CHAPTER 76
EXTERNAL REVIEW

191—76.1(84GA,HF597) Purpose. This chapter is intended to implement 2011 Iowa Acts, House File 597, to 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 Acts, House File 597, sections 2(1) and 2(18), and as referenced in 2011 Iowa Acts, House File 597, section 9(1). Health carriers defined in 2011 Iowa Acts, House File 597, section 2(23), are subject to these rules.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11]

191—76.2(84GA,HF597) Applicable law. The rules contained in this chapter shall apply to any health benefit plan as defined in 2011 Iowa Acts, House File 597, section 2(19), offered or issued by a health carrier as defined in 2011 Iowa Acts, House File 597, section 2(23), subject to the limitations set forth in 2011 Iowa Acts, House File 597, section 3(2), if the covered person is an Iowa resident or if the plan was issued in Iowa, and if the external review request is filed with the commissioner on or after July 1, 2011. For purposes of applying the exemption in 2011 Iowa Acts, House File 597, section 3(2)*"b,"* a "Medicare supplement policy of insurance" shall mean the same as a "Medicare supplement policy" as defined in rule 191—37.3(514D). For purposes of this chapter, the definitions used in 2011 Iowa Acts, House File 597, shall be used in this chapter.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11]

191—76.3(84GA,HF597) External review request. Except for requests for expedited review, the covered person or the covered person's authorized representative shall send a request for external review (completed Appendix B) in writing, by mail, by fax or by electronic transmission, including a copy of the health carrier's written notice containing the final adverse determination, to the commissioner within the time periods specified in 2011 Iowa Acts, House File 597, section 7(1) or 9(1), as applicable. The request form and notice shall be sent to the commissioner at Insurance Division, 330 Maple Street, Des Moines, Iowa 50319; fax (515)281-3059; or E-mail iid.marketregulation@iid.iowa.gov.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11]

191—76.4(84GA,HF597) Decision notification. The independent review organization shall immediately provide a copy of a draft of the decision notification to the commissioner for review. The commissioner shall review the draft of the decision notification. The commissioner shall make any suggestions for changes. The independent review organization shall make such required changes. Once the commissioner determines that the decision notification meets the requirements of 2011 Iowa Acts, House File 597, section 7(12), 8(6), or 9(18), as applicable, the independent review organization shall immediately send the decision notification to the commissioner, the health carrier, and the covered person or covered person's authorized representative. The decision notification approved by the commissioner shall be delivered by telephone, fax or electronic transmission, and a hard copy of the decision notification also shall be delivered by regular mail.
[**ARC 9637B**, IAB 7/27/11, effective 7/8/11]

191—76.5(84GA,HF597) Disclosure requirements. The description of external review procedures required by 2011 Iowa Acts, House File 597, section 16, 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]

191—76.6(84GA,HF597) Health carrier information.

76.6(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. Any changes in personnel or communication information shall be immediately sent to the commissioner.

76.6(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 Acts, House File 597. 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 or organized delivery system, and

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

76.6(3) Each health carrier shall provide to the commissioner, upon request, information set forth in 2011 Iowa Acts, House File 597, section 14(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]

191—76.7(84GA,HF597) Certification of independent review organization.

76.7(1) In addition to the minimum qualifications set forth in 2011 Iowa Acts, House File 597, section 12, 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 Acts, House File 597, section 12(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 by the independent review organization for external reviews. Fees shall be reasonable in relation to those of other independent review organizations providing external review services in Iowa. A health carrier or the commissioner may object to a fee as unreasonable, and the commissioner or the commissioner's designee, at the discretion of the commissioner, may conduct a review.

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.

76.7(2) The independent review organization shall develop written policies and procedures to ensure adherence to the requirements of this chapter and 2011 Iowa Acts, House File 597, by any contractor, subcontractor, subvendor, agent or employee affiliated with the certified independent review organization.

76.7(3) In addition to the toll-free telephone service required by 2011 Iowa Acts, House File 597, section 12(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 Acts, House File 597.

76.7(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 Acts, House File 597, or a report in the format of Appendix C to comply with 2011 Iowa Acts, House File 597, section 14(1).

76.7(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. All applicants will be notified of the certification decision. 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]

These rules are intended to implement 2011 Iowa Acts, House File 597.

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 more 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 guideline, 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 where appeals should be sent to the health carrier] within **180 days** of the date you receive your 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 you have exhausted all of your internal appeals with us, you may have a right to have our decision reviewed by independent health care professionals who have no association with us. This process is called "external review."

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 payment for the service 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 can obtain a copy of the External Review Request Form from the Iowa Insurance Division or from the Division's website (330 Maple, Des Moines, Iowa 50319; telephone 877-955-1212 or 515-281-6348; facsimile 515-281-3059; 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.

If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial.

If 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, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us, or contact the Iowa Insurance Division.

Appendix B

EXTERNAL REVIEW REQUEST FORM

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.

APPLICANT NAME:
The applicant is a:
☐ Covered Person/Patient ☐ Provider ☐ Authorized Representative

COVERED PERSON/PATIENT INFORMATION
Covered Person Name:
Patient Name:
Address:

Covered Person Telephone Number:
Daytime:
Evening:
E-mail Address:
Fax Number:

INSURANCE INFORMATION
Insurer/HMO Name:
Covered Person Insurance ID and/or Policy Number:
Insurance Claim/Reference Number:
Insurer/HMO Mailing Address:

Insurer/HMO Telephone Number:
E-mail Address:
Fax Number:

EMPLOYER INFORMATION
Employer's Name:
Is the health coverage 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:
Medical Record Number:

REASON FOR HEALTH CARRIER DENIAL
(Please check one)
☐ The health care service or treatment is not medically necessary.
☐ The health care service or treatment is experimental or investigational.
☐ Other: _____.

SUMMARY OF EXTERNAL REVIEW REQUEST
Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or 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 in dispute and why you are appealing this denial by attaching additional pages. Describe the disagreement with your health carrier. Indicate clearly the services being denied and the specific dates 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/health care provider that you want the independent review organization reviewer to consider.

EXPEDITED REVIEW
If you need a fast decision, you may request that your external review be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited review? Yes _____ No _____

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*)

Date:

*(Parent, Guardian, Conservator or Other—Please Specify)

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*)

Date:

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative:

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

WHAT TO SEND AND WHERE TO SEND IT

YOU MUST SUBMIT BOTH OF THE ITEMS BELOW*:

1. ☐ **YES**, I have included this completed request form, signed and dated.

2. ☐ **YES****, I have enclosed the letter from my health carrier or utilization review company that states:

(a) That their decision is final and that I have exhausted all internal review procedures; or

(b) That they have waived the requirement to exhaust all of the health carrier's internal review procedures.

*Contact the Consumer Assistance Program of the Iowa Insurance Division by calling 515-281-4458 or 877-955-1212, or by E-mail through the website at http://insuranceca.iowa.gov, if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact 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).

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 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.

CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR EXPEDITED CONSIDERATION OF
A PATIENT'S EXTERNAL REVIEW REQUEST
(To Be Completed by Treating Health Care Provider)

NOTE TO THE TREATING HEALTH CARE PROVIDER
Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Iowa Insurance Division oversees external reviews. The standard external review process can take up to 45 days from the date the patient's request for external review is received by the Division. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION
Name of Treating Health Care Provider:
Mailing Address:

Telephone Number:
E-mail Address:
Fax Number:

Licensure and Area of Clinical Specialty:

Name of Patient:

Patient's Insurer Member ID Number:

CERTIFICATION
I hereby certify that: I am a treating health care provider for _____ (hereafter referred to as "the patient"); that 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; and that, 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)
_____

PHYSICIAN CERTIFICATION: EXPERIMENTAL/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 medical condition meets certain requirements:

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

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

☐ 1) The covered person/patient has a terminal medical condition, life-threatening condition, or a seriously debilitating condition.

☐ 2) The covered person/patient has a condition that qualifies under one or more of the following (please indicate which descriptions 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; or
- ☐ 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.

☐ 3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

☐ 4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.
Explain:

☐ 5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person/patient and which has been denied 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 sheets as necessary)
Physician's Signature_____ Date: _____
Physician's Name (Please Print)
_____

Appendix C

Iowa Insurance Division

Independent Review Organization

External Review Annual Report Form

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 website:

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 website:

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 a full 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:

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