decision comply with the requirements. The independent review organization shall make such required changes within two business days. Once the commissioner determines that the decision meets the requirements of 2011 Iowa Code Supplement section 514J.107, 514J.108, or 514J.109, as applicable, the independent review organization shall immediately send the decision to the commissioner, the health carrier, and the covered person or covered person's authorized representative. The decision approved by the commissioner shall be delivered by telephone, fax or electronic transmission to the health carrier, the commissioner and the covered person or covered person's authorized representative, and a hard copy of the decision also shall be delivered by mail to the covered person or covered person's authorized representative.

[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.8(514J) Health carrier information.

76.8(1) Each health carrier shall provide to the commissioner the name, title, telephone number, fax number and e-mail address of the individual who shall be the health carrier's contact person for

external review procedures. The carrier's contact person or an appointed alternate shall be available to the commissioner during the Iowa insurance division's normal business hours, 8 a.m. to 4:30 p.m., Monday through Friday, central time, excluding state holidays. Any change in personnel or contact information shall be immediately sent to the commissioner.

76.8(2) Each health carrier shall make available to the commissioner upon request within five business days a detailed description of the process the health carrier has in place to ensure compliance with the requirements found in this chapter and in 2011 Iowa Code Supplement chapter 514J. The description shall include:

a. An explanation of how the carrier determines when a person has qualified for external review and should receive a notice from the carrier, and

b. A copy of the notice sent to persons who fall within the scope of the law.

76.8(3) Each health carrier shall provide to the commissioner, upon request, information set forth in 2011 Iowa Code Supplement section 514J.114(2)*"b,"* in a format substantially similar to Appendix D, or as approved by the commissioner.

[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.9(514J) Certification of independent review organization.

76.9(1) In addition to the minimum qualifications set forth in 2011 Iowa Code Supplement section 514J.112, the following minimum standards are required for certification as an independent review organization:

a. The applicant shall provide a description of the procedures employed to comply with 2011 Iowa Code Supplement section 514J.112(1)*"a."*

b. The applicant shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review.

c. The applicant shall provide the names and résumés of all directors, officers, and executives of the independent review organization.

d. The applicant shall provide a description of the fees to be charged to the carrier by the independent review organization for external reviews.

e. The applicant shall provide the name of the medical director or health professional director responsible for the supervision and oversight of the independent review procedure.

76.9(2) The independent review organization shall develop written policies and procedures to ensure adherence to the requirements of this chapter and 2011 Iowa Code Supplement chapter 514J by any contractor, subcontractor, subvendor, agent or employee affiliated with the certified independent review organization.

76.9(3) In addition to the toll-free telephone service required by 2011 Iowa Code Supplement section 514J.112(1)*"b,"* the independent review organization shall establish a facsimile and electronic mail service to receive information relating to external reviews pursuant to this chapter and 2011 Iowa Code Supplement chapter 514J.

76.9(4) The independent review organization shall provide the commissioner within ten business days of request such data, information, and reports as the commissioner determines necessary to evaluate the external review process established under 2011 Iowa Code Supplement chapter 514J or a report in the format of Appendix C to comply with 2011 Iowa Code Supplement section 514J.114(1).

76.9(5) Applications shall be submitted to the Commissioner of Insurance, 330 Maple Street, Des Moines, Iowa 50319; or as designated by the commissioner. Applications must be submitted in full to be considered. The form for initially approving and for reapproving independent review organizations required by 2011 Iowa Code Supplement section 514J.111(4) shall be in the form of Appendix E. If the commissioner designates an entity to review applications, the designee may charge a fee, as permitted by 2011 Iowa Code Supplement section 514J.111(5) and as approved by the commissioner. All applicants will be notified of the certification decision.

76.9(6) A list of certified independent review organizations shall be maintained by the commissioner and shall be available through the Web site of the Iowa insurance division, www.iid.state.ia.us.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11; **ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.10(514J) Fees charged by independent review organizations.

76.10(1) Fees charged by independent review organizations shall be reasonable.

76.10(2) A health carrier objecting to the fee charged by an independent review organization shall file a written notice with the commissioner and the independent review organization indicating the health carrier's objections to the fee and the reasons and any documentation for the objections.

76.10(3) Five days after receipt of the notice, the independent review organization may submit to the commissioner written documentation supporting the fee.

76.10(4) If the parties do not come to an agreement within 30 days of the initial notice, the commissioner or the commissioner's designee shall conduct a review of the fee and submissions and issue a written decision within 60 days. Factors to consider in determining whether a fee is unreasonable may include the following:

a. The time and labor required to perform the independent review;

b. The novelty and difficulty of the issues;

c. The skill requisite to perform the independent review properly;

d. The customary fee;

e. The experience, reputation and ability of the independent review organization and those performing the independent review.

76.10(5) A party may appeal the commissioner's decision pursuant to 191—Chapter 3.
[**ARC 9979B**, IAB 1/25/12, effective 2/29/12]

191—76.11(514J) Penalties.

76.11(1) *Independent review organizations.* The commissioner may withdraw the approval of an independent review organization for any of the following reasons:

a. Failure to maintain the minimum standards set forth in 2011 Iowa Code Supplement sections 514J.111 and 514J.112 or in subrule 76.9(1).

b. Failure to comply with any of the requirements in subrules 76.9(2) through 76.9(5) or rule 191—76.10(514J).

c. Failure to meet any time requirements for conducting a standard, an experimental or investigational, or an expedited external review.

d. Failure to comply with any other requirements set forth in this chapter or in 2011 Iowa Code Supplement chapter 514J.

76.11(2) *Health carriers.*

a. Failure to comply with any of the provisions of this chapter is a violation of Iowa Code chapter 507B.

b. The commissioner may require a health carrier to provide additional time for a covered person to request an external review or submit documentation if the health carrier failed to comply with any part of 2011 Iowa Code Supplement chapter 514J or of this chapter.

c. The commissioner may order restitution or take other corrective action pursuant to Iowa Code section 505.8(10).
[**ARC 9979B**, IAB 1/25/12, effective 2/29/12]

These rules are intended to implement 2011 Iowa Code Supplement chapter 514J.

Appendix A

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request additional explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact us when you:

- Do not understand the reason for denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guidelines, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

Internal Appeal: All appeals to us for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [insert address of the health carrier contact person where appeals should be sent] within **180 days** of the date you receive our denial. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim, and you may request copies of information that we have that pertains to your claim. We will notify you of our decision in writing within **30 days** of receiving your appeal. If you do not receive our decision within **30 days** of receiving your appeal, you may be entitled to file a request for external review.

External Review: We have denied your request for the provision of or payment for a health care service or course of treatment. If our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, **you may have a right to have our decision reviewed** by health care professionals who have no association with us. Requests for external review may be submitted to the Commissioner of Insurance.

You may obtain an external review if:

- Our decision involved the admission, availability of care, continued stay, or other health care service that is a covered benefit; and

- We denied, reduced or terminated the requested service or treatment or payment for the service or treatment because we determined it did not meet our requirements for medical necessity, health care setting, level of care or effectiveness of the health care service or treatment you requested.

- You have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. In this situation, you may file a request for an **expedited external review** of our denial.

- The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which you received emergency services, but you have not been discharged from a facility. In this situation, you or your authorized representative may request an **expedited external review**.

- Our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational. In addition, if your treating health care professional certifies in writing that the recommended or requested health care service or treatment that is the subject of the recommendation or request would be significantly less effective if not promptly initiated, then you or your authorized representative may request an **expedited external review**.

You can obtain a copy of the External Review Request Form from: the Iowa Insurance Division, 330 Maple, Des Moines, Iowa 50319; telephone 877-955-1212 or 515-281-6348; facsimile 515-281-3059; Web site www.iid.state.ia.us.

Within **four months** after receipt of our notice containing the final adverse determination and this Notice of Appeal Rights, you should submit a request for external review to the Iowa Insurance Division, 330 Maple, Des Moines, Iowa 50319; telephone 877-955-1212 or 515-281-6348; facsimile 515-281-3059; e-mail iid.marketregulation@iid.iowa.gov.

For standard external review, a decision will be made within **45 days** after the independent review organization receives your request.

For details, please review your Benefit Plan Document, contact us, or contact the Iowa Insurance Division.

Appendix B

EXTERNAL REVIEW REQUEST FORM

SECTION 1. ELIGIBILITY FOR EXTERNAL REVIEW

This External Review Request Form must be filed with the Iowa Insurance Division within **four months** after your health carrier denied, reduced or terminated the requested health care service or treatment or payment for the service or treatment. You or your authorized representative may request an external review under any of the following circumstances:

1. Your health carrier has made a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, and Section 7 if you are requesting an expedited review.**

2. Your health carrier has made a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, Section 6, and Section 7 if you are requesting an expedited review.**

3. The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which you received emergency services, but you have not been discharged from a facility. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, and Section 7.**

If coverage was denied for a service or treatment specifically listed in your health insurance policy as excluded from coverage (other than what is listed in paragraphs 1 and 2 above), you will not be eligible for external review.

You also will need to have completed any internal appeals with your health carrier before you can request an external review, unless:

1. You already did request an internal appeal with your health carrier and have not received a decision and it has been 30 days since you requested the appeal; or

2. Your health carrier has waived the requirement that you complete an internal appeal before requesting an external review; or

3. You need an expedited review because time is a factor in your treatment.

SECTION 2. WHAT TO SEND AND WHERE TO SEND IT

YOU MUST SUBMIT ITEMS 1 AND 2 BELOW:

1. This External Review Request Form, signed and dated, with the sections completed for your particular situation as described in Section 1. If you would like help completing your external review request for submission, contact the Consumer Assistance Program of the Iowa Insurance Division by calling 877-955-1212, or by e-mail at http://insuranceca.iowa.gov.

2. One of the following:

   a. The letter from the covered person's health carrier or utilization review company that states that the decision is final and that the covered person or the covered person's authorized representative has exhausted all internal appeal procedures;

   b. The letter from the covered person's health carrier or utilization review company that states it has waived the requirement to exhaust all of the health carrier's internal appeal procedures;

   c. A copy of the covered person's or the covered person's authorized representative's request for internal appeal and a statement that no decision from the health carrier has been received for 30 days; or

   d. A completed request for expedited review, Section 7 of this form.

WHERE TO SEND IT:

If you are requesting a standard external review, send all paperwork to the Iowa Insurance Division, 330 Maple, Des Moines, Iowa 50319; facsimile 515-281-3059; e-mail iid.marketregulation@iid.iowa.gov. If you have questions, telephone 877-955-1212 or 515-281-6348.

If you are requesting an expedited external review, call the Iowa Insurance Division (telephone 877-955-1212 or 515-281-6348) before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

SECTION 3. INFORMATION REQUIRED FOR ALL EXTERNAL REVIEW REQUESTS

APPLICANT NAME

The applicant is a:

☐ Covered Person/Patient

☐ Provider (the covered person/patient must complete Section 4)

☐ Authorized Representative (submit completed Sections 4 and 5)

COVERED PERSON/PATIENT INFORMATION

Covered Person's/Patient's Name:
Address:
Telephone Number:
Daytime:
Evening:
E-mail Address:
Fax Number:

INSURANCE INFORMATION

Name of Insurer or HMO:
Covered Person's Insurance ID Number and/or Policy Number:
Insurance Claim/Reference Number:
Insurer/HMO Mailing Address:
Insurer/HMO Telephone Number:
Insurer/HMO E-mail Address:
Insurer/HMO Fax Number:

EMPLOYER INFORMATION

Employer's Name:

Is the health coverage that you have through your employer a self-funded plan? (Y/N)_____.

Some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider:
Address:
Contact Person:
Telephone Number:
E-mail Address:
Fax Number:
Patient Medical Record Number:

REASON FOR HEALTH CARRIER'S DENIAL

(Please check one.)

☐ The health care service or treatment was denied due to medical necessity, appropriateness, health care setting, level of care or effectiveness.

☐ The health care service or treatment is experimental or investigational (submit completed Section 6).

☐ Other: _____.

SUMMARY OF EXTERNAL REVIEW REQUEST

Enter a brief description of the claim and the request for health care service or treatment that was denied and attach a copy of the denial from your health carrier.

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the health care service or treatment decision in dispute and why you are appealing this denial. Indicate clearly the services being denied and the specific dates for the services being denied. Explain why you disagree. Attach additional pages if necessary and include available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies, and any additional information from your physician or health care provider that you want the independent review organization to consider.

SECTION 4. SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external review. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Iowa Insurance Division. I understand that the independent review organization and the Iowa Insurance Division will use this information to make a determination on my external review and that the information will be kept confidential and will not be released to anyone else. This release is valid for one year.

_____

Signature of covered person/patient or legal representative (parent, guardian, conservator or other – please specify)

Date:

SECTION 5. APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this request for external review.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my external review request on my behalf.

_____
Signature of covered person/patient or legal representative (parent, guardian, conservator or other – please specify)

Date:

Address of Authorized Representative:
Authorized Representative's Telephone Number:
Daytime:
Evening:
Fax Number:
E-mail Address:

SECTION 6. REQUEST FOR EXTERNAL REVIEW OF DENIALS BASED ON THE REASON THAT THE TREATMENT WAS EXPERIMENTAL OR INVESTIGATIONAL

PHYSICIAN CERTIFICATION: EXPERIMENTAL OR INVESTIGATIONAL DENIALS

(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____ (covered person's/patient's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance carrier's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person/patient to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's/patient's medical condition meets certain requirements:

In my medical opinion as the insured's treating physician, I hereby certify to the following:

(**NOTE:** Requirements 1 through 3 below must all apply for the covered person/patient to qualify for an external review.)

1. The covered person/patient has a condition that qualifies under one or more of the following descriptions.

   (Please check all descriptions that apply.)

☐ Standard health care services or treatments have not been effective in improving the covered person's/patient's condition.

☐ Standard health care services or treatments are not medically appropriate for the covered person/patient.

☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

2. The physician is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition.

3. Scientifically valid studies using accepted protocols demonstrate that the health care service or treatment recommended or that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person/patient than any available standard health care services or treatments.

Explain:

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional information as necessary.)

Physician's Signature_____ Date: _____

Physician's Name (Please print.)_____

SECTION 7. REQUEST FOR EXPEDITED EXTERNAL REVIEW

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED EXTERNAL REVIEW REQUEST

(To Be Completed by Treating Health Care Provider)

NOTE TO THE TREATING HEALTH CARE PROVIDER:

The standard external review process can take up to 60 days from the date the patient's request for external review is received by the Iowa Insurance Division.

The independent review organization should complete an expedited external review within 72 hours.

This form is for the purpose of providing the certification necessary to trigger expedited review.

CERTIFICATION

I hereby certify that I am a treating health care provider for the patient, _____; and that one of the following is true: (Please check all that apply.)

☐ Adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

☐ The recommended or requested health care service or treatment that is the subject of the external review request would be significantly less effective if not promptly initiated.

☐ The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which the patient received emergency services, but has not been discharged from a facility.

For this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Signature_____ Date_____

Treating Health Care Provider's Name (Please print.) _____

Provider's Mailing Address:
Telephone Number:
E-mail Address:
Fax Number:

Licensure and Area of Clinical Specialty:

Appendix C

IOWA INSURANCE DIVISION

INDEPENDENT REVIEW ORGANIZATION EXTERNAL REVIEW ANNUAL REPORT FORM

(Attach information to this form if necessary.)

External Review Annual Summary for 20__

Each independent review organization (IRO) shall submit upon request of the Commissioner an annual report with information for each health carrier in the aggregate for Iowa on external reviews performed and by type of health benefit plan.

1. IRO name:

   Filing date:

2. IRO address:

3. IRO Web site:

4. Name, e-mail address, telephone number and fax number of the person completing this form:

5. Name, title, e-mail address, telephone number and fax number of the person responsible for regulatory compliance and quality of external reviews:

6. Total number of requests for external review received from the Iowa Insurance Division during the reporting period:

7. Number of standard external reviews:

8. Average number of days the IRO required to reach a final decision in standard reviews:

9. Number of expedited reviews completed to a final decision:

10. Average number of days the IRO required to reach a final decision in expedited reviews:

11. Number of medical necessity reviews decided in favor of the health carrier:

    Briefly list procedures denied:

12. Number of medical necessity reviews decided in favor of the covered person/patient:

    Briefly list procedures approved:

13. Number of experimental/investigational reviews decided in favor of the health carrier:

    Briefly list procedures denied:

14. Number of experimental/investigational reviews decided in favor of the covered person/patient:

    Briefly list procedures approved:

15. Number of reviews terminated as the result of a reconsideration by the health carrier:

16. Number of reviews terminated by the covered person/patient prior to issuance by the IRO of external review decision:

17. Number of reviews declined due to possible conflict with:

    Health carrier:

    Covered person/patient:

    Health care provider:

    Describe possible conflicts of interest:

18. Number of reviews declined due to other reasons not reflected in #17 above:

Appendix D

IOWA INSURANCE DIVISION

HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT FORM

(Attach information to this form if necessary.)

External Review Annual Summary for 20__

Each health carrier shall submit upon request of the Commissioner an annual report with information in the aggregate for Iowa and by type of health benefit plan.

1. Health carrier name:

2. Health carrier address:

3. Health carrier Web site:

4. Name, e-mail address, telephone number and fax number of the person completing this form:

5. Name, title, e-mail address, telephone number and fax number of the person responsible for regulatory compliance:

6. Total number of external review requests of the health carrier's adverse determinations and final adverse determinations received from the Iowa Insurance Division during the reporting period:

7. From the total number of external review requests provided in Question 6, the number of requests determined eligible for an external review:

8. Total number of external review requests resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination of the health carrier and the number resolved reversing the adverse determination or final adverse determination of the health carrier:

9. Total number of external review requests that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative:

Appendix E

INDEPENDENT REVIEW ORGANIZATION APPLICATION

1. BASIC INFORMATION:

   Name:

   Street Address:

   City, State, ZIP:

   Telephone (a toll-free telephone service to receive information related to external reviews 24 hours a day, 7 days a week, that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers outside normal business hours):

   Fax Number:

   E-mail Address:

   Director, Officer, or Executive Officer responsible for supervision and oversight of review procedures:

   Telephone:

   Fax Number:

   E-mail Address:

   Contact person to receive contacts, notices, and information from the Division:

   Telephone:

   Fax Number:

   E-mail Address:

2. Names and titles of all directors, officers, and executives:

3. Identify independent review accreditation by nationally recognized private accrediting entity:

4. Identify all clinical reviewers to be assigned by your IRO by name, general certification, and specialty or subspecialty certification:

   A clinical reviewer shall be a physician or other appropriate health care professional who is an expert in the treatment of the covered person's medical condition, is knowledgeable about the recommended or requested health care service or treatment through actual clinical experience treating patients with the same or similar medical condition, holds a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review, and has no history of disciplinary actions or sanctions.

5. I, _____(authorized signatory), agree to the following undertakings and have provided attachments as required:

   a. To provide notices and conduct reviews within the specified time frames.

   b. To ensure the selection of qualified and impartial clinical reviewers and suitable matching of reviewers to specific cases.

c. To ensure the confidentiality of medical and treatment records and clinical review criteria.

d. To establish and maintain written procedures to ensure the IRO is unbiased.

Specifically, the IRO shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with, a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers. Further, neither the independent review organization nor any clinical reviewer assigned by the independent organization to conduct an external review shall have a material professional, familial, or financial conflict of interest with the health carrier, the covered person or covered person's representative, any officer, director, or management employee of the health carrier, the health care professional, the health care professional's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review, the facility at which the recommended health care service or treatment would be provided, the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose health care service or treatment is the subject of the external review.

e. To maintain required records and provide access to those records by the commissioner upon request.

6. Set forth a description of fees to be charged by the independent review organization for external reviews:

[Filed 10/29/99, Notice 9/22/99—published 11/17/99, effective 12/22/99]
[Filed 4/10/00, Notice 1/12/00—published 5/3/00, effective 6/7/00]
[Filed 11/21/01, Notice 10/17/01—published 12/12/01, effective 1/16/02]
[Filed Emergency ARC 9637B, IAB 7/27/11, effective 7/8/11]
[Filed ARC 9979B (Notice ARC 9854B, IAB 11/16/11), IAB 1/25/12, effective 2/29/12]