MANAGED HEALTH CARE

CHAPTER 70
UTILIZATION REVIEW

191—70.1(505,514F) Purpose. The purpose of this chapter is to:

1. Promote the delivery of appropriate health care in a cost-effective manner.
2. Ensure that any utilization review system used by a third-party payor adheres to reasonable standards for conducting orderly and efficient utilization review processes.
3. Ensure that any utilization review system used by a third-party payor does not result in an unfair discrimination between enrollees of essentially the same class or risk in the benefits payable under a contract for health benefits.
4. Foster greater coordination and cooperation between health care providers and utilization reviewers.
5. Improve communications and knowledge of benefits among all parties concerned before expenses are incurred.

191—70.2(505,514F) Definitions. As used in this chapter, unless the context otherwise requires:

"Commissioner" means the commissioner of insurance.

"Enrollee" means an individual who has contracted for or who participates in health benefits coverage provided through any third-party payor.

"Third-party payor" means any of the following entities:

1. An insurer subject to Iowa Code chapter 509 or 514A.
2. A health service corporation subject to Iowa Code chapter 514.
3. A health maintenance organization subject to Iowa Code chapter 514B.
4. A preferred provider arrangement subject to 191—Chapter 27, Iowa Administrative Code.
5. A multiple employer welfare arrangement.
6. A third-party administrator.
7. A fraternal benefit society.
8. Any other benefit program providing payment, reimbursement, or indemnification for health care costs for an enrollee or an enrollee's eligible dependents.

"Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. These standards do not apply to requests by any person or provider for a clarification, guarantee or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically so stated, verification of benefits, preauthorization, and prospective or concurrent utilization review programs shall not be construed in any context as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.

191—70.3(505,514F) Application.

70.3(1) A third-party payor which provides health benefits to enrollees residing in the state of Iowa shall not conduct utilization review, either directly or indirectly, by contract with a third party that does not meet the requirements established for accreditation by the Utilization Review Accreditation Commission (URAC) or another national accreditation entity recognized and approved by the commissioner.

70.3(2) On or before March 1 of each year, a third-party payor conducting utilization review shall provide the commissioner with a certification that it is in compliance with this chapter, and shall continuously meet all requirements of the relevant standards in addition to the following information:

a. Name, address, telephone number and normal business hours of the third-party payor and of the utilization review agent if not the same as the third-party payor.

b. Name, address, and telephone number of a person for the commissioner to contact in connection with utilization review compliance.

Any material changes in the information filed in accordance with this rule shall be filed with the commissioner within 30 days of the change.

70.3(3) This chapter does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under:

a. Title XVIII (Medicare) of the federal Social Security Act;

b. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

c. Any other federal employee health benefit plan.

191—70.4(505,514F) Standards. For the purpose of certification and compliance under rule 70.3(505,514F), the most recently available utilization review standards adopted by URAC shall be used.

A copy of the standards and application for accreditation may be obtained from the Utilization Review Accreditation Commission, 1227 25th Street N.W., Suite 610, Washington, D.C. 20037. A copy of the standards shall be readily available and maintained on the premises of any third-party payor conducting utilization review.

191—70.5(505,514F) Retroactive application. A third-party payor shall not impose a retroactive change in procedure that creates an impossibility or impracticability of compliance that would result in a refusal of payment.

191—70.6(505,514F) Variances allowed. Upon application by a third-party payor, the commissioner may approve a variance from the URAC standards for good cause shown, provided such conditions are consistent with the purpose of this chapter. The commissioner shall require the third-party payor to provide reasonable written notice to providers of any approved variance.

70.6(1) Notification of allowed coverage and denials. Notification of the attending physician and treatment facility (as used and defined in the URAC standards) by telephone within one working day is not required provided a documented communication with the physician or the physician's staff and treatment facility is made within one working day of a determination not to certify an admission or extension of a hospital stay.

70.6(2) Individuals who are not licensed health care professionals, but who are otherwise qualified, may perform routine utilization review under the following conditions:

a. They have received full orientation by the utilization review organization relating to administrative practices and policies;

b. They have been fully trained in the application of the medical and/or benefit screening criteria established or endorsed by the utilization review organization;

c. They are trained to refer review requests to licensed health care professionals when the required review exceeds their own expertise, when not addressed in the criteria established or endorsed by the utilization review organization, or when requested by the provider; and

d. They are under the direct supervision of a licensed health care professional.

191—70.7(505,514F) Confidentiality. A third-party payor shall require a contract utilization review agent to adhere to the same standards of patient medical record confidentiality as are directly applicable to the third-party payor.

191—70.8(76GA,ch1202) Utilization review of postdelivery benefits and care. When performing utilization review of inpatient hospital services related to maternity and newborn care, including but not limited to length of postdelivery stay and postdelivery follow-up care, a third-party payor shall use the guidelines adopted under the provisions of 191—81.3(76GA,ch1202) and shall not deselect, require additional documentation, require additional utilization review, terminate services to, reduce payment to, or in any manner provide a disincentive to an attending physician solely on the basis that the attending physician provided or directed the provision of services in compliance with those guidelines. This does not preclude a third-party payor from monitoring a patient's stay or making

reasonable inquiries necessary to assess patient progress in accordance with the guidelines and to coordinate discharge planning or postdischarge care.

191—70.9(505,507B,514F) Enforcement. The remedy for noncompliance with this chapter shall be those remedies authorized by Iowa Code chapters 505 and 507B, including, upon order of the commissioner, payment of outstanding charges, as determined to be reasonable by the commissioner. Upon a finding of a pattern or practice of noncompliance with this chapter, the commissioner may also suspend a person's authority to conduct utilization review.

191—70.10(514F) Credentialing—retrospective payment.

70.10(1) *Purpose.* This rule implements Iowa Code section 514F.6 [2008 Iowa Acts, House File 2555, section 28] which requires the commissioner to adopt rules to provide for the retrospective payment of clean claims for covered services provided by a physician during the credentialing period, once the physician is credentialed.

70.10(2) *Definitions.* For purposes of this rule, the definitions found in Iowa Code section 514F.6 [2008 Iowa Acts, House File 2555, section 28] shall apply. In addition, the following definitions shall apply:

"Application date" means the date on which the health insurer or other entity responsible for the credentialing of physicians on behalf of the health insurer receives the physician's completed application for credentialing.

"Clean claim" means clean claim as defined in Iowa Code section 507B.4A(2)*"b."*

"Health insurer" means the same as a carrier, as defined in Iowa Code section 513B.2(4), that provides health insurance coverage, as defined in Iowa Code section 513B.2(12).

70.10(3) *Retrospective payment of clean claims.* A health insurer shall make retrospective payment for all clean claims submitted by a physician after the credentialing period for covered services provided by the physician during the credentialing period subject to all of the following:

a. The credentialing period shall begin on the application date and end on the date the health insurer or other entity responsible for credentialing physicians on behalf of the health insurer makes a final determination approving the physician's application to be credentialed.

b. The health insurer or other entity responsible for credentialing physicians on behalf of the health insurer shall notify an applicant of its determination regarding a properly completed application for credentialing within 90 days of receipt of an application containing all information required by the health insurer's credentialing form.

c. The physician shall not submit any claims to the health insurer during the credentialing period.

d. A health insurer shall not be required to pay any claims submitted by a physician during the credentialing period.

e. The health insurer's time period for timely submission of claims shall not start until the credentialing period has ended. The health insurer's rules pertaining to timely submission shall not be used to deny payment of any clean claims for medical services provided by a physician during the credentialing period, so long as the physician submits all such claims within the time period required by the health insurer's rules beginning on the date the physician is credentialed.

f. After the physician has been credentialed, the physician shall submit all claims to the health insurer for covered services provided by the physician during the credentialing period.

g. After the physician has been credentialed, a health insurer shall pay all clean claims submitted by the physician for covered services provided by the physician during the credentialing period within the time periods specified in 191—15.32(507B).

70.10(4) *Applicability.*

a. This rule shall not apply to services provided by a physician that are covered by Medicaid, Medicare, TRICARE, or other health care benefit programs subject to federal regulations regarding eligibility and provider payments.

b. Nothing contained in this rule shall require a health insurer or other entity responsible for credentialing physicians on behalf of the health insurer to take any action in violation of the requirements

of the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC).

c. Nothing contained in this rule shall require a health insurer or other entity responsible for credentialing physicians on behalf of the health insurer to credential a physician or to permit a noncredentialed physician to participate in the health insurer's provider network.

70.10(5) *Effective date.* This rule shall become effective on July 22, 2009.

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These rules are intended to implement Iowa Code chapter 507B and sections 505.8, 514C.12, and 514F.2.

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