

IOWA INSURANCE DIVISION — REGULATORY PROTECTIONS FOR PHYSICIANS AND PATIENTS

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The Iowa Division of Insurance is established by law to regulate and supervise the business of insurance, including health insurance, in this state. Division oversight is primarily focused on company solvency, compliance with fair insurance trade practices, and consumer complaints. With respect to health plans, there are three important provisions of regulatory relief that physicians should be aware of.

Prompt pay – Health insurers are required by Iowa law to either accept and pay or deny a clean claim within 30 days after the insurer's receipt of such claim. If payment is late, the insurer is required to automatically pay interest on the claim at the rate of 10% per annum. Exceptions include those claims the insurer suspects are fraudulent, matters beyond the insurer's control, or special circumstances that prevent an insurer from timely paying otherwise clean claims. The insurer cannot escape liability simply because a contractor it employs fails to pay clean claims in a timely manner. A clean claim is a properly completed paper or electronic bill (i.e., the HCFA 1500) containing all reasonably necessary information.

Audits of medical claims – Absent a reasonable basis to suspect fraud, an insurer (or an agent acting on behalf of an insurer) may not audit a claim more than two years after the submission of the claim to the insurer. Further, an insurer cannot audit a claim with a billed charge of less than \$25. In auditing a claim, the insurer must make a reasonable effort to ensure that the audit is performed by qualified persons and must employ coding guidelines and instructions in effect on the date the medical service was provided. Correspondence regarding an audit of a claim must include contact information identifying the auditor, the purpose of the audit, and, where applicable, the specific coding or billing procedure under review.

Consistent failure of a health insurer to timely pay clean claims or to pay interest on late claims or to comply with the audit rules is an unfair insurance trade practice that subjects the insurer to sanctions issued by the commissioner of insurance.

External review of medical necessity decisions – A patient, or a physician acting on behalf of the patient, can seek independent medical review of a denial of coverage by a health insurer based on medical necessity. The external review process (Xrp) can be used only after exhaustion of the insurer's internal appeals. Upon issuance of its final denial of coverage based on medical necessity, the insurer must inform the patient in writing of the patient's right to ask for an independent review of the denial; the patient's physician can pursue the Xrp on behalf of the patient. Expedited procedures exist if the patient's need for denied medical coverage is more immediate. There is a \$25 filing fee associated with the Xrp which can be waived by the commissioner; if the Xrp is favorable to the patient, the insurer must refund the fee. There are many details associated with Xrp (see box below). In Iowa, approximately one-half of all external reviews have been decided favorably to the patient.

Regulations of the Insurance Division —

Prompt pay, Iowa Administrative Code rule 191-15.32

Retrospective audits, Iowa Administrative Code rule 191-15.33

External review of medical necessity decisions, Iowa Administrative Code rule 191-76. Also, the Xrp is described in a consumer-friendly fashion on the Division's Web site at www.iid.state.ia.us; click on "Consumer Information."