**514J.107 External review — standard.**

1. A covered person or the covered person's authorized representative may file a written request for an external review with the commissioner within four months after any of the following events:

*a.* The date of receipt of a final adverse determination.

*b.* The failure of a health carrier to issue a written decision within thirty days following the date the covered person or the covered person's authorized representative filed a grievance involving an adverse determination as provided in section 514J.106, subsection 2.

*c.* The agreement of the health carrier to waive the requirement that the covered person or the covered person's authorized representative exhaust the health carrier's internal grievance procedures before filing a request for external review of an adverse determination as provided in section 514J.106, subsection 4.

2. Within one business day after the date of receipt of a request for external review, the commissioner shall send a copy of the request to the health carrier.

3. Within five business days following the date of receipt of the external review request from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

*a.* The individual is or was a covered person under the health benefit plan at the time the health care service was recommended or requested.

*b.* The health care service that is the subject of the adverse determination or of the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.

*c.* The covered person or the covered person's authorized representative has exhausted the health carrier's internal grievance process, unless the covered person or the covered person's authorized representative is not required to exhaust the health carrier's internal grievance process pursuant to section 514J.106 or this section.

*d.* The covered person or the covered person's authorized representative has provided all the information and forms required to process an external review request.

4. Within one business day after completion of a preliminary review pursuant to subsection 3, the health carrier shall notify the commissioner and the covered person or the covered person's authorized representative in writing whether the request is complete and whether the request is eligible for external review.

*a.* If the health carrier determines that the request is not complete, the health carrier shall notify the covered person or the covered person's authorized representative and the commissioner in writing that the request is not complete and what information or materials are needed to make the request complete.

*b.* If the health carrier determines that the request is not eligible for external review, the health carrier shall issue a notice of initial determination in writing informing the covered person or the covered person's authorized representative and the commissioner of that determination and the reasons the request is not eligible for review. The health carrier shall also include a statement in the notice informing the covered person or the covered person's authorized representative that the health carrier's initial determination of ineligibility may be appealed to the commissioner.

5. 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.

6. The commissioner may determine that a request is eligible for external review, notwithstanding a health carrier's initial determination that the request is not eligible, and refer the request for external review. In making this 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.

7. Within one business day after receipt of notice from a health carrier that a request for external review is eligible for external review or upon a determination by the commissioner that a request is eligible for external review, the commissioner shall do all of the following:

*a.* Assign an independent review organization from the list of approved independent

review organizations maintained by the commissioner and notify the health carrier of the name of the assigned independent review organization. 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.

*b.* Notify the covered person or the covered person's authorized representative in writing that the request is eligible and has been accepted for external review including the name of the assigned independent review organization and that the covered person or the covered person's authorized representative may submit in writing to the independent review organization within five business days following receipt of such notice from the commissioner, additional information that the independent review organization shall consider when conducting the external review. The independent review organization may, in the organization's discretion, accept and consider additional information submitted by the covered person or the covered person's authorized representative after five business days.

8. Within five business days after receipt of notice from the commissioner pursuant to subsection 7, the health carrier shall provide to the independent review organization the documents and any information considered in making the adverse determination or final adverse determination. Failure by the health carrier to provide the documents and information within the time specified shall not delay the conduct of the external review.

9. If the health carrier fails to provide the documents and information within the time specified, the independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Within one business day after making such a decision, the independent review organization shall notify the covered person or the covered person's authorized representative, the health carrier, and the commissioner of its decision.

10. The independent review organization shall review all of the information and documents received pursuant to subsection 8 and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subsection 7, paragraph "*b*". Upon receipt of any information submitted by the covered person or the covered person's authorized representative, the independent review organization shall, within one business day, forward the information to the health carrier. In reaching a decision the independent review organization is not bound by any decisions or conclusions reached during the health carrier's internal grievance process.

11. Upon receipt of information forwarded pursuant to subsection 10, a health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

*a.* Reconsideration by the health carrier of its determination shall not delay or terminate the external review. The external review shall only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

*b.* Within one business day after making a decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person or the covered person's authorized representative, the independent review organization, and the commissioner in writing of its decision. The independent review organization shall terminate the external review upon receipt of notice of the health carrier's decision to reverse its adverse determination or final adverse determination.

12. In addition to the documents and information provided to the independent review organization pursuant to this section, the independent review organization shall, to the extent the information or documents are available and the independent review organization considers them appropriate, 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 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.

13. *a.* Within forty-five days after the date of receipt of a request for an external review, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or final adverse determination of the health carrier to the covered person or the covered person's authorized representative, the health carrier, and the commissioner.

*b.* The independent review organization shall include in its decision all of the following:

(1) A general description of the reason for the request for external review.

(2) The date the independent review organization received the assignment from the commissioner to conduct the external review.

(3) The date the external review was conducted.

(4) The date of the decision.

(5) The principal reason or reasons for its decision, including what applicable evidence-based standards, if any, were a basis for its decision.

(6) The rationale for its decision.

(7) References to evidence or documentation, including evidence-based standards, considered in reaching its decision.

14. Upon receipt of notice of a decision reversing the adverse determination or final adverse determination of the health carrier, the health carrier shall immediately approve the coverage that was the subject of the determination.

2011 Acts, ch 101, §7; 2016 Acts, ch 1011, §96

Referred to in §514J.108