Sen. Heather A. Steans

Filed: 5/23/2011

AMENDMENT TO HOUSE BILL 224

AMENDMENT NO. _____. Amend House Bill 224 by replacing everything after the enacting clause with the following:

"Section 5. The Health Carrier External Review Act is amended by changing Sections 10, 20, 25, 30, 35, 40, 55, 65, and 75 and by adding Sections 42 and 80 as follows:

(215 ILCS 180/10)

Sec. 10. Definitions. For the purposes of this Act:

"Adverse determination" means:

(1) a determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or

effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

(2) the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or

(3) a recission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. ~~means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, 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.~~

"Authorized representative" means:

(1) a person to whom a covered person has given express written consent to represent the covered person for

purposes of this Law;

(2) a person authorized by law to provide substituted consent for a covered person;

(3) a family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(4) a health care provider when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care provider; or

(5) in the case of an urgent care request, a health care provider with knowledge of the covered person's medical condition.

~~(1) a person to whom a covered person has given express written consent to represent the covered person in an external review, including the covered person's health care provider;~~

~~(2) a person authorized by law to provide substituted consent for a covered person; or~~

~~(3) the covered person's health care provider when the covered person is unable to provide consent.~~

"Best evidence" means evidence based on:

(1) randomized clinical trials;

(2) if randomized clinical trials are not available, then cohort studies or case-control studies;

(3) if items (1) and (2) are not available, then case-series; or

(4) if items (1), (2), and (3) are not available, then expert opinion.

"Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

"Cohort study" means a prospective evaluation of 2 groups of patients with only one group of patients receiving specific intervention.

"Concurrent review" means a review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Director" means the Director of the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent

layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

"Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on an overall systematic review of the research in making decisions about the care of individual patients.

"Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

"Facility" means an institution providing health care services or a health care setting.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth by the

Managed Care Reform and Patient Rights Act.

"Health benefit plan" means a policy, contract, certificate, plan, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care provider" or "provider" means a physician, hospital facility, or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with State law, responsible for recommending health care services on behalf of a covered person.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, or any other entity providing a plan of health insurance, health benefits, or health care services. "Health carrier" also means Limited Health Service Organizations (LHSO) and Voluntary Health Service Plans.

"Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or

information about events or relationships that relate to:

(1) the past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) the provision of health care services to an individual; or

(3) payment for the provision of health care services to an individual.

"Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

"Medical or scientific evidence" means evidence found in the following sources:

(1) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus

(EMBASE);

(3) medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) the following standard reference compendia:

(a) The American Hospital Formulary Service-Drug Information;

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia-Drug Information;

(5) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) the federal Agency for Healthcare Research and Quality;

(b) the National Institutes of Health;

(c) the National Cancer Institute;

(d) the National Academy of Sciences;

(e) the Centers for Medicare & Medicaid Services;

(f) the federal Food and Drug Administration; and

(g) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) any other medical or scientific evidence that is comparable to the sources listed in items (1) through (5).

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

"Prospective review" means a review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

"Protected health information" means health information (i) that identifies an individual who is the subject of the information; or (ii) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

"Randomized clinical trial" means a controlled prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

"Retrospective review" means any review of a request for a benefit that is not a concurrent or prospective review request. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of

coding. ~~means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment~~.

"Utilization review" has the meaning provided by the Managed Care Reform and Patient Rights Act.

"Utilization review organization" means a utilization review program as defined in the Managed Care Reform and Patient Rights Act.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/20)

Sec. 20. Notice of right to external review.

(a) At the same time the health carrier sends written notice of a covered person's right to appeal a coverage decision upon an adverse determination or a final adverse determination ~~as provided by the Managed Care Reform and Patient Rights Act~~, a health carrier shall notify a covered person, the covered person's authorized representative, if any, and a covered person's health care provider in writing of the covered person's right to request an external review as provided by this Act. The written notice required shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right

to have our decision reviewed by an independent review organization not associated with us ~~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~~ by submitting a written request for an external review to the Department of Insurance, Office of Consumer Health Information, 320 West Washington Street, 4th Floor, Springfield, Illinois, 62767." ~~us~~. ~~Upon receipt of your request an independent review organization registered with the Department of Insurance will be assigned to review our decision.~~

(a-5) The Department may prescribe the form and content of the notice required under this Section.

(b) ~~This subsection (b) shall apply to an expedited review prior to a final adverse determination.~~ In addition to the notice required in subsection (a), for ~~the health carrier shall include~~ a notice related to an adverse determination, the health carrier shall include a statement informing the covered person of all of the following:

(1) If the covered person has a medical condition where the timeframe for completion of (A) an expedited internal review of an appeal ~~a grievance~~ involving an adverse determination, (B) a final adverse determination ~~as set forth in the Managed Care Reform and Patient Rights Act~~, or (C) a standard external review as established in this Act, would seriously jeopardize the life or health of the

covered person or would jeopardize the covered person's ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review.

(2) The covered person or the covered person's authorized representative may file an appeal under the health carrier's internal appeal process, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative 30 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a concurrent or prospective review request or 60 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a retrospective review request with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, then the covered person or the covered person's authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process for purposes of this Act. ~~The covered person or the covered person's authorized representative may file a request for an expedited external review at the same time the covered person or the covered person's authorized representative~~

~~files a request for an expedited internal appeal involving an adverse determination as set forth in the Managed Care Reform and Patient Rights Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review.~~

(3) If the covered person or the covered person's authorized representative filed a request for an expedited internal review of an adverse determination and has not received a decision on such request from the health carrier within 48 hours, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, then the covered person or the covered person's authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process for the purposes of this Act.

(4) ~~(3)~~ If an adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, then the covered person or the covered person's authorized representative may request an expedited external review at the same time the covered person or the covered person's authorized representative files a request for an expedited internal appeal involving an adverse determination. The independent review organization assigned to conduct the expedited external review shall determine whether the covered person is required to complete the expedited review of the appeal prior to conducting the expedited external review.

(c) ~~This subsection (c) shall apply to an expedited review upon final adverse determination.~~ In addition to the notice required in subsection (a), for ~~the health carrier shall include~~ a notice related to a final adverse determination, the health carrier shall include a statement informing the covered person of all of the following:

(1) if the covered person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the

covered person or would jeopardize the covered person's ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review; or

(2) if a final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, then the covered person, or the covered person's authorized representative, may request an expedited external review; or

(3) if a final adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and the covered person's health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, then the covered person or the covered person's authorized representative may request an expedited external review.

(d) In addition to the information to be provided pursuant to subsections (a), (b), and (c) of this Section, the health carrier shall include a copy of the description of both the required standard and expedited external review procedures. The description shall highlight the external review procedures

that give the covered person or the covered person's authorized representative the opportunity to submit additional information, including any forms used to process an external review.

(e) As part of any forms provided under subsection (d) of this Section, the health carrier shall include an authorization form, or other document approved by the Director, by which the covered person, for purposes of conducting an external review under this Act, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review, as provided in the Illinois Insurance Code.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/25)

Sec. 25. Request for external review. A covered person or the covered person's authorized representative may make a request for a standard external or expedited external review of an adverse determination or final adverse determination. Except as set forth in Sections 40 and 42 of this Act, all requests for external review ~~Requests under this Section~~ shall be made in writing to the Director ~~directly to the health carrier that made the adverse or final adverse determination. All requests for external review shall be in writing except for requests for expedited external reviews which may me made~~

~~orally~~. Health carriers must provide covered persons with forms to request external reviews.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/30)

Sec. 30. Exhaustion of internal appeal ~~grievance~~ process.

(a) Except as provided in subsection (b) of this Section ~~20~~, a request for an external review shall not be made until the covered person has exhausted the health carrier's internal appeal ~~grievance~~ process ~~as set forth in the Managed Care Reform and Patient Rights Act~~.

(b) A covered person shall ~~also~~ be considered to have exhausted the health carrier's internal appeal ~~grievance~~ process for purposes of this Section if:

(1) the covered person or the covered person's authorized representative has filed an appeal under the health carrier's internal appeal process ~~a request for an internal review of an adverse determination pursuant to the Managed Care Reform and Patient Rights Act~~ and has not received a written decision on the appeal 30 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a concurrent or prospective review request or 60 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a

retrospective review request ~~request from the health carrier within 15 days after receipt of the required information but not more than 30 days after the request was filed by the covered person or the covered person's authorized representative~~, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay; ~~however, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination until the covered person has exhausted the health carrier's internal grievance process;~~

(2) the covered person or the covered person's authorized representative filed a request for an expedited internal review of an adverse determination ~~pursuant to the Managed Care Reform and Patient Rights Act~~ and has not received a decision on such request from the health carrier within 48 hours, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay; ~~or~~

(3) the health carrier agrees to waive the exhaustion requirement; ~~.~~

(4) the covered person has a medical condition in which the timeframe for completion of (A) an expedited internal review of a appeal involving an adverse determination, (B)

a final adverse determination, or (C) a standard external review as established in this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

(5) an adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated; in such cases, the covered person or the covered person's authorized representative may request an expedited external review at the same time the covered person or the covered person's authorized representative files a request for an expedited internal appeal involving an adverse determination; the independent review organization assigned to conduct the expedited external review shall determine whether the covered person is required to complete the expedited review of the appeal prior to conducting the expedited external review; or

(6) the health carrier has failed to comply with applicable State and federal law governing internal claims and appeals procedures.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/35)

Sec. 35. Standard external review.

(a) Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination, a covered person or the covered person's authorized representative may file a request for an external review with the Director. Within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to the health carrier.

(b) Within 5 business days following the date of receipt of the external review request, the health carrier shall complete a preliminary review of the request to determine whether:

(1) the individual is or was a covered person in the health benefit plan at the time the health care service was requested or at the time the health care service was provided;

(2) the health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but the health carrier has determined 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~~;

(3) the covered person has exhausted the health carrier's internal appeal ~~grievance~~ process unless the covered person is not required to exhaust the health carrier's internal appeal process pursuant to ~~as set forth in~~ this Act;

(4) (blank); and ~~for appeals relating to a determination based on treatment being experimental or investigational, the requested health care service or treatment that is the subject of the adverse determination or final adverse determination is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier and that the covered person's health care provider, who ordered or provided the services in question and who is licensed under the Medical Practice Act of 1987, has certified that one of the following situations is applicable:~~

~~(A) standard health care services or treatments have not been effective in improving the condition of the covered person;~~

~~(B) standard health care services or treatments are not medically appropriate for the covered person;~~

~~(C) there is no available standard health care~~

~~service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment;~~

~~(D) the health care service or treatment is likely to be more beneficial to the covered person, in the health care provider's opinion, than any available standard health care services or treatments; or~~

~~(E) that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the covered person than any available standard health care services or treatments; and~~

(5) the covered person has provided all the information and forms required to process an external review, as specified in this Act.

(c) Within one business day after completion of the preliminary review, the health carrier shall notify the Director and covered person and, if applicable, the covered person's authorized representative in writing whether the request is complete and eligible for external review. If the request:

(1) is not complete, the health carrier shall inform the Director and covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are required by this Act to make the request complete; or

(2) is not eligible for external review, the health carrier shall inform the Director and covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

The Department may specify the form for the health carrier's notice of initial determination under this subsection (c) and any supporting information to be included in the notice.

The notice of initial determination of ineligibility shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director.

Notwithstanding a health carrier's initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(d) Whenever the Director receives notice that a request is eligible for external review following the preliminary review

conducted pursuant to this Section ~~the health carrier shall~~, within one ~~5~~ business day after the date of receipt of the notice, the Director shall ~~days~~:

(1) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director pursuant to this Act and notify the health carrier of the name of the assigned independent review organization; and

(2) notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director ~~health carrier~~ shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may, within 5 business days following the date of receipt of the notice provided pursuant to item (2) of this subsection (d), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

(e) The assignment by the Director of an approved independent review organization to conduct an external review

in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director pursuant to this Act. ~~The assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be made from those approved independent review organizations qualified to conduct external review as required by Sections 50 and 55 of this Act.~~

(f) Within ~~Upon assignment of an independent review organization, the health carrier or its designee utilization review organization shall, within~~ 5 business days after the date of receipt of the notice provided pursuant to item (1) of subsection (d) of this Section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

(1) Except as provided in item (2) of this subsection (f), failure by the health carrier or its utilization review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

(2) If the health carrier or its utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external

review and make a decision to reverse the adverse determination or final adverse determination.

(3) Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (2) of this subsection (f), the independent review organization shall notify the Director, the health carrier, the covered person and, if applicable, the covered person's authorized representative, of its decision to reverse the adverse determination.

(g) Upon receipt of the information from the health carrier or its utilization review organization, the assigned independent review organization shall review all of the information and documents and any other information submitted in writing to the independent review organization by the covered person and the covered person's authorized representative.

(h) Upon receipt of any information submitted by the covered person or the covered person's authorized representative, the independent review organization shall forward the information to the health carrier within 1 business day.

(1) Upon receipt of the information, if any, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:

(A) Within one business day after making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the Director, the covered person and, if applicable, the covered person's authorized representative, and the assigned independent review organization in writing of its decision.

(B) Upon notice from the health carrier that the health carrier has made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

(i) In addition to the documents and information provided by the health carrier or its utilization review organization and the covered person and the covered person's authorized representative, if any, the independent review organization,

to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) the covered person's pertinent medical records;

(2) the covered person's health care provider's recommendation;

(3) consulting reports from appropriate health care providers and other documents submitted by the health carrier or its designee utilization review organization, the covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) 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, unless the terms are inconsistent with applicable law;

(5) 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;

(6) any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; ~~and~~

(7) the opinion of the independent review organization's clinical reviewer or reviewers after considering items (1) through (6) of this subsection (i) to the extent the information or documents are available and the clinical reviewer or reviewers considers the information or documents appropriate; and

(8) (blank). ~~for a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether and to what extent:~~

~~(A) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition;~~

~~(B) medical or scientific evidence or evidence based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments; or~~

~~(C) the terms of coverage under the covered person's health benefit plan with the health carrier to~~

~~ensure that the health care service or treatment that is the subject of the opinion is experimental or investigational would otherwise be covered under the terms of coverage of the covered person's health benefit plan with the health carrier.~~

(j) Within 5 days after the date of receipt of all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative. In reaching a decision, the assigned independent review organization is not bound by any claim determinations reached prior to the submission of information to the independent review organization. In such cases, the following provisions shall apply:

(1) The independent review organization shall include in the notice:

(A) a general description of the reason for the request for external review;

(B) the date the independent review organization received the assignment from the Director ~~health carrier~~ to conduct the external review;

(C) the time period during which the external

review was conducted;

(D) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;

(E) the date of its decision; ~~and~~

(F) the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and~~.~~

(G) the rationale for its decision.

(2) (Blank). ~~For reviews of experimental or investigational treatments, the notice shall include the following information:~~

~~(A) a description of the covered person's medical condition;~~

~~(B) a description of the indicators relevant to whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;~~

~~(C) a description and analysis of any medical or~~

~~scientific evidence considered in reaching the opinion;~~

~~(D) a description and analysis of any evidence-based standards;~~

~~(E) whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, for the condition;~~

~~(F) whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments; and~~

~~(G) the written opinion of the clinical reviewer, including the reviewer's recommendation as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation.~~

(3) (Blank). ~~In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health~~

~~carrier's utilization review process or the health carrier's internal grievance or appeals process.~~

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

(Source: P.A. 96-857, eff. 7-1-10; 96-967, eff. 1-1-11.)

(215 ILCS 180/40)

Sec. 40. Expedited external review.

(a) A covered person or a covered person's authorized representative may file a request for an expedited external review with the Director ~~health carrier~~ either orally or in writing:

(1) immediately after the date of receipt of a notice prior to a final adverse determination as provided by subsection (b) of Section 20 of this Act;

(2) immediately after the date of receipt of a notice upon ~~a~~ final adverse determination as provided by subsection (c) of Section 20 of this Act; or

(3) if a health carrier fails to provide a decision on request for an expedited internal appeal within 48 hours as provided by item (2) of Section 30 of this Act.

(b) Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the

request to the health carrier. Immediately upon receipt of the request for an expedited external review ~~as provided under subsections (b) and (c) of Section 20~~, the health carrier shall determine whether the request meets the reviewability requirements set forth in ~~items (1), (2), and (4) of~~ subsection (b) of Section 35. In such cases, the following provisions shall apply:

(1) The health carrier shall immediately notify the Director, the covered person, and, if applicable, the covered person's authorized representative of its eligibility determination.

(2) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the Director.

(3) The Director may determine that a request is eligible for expedited external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(4) In making a determination under item (3) of this subsection (b), the Director's decision shall be made in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with

applicable law, and shall be subject to all applicable provisions of this Act.

(5) The Director may specify the form for the health carrier's notice of initial determination under this subsection (b) and any supporting information to be included in the notice.

(c) Upon receipt of the notice that the request meets the reviewability requirements, ~~determining that a request meets the requirements of subsections (b) and (c) of Section 20,~~ the Director ~~health carrier~~ shall immediately assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director to conduct the expedited review. In such cases, the following provisions shall apply:

(1) The assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be made from those approved independent review organizations qualified to conduct external review as required by Sections 50 and 55 of this Act.

(2) The Director shall immediately notify the health carrier of the name of the assigned independent review organization. Immediately upon receipt from the Director of the name of the independent review organization assigned to conduct the external review ~~assigning an independent review organization to perform an expedited external~~

~~review~~, but in no case more than 24 hours after receiving such notice ~~assigning the independent review organization~~, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(3) If the health carrier or its utilization review organization fails to provide the documents and information within the specified timeframe, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(4) Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (3) of this subsection (c), the independent review organization shall notify the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative of its decision to reverse the adverse determination or final adverse determination.

(d) In addition to the documents and information provided by the health carrier or its utilization review organization

and any documents and information provided by the covered person and the covered person's authorized representative, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider information as required by subsection (i) of Section 35 of this Act in reaching a decision.

(e) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of the request for an expedited external review ~~2 business days after the receipt of all pertinent information~~, the assigned independent review organization shall:

(1) make a decision to uphold or reverse the final adverse determination; and

(2) notify the Director, the health carrier, the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative, of the decision.

(f) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal appeal ~~grievance~~ process ~~as set forth in the Managed Care Reform and Patient Rights Act~~.

(g) Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, the

health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(h) If the notice provided pursuant to subsection (e) of this Section was not in writing, then within ~~Within~~ 48 hours after the date of providing that ~~the~~ notice ~~required in item (2) of subsection (e)~~, the assigned independent review organization shall provide written confirmation of the decision to the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative including the information set forth in subsection (j) of Section 35 of this Act as applicable.

(i) An expedited external review may not be provided for retrospective adverse or final adverse determinations.

(j) The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director pursuant to this Act.

(Source: P.A. 96-857, eff. 7-1-10; revised 9-16-10.)

(215 ILCS 180/42 new)

Sec. 42. External review of experimental or investigational treatment adverse determinations.

(a) Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination that

involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for an external review with the Director.

(b) The following provisions apply to cases concerning expedited external reviews:

(1) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subsection (a) of this Section if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(2) Upon receipt of a request for an expedited external review, the Director shall immediately notify the health carrier.

(3) The following provisions apply concerning notice:

(A) Upon notice of the request for an expedited external review, the health carrier shall immediately determine whether the request meets the reviewability requirements of subsection (d) of this Section. The health carrier shall immediately notify the Director and the covered person and, if applicable, the covered

person's authorized representative of its eligibility determination.

(B) The Director may specify the form for the health carrier's notice of initial determination under subdivision (A) of this item (3) and any supporting information to be included in the notice.

(C) The notice of initial determination under subdivision (A) of this item (3) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Director.

(4) The following provisions apply concerning the Director's determination:

(A) The Director may determine that a request is eligible for external review under subsection (d) of this Section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(B) In making a determination under subdivision (A) of this item (4), the Director's decision shall be made in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(5) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subsection (d) of this Section, the Director shall immediately assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Director and notify the health carrier of the name of the assigned independent review organization.

(6) At the time the health carrier receives the notice of the assigned independent review organization, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(c) Except for a request for an expedited external review made pursuant to subsection (b) of this Section, within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to the health carrier.

(d) Within 5 business days following the date of receipt of the external review request, the health carrier shall complete a preliminary review of the request to determine whether:

(1) the individual is or was a covered person in the

health benefit plan at the time the health care service was recommended or requested or, in the case of a retrospective review, at the time the health care service was provided;

(2) the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(3) the covered person's health care provider has certified that one of the following situations is applicable:

(A) standard health care services or treatments have not been effective in improving the condition of the covered person;

(B) standard health care services or treatments are not medically appropriate for the covered person; or

(C) there is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment;

(4) the covered person's health care provider:

(A) has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(B) who 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, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(5) the covered person has exhausted the health carrier's internal appeal process, unless the covered person is not required to exhaust the health carrier's internal appeal process pursuant to Section 30 of this Act; and

(6) the covered person has provided all the information and forms required to process an external review, as specified in this Act.

(e) The following provisions apply concerning requests:

(1) Within one business day after completion of the

preliminary review, the health carrier shall notify the Director and covered person and, if applicable, the covered person's authorized representative in writing whether the request is complete and eligible for external review.

(2) If the request:

(A) is not complete, then the health carrier shall inform the Director and the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are required by this Act to make the request complete; or

(B) is not eligible for external review, then the health carrier shall inform the Director and the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

(3) The Department may specify the form for the health carrier's notice of initial determination under this subsection (e) and any supporting information to be included in the notice.

(4) The notice of initial determination of ineligibility shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is

ineligible for review may be appealed to the Director by filing a complaint with the Director.

(5) Notwithstanding a health carrier's initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(f) Whenever a request for external review is determined eligible for external review, the health carrier shall notify the Director and the covered person and, if applicable, the covered person's authorized representative.

(g) Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted pursuant to this Section, within one business day after the date of receipt of the notice, the Director shall:

(1) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director pursuant to this Act and notify the health carrier of the name of the assigned independent review organization; and

(2) notify in writing the covered person and, if

applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may, within 5 business days following the date of receipt of the notice provided pursuant to item (2) of this subsection (g), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

(h) The following provisions apply concerning assignments and clinical reviews:

(1) Within one business day after the receipt of the notice of assignment to conduct the external review pursuant to subsection (g) of this Section, the assigned independent review organization shall select one or more clinical reviewers, as it determines is appropriate, pursuant to item (2) of this subsection (h) to conduct the external review.

(2) The provisions of this item (2) apply concerning the selection of reviewers:

(A) In selecting clinical reviewers pursuant to item (1) of this subsection (h), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section 55 of this Act and, through clinical experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(B) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(3) In accordance with subsection (l) of this Section, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(4) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal appeal process.

(i) Within 5 business days after the date of receipt of the notice provided pursuant to subsection (g) of this Section, the

health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

(1) Except as provided in item (2) of this subsection (i), failure by the health carrier or its utilization review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

(2) If the health carrier or its utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(3) Immediately upon making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (2) of this subsection (i), the independent review organization shall notify the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative of its decision to reverse the adverse determination.

(j) Upon receipt of the information from the health carrier or its utilization review organization, each clinical reviewer

selected pursuant to subsection (h) of this Section shall review all of the information and documents and any other information submitted in writing to the independent review organization by the covered person and the covered person's authorized representative.

(k) Upon receipt of any information submitted by the covered person or the covered person's authorized representative, the independent review organization shall forward the information to the health carrier within one business day. In such cases, the following provisions shall apply:

(1) Upon receipt of the information, if any, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

(3) The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:

(A) Immediately upon making its decision to

reverse its adverse determination or final adverse determination, the health carrier shall notify the Director, the covered person and, if applicable, the covered person's authorized representative, and the assigned independent review organization in writing of its decision.

(B) Upon notice from the health carrier that the health carrier has made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

(l) The following provisions apply concerning clinical review opinions:

(1) Except as provided in item (3) of this subsection (l), within 20 days after being selected in accordance with subsection (h) of this Section to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to item (3) of this subsection (l), each clinical reviewer's opinion shall be in writing and include the following information:

(A) a description of the covered person's medical condition;

(B) a description of the indicators relevant to

determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(C) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(D) a description and analysis of any evidence-based standard; and

(E) information on whether the reviewer's rationale for the opinion is based on clause (A) or (B) of item (5) of subsection (m) of this Section.

(3) The provisions of this item (3) apply concerning the timing of opinions:

(A) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than 5 calendar days after being selected in accordance with subsection (h) of this Section.

(B) If the opinion provided pursuant to subdivision (A) of this item (3) was not in writing, then within 48 hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under item (2) of this subsection (l).

(m) In addition to the documents and information provided by the health carrier or its utilization review organization and the covered person and the covered person's authorized representative, if any, each clinical reviewer selected pursuant to subsection (h) of this Section, to the extent the information or documents are available and the clinical reviewer considers appropriate, shall consider the following in reaching a decision:

(1) the covered person's pertinent medical records;

(2) the covered person's health care provider's recommendation;

(3) consulting reports from appropriate health care providers and other documents submitted by the health carrier or its designee utilization review organization, the covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

(4) the terms of coverage under the covered person's

health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

(5) whether (A) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition or (B) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(n) The following provisions apply concerning decisions, notices, and recommendations:

(1) The provisions of this item (1) apply concerning decisions and notices:

(A) Except as provided in subdivision (B) of this item (1), within 20 days after the date it receives the

opinion of each clinical reviewer, the assigned independent review organization, in accordance with item (2) of this subsection (n), shall make a decision and provide written notice of the decision to the Director, the health carrier, the covered person, and the covered person's authorized representative, if applicable.

(B) For an expedited external review, within 48 hours after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, in accordance with item (2) of this subsection (n), shall make a decision and provide notice of the decision orally or in writing to the Director, the health carrier, the covered person, and the covered person's authorized representative, if applicable. If such notice is not in writing, within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, the health carrier, the covered person, and the covered person's authorized representative, if applicable.

(2) The provisions of this item (2) apply concerning recommendations:

(A) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, then the

independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(B) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(C) The provisions of this subdivision (C) apply to cases in which the clinical reviewers are evenly split:

(i) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, then the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subdivision (A) or (B) of this item (2).

(ii) The additional clinical reviewer selected under clause (i) of this subdivision (C) shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions.

(iii) The selection of the additional clinical

reviewer under this subdivision (C) shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers.

(o) The independent review organization shall include in the notice provided pursuant to subsection (n) of this Section:

(1) a general description of the reason for the request for external review;

(2) the written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(3) the date the independent review organization received the assignment from the Director to conduct the external review;

(4) the time period during which the external review was conducted;

(5) the date of its decision;

(6) the principal reason or reasons for its decision; and

(7) the rationale for its decision.

(p) Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was

the subject of the adverse determination or final adverse determination.

(q) The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director pursuant to this Act.

(215 ILCS 180/55)

Sec. 55. Minimum qualifications for independent review organizations.

(a) To be approved to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this Act that include, at a minimum:

(1) a quality assurance mechanism that ensures that:

(A) external reviews are conducted within the specified timeframes and required notices are provided in a timely manner;

(B) selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an

adequate number of clinical reviewers to meet this objective;

(C) for adverse determinations involving experimental or investigational treatments, in assigning clinical reviewers, the independent review organization selects physicians or other health care professionals who, through clinical experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment;

(D) the health carrier, the covered person, and the covered person's authorized representative shall not choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review;

(E) confidentiality of medical and treatment records and clinical review criteria; and

(F) any person employed by or under contract with the independent review organization adheres to the requirements of this Act;

(2) a toll-free telephone service operating on a 24-hour-day, 7-day-a-week basis that accepts, receives, and records information related to external reviews and provides appropriate instructions; and

(3) an agreement to maintain and provide to the

Director the information set out in Section 70 of this Act.

(b) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) hold a non-restricted 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

(4) have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a), an independent review organization may 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.

(d) Conflicts of interest prohibited. In addition to the requirements set forth in subsections (a), (b), and (c) of this Section, to be approved pursuant to this Act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(1) the health carrier that is the subject of the external review;

(2) the covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(3) any officer, director or management employee of the health carrier that is the subject of the external review;

(4) the health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(5) the facility at which the recommended health care

service or treatment would be provided; or

(6) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the Director has determined are equivalent to or exceed the minimum qualifications of this Section shall be presumed to be in compliance with this Section and shall be eligible for approval under this Act.

(f) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this Section.

(g) Nothing in this Act precludes or shall be interpreted to preclude a health carrier from contracting with approved independent review organizations to conduct external reviews ~~assigned to it from such health carrier~~.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/65)

Sec. 65. External review reporting requirements.

(a) Each health carrier shall maintain written records in the aggregate<u>, by state, and for each type of health benefit</u>

plan offered by the health carrier on all requests for external review that the health carrier received notice from the Director for each calendar year and submit a report to the Director in the format specified by the Director by March 1 of each year.

(a-5) An independent review organization assigned pursuant to this Act to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and submit a report in the format specified by the Director by March 1 of each year.

(a-10) The report required by subsection (a-5) shall include in the aggregate by state, and for each health carrier:

(1) the total number of requests for external review;

(2) the number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(3) the average length of time for resolution;

(4) a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Director;

(5) the number of external reviews 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; and

(6) any other information the Director may request or require.

(a-15) The independent review organization shall retain the written records required pursuant to this Section for at least 3 years.

(b) The report required under subsection (a) of this Section shall include in the aggregate, by state, and by type of health benefit plan:

(1) the total number of requests for external review;

(2) the total number of requests for expedited external review;

(3) the total number of requests for external review denied;

(4) the number of requests for external review resolved, including:

(A) the number of requests for external review resolved upholding the adverse determination or final adverse determination;

(B) the number of requests for external review resolved reversing the adverse determination or final adverse determination;

(C) the number of requests for expedited external review resolved upholding the adverse determination or

final adverse determination; and

(D) the number of requests for expedited external review resolved reversing the adverse determination or final adverse determination;

(5) the average length of time for resolution for an external review;

(6) the average length of time for resolution for an expedited external review;

(7) a summary of the types of coverages or cases for which an external review was sought, as specified below:

(A) denial of care or treatment (dissatisfaction regarding prospective non-authorization of a request for care or treatment recommended by a provider excluding diagnostic procedures and referral requests; partial approvals and care terminations are also considered to be denials);

(B) denial of diagnostic procedure (dissatisfaction regarding prospective non-authorization of a request for a diagnostic procedure recommended by a provider; partial approvals are also considered to be denials);

(C) denial of referral request (dissatisfaction regarding non-authorization of a request for a referral to another provider recommended by a PCP);

(D) claims and utilization review (dissatisfaction regarding the concurrent or retrospective evaluation

of the coverage, medical necessity, efficiency or appropriateness of health care services or treatment plans; prospective "Denials of care or treatment", "Denials of diagnostic procedures" and "Denials of referral requests" should not be classified in this category, but the appropriate one above);

(8) the number of external reviews 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; and

(9) any other information the Director may request or require.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/75)

Sec. 75. Disclosure requirements.

(a) Each health carrier shall include a description of the external review procedures in, or attached to, the policy, certificate, membership booklet, and outline of coverage or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this Section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse

determination with the Director ~~health carrier~~. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the toll-free telephone number and address of the Office of Consumer Health Insurance within the Department of Insurance.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/80 new)

Sec. 80. Administration and enforcement.

(a) The Director of Insurance may adopt rules necessary to implement the Department's responsibilities under this Act.

(b) The Director is authorized to make use of any of the powers established under the Illinois Insurance Code to enforce the laws of this State. This includes but is not limited to, the Director's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, including, without limitation, orders pursuant to Article XII 1/2 and Section 401.1 of the Illinois Insurance Code, and impose penalties.

Section 99. Effective date. This Act takes effect on July 1, 2011.".