

1 AN ACT concerning insurance.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 ARTICLE 5.
5 UTILIZATION REVIEW AND
6 BENEFIT DETERMINATION

7 Section 5-1. Short title. This Article may be cited as the
8 Utilization Review and Benefit Determination Law.

9 Section 5-5. Purpose and intent. This Law establishes
10 standards and criteria for the structure and operation of
11 utilization review and benefit determination processes
12 designed to facilitate ongoing assessment and management of
13 health care services.

14 Section 5-10. Definitions. For purposes of this Act:

15 "Adverse determination" has the same meaning given that
16 term in the Health Carrier Grievance Procedure Law.

17 "Ambulatory review" has the same meaning given that term in
18 the Health Carrier Grievance Procedure Law.

19 "Authorized representative" has the same meaning given
20 that term in the Health Carrier Grievance Procedure Law.

21 "Case management" has the same meaning given that term in

1 the Health Carrier Grievance Procedure Law.

2 "Certification" has the same meaning given that term in the
3 Health Carrier Grievance Procedure Law.

4 "Clinical peer" has the same meaning given that term in the
5 Managed Care Reform and Patient Rights Law.

6 "Clinical review criteria" has the same meaning given that
7 term in the Health Carrier Grievance Procedure Law.

8 "Department" means the Department of Insurance.

9 "Director" means the Director of Insurance.

10 "Concurrent review" has the same meaning given that term in
11 the Health Carrier Grievance Procedure Law.

12 "Covered benefits" or "benefits" have the same meaning
13 given those terms in the Health Carrier Grievance Procedure
14 Law.

15 "Covered person" has the same meaning given that term in
16 the Health Carrier Grievance Procedure Law.

17 "Discharge planning" has the same meaning given that term
18 in the Health Carrier Grievance Procedure Law.

19 "Emergency medical condition" has the same meaning given
20 that term in the Health Carrier Grievance Procedure Law.

21 "Emergency services" has the same meaning given that term
22 in the Health Carrier Grievance Procedure Law.

23 "Facility" has the same meaning given that term in the
24 Health Carrier Grievance Procedure Law.

25 "Health benefit plan" has the same meaning given that term
26 in the Health Carrier Grievance Procedure Law.

1 "Health care professional" has the same meaning given that
2 term in the Health Carrier Grievance Procedure Law.

3 "Health care provider" or "provider" has the same meaning
4 given that term in the Health Carrier Grievance Procedure Law.

5 "Health care services" has the same meaning given that term
6 in the Health Carrier Grievance Procedure Law.

7 "Health carrier" has the same meaning given that term in
8 the Health Carrier Grievance Procedure Law.

9 "Managed care plan" has the same meaning given that term in
10 the Health Carrier Grievance Procedure Law.

11 "Network" has the same meaning given that term in the
12 Health Carrier Grievance Procedure Law.

13 "Participating provider" means a provider who, under a
14 contract with the health carrier or with its contractor or
15 subcontractor, has agreed to provide health care services to
16 covered persons with an expectation of receiving payment, other
17 than coinsurance, copayments, or deductibles, directly or
18 indirectly from the health carrier.

19 "Person" has the same meaning given that term in the Health
20 Carrier Grievance Procedure Law.

21 "Prospective review" has the same meaning given that term
22 in the Health Carrier Grievance Procedure Law.

23 "Rescission" has the same meaning given that term in the
24 Health Carrier Grievance Procedure Law.

25 "Retrospective review" has the same meaning given that term
26 in the Health Carrier Grievance Procedure Law.

1 "Second opinion" has the same meaning given that term in
2 the Health Carrier Grievance Procedure Law.

3 "Stabilization" has the same meaning given that term in the
4 Managed Care Reform and Patient Rights Act.

5 "Urgent care request" has the same meaning given that term
6 in the Health Carrier Grievance Procedure Law.

7 "Utilization review" has the same meaning given that term
8 in the Managed Care Reform and Patient Rights Act.

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

12 Section 5-15. Applicability and scope. This Law shall apply
13 to a health carrier offering a health benefit plan that
14 provides or performs utilization review services. The
15 requirements of this Law also shall apply to any designee of
16 the health carrier or utilization review organization that
17 performs utilization review functions on the carrier's behalf.
18 This Law also shall apply to a health carrier or its designee
19 utilization review organization that provides or performs
20 concurrent review, prospective review, or retrospective review
21 benefit determinations.

22 Section 5-20. Corporate oversight of utilization review
23 program. A health carrier shall be responsible for monitoring
24 all utilization review activities carried out by, or on behalf

1 of, the health carrier and for ensuring that all requirements
2 of this Law and applicable regulations are met. The health
3 carrier also shall ensure that appropriate personnel have
4 operational responsibility for the conduct of the health
5 carrier's utilization review program.

6 Section 5-25. Contracting. Whenever a health carrier
7 contracts to have a utilization review organization or other
8 entity perform the utilization review functions required by
9 this Law or applicable regulations, the Director shall hold the
10 health carrier responsible for monitoring the activities of the
11 utilization review organization or entity with which the health
12 carrier contracts and for ensuring that the requirements of
13 this Law and applicable regulations are met.

14 Section 5-30. Scope and content of utilization review
15 program.

16 (a) A health carrier that requires a request for benefits
17 under the covered person's health benefit plan to be subjected
18 to utilization review shall implement a written utilization
19 review program that describes all review activities and
20 procedures, both delegated and non-delegated, for the
21 following:

22 (1) the filing of benefit requests;

23 (2) the notification of utilization review and benefit
24 determinations; and

1 (3) the review of adverse determinations in accordance
2 with the Health Carrier Grievance Procedure Law.

3 (b) The program document shall describe the following:

4 (1) procedures to evaluate the medical necessity,
5 appropriateness, efficacy, or efficiency of health care
6 services;

7 (2) data sources and clinical review criteria used in
8 decision-making;

9 (3) mechanisms to ensure consistent application of
10 clinical review criteria and compatible decisions;

11 (4) data collection processes and analytical methods
12 used in assessing utilization of health care services;

13 (5) provisions for assuring confidentiality of
14 clinical and proprietary information;

15 (6) the organizational structure, including, but not
16 limited to, utilization review committee, quality
17 assurance committee, or other committee that periodically
18 assesses utilization review activities and reports to the
19 health carrier's governing body; and

20 (7) the staff position functionally responsible for
21 day-to-day program management.

22 (c) A health carrier shall file an annual summary report of
23 its utilization review program activities with the Director in
24 the format specified by the Director.

25 (d) A health carrier shall maintain records for a minimum
26 of 6 years of all benefit requests and claims and notices

1 associated with utilization review and benefit determinations
2 made in accordance with Sections 5-40 and 5-45 of this Law. The
3 health carrier shall make the records available for examination
4 by covered persons and the Department upon request.

5 Section 5-35. Operational requirements.

6 (a) A utilization review program shall use documented
7 clinical review criteria that are based on sound clinical
8 evidence and are evaluated periodically to assure ongoing
9 efficacy. A health carrier may develop its own clinical review
10 criteria or it may purchase or license clinical review criteria
11 from qualified vendors. A health carrier shall make available
12 its clinical review criteria upon request to the Department.

13 (b) Qualified health care professionals shall administer
14 the utilization review program and oversee utilization review
15 decisions. A clinical peer shall evaluate the clinical
16 appropriateness of adverse determinations.

17 (c) A health carrier shall issue utilization review and
18 benefit determinations in a timely manner pursuant to the
19 requirements of Sections 5-40 and 5-45 of this Law.

20 (d) The following provisions shall apply:

21 (1) Whenever a health carrier fails to strictly adhere
22 to the requirements of Sections 5-40 or 5-45 of this Law
23 with respect to making utilization review and benefit
24 determinations of a benefit request or claim, the covered
25 person shall be deemed to have exhausted the provisions of

1 this Law and may take action under paragraph (2) of this
2 subsection (d) regardless of whether the health carrier
3 asserts that it substantially complied with the
4 requirements of Sections 5-40 or 5-45 of this Law, as
5 applicable, or that any error it committed was de minimus.

6 (2) A covered person may file a request for external
7 review in accordance with the procedures outlined in the
8 Health Carrier External Review Act. In addition, a covered
9 person is entitled to pursue any available remedies under
10 State or federal law on the basis that the health carrier
11 failed to provide a reasonable internal claims and appeals
12 process that would yield a decision on the merits of the
13 claim.

14 (e) A health carrier shall have a process to ensure that
15 utilization reviewers apply clinical review criteria in
16 conducting utilization review consistently.

17 (f) A health carrier shall routinely assess the
18 effectiveness and efficiency of its utilization review
19 program.

20 (g) A health carrier's data systems shall be sufficient to
21 support utilization review program activities and to generate
22 management reports to enable the health carrier to monitor and
23 manage health care services effectively.

24 (h) If a health carrier delegates any utilization review
25 activities to a utilization review organization, then the
26 health carrier shall maintain adequate oversight, which shall

1 include:

2 (1) a written description of the utilization review
3 organization's activities and responsibilities, including
4 reporting requirements;

5 (2) evidence of formal approval of the utilization
6 review organization program by the health carrier; and

7 (3) a process by which the health carrier evaluates the
8 performance of the utilization review organization.

9 (i) The health carrier shall coordinate the utilization
10 review program with other medical management activity
11 conducted by the carrier, such as quality assurance,
12 credentialing, provider contracting, data reporting, grievance
13 procedures, processes for assessing member satisfaction, and
14 risk management.

15 (j) A health carrier shall provide covered persons and
16 participating providers with access to its review staff by a
17 toll-free number or collect-call telephone line.

18 (k) When conducting utilization review, the health carrier
19 shall collect only the information necessary, including
20 pertinent clinical information, to make the utilization review
21 or benefit determination.

22 (l) In conducting utilization review, the health carrier
23 shall ensure that the review is conducted in a manner to ensure
24 the independence and impartiality of the individuals involved
25 in making the utilization review or benefit determination. In
26 ensuring the independence and impartially of individuals

1 involved in making the utilization review or benefit
2 determination, the health carrier shall not make decisions
3 regarding hiring, compensation, termination, promotion, or
4 other similar matters based upon the likelihood that the
5 individual will support the denial of benefits.

6 Section 5-40. Procedures for standard utilization review
7 and benefit determinations.

8 (a) A health carrier shall maintain written procedures
9 pursuant to this Section for making standard utilization review
10 and benefit determinations on requests submitted to the health
11 carrier by covered persons or their authorized representatives
12 for benefits and for notifying covered persons and their
13 authorized representatives of its determinations with respect
14 to these requests within the specified time frames required
15 under this Section.

16 (b) Subject to subsection (d) of this Section, for
17 prospective review determinations, a health carrier shall make
18 the determination and notify the covered person or, if
19 applicable, the covered person's authorized representative of
20 the determination, whether the carrier certifies the provision
21 of the benefit or not, within a reasonable period of time
22 appropriate to the covered person's medical condition, but in
23 no event later than 15 days after the date the health carrier
24 receives the request.

25 (c) Whenever the determination is an adverse

1 determination, the health carrier shall make the notification
2 of the adverse determination in accordance with subsection (q)
3 of this Section.

4 (d) The time period for making a determination and
5 notifying the covered person or, if applicable, the covered
6 person's authorized representative of the determination
7 pursuant to subsections (b) and (c) of this Section may be
8 extended one time by the health carrier for up to 15 days,
9 provided the health carrier:

10 (1) determines that an extension is necessary due to
11 matters beyond the health carrier's control; and

12 (2) notifies the covered person or, if applicable, the
13 covered person's authorized representative, prior to the
14 expiration of the initial 15-day time period, of the
15 circumstances requiring the extension of time and the date
16 by which the health carrier expects to make a
17 determination.

18 (e) If the extension under subsection (d) of this Section
19 is necessary due to the failure of the covered person or the
20 covered person's authorized representative to submit
21 information necessary to reach a determination on the request,
22 then the notice of extension shall:

23 (1) specifically describe the required information
24 necessary to complete the request; and

25 (2) give the covered person or, if applicable, the
26 covered person's authorized representative at least 45

1 days from the date of receipt of the notice to provide the
2 specified information.

3 (f) Whenever the health carrier receives a prospective
4 review request from a covered person or the covered person's
5 authorized representative that fails to meet the health
6 carrier's filing procedures, the health carrier shall notify
7 the covered person or, if applicable, the covered person's
8 authorized representative of this failure and provide in the
9 notice information on the proper procedures to be followed for
10 filing a request.

11 (g) The notice required under subsection (f) of this
12 Section shall be provided, as soon as possible, but in no event
13 later than 5 days following the date of the failure. The health
14 carrier may provide the notice orally or, if requested by the
15 covered person or the covered person's authorized
16 representative, in writing.

17 (h) The provisions of subsections (f) and (g) shall apply
18 only in the case of a failure that:

19 (1) is a communication by a covered person or the
20 covered person's authorized representative that is
21 received by a person or organizational unit of the health
22 carrier responsible for handling benefit matters; and

23 (2) is a communication that refers to a specific
24 covered person, a specific medical condition or symptom,
25 and a specific health care service, treatment, or provider
26 for which certification is being requested.

1 (i) For concurrent review determinations, if a health
2 carrier has certified an ongoing course of treatment to be
3 provided over a period of time or number of treatments, then
4 the following provisions shall apply:

5 (1) any reduction or termination by the health carrier
6 during the course of treatment before the end of the period
7 or number treatments, other than by a health benefit plan
8 amendment or termination of the health benefit plan, shall
9 constitute an adverse determination;

10 (2) the health carrier shall notify the covered person
11 of the adverse determination in accordance with subsection
12 (q) of this Section at a time sufficiently in advance of
13 the reduction or termination to allow the covered person
14 or, if applicable, the covered person's authorized
15 representative to file a grievance to request a review of
16 the adverse determination pursuant to the Health Carrier
17 Grievance Procedure Law and obtain a determination with
18 respect to that review of the adverse determination before
19 the benefit is reduced or terminated; and

20 (3) the health care service or treatment that is the
21 subject of the adverse determination shall be continued
22 without liability to the covered person with respect to the
23 internal review request made pursuant to Health Carrier
24 Grievance Procedure Law.

25 (j) For retrospective review determinations, a health
26 carrier shall make the determination within a reasonable period

1 of time, but in no event later than 30 days after the date of
2 receiving the benefit request.

3 (k) If the determination is an adverse determination, then
4 the health carrier shall provide notice of the adverse
5 determination to the covered person or, if applicable, the
6 covered person's authorized representative in accordance with
7 subsection (q) of this Section.

8 (l) The time period for making a determination and
9 notifying the covered person or, if applicable, the covered
10 person's authorized representative of the determination
11 pursuant to subsections (j) and (k) of this Section may be
12 extended one time by the health carrier for up to 15 days,
13 provided the health carrier:

14 (1) determines that an extension is necessary due to
15 matters beyond the health carrier's control; and

16 (2) notifies the covered person or, if applicable, the
17 covered person's authorized representative, prior to the
18 expiration of the initial 30-day time period, of the
19 circumstances requiring the extension of time and the date
20 by which the health carrier expects to make a
21 determination.

22 (m) If the extension under subsection (l) of this Section
23 is necessary due to the failure of the covered person or, if
24 applicable, the covered person's authorized representative to
25 submit information necessary to reach a determination on the
26 request, the notice of extension shall:

1 (1) specifically describe the required information
2 necessary to complete the request; and

3 (2) give the covered person or, if applicable, the
4 covered person's authorized representative at least 45
5 days after the date of receipt of the notice to provide the
6 specified information.

7 (n) For purposes of calculating the time periods within
8 which a determination is required to be made under this
9 Section, the time period within which the determination is
10 required to be made shall begin on the date the request is
11 received by the health carrier in accordance with the health
12 carrier's procedures established pursuant to Section 5-30 of
13 this Law for filing a request without regard to whether all of
14 the information necessary to make the determination
15 accompanies the filing.

16 (o) If the time period for making the determination under
17 this Section is extended due to the covered person's or, if
18 applicable, the covered person's authorized representative's
19 failure to submit the information necessary to make the
20 determination, the time period for making the determination
21 shall be tolled from the date on which the health carrier sends
22 the notification of the extension to the covered person or, if
23 applicable, the covered person's authorized representative
24 until the earlier of:

25 (1) the date on which the covered person or, if
26 applicable, the covered person's authorized representative

1 responds to the request for additional information; or

2 (2) the date on which the specified information was to
3 have been submitted.

4 (p) If the covered person or the covered person's
5 authorized representative fails to submit the information
6 before the end of the period of the extension as specified in
7 this Section, then the health carrier may deny the
8 certification of the requested benefit.

9 (q) Notice requirements are as follows:

10 (1) A notification of an adverse determination under
11 this Section shall, in a manner calculated to be understood
12 by the covered person, set forth:

13 (A) information sufficient to identify the benefit
14 request or claim involved, including the date of
15 service, if applicable, the health care provider, the
16 claim amount, if applicable, the diagnosis code and its
17 corresponding meaning, and the treatment code and its
18 corresponding meaning;

19 (B) the specific reasons or reasons for the adverse
20 determination, including the denial code and its
21 corresponding meaning, as well as a description of the
22 health carrier's standard, if any, that was used in
23 denying the benefit request or claim;

24 (C) reference to the specific plan provisions on
25 which the determination is based;

26 (D) a description of any additional material or

1 information necessary for the covered person to
2 perfect the benefit request, including an explanation
3 of why the material or information is necessary to
4 perfect the request;

5 (E) a description of the health carrier's
6 grievance procedures established pursuant to the
7 Health Carrier Grievance Procedure Law, including any
8 time limits applicable to those procedures;

9 (F) if the health carrier relied upon an internal
10 rule, guideline, protocol, or other similar criterion
11 to make the adverse determination, either the specific
12 rule, guideline, protocol, or other similar criterion
13 or a statement that a specific rule, guideline,
14 protocol, or other similar criterion was relied upon to
15 make the adverse determination and that a copy of the
16 rule, guideline, protocol, or other similar criterion
17 will be provided free of charge to the covered person
18 upon request;

19 (G) if the adverse determination is based on a
20 medical necessity or experimental or investigational
21 treatment or similar exclusion or limit, either an
22 explanation of the scientific or clinical judgment for
23 making the determination, applying the terms of the
24 health benefit plan to the covered person's medical
25 circumstances or a statement that an explanation will
26 be provided to the covered person free of charge upon

1 request;

2 (H) a copy of the rule, guideline, protocol, or
3 other similar criterion relied upon in making the
4 adverse determination, as provided in subparagraph (F)
5 of this paragraph (1); or

6 (I) the written statement of the scientific or
7 clinical rationale for the adverse determination, as
8 provided in subparagraph (G) of this paragraph (1); and

9 (J) a statement explaining the availability of and
10 the right of the covered person, as appropriate, to
11 contact the Department or the Office of Consumer Health
12 Insurance at any time for assistance or, upon
13 completion of the health carrier's grievance procedure
14 process as provided under the Health Carrier Grievance
15 Procedure Law, to file a civil suit in a court of
16 competent jurisdiction; the statement shall include
17 contact information for the Department and the Office
18 of Consumer Health Insurance.

19 (2) A health carrier shall provide the notice required
20 under this Section in a culturally and linguistically
21 appropriate manner if required in accordance with federal
22 regulations. If a health carrier is required to provide the
23 notice required under this Section in a culturally and
24 linguistically appropriate manner in accordance with
25 federal regulations, then the health carrier shall:

26 (A) include a statement in the English version of

1 the notice, prominently displayed in the non-English
2 language, offering the provision of the notice in the
3 non-English language;

4 (B) once a utilization review or benefit
5 determination request has been made by a covered
6 person, provide all subsequent notices to the covered
7 person in the non-English language; and

8 (C) to the extent the health carrier maintains a
9 consumer assistance process, such as a telephone
10 hotline that answers questions or provides assistance
11 with filing claims and appeals, provide this
12 assistance in the non-English language.

13 (3) If the adverse determination is a rescission, then
14 the health carrier shall, in addition to any applicable
15 disclosures required under this subsection (q), provide:

16 (A) clear identification of the alleged fraudulent
17 act, practice, or omission or the intentional
18 misrepresentation of material fact;

19 (B) an explanation as to why the act, practice, or
20 omission was fraudulent or was an intentional
21 misrepresentation of a material fact;

22 (C) notice that the covered person or the covered
23 person's authorized representative, prior to the
24 effective date of the proposed rescission, may
25 immediately file a grievance to request a review of the
26 adverse determination to rescind coverage pursuant to

1 the Health Carrier Grievance Procedure Law;

2 (D) a description of the health carrier's
3 grievance procedures established pursuant to the
4 Health Carrier Grievance Procedure Law, including any
5 time limits applicable to those procedures; and

6 (E) the effective date of the proposed rescission
7 and the date back to which the coverage will be
8 retroactively rescinded.

9 (4) A health carrier must provide the notice required
10 under this Section in writing.

11 Section 5-45. Procedures for expedited utilization review
12 and benefit determinations.

13 (a) A health carrier shall establish written procedures in
14 accordance with this Section for receiving benefit requests
15 from covered persons or their authorized representatives and
16 for making and notifying covered persons or their authorized
17 representatives of expedited utilization review and benefit
18 determinations with respect to urgent care requests and
19 concurrent review urgent care requests.

20 (b) As part of the procedures required under subsection (a)
21 of this Section, a health carrier shall provide that, in the
22 case of a failure by a covered person or the covered person's
23 authorized representative to follow the health carrier's
24 procedures for filing an urgent care request, the covered
25 person or the covered person's authorized representative shall

1 be notified of the failure and the proper procedures to be
2 followed for filing the request.

3 (c) The notice required under subsection (b) of this
4 Section:

5 (1) shall be provided to the covered person or the
6 covered person's authorized representative, as
7 appropriate, as soon as possible, but not later than 24
8 hours after receipt of the request; and

9 (2) may be oral, unless the covered person or the
10 covered person's authorized representative requests the
11 notice in writing.

12 (d) The provisions of subsections (b) and (c) of this
13 Section apply only in the case of a failure that:

14 (1) is a communication by a covered person or, if
15 applicable, the covered person's authorized representative
16 that is received by a person or organizational unit of the
17 health carrier responsible for handling benefit matters;
18 and

19 (2) is a communication that refers to a specific
20 covered person, a specific medical condition or symptom,
21 and a specific health care service, treatment or provider
22 for which approval is being requested.

23 (e) For an urgent care request, unless the covered person
24 or the covered person's authorized representative has failed to
25 provide sufficient information for the health carrier to
26 determine whether, or to what extent, the benefits requested

1 are covered benefits or payable under the health carrier's
2 health benefit plan, the health carrier shall notify the
3 covered person or, if applicable, the covered person's
4 authorized representative of the health carrier's
5 determination with respect to the request, whether or not the
6 determination is an adverse determination, as soon as possible,
7 taking into account the medical condition of the covered
8 person, but in no event later than 24 hours after the receipt
9 of the request by the health carrier.

10 (f) If the health carrier's determination is an adverse
11 determination, then the health carrier shall provide notice of
12 the adverse determination in accordance with subsection (o) of
13 this Section.

14 (g) If the covered person or, if applicable, the covered
15 person's authorized representative has failed to provide
16 sufficient information for the health carrier to make a
17 determination, then the health carrier shall notify the covered
18 person or, if applicable, the covered person's authorized
19 representative either orally or, if requested by the covered
20 person or the covered person's authorized representative, in
21 writing of this failure and state what specific information is
22 needed as soon as possible, but in no event later than 24 hours
23 after receipt of the request.

24 (h) The health carrier shall provide the covered person or,
25 if applicable, the covered person's authorized representative
26 a reasonable period of time to submit the necessary

1 information, taking into account the circumstances, but in no
2 event less than 48 hours after notifying the covered person or
3 the covered person's authorized representative of the failure
4 to submit sufficient information, as provided in subsection (g)
5 of this Section.

6 (i) The health carrier shall notify the covered person or,
7 if applicable, the covered person's authorized representative
8 of its determination with respect to the urgent care request as
9 soon as possible, but in no event more than 48 hours after the
10 earlier of:

11 (1) the health carrier's receipt of the requested
12 specified information; or

13 (2) the end of the period provided for the covered
14 person or, if applicable, the covered person's authorized
15 representative to submit the requested specified
16 information.

17 (j) If the covered person or the covered person's
18 authorized representative fails to submit the information
19 before the end of the period of the extension, as specified in
20 subsection (h) of this Section, then the health carrier may
21 deny the certification of the requested benefit.

22 (k) If the health carrier's determination is an adverse
23 determination, then the health carrier shall provide notice of
24 the adverse determination in accordance with subsection (o) of
25 this Section.

26 (l) For concurrent review urgent care requests involving a

1 request by the covered person or the covered person's
2 authorized representative to extend the course of treatment
3 beyond the initial period of time or the number of treatments,
4 if the request is made at least 24 hours prior to the
5 expiration of the prescribed period of time or number of
6 treatments, then the health carrier shall make a determination
7 with respect to the request and notify the covered person or,
8 if applicable, the covered person's authorized representative
9 of the determination, whether it is an adverse determination or
10 not, as soon as possible, taking into account the covered
11 person's medical condition, but in no event more than 24 hours
12 after the health carrier's receipt of the request.

13 (m) If the health carrier's determination is an adverse
14 determination, then the health carrier shall provide notice of
15 the adverse determination in accordance with subsection (o) of
16 this Section.

17 (n) For purposes of calculating the time periods within
18 which a determination is required to be made under this
19 Section, the time period within which the determination is
20 required to be made shall begin on the date the request is
21 filed with the health carrier in accordance with the health
22 carrier's procedures established pursuant to Section 5-30 of
23 this Law for filing a request without regard to whether all of
24 the information necessary to make the determination
25 accompanies the filing.

26 (o) Notice requirements are as follows:

1 (1) A notification of an adverse determination under
2 this Section shall, in a manner calculated to be understood
3 by the covered person, set forth:

4 (A) information sufficient to identify the benefit
5 request or claim involved, including the date of
6 service, if applicable, the health care provider, the
7 claim amount, if applicable, the diagnosis code and its
8 corresponding meaning and the treatment code and its
9 corresponding meaning;

10 (B) the specific reasons or reasons for the adverse
11 determination, including the denial code and its
12 corresponding meaning, as well as a description of the
13 health carrier's standard, if any, that was used in
14 denying the benefit request or claim;

15 (C) reference to the specific plan provisions on
16 which the determination is based;

17 (D) a description of any additional material or
18 information necessary for the covered person to
19 complete the request, including an explanation of why
20 the material or information is necessary to complete
21 the request;

22 (E) a description of the health carrier's internal
23 review procedures established pursuant to the Health
24 Carrier Grievance Procedure Law, including any time
25 limits applicable to those procedures;

26 (F) a description of the health carrier's

1 expedited review procedures established pursuant to
2 Section 10-40 of the Health Carrier Grievance
3 Procedure Law;

4 (G) if the health carrier relied upon an internal
5 rule, guideline, protocol, or other similar criterion
6 to make the adverse determination, either the specific
7 rule, guideline, protocol, or other similar criterion
8 or a statement that a specific rule, guideline,
9 protocol, or other similar criterion was relied upon to
10 make the adverse determination and that a copy of the
11 rule, guideline, protocol, or other similar criterion
12 will be provided free of charge to the covered person
13 upon request;

14 (H) if the adverse determination is based on a
15 medical necessity or experimental or investigational
16 treatment or similar exclusion or limit, either an
17 explanation of the scientific or clinical judgment for
18 making the determination, applying the terms of the
19 health benefit plan to the covered person's medical
20 circumstances or a statement that an explanation will
21 be provided to the covered person free of charge upon
22 request;

23 (I) if applicable, instructions for requesting:

24 (i) a copy of the rule, guideline, protocol, or
25 other similar criterion relied upon in making the
26 adverse determination in accordance with

1 subparagraph (G) of this paragraph (1); or
2 (ii) the written statement of the scientific
3 or clinical rationale for the adverse
4 determination in accordance with subparagraph (H)
5 of this paragraph (1); and

6 (J) a statement explaining the availability of and
7 the right of the covered person, as appropriate, to
8 contact the Department or the Office of Consumer Health
9 Insurance at any time for assistance or, upon
10 completion of the health carrier's grievance procedure
11 process as provided under the Health Carrier Grievance
12 Procedure Law, to file a civil suit in a court of
13 competent jurisdiction; the statement shall include
14 contact information for the Department and the Office
15 of Consumer Health Insurance.

16 (2) A health carrier shall provide the notice required
17 under this Section in a culturally and linguistically
18 appropriate manner if required in accordance with federal
19 regulations. If a health carrier is required to provide the
20 notice required under this Section in a culturally and
21 linguistically appropriate manner in accordance with
22 federal regulations, the health carrier shall do the
23 following:

24 (A) include a statement in the English version of
25 the notice, prominently displayed in the non-English
26 language, offering the provision of the notice in the

1 non-English language;

2 (B) once a utilization review or benefit
3 determination request has been made by a covered
4 person, provide all subsequent notices to the covered
5 person in the non-English language; and

6 (C) to the extent the health carrier maintains a
7 consumer assistance process, such as a telephone
8 hotline that answers questions or provides assistance
9 with filing claims and appeals, the health carrier
10 shall provide this assistance in the non-English
11 language.

12 (3) If the adverse determination is a rescission, then
13 the health carrier shall provide the following, in addition
14 to any applicable disclosures required under this
15 subsection (o):

16 (A) clear identification of the alleged fraudulent
17 act, practice or omission or the intentional
18 misrepresentation of material fact;

19 (B) an explanation as to why the act, practice or
20 omission was fraudulent or was an intentional
21 misrepresentation of a material fact;

22 (C) the date the health carrier made the decision
23 to rescind the coverage; and

24 (D) the effective date of the proposed rescission.

25 (4) A health carrier may provide the notice required
26 under this Section orally or in writing. If notice of the

1 adverse determination is provided orally, then the health
2 carrier shall provide written notice of the adverse
3 determination within 3 days following the oral
4 notification.

5 Section 5-50. Emergency services. For immediately required
6 post-evaluation or post-stabilization services, a health
7 carrier shall provide access to designated representative 24
8 hours a day, 7 days a week, to facilitate review.

9 Section 5-55. Confidentiality requirements. A health
10 carrier shall annually certify in writing to the Director that
11 the utilization review program of the health carrier or its
12 designee complies with all applicable State and federal law
13 establishing confidentiality and reporting requirements.

14 Section 5-60. Disclosure requirements.

15 (a) In the certificate of coverage or member handbook
16 provided to covered persons, a health carrier shall include a
17 clear and comprehensive description of its utilization review
18 procedures, including the procedures for obtaining review of
19 adverse determinations, and a statement of rights and
20 responsibilities of covered persons with respect to those
21 procedures.

22 (b) A health carrier shall include a summary of its
23 utilization review and benefit determination procedures in

1 materials intended for prospective covered persons.

2 (c) A health carrier shall print on its membership cards a
3 toll-free telephone number to call for utilization review and
4 benefit decisions.

5 Section 5-65. Administration and enforcement.

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

8 (b) The Director is authorized to make use of any of the
9 powers established under the Illinois Insurance Code to enforce
10 the laws of this State. This includes but is not limited to,
11 the Director's administrative authority to investigate, issue
12 subpoenas, conduct depositions and hearings, issue orders,
13 including, without limitation, orders pursuant to Article XII
14 1/2 and Section 401.1 of the Illinois Insurance Code, and
15 impose penalties.

16 ARTICLE 10. HEALTH CARRIER GRIEVANCE PROCEDURES

17 Section 10-1. Short title. This Article may be cited as the
18 Health Carrier Grievance Procedure Law.

19 Section 10-5. Purpose and intent. The purpose of this Law
20 is to provide standards for the establishment and maintenance
21 of procedures by health carriers to ensure that covered persons
22 have the opportunity for the appropriate resolution of

1 grievances, as defined in this Law.

2 Section 10-10. Definitions. For purposes of this Law:

3 "Adverse determination" means:

4 (1) a determination by a health carrier or its designee
5 utilization review organization that, based upon the
6 information provided, a request for a benefit under the
7 health carrier's health benefit plan upon application of
8 any utilization review technique does not meet the health
9 carrier's requirements for medical necessity,
10 appropriateness, health care setting, level of care, or
11 effectiveness or is determined to be experimental or
12 investigational and the requested benefit is therefore
13 denied, reduced, or terminated or payment is not provided
14 or made, in whole or in part, for the benefit;

15 (2) the denial, reduction, termination or failure to
16 provide or make payment, in whole or in part, for a benefit
17 based on a determination by a health carrier or its
18 designee utilization review organization of a covered
19 person's eligibility to participate in the health
20 carrier's health benefit plan;

21 (3) any prospective review or retrospective review
22 determination that denies, reduces, or terminates or fails
23 to provide or make payment, in whole or in part, for a
24 benefit; or

25 (4) a rescission of coverage determination.

1 "Ambulatory review" means utilization review of health
2 care services performed or provided in an outpatient setting.

3 "Authorized representative" means:

4 (1) a person to whom a covered person has given express
5 written consent to represent the covered person for
6 purposes of this Law;

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

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

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

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

18 "Case management" means a coordinated set of activities
19 conducted for individual patient management of serious,
20 complicated, protracted, or other health conditions.

21 "Certification" means a determination by a health carrier
22 or its designee utilization review organization that a request
23 for a benefit under the health carrier's health benefit plan
24 has been reviewed and, based on the information provided,
25 satisfies the health carrier's requirements for medical
26 necessity, appropriateness, health care setting, level of

1 care, and effectiveness.

2 "Clinical peer" has the same meaning given that term in the
3 Managed Care Reform and Patients Rights Act.

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

8 "Closed plan" means a managed care plan that requires
9 covered persons to use participating providers under the terms
10 of the managed care plan.

11 "Director" means the Director of Insurance.

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

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

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

22 "Discharge planning" means the formal process for
23 determining, prior to discharge from a facility, the
24 coordination and management of the care that a patient receives
25 following discharge from a facility.

26 "Emergency medical condition" means a medical condition

1 manifesting itself by acute symptoms of sufficient severity,
2 including severe pain, such that a prudent layperson who
3 possesses an average knowledge of health and medicine could
4 reasonably expect that the absence of immediate medical
5 attention would result in serious impairment to bodily
6 functions, serious dysfunction of a bodily organ or part, or
7 would place the person's health or, with respect to a pregnant
8 woman, the health of the woman or her unborn child in serious
9 jeopardy.

10 "Emergency services" means, with respect to an emergency
11 medical condition:

12 (1) a medical screening examination that is within the
13 capability of the emergency department of a hospital,
14 including ancillary services routinely available to the
15 emergency department to evaluate such emergency medical
16 condition; and

17 (2) such further medical examination and treatment to
18 stabilize a patient, to the extent they are within the
19 capability of the staff and facilities available at a
20 hospital.

21 "Facility" means an institution providing health care
22 services or a health care setting, including, but not limited
23 to, hospitals and other licensed inpatient centers, ambulatory
24 surgical or treatment centers, skilled nursing centers,
25 residential treatment centers, diagnostic, laboratory and
26 imaging centers, and rehabilitation and other therapeutic

1 health settings.

2 "Final adverse determination" means an adverse
3 determination that has been upheld by the health carrier at the
4 completion of the internal appeals process applicable under
5 Section 10-30 or Section 10-40 of this Law or an adverse
6 determination that with respect to which the internal appeals
7 process has been deemed exhausted in accordance with subsection
8 (b) or (c) of Section 10-25 of this Law.

9 "Grievance" means a written complaint or oral complaint if
10 the complaint involves an urgent care request submitted by or
11 on behalf of a covered person regarding:

12 (1) availability, delivery, or quality of health care
13 services, including a complaint regarding an adverse
14 determination made pursuant to utilization review;

15 (2) claims payment, handling, or reimbursement for
16 health care services; or

17 (3) matters pertaining to the contractual relationship
18 between a covered person and a health carrier.

19 "Health benefit plan" means a policy, contract,
20 certificate, or agreement offered or issued by a health carrier
21 to provide, deliver, arrange for, pay for, or reimburse any of
22 the costs of health care services. "Health benefit plan"
23 includes short-term and catastrophic health insurance
24 policies, and policies that pay on a cost-incurred basis,
25 except as otherwise specifically exempted in this definition.

26 "Health benefit plan" does not include:

1 (1) coverage only for accident or disability income
2 insurance or any combination thereof;

3 (2) coverage issued as a supplement to liability
4 insurance;

5 (3) liability insurance, including general liability
6 insurance and automobile liability insurance;

7 (4) workers' compensation or similar insurance;

8 (5) automobile medical payment insurance;

9 (6) credit-only insurance;

10 (7) coverage for on-site medical clinics; and

11 (8) other similar insurance coverage, specified in
12 federal regulations issued pursuant to Pub. L. No. 104-191,
13 under which benefits for medical care are secondary or
14 incidental to other insurance benefits.

15 "Health benefit plan" does not include the following
16 benefits if they are provided under a separate policy,
17 certificate, or contract of insurance or are otherwise not an
18 integral part of the plan:

19 (1) limited scope dental or vision benefits;

20 (2) benefits for long-term care, nursing home care,
21 home health care, community-based care, or any combination
22 thereof; or

23 (3) other similar, limited benefits specified in
24 federal regulations issued pursuant to Pub. L. No. 104-191.

25 "Health benefit plan" does not include the following
26 benefits if the benefits are provided under a separate policy,

1 certificate, or contract of insurance, there is no coordination
2 between the provision of the benefits and any exclusion of
3 benefits under any group health plan maintained by the same
4 plan sponsor and the benefits are paid with respect to an event
5 without regard to whether benefits are provided with respect to
6 such an event under any group health plan maintained by the
7 same plan sponsor:

8 (1) coverage only for a specified disease or illness;

9 or

10 (2) hospital indemnity or other fixed indemnity
11 insurance.

12 "Health benefit plan" does not include the following if
13 offered as a separate policy, certificate, or contract of
14 insurance:

15 (1) medicare supplemental health insurance as defined
16 under Section 1882(g)(1) of the Social Security Act;

17 (2) coverage supplemental to the coverage provided
18 under Chapter 55 of Title 10, United States Code (Civilian
19 Health and Medical Program of the Uniformed Services
20 (CHAMPUS)); or

21 (3) similar supplemental coverage provided to coverage
22 under a group health plan.

23 "Health care professional" means a physician or other
24 health care practitioner licensed, accredited, or certified to
25 perform specified health care services consistent with State
26 law.

1 "Health care provider" or "provider" means a health care
2 professional or a facility.

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

6 "Health carrier" means an entity subject to the insurance
7 laws and regulations of this State, or subject to the
8 jurisdiction of the Director, that contracts or offers to
9 contract to provide, deliver, arrange for, pay for, or
10 reimburse any of the costs of health care services, including a
11 sickness and accident insurance company, a health maintenance
12 organization, a nonprofit hospital and health service
13 corporation, or any other entity providing a plan of health
14 insurance, health benefits or health care services.

15 "Health indemnity plan" means a health benefit plan that is
16 not a managed care plan.

17 "Managed care plan" means a health benefit plan that
18 requires a covered person to use or creates incentives,
19 including financial incentives, for a covered person to use
20 health care providers managed, owned, under contract with, or
21 employed by the health carrier. "Managed care plan" includes:

22 (1) a closed plan, as defined in this Law; and

23 (2) an open plan, as defined in this Law.

24 "Network" means the group of participating providers
25 providing services to a managed care plan.

26 "Open plan" means a managed care plan other than a closed

1 plan that provides incentives, including financial incentives,
2 for covered persons to use participating providers under the
3 terms of the managed care plan.

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

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

13 "Rescission" means a cancellation or discontinuance of
14 coverage under a health benefit plan that has a retroactive
15 effect. "Rescission" does not include a cancellation or
16 discontinuance of coverage under a health benefit plan if:

17 (1) the cancellation or discontinuance of coverage has
18 only a prospective effect; or

19 (2) the cancellation or discontinuance of coverage is
20 effective retroactively to the extent it is attributable to
21 a failure to timely pay required premiums or contributions
22 towards the cost of coverage.

23 "Retrospective review" means any review of a request for a
24 benefit that is not a concurrent or prospective review request.

25 "Retrospective review" does not include the review of a claim
26 that is limited to veracity of documentation or accuracy of

1 coding.

2 "Second opinion" means an opportunity or requirement to
3 obtain a clinical evaluation by a provider other than the one
4 originally making a recommendation for a proposed health care
5 service to assess the medical necessity and appropriateness of
6 the initially proposed health care service.

7 "Stabilization" has the same meaning given that term in
8 Managed Care Reform and Patient Rights Act.

9 "Urgent care request" means a request for a health care
10 service or course of treatment with respect to which the time
11 periods for making non-urgent care request determination:

12 (1) could seriously jeopardize the life or health of
13 the covered person or the ability of the covered person to
14 regain maximum function; or

15 (2) in the opinion of a physician with knowledge of the
16 covered person's medical condition, would subject the
17 covered person to severe pain that cannot be adequately
18 managed without the health care service or treatment that
19 is the subject of the request.

20 Except as provided in item (2) of this definition of
21 "urgent care request", in determining whether a request is to
22 be treated as an urgent care request, an individual acting on
23 behalf of the health carrier shall apply the judgment of a
24 prudent layperson who possesses an average knowledge of health
25 and medicine.

26 Any request that a physician with knowledge of the covered

1 person's medical condition determines is an urgent care request
2 shall be treated as an urgent care request.

3 "Utilization review" has the same meaning given that term
4 in Managed Care Reform and Patient Rights Act.

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

8 Section 10-15. Applicability and scope. Except as
9 otherwise specified, this Law shall apply to all health
10 carriers offering a health benefit plan.

11 Section 10-20. Grievance reporting and record-keeping
12 requirements.

13 (a) A health carrier shall maintain written records to
14 document all grievances received, including the notices and
15 claims associated with the grievances, during a calendar year.

16 (b) Notwithstanding the provisions under subsections (g)
17 and (h) of this Section, a health carrier shall maintain the
18 records required under subsection (a) of this Section for at
19 least 6 years related to the notices provided under subsection
20 (g) of Section 10-30 and subsection (h) of Section 10-40 of
21 this Law.

22 (c) The health carrier shall make the records available for
23 examination by covered persons and the Director upon request,
24 and shall annually file a copy of the register with the

1 Department. The Department shall make a summary of all data
2 collected available upon request and shall publish the summary
3 on the World Wide Web. No Department publication or release of
4 information shall identify any enrollee, health care provider,
5 or individual complainant.

6 (d) A request for a review of a grievance involving an
7 adverse determination shall be processed in compliance with
8 Section 10-30 of this Law and shall be included in the
9 register.

10 (e) For each grievance the register shall contain, at a
11 minimum, the following information:

12 (1) an indication regarding whether the grievance was
13 filed by:

14 (A) a consumer or enrollee;

15 (B) a provider; or

16 (C) any other individual;

17 (2) classification of the grievance under one of the
18 following categories:

19 (A) denial of care or treatment;

20 (B) denial of a diagnostic procedure;

21 (C) denial of a referral request;

22 (D) sufficient choice and accessibility of health
23 care providers;

24 (E) underwriting;

25 (F) marketing and sales;

26 (G) claims and utilization review;

1 (H) member services;

2 (I) provider relations; and

3 (J) miscellaneous;

4 (3) a general description of the reason for the
5 grievance;

6 (4) the date received;

7 (5) the date of each review or, if applicable, review
8 meeting;

9 (6) resolution at each level of the grievance, if
10 applicable;

11 (7) the date of resolution at each level, if
12 applicable; and

13 (8) the name of the covered person for whom the
14 grievance was filed.

15 (f) The register shall be maintained in a manner that is
16 reasonably clear and accessible to the Director.

17 (g) Subject to the provisions of subsection (a) of this
18 Section, a health carrier shall retain the register compiled
19 for a calendar year for the longer of 3 years or until the
20 Director has adopted a final report of an examination that
21 contains a review of the register for that calendar year.

22 (h) A health carrier shall submit to the Director, at least
23 annually, a report in the format specified by the Director. The
24 report shall include for each type of health benefit plan
25 offered by the health carrier:

26 (1) the certificate of compliance required by Section

- 1 10-25 of this Law;
- 2 (2) the number of covered lives;
- 3 (3) the total number of grievances;
- 4 (4) the number of grievances resolved at each level, if
- 5 applicable, and their resolution;
- 6 (5) the number of grievances appealed to the Director
- 7 of which the health carrier has been informed;
- 8 (6) the number of grievances referred to alternative
- 9 dispute resolution procedures or resulting in litigation;
- 10 and
- 11 (7) a synopsis of actions being taken to correct
- 12 problems identified.

13 Section 10-25. Grievance review procedures.

14 (a) Except as specified in Section 10-40 of this Law, a

15 health carrier shall use written procedures for receiving and

16 resolving grievances from covered persons, as provided in

17 Sections 10-30 and 10-35 of this Law.

18 (b) The following provisions shall apply:

19 (1) Whenever a health carrier fails to strictly adhere

20 to the requirements of Section 10-30 or Section 10-40 of

21 this Law with respect to receiving and resolving grievances

22 involving an adverse determination, the covered person

23 shall be deemed to have exhausted the provisions of this

24 Law and may take action under paragraph (2) of this

25 subsection (b) regardless of whether the health carrier

1 asserts that it substantially complied with the
2 requirements of Section 10-30 or Section 10-40, as
3 applicable, or that any error it committed was de minimus.

4 (2) A covered person may file a request for external
5 review in accordance with the procedures outlined in the
6 Health Carrier External Review Act. In addition, a covered
7 person is entitled to pursue any available remedies under
8 State or federal law on the basis that the health carrier
9 failed to provide a reasonable internal claims and appeals
10 process that would yield a decision on the merits of the
11 claim.

12 (c) A health carrier shall file a copy of the procedures
13 required under subsections (a) and (b) of this Section,
14 including all forms used to process requests made pursuant to
15 Sections 10-30 and 10-35 of this Law, with the Director. Any
16 subsequent modifications to the documents also shall be filed.

17 (d) The Director may disapprove a filing received in
18 accordance with subsection (c) of this Section that fails to
19 comply with this Law or applicable regulations.

20 (e) A health carrier shall file annually with the Director,
21 as part of its annual report required by Section 10-20 of this
22 Law, a certificate of compliance stating that the health
23 carrier has established and maintains, for each of its health
24 benefit plans, grievance procedures that fully comply with the
25 provisions of this Law.

26 (f) A description of the grievance procedures required

1 under this Section shall be set forth in or attached to the
2 policy, certificate, membership booklet, outline of coverage
3 or other evidence of coverage provided to covered persons.

4 (g) The grievance procedure documents shall include a
5 statement of a covered person's right to contact the Department
6 or the Office of Consumer Health Insurance for assistance at
7 any time. The statement shall include the telephone number and
8 address of the Department and the Office of Consumer Health
9 Insurance.

10 Section 10-30. Reviews of grievances involving an adverse
11 determination.

12 (a) Within 180 days after the date of receipt of a notice
13 of an adverse determination sent pursuant to the Managed Care
14 Reform and Patient Rights Act, a covered person or the covered
15 person's authorized representative may file a grievance with
16 the health carrier requesting a review of the adverse
17 determination.

18 (b) The health carrier shall provide the covered person
19 with the name, address, and telephone number of a person or
20 organizational unit designated to coordinate the review on
21 behalf of the health carrier.

22 (c) In providing for a review under this Section, the
23 health carrier shall ensure that the review is conducted in a
24 manner under this Section to ensure the independence and
25 impartiality of the individuals involved in making the review

1 decision.

2 (d) In ensuring the independence and impartially of
3 individuals involved in making the review decision, the health
4 carrier shall not make decisions related to such individuals
5 regarding hiring, compensation, termination, promotion, or
6 other similar matters based upon the likelihood that the
7 individual will support the denial of benefits.

8 (e) In the case of an adverse determination involving
9 utilization review, the health carrier shall designate an
10 appropriate clinical peer or peers of the same or similar
11 specialty as would typically manage the case being reviewed to
12 review the adverse determination. The clinical peer shall not
13 have been involved in the initial adverse determination.

14 (f) In designating an appropriate clinical peer or peers
15 pursuant to subsection (e) of this Section, the health carrier
16 shall ensure that, if more than one clinical peer is involved
17 in the review, a majority of the individuals reviewing the
18 adverse determination are health care professionals who have
19 appropriate expertise.

20 (g) In conducting a review under this Section, the reviewer
21 or reviewers shall take into consideration all comments,
22 documents, records, and other information regarding the
23 request for services submitted by the covered person or the
24 covered person's authorized representative, without regard to
25 whether the information was submitted or considered in making
26 the initial adverse determination.

1 (h) A covered person does not have the right to attend or
2 to have a representative in attendance at the review, but the
3 covered person or, if applicable, the covered person's
4 authorized representative is entitled to:

5 (1) submit written comments, documents, records, and
6 other material relating to the request for benefits for the
7 reviewer or reviewers to consider when conducting the
8 review; and

9 (2) receive from the health carrier, upon request and
10 free of charge, reasonable access to and copies of all
11 documents, records, and other information relevant to the
12 covered person's request for benefits.

13 (i) For purposes of paragraph (2) of subsection (h) of this
14 Section, a document, record, or other information shall be
15 considered "relevant" to a covered person's request for
16 benefits if the document, record, or other information:

17 (1) was relied upon in making the benefit
18 determination;

19 (2) was submitted, considered, or generated in the
20 course of making the adverse determination, without regard
21 to whether the document, record, or other information was
22 relied upon in making the benefit determination;

23 (3) demonstrates that, in making the benefit
24 determination, the health carrier or its designated
25 representatives consistently applied required
26 administrative procedures and safeguards with respect to

1 the covered person as other similarly situated covered
2 persons; or

3 (4) constitutes a statement of policy or guidance with
4 respect to the health benefit plan concerning the denied
5 health care service or treatment for the covered person's
6 diagnosis, without regard to whether the advice or
7 statement was relied upon in making the benefit
8 determination.

9 (j) The health carrier shall make the provisions of
10 subsections (h) and (i) of this Section known to the covered
11 person or, if applicable, the covered person's authorized
12 representative within 3 business days after the date of receipt
13 of the grievance.

14 (k) For purposes of calculating the time periods within
15 which a determination is required to be made and notice
16 provided under subsections (l), (m), and (n) of this Section,
17 the time period shall begin on the date the grievance
18 requesting the review is filed with the health carrier in
19 accordance with the health carrier's procedures established
20 pursuant to Section 10-25 of this Law for filing a request
21 without regard to whether all of the information necessary to
22 make the determination accompanies the filing.

23 (l) A health carrier shall notify and issue a decision in
24 writing or electronically to the covered person or, if
25 applicable, the covered person's authorized representative
26 within the time frames provided in subsection (m) or (n) of

1 this Section.

2 (m) With respect to a grievance requesting a review of an
3 adverse determination involving a prospective review request,
4 the health carrier shall notify and issue a decision within a
5 reasonable period of time that is appropriate given the covered
6 person's medical condition, but no later than 30 days after the
7 date of the health carrier's receipt of the grievance
8 requesting the review made pursuant to subsection (a) of this
9 Section.

10 (n) With respect to a grievance requesting a review of an
11 adverse determination involving a retrospective review
12 request, the health carrier shall notify and issue a decision
13 within a reasonable period of time, but no later than 60 days
14 after the date of the health carrier's receipt of the grievance
15 requesting the review made pursuant to subsection (a) of this
16 Section.

17 (o) Prior to issuing a decision in accordance with the
18 timeframes provided in subsection (m) or (n) of this Section,
19 the health carrier shall provide free of charge to the covered
20 person, or the covered person's authorized representative, any
21 new or additional evidence relied upon or generated by the
22 health carrier or at the direction of the health carrier, in
23 connection with the grievance sufficiently in advance of the
24 date the decision is required to be provided to permit the
25 covered person or the covered person's authorized
26 representative, a reasonable opportunity to respond prior to

1 that date.

2 (p) Before the health carrier issues or provides notice of
3 a final adverse determination in accordance with the timeframes
4 provided in subsection (m) or (n) of this Section that is based
5 on new or additional rationale, the health carrier shall
6 provide the new or additional rationale to the covered person
7 or the covered person's authorized representative free of
8 charge as soon as possible and sufficiently in advance of the
9 date the notice of final adverse determination is to be
10 provided to permit the covered person or the covered person's
11 authorized representative a reasonable opportunity to respond
12 prior to that date.

13 The decision issued pursuant to subsection (m) or (n) of
14 this Section shall set forth the following in a manner
15 calculated to be understood by the covered person or, if
16 applicable, the covered person's authorized representative:

17 (1) the titles and qualifying credentials of the person
18 or persons participating in the review process (the
19 reviewers);

20 (2) information sufficient to identify the claim
21 involved with respect to the grievance, including the date
22 of service, the health care provider, if applicable, the
23 claim amount, the diagnosis code and its corresponding
24 meaning, and the treatment code and its corresponding
25 meaning;

26 (3) a statement of the reviewers' understanding of the

1 covered person's grievance;

2 (4) the reviewers' decision in clear terms and the
3 contract basis or medical rationale in sufficient detail
4 for the covered person to respond further to the health
5 carrier's position;

6 (5) a reference to the evidence or documentation used
7 as the basis for the decision;

8 (6) for a decision issued pursuant to this Section that
9 upholds the grievance:

10 (A) the specific reason or reasons for the final
11 adverse determination, including the denial code and
12 its corresponding meaning, as well as a description of
13 the health carrier's standard, if any, that was used in
14 reaching the denial;

15 (B) the reference to the specific plan provisions
16 on which the determination is based;

17 (C) a statement that the covered person is entitled
18 to receive, upon request and free of charge, reasonable
19 access to and copies of all documents, records, and
20 other information relevant, as the term "relevant" is
21 defined in subsection (i) of this Section, to the
22 covered person's benefit request;

23 (D) if the health carrier relied upon an internal
24 rule, guideline, protocol, or other similar criterion
25 to make the final adverse determination, either the
26 specific rule, guideline, protocol, or other similar

1 criterion or a statement that a specific rule,
2 guideline, protocol, or other similar criterion was
3 relied upon to make the final adverse determination and
4 that a copy of the rule, guideline, protocol, or other
5 similar criterion will be provided free of charge to
6 the covered person upon request;

7 (E) if the final adverse determination is based on
8 a medical necessity or experimental or investigational
9 treatment or similar exclusion or limit, either an
10 explanation of the scientific or clinical judgment for
11 making the determination, applying the terms of the
12 health benefit plan to the covered person's medical
13 circumstances or a statement that an explanation will
14 be provided to the covered person free of charge upon
15 request; and

16 (F) if applicable, instructions for requesting:

17 (i) a copy of the rule, guideline, protocol or
18 other similar criterion relied upon in making the
19 final adverse determination, as provided in
20 subparagraph (D) of paragraph (6) of subsection
21 (p) of this Section; and

22 (ii) the written statement of the scientific
23 or clinical rationale for the determination, as
24 provided in subparagraph (E) of paragraph (6) of
25 subsection (p) of this Section;

26 (G) If applicable, a statement indicating:

1 (i) a description of the procedures for
2 obtaining an independent external review of the
3 final adverse determination pursuant to the Health
4 Carrier External Review Act; and

5 (ii) the covered person's right to bring a
6 civil action in a court of competent jurisdiction;
7 and

8 (iii) notice of the covered person's right to
9 contact the Department or the Office of Consumer
10 Health Insurance for assistance with respect to
11 any claim, grievance, or appeal at any time,
12 including the telephone number and address of the
13 Department and the Office of Consumer Health
14 Insurance.

15 (q) A health carrier shall provide the notice required
16 under subsection (p) of this Section in a culturally and
17 linguistically appropriate manner if required in accordance
18 with federal regulations. If a health carrier is required to
19 provide the notice in a culturally and linguistically
20 appropriate manner in accordance with federal regulations,
21 then the health carrier shall:

22 (1) include a statement in the English version of the
23 notice, prominently displayed in the non-English language,
24 offering the provision of the notice in the non-English
25 language;

26 (2) once a utilization review or benefit determination

1 request has been made by a covered person, provide all
2 subsequent notices to the covered person in the non-English
3 language; and

4 (3) to the extent the health carrier maintains a
5 consumer assistance process, such as a telephone hotline
6 that answers questions or provides assistance with filing
7 claims and appeals, the health carrier shall provide this
8 assistance in the non-English language.

9 Section 10-35. Standard reviews of grievances not
10 involving an adverse determination.

11 (a) A health carrier shall establish written procedures for
12 a standard review of a grievance that does not involve an
13 adverse determination.

14 (b) The procedures shall permit a covered person or the
15 covered person's authorized representative to file a grievance
16 that does not involve an adverse determination with the health
17 carrier under this Section.

18 (c) A covered person does not have the right to attend or
19 to have a representative in attendance at the standard review,
20 but the covered person or the covered person's authorized
21 representative is entitled to submit written material for the
22 person or persons designated by the carrier pursuant to
23 subsection (e) of this Section to consider when conducting the
24 review.

25 (d) The health carrier shall make the provisions of

1 subsection (c) of this Section known to the covered person or,
2 if applicable, the covered person's authorized representative
3 within 3 business days after the date of receiving the
4 grievance.

5 (e) Upon receipt of the grievance, a health carrier shall
6 designate a person or persons to conduct the standard review of
7 the grievance. The health carrier shall not designate the same
8 person or persons to conduct the standard review of the
9 grievance that denied the claim or handled the matter that is
10 the subject of the grievance. The health carrier shall provide
11 the covered person or, if applicable, the covered person's
12 authorized representative with the name, address, and
13 telephone number of a person designated to coordinate the
14 standard review on behalf of the health carrier.

15 (f) The health carrier shall notify in writing the covered
16 person or, if applicable, the covered person's authorized
17 representative of the decision within 20 business days after
18 the date of receipt of the request for a standard review of a
19 grievance filed pursuant to this Section.

20 (g) Subject to subsection (h) of this Section, if, due to
21 circumstances beyond the carrier's control, the health carrier
22 cannot make a decision and notify the covered person or, if
23 applicable, the covered person's authorized representative
24 pursuant to subsection (f) of this Section within 20 business
25 days, the health carrier may take up to an additional 10
26 business days to issue a written decision.

1 (h) A health carrier may extend the time for making and
2 notifying the covered person or, if applicable, the covered
3 person's authorized representative in accordance with
4 subsection (g) of this Section, if, on or before the 20th
5 business day after the date of receiving the request for a
6 standard review of a grievance, the health carrier provides
7 written notice to the covered person or, if applicable, the
8 covered person's authorized representative of the extension
9 and the reasons for the delay.

10 (i) The written decision issued pursuant to this Section
11 shall contain all of the following:

12 (1) The titles and qualifying credentials of the person
13 or persons participating in the standard review process
14 (the reviewers).

15 (2) A statement of the reviewers' understanding of the
16 covered person's grievance.

17 (3) The reviewers' decision in clear terms and the
18 contract basis in sufficient detail for the covered person
19 to respond further to the health carrier's position.

20 (4) Reference to the evidence or documentation used as
21 the basis for the decision.

22 (5) Notice of the covered person's right, at any time,
23 to contact the Department or the Office of Consumer Health
24 Insurance, including the telephone number and address of
25 the Department and the Office of Consumer Health Insurance.

1 Section 10-40. Expedited reviews of grievances involving
2 an adverse determination.

3 (a) A health carrier shall establish written procedures for
4 the expedited review of urgent care requests of grievances
5 involving an adverse determination.

6 (b) In addition to subsection (a) of this Section, a health
7 carrier shall provide an expedited review of a grievance
8 involving an adverse determination with respect to concurrent
9 review urgent care requests involving an admission,
10 availability of care, continued stay or health care service for
11 a covered person who has received emergency services, but has
12 not been discharged from a facility.

13 (c) The procedures shall allow a covered person or the
14 covered person's authorized representative to request an
15 expedited review under this Section orally or in writing.

16 (d) A health carrier shall appoint an appropriate clinical
17 peer or peers in the same or similar specialty as would
18 typically manage the case being reviewed to review the adverse
19 determination. The clinical peer or peers shall not have been
20 involved in making the initial adverse determination.

21 (e) In an expedited review, all necessary information,
22 including the health carrier's decision, shall be transmitted
23 between the health carrier and the covered person or, if
24 applicable, the covered person's authorized representative by
25 telephone, facsimile, or the most expeditious method
26 available.

1 (f) An expedited review decision shall be made and the
2 covered person or, if applicable, the covered person's
3 authorized representative shall be notified of the decision in
4 accordance with this Section as expeditiously as the covered
5 person's medical condition requires, but in no event more than
6 48 hours after the receipt of the request for the expedited
7 review. If the expedited review is of a grievance involving an
8 adverse determination with respect to a concurrent review
9 urgent care request, the service shall be continued without
10 liability to the covered person until the covered person has
11 been notified of the determination.

12 (g) For purposes of calculating the time periods within
13 which a decision is required to be made under subsection (f) of
14 this Section, the time period within which the decision is
15 required to be made shall begin on the date the request is
16 filed with the health carrier in accordance with the health
17 carrier's procedures established pursuant to Section 10-25 of
18 this Law for filing a request without regard to whether all of
19 the information necessary to make the determination
20 accompanies the filing.

21 (h) A notification of a decision under this Section shall,
22 in a manner calculated to be understood by the covered person
23 or, if applicable, the covered person's authorized
24 representative, set forth:

25 (1) the titles and qualifying credentials of the person
26 or persons participating in the expedited review process

1 (the reviewers);

2 (2) information sufficient to identify the claim
3 involved with respect to the grievance, including the date
4 of service, the health care provider, if applicable, the
5 claim amount, the diagnosis code and its corresponding
6 meaning, and the treatment code and its corresponding
7 meaning;

8 (3) a statement of the reviewers' understanding of the
9 covered person's grievance;

10 (4) the reviewers' decision in clear terms and the
11 contract basis or medical rationale in sufficient detail
12 for the covered person to respond further to the health
13 carrier's position;

14 (5) a reference to the evidence or documentation used
15 as the basis for the decision; and

16 (6) if the decision involves a final adverse
17 determination, then the notice shall provide:

18 (A) the specific reasons or reasons for the final
19 adverse determination, including the denial code and
20 its corresponding meaning, as well as a description of
21 the health carrier's standard, if any, that was used in
22 reaching the denial;

23 (B) reference to the specific plan provisions on
24 which the determination is based;

25 (C) a description of any additional material or
26 information necessary for the covered person to

1 complete the request, including an explanation of why
2 the material or information is necessary to complete
3 the request;

4 (D) if the health carrier relied upon an internal
5 rule, guideline, protocol, or other similar criterion
6 to make the adverse determination, then either the
7 specific rule, guideline, protocol, or other similar
8 criterion or a statement that a specific rule,
9 guideline, protocol, or other similar criterion was
10 relied upon to make the adverse determination and that
11 a copy of the rule, guideline, protocol, or other
12 similar criterion will be provided free of charge to
13 the covered person upon request;

14 (E) if the final adverse determination is based on
15 a medical necessity or experimental or investigational
16 treatment or similar exclusion or limit, then either an
17 explanation of the scientific or clinical judgment for
18 making the determination, applying the terms of the
19 health benefit plan to the covered person's medical
20 circumstances or a statement that an explanation will
21 be provided to the covered person free of charge upon
22 request;

23 (F) If applicable, instructions for requesting:

24 (i) a copy of the rule, guideline, protocol or
25 other similar criterion relied upon in making the
26 adverse determination in accordance with

1 subparagraph (4) of paragraph (F) of subsection
2 (h) of this Section; or

3 (ii) the written statement of the scientific
4 or clinical rationale for the adverse
5 determination in accordance with subparagraph (5)
6 of paragraph (F) of subsection (h) of this Section;

7 (G) a statement describing the procedures for
8 obtaining an independent external review of the
9 adverse determination pursuant to the Health Carrier
10 External Review Act;

11 (H) a statement indicating the covered person's
12 right to bring a civil action in a court of competent
13 jurisdiction; and

14 (I) a notice of the covered person's right to
15 contact the Department or the Office of Consumer Health
16 Insurance for assistance with respect to the claim,
17 grievance or appeal at any time, including the
18 telephone number and address of the Department and the
19 Office of Consumer Health Insurance.

20 (i) A health carrier shall provide the notice required
21 under this Section in a culturally and linguistically
22 appropriate manner if required in accordance with federal
23 regulations.

24 (j) If a health carrier is required to provide the notice
25 required under this Section in a culturally and linguistically
26 appropriate manner in accordance with federal regulations,

1 then the health carrier shall:

2 (1) include a statement in the English version of the
3 notice, prominently displayed in the non-English language,
4 offering the provision of the notice in the non- English
5 language;

6 (2) once a utilization review or benefit determination
7 request has been made by a covered person, provide all
8 subsequent notices to the covered person in the non-
9 English language; and

10 (3) to the extent the health carrier maintains a
11 consumer assistance process, such as a telephone hotline
12 that answers questions or provides assistance with filing
13 claims and appeals, the health carrier shall provide this
14 assistance in the non-English language.

15 (k) A health carrier may provide the notice required under
16 this Section orally, in writing, or electronically.

17 (l) If notice of the adverse determination is provided
18 orally, then the health carrier shall provide written or
19 electronic notice of the adverse determination within 3 days
20 following the oral notification.

21 Section 10-45. Administration and enforcement.

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

24 (b) The Director is authorized to make use of any of the
25 powers established under the Illinois Insurance Code to enforce

1 the laws of this State. This includes but is not limited to,
2 the Director's administrative authority to investigate, issue
3 subpoenas, conduct depositions and hearings, issue orders,
4 including, without limitation, orders pursuant to Article XII
5 1/2 and Section 401.1 of the Illinois Insurance Code, and
6 impose penalties.

7 ARTICLE 90. AMENDATORY PROVISIONS

8 Section 90-5. The Managed Care Reform and Patient Rights
9 Act is amended by changing Sections 10, 45, and 85 as follows:

10 (215 ILCS 134/10)

11 Sec. 10. Definitions:

12 "Adverse determination" has the same meaning given that
13 term in the Health Carrier Grievance Procedure Law ~~means a~~
14 ~~determination by a health care plan under Section 45 or by a~~
15 ~~utilization review program under Section 85 that a health care~~
16 ~~service is not medically necessary.~~

17 "Clinical peer" means a health care professional who is in
18 the same profession and the same or similar specialty as the
19 health care provider who typically manages the medical
20 condition, procedures, or treatment under review.

21 "Covered person" has the same meaning given that term in
22 the Health Carrier Grievance Procedure Law.

23 "Department" means the Department of Insurance.

1 "Emergency medical condition" means a medical condition
2 manifesting itself by acute symptoms of sufficient severity
3 (including, but not limited to, severe pain) such that a
4 prudent layperson, who possesses an average knowledge of health
5 and medicine, could reasonably expect the absence of immediate
6 medical attention to result in:

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

10 (2) serious impairment to bodily functions; or

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

12 "Emergency medical screening examination" means a medical
13 screening examination and evaluation by a physician licensed to
14 practice medicine in all its branches, or to the extent
15 permitted by applicable laws, by other appropriately licensed
16 personnel under the supervision of or in collaboration with a
17 physician licensed to practice medicine in all its branches to
18 determine whether the need for emergency services exists.

19 "Emergency services" means, with respect to an enrollee of
20 a health care plan, transportation services, including but not
21 limited to ambulance services, and covered inpatient and
22 outpatient hospital services furnished by a provider qualified
23 to furnish those services that are needed to evaluate or
24 stabilize an emergency medical condition. "Emergency services"
25 does not refer to post-stabilization medical services.

26 "Enrollee" means any person and his or her dependents

1 enrolled in or covered by a health care plan.

2 "Health benefit plan" has the same meaning given that term
3 in the Health Carrier Grievance Procedure Law.

4 "Health care plan" means a plan that establishes, operates,
5 or maintains a network of health care providers that has
6 entered into an agreement with the plan to provide health care
7 services to enrollees to whom the plan has the ultimate
8 obligation to arrange for the provision of or payment for
9 services through organizational arrangements for ongoing
10 quality assurance, utilization review programs, or dispute
11 resolution. Nothing in this definition shall be construed to
12 mean that an independent practice association or a physician
13 hospital organization that subcontracts with a health care plan
14 is, for purposes of that subcontract, a health care plan.

15 For purposes of this definition, "health care plan" shall
16 not include the following:

17 (1) indemnity health insurance policies including
18 those using a contracted provider network;

19 (2) health care plans that offer only dental or only
20 vision coverage;

21 (3) preferred provider administrators, as defined in
22 Section 370g(g) of the Illinois Insurance Code;

23 (4) employee or employer self-insured health benefit
24 plans under the federal Employee Retirement Income
25 Security Act of 1974;

26 (5) health care provided pursuant to the Workers'

1 Compensation Act or the Workers' Occupational Diseases
2 Act; and

3 (6) not-for-profit voluntary health services plans
4 with health maintenance organization authority in
5 existence as of January 1, 1999 that are affiliated with a
6 union and that only extend coverage to union members and
7 their dependents.

8 "Health care professional" means a physician, a registered
9 professional nurse, or other individual appropriately licensed
10 or registered to provide health care services.

11 "Health care provider" means any physician, hospital
12 facility, or other person that is licensed or otherwise
13 authorized to deliver health care services. Nothing in this Act
14 shall be construed to define Independent Practice Associations
15 or Physician-Hospital Organizations as health care providers.

16 "Health care services" means any services included in the
17 furnishing to any individual of medical care, or the
18 hospitalization incident to the furnishing of such care, as
19 well as the furnishing to any person of any and all other
20 services for the purpose of preventing, alleviating, curing, or
21 healing human illness or injury including home health and
22 pharmaceutical services and products.

23 "Health carrier" has the same meaning given that term in
24 the Health Carrier Grievance Procedure Law.

25 "Medical director" means a physician licensed in any state
26 to practice medicine in all its branches appointed by a health

1 care plan.

2 "Person" means a corporation, association, partnership,
3 limited liability company, sole proprietorship, or any other
4 legal entity.

5 "Physician" means a person licensed under the Medical
6 Practice Act of 1987.

7 "Post-stabilization medical services" means health care
8 services provided to an enrollee that are furnished in a
9 licensed hospital by a provider that is qualified to furnish
10 such services, and determined to be medically necessary and
11 directly related to the emergency medical condition following
12 stabilization.

13 "Prospective review" has the same meaning given that term
14 in the Health Carrier Grievance Procedure Law.

15 "Rescission" has the same meaning given that term in the
16 Health Carrier Grievance Procedure Law.

17 "Retrospective review" has the same meaning given that term
18 in the Health Carrier Grievance Procedure Law.

19 "Stabilization" means, with respect to an emergency
20 medical condition, to provide such medical treatment of the
21 condition as may be necessary to assure, within reasonable
22 medical probability, that no material deterioration of the
23 condition is likely to result.

24 "Utilization review" means a set of formal techniques
25 designed to monitor the use of, or evaluate ~~the evaluation of~~
26 the medical necessity, appropriateness, efficacy, or ~~and~~

1 efficiency of, ~~the use of~~ health care services, procedures,
2 settings or ~~and~~ facilities.

3 "Utilization review program" means a program established
4 by a person to perform utilization review.

5 (Source: P.A. 91-617, eff. 1-1-00.)

6 (215 ILCS 134/45)

7 Sec. 45. Appeals of external ~~Health care services appeals,~~
8 ~~complaints, and external~~ independent reviews.

9 (a) (Blank). ~~A health care plan shall establish and~~
10 ~~maintain an appeals procedure as outlined in this Act.~~
11 ~~Compliance with this Act's appeals procedures shall satisfy a~~
12 ~~health care plan's obligation to provide appeal procedures~~
13 ~~under any other State law or rules. All appeals of a health~~
14 ~~care plan's administrative determinations and complaints~~
15 ~~regarding its administrative decisions shall be handled as~~
16 ~~required under Section 50.~~

17 (b) (Blank). ~~When an appeal concerns a decision or action~~
18 ~~by a health care plan, its employees, or its subcontractors~~
19 ~~that relates to (i) health care services, including, but not~~
20 ~~limited to, procedures or treatments, for an enrollee with an~~
21 ~~ongoing course of treatment ordered by a health care provider,~~
22 ~~the denial of which could significantly increase the risk to an~~
23 ~~enrollee's health, or (ii) a treatment referral, service,~~
24 ~~procedure, or other health care service, the denial of which~~
25 ~~could significantly increase the risk to an enrollee's health,~~

1 ~~the health care plan must allow for the filing of an appeal~~
2 ~~either orally or in writing. Upon submission of the appeal, a~~
3 ~~health care plan must notify the party filing the appeal, as~~
4 ~~soon as possible, but in no event more than 24 hours after the~~
5 ~~submission of the appeal, of all information that the plan~~
6 ~~requires to evaluate the appeal. The health care plan shall~~
7 ~~render a decision on the appeal within 24 hours after receipt~~
8 ~~of the required information. The health care plan shall notify~~
9 ~~the party filing the appeal and the enrollee, enrollee's~~
10 ~~primary care physician, and any health care provider who~~
11 ~~recommended the health care service involved in the appeal of~~
12 ~~its decision orally followed up by a written notice of the~~
13 ~~determination.~~

14 (c) (Blank). ~~For all appeals related to health care~~
15 ~~services including, but not limited to, procedures or~~
16 ~~treatments for an enrollee and not covered by subsection (b)~~
17 ~~above, the health care plan shall establish a procedure for the~~
18 ~~filing of such appeals. Upon submission of an appeal under this~~
19 ~~subsection, a health care plan must notify the party filing an~~
20 ~~appeal, within 3 business days, of all information that the~~
21 ~~plan requires to evaluate the appeal. The health care plan~~
22 ~~shall render a decision on the appeal within 15 business days~~
23 ~~after receipt of the required information. The health care plan~~
24 ~~shall notify the party filing the appeal, the enrollee, the~~
25 ~~enrollee's primary care physician, and any health care provider~~
26 ~~who recommended the health care service involved in the appeal~~

1 ~~erally of its decision followed up by a written notice of the~~
2 ~~determination.~~

3 (d) (Blank). ~~An appeal under subsection (b) or (c) may be~~
4 ~~filed by the enrollee, the enrollee's designee or guardian, the~~
5 ~~enrollee's primary care physician, or the enrollee's health~~
6 ~~care provider. A health care plan shall designate a clinical~~
7 ~~peer to review appeals, because these appeals pertain to~~
8 ~~medical or clinical matters and such an appeal must be reviewed~~
9 ~~by an appropriate health care professional. No one reviewing an~~
10 ~~appeal may have had any involvement in the initial~~
11 ~~determination that is the subject of the appeal. The written~~
12 ~~notice of determination required under subsections (b) and (c)~~
13 ~~shall include (i) clear and detailed reasons for the~~
14 ~~determination, (ii) the medical or clinical criteria for the~~
15 ~~determination, which shall be based upon sound clinical~~
16 ~~evidence and reviewed on a periodic basis, and (iii) in the~~
17 ~~case of an adverse determination, the procedures for requesting~~
18 ~~an external independent review as provided by the Illinois~~
19 ~~Health Carrier External Review Act.~~

20 (e) (Blank). ~~If an appeal filed under subsection (b) or (c)~~
21 ~~is denied for a reason including, but not limited to, the~~
22 ~~service, procedure, or treatment is not viewed as medically~~
23 ~~necessary, denial of specific tests or procedures, denial of~~
24 ~~referral to specialist physicians or denial of hospitalization~~
25 ~~requests or length of stay requests, any involved party may~~
26 ~~request an external independent review as provided by the~~

1 ~~Illinois Health Carrier External Review Act.~~

2 (f) Until July 1, 2013, if an external independent review
3 decision made pursuant to the Illinois Health Carrier External
4 Review Act upholds a determination adverse to the covered
5 person, the covered person has the right to appeal the final
6 decision to the Department; if the external review decision is
7 found by the Director to have been arbitrary and capricious,
8 then the Director, with consultation from a licensed medical
9 professional, may overturn the external review decision and
10 require the health carrier to pay for the health care service
11 or treatment; such decision, if any, shall be made solely on
12 the legal or medical merits of the claim. If an external review
13 decision is overturned by the Director pursuant to this Section
14 and the health carrier so requests, then the Director shall
15 assign a new independent review organization to reconsider the
16 overturned decision. The new independent review organization
17 shall follow subsection (d) of Section 40 of the Health Carrier
18 External Review Act in rendering a decision.

19 (g) Future contractual or employment action by the health
20 care plan regarding the patient's physician or other health
21 care provider shall not be based solely on the physician's or
22 other health care provider's participation in health care
23 services appeals, complaints, or external independent reviews
24 under the Illinois Health Carrier External Review Act.

25 (h) Nothing in this Section shall be construed to require a
26 health care plan to pay for a health care service not covered

1 under the terms of the enrollee's certificate of coverage or
2 policy, unless the terms are inconsistent with applicable law.

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

4 (215 ILCS 134/85)

5 Sec. 85. Utilization review program registration.

6 (a) No person may conduct a utilization review program in
7 this State unless once every 2 years the person registers the
8 utilization review program with the Department and certifies
9 compliance with the Health Utilization Management Standards of
10 the American Accreditation Healthcare Commission (URAC)
11 sufficient to achieve American Accreditation Healthcare
12 Commission (URAC) accreditation or submits evidence of
13 accreditation by the American Accreditation Healthcare
14 Commission (URAC) for its Health Utilization Management
15 Standards. Nothing in this Act shall be construed to require a
16 health carrier ~~care plan~~ or its subcontractors to become
17 American Accreditation Healthcare Commission (URAC)
18 accredited.

19 (b) In addition, the Director of the Department, in
20 consultation with the Director of the Department of Public
21 Health, may certify alternative utilization review standards
22 of national accreditation organizations or entities in order
23 for plans to comply with this Section. Any alternative
24 utilization review standards shall meet or exceed those
25 standards required under subsection (a).

1 (c) The provisions of this Section do not apply to:

2 (1) persons providing utilization review program
3 services only to the federal government;

4 (2) self-insured health plans under the federal
5 Employee Retirement Income Security Act of 1974, however,
6 this Section does apply to persons conducting a utilization
7 review program on behalf of these health plans;

8 (3) hospitals and medical groups performing
9 utilization review activities for internal purposes unless
10 the utilization review program is conducted for another
11 person.

12 Nothing in this Act prohibits a health care plan or other
13 entity from contractually requiring an entity designated in
14 item (3) of this subsection to adhere to the utilization review
15 program requirements of this Act.

16 (d) This registration shall include submission of all of
17 the following information regarding utilization review program
18 activities:

19 (1) The name, address, and telephone number of the
20 utilization review programs.

21 (2) The organization and governing structure of the
22 utilization review programs.

23 (3) The number of lives for which utilization review is
24 conducted by each utilization review program.

25 (4) Hours of operation of each utilization review
26 program.

1 (5) Description of the grievance process for each
2 utilization review program.

3 (6) Number of covered lives for which utilization
4 review was conducted for the previous calendar year for
5 each utilization review program.

6 (7) Written policies and procedures for protecting
7 confidential information according to applicable State and
8 federal laws for each utilization review program.

9 (e) (1) A utilization review program shall have written
10 procedures for assuring that patient-specific information
11 obtained during the process of utilization review will be:

12 (A) kept confidential in accordance with applicable
13 State and federal laws; and

14 (B) shared only with the enrollee, the enrollee's
15 designee, the enrollee's health care provider, and those
16 who are authorized by law to receive the information.

17 Summary data shall not be considered confidential if it
18 does not provide information to allow identification of
19 individual patients or health care providers.

20 (2) Only a health care professional may make
21 determinations regarding the medical necessity of health
22 care services during the course of utilization review.

23 (3) When making retrospective reviews, utilization
24 review programs shall base reviews solely on the medical
25 information available to the attending physician or
26 ordering provider at the time the health care services were

1 provided.

2 (4) When making prospective, concurrent, and
3 retrospective determinations, utilization review programs
4 shall collect only information that is necessary to make
5 the determination and shall not routinely require health
6 care providers to numerically code diagnoses or procedures
7 to be considered for certification, unless required under
8 State or federal Medicare or Medicaid rules or regulations,
9 but may request such code if available, or routinely
10 request copies of medical records of all enrollees
11 reviewed. During prospective or concurrent review, copies
12 of medical records shall only be required when necessary to
13 verify that the health care services subject to review are
14 medically necessary. In these cases, only the necessary or
15 relevant sections of the medical record shall be required.

16 (f) If the Department finds that a utilization review
17 program is not in compliance with this Section, the Department
18 shall issue a corrective action plan and allow a reasonable
19 amount of time for compliance with the plan. If the utilization
20 review program does not come into compliance, the Department
21 may issue a cease and desist order. Before issuing a cease and
22 desist order under this Section, the Department shall provide
23 the utilization review program with a written notice of the
24 reasons for the order and allow a reasonable amount of time to
25 supply additional information demonstrating compliance with
26 requirements of this Section and to request a hearing. The

1 hearing notice shall be sent by certified mail, return receipt
2 requested, and the hearing shall be conducted in accordance
3 with the Illinois Administrative Procedure Act.

4 (g) A utilization review program subject to a corrective
5 action may continue to conduct business until a final decision
6 has been issued by the Department.

7 (h) Any adverse determination made by a health carrier care
8 ~~plan~~ or its subcontractors may be appealed in accordance with
9 the Health Carrier Grievance Procedure Law subsection (f) of
10 Section 45.

11 (i) The Director may by rule establish a registration fee
12 for each person conducting a utilization review program. All
13 fees paid to and collected by the Director under this Section
14 shall be deposited into the Insurance Producer Administration
15 Fund.

16 (Source: P.A. 91-617, eff. 7-1-00.)

17 Section 90-10. The Health Carrier External Review Act is
18 amended by changing Sections 10, 20, 25, 30, 35, 40, 55, 65,
19 and 75 and by adding Sections 42 and 80 as follows:

20 (215 ILCS 180/10)

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

22 "Adverse determination" has the same meaning given that
23 term in the Health Carrier Grievance Procedure Law ~~means a~~
24 ~~determination by a health carrier or its designee utilization~~

1 ~~review organization that an admission, availability of care,~~
2 ~~continued stay, or other health care service that is a covered~~
3 ~~benefit has been reviewed and, based upon the information~~
4 ~~provided, does not meet the health carrier's requirements for~~
5 ~~medical necessity, appropriateness, health care setting, level~~
6 ~~of care, or effectiveness, and the requested service or payment~~
7 ~~for the service is therefore denied, reduced, or terminated.~~

8 "Authorized representative" has the same meaning given
9 that term in the Health Carrier Grievance Procedure Law. means:

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

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

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

18 "Best evidence" means evidence based on:

19 (1) randomized clinical trials;

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

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

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

26 "Case-series" means an evaluation of a series of patients

1 with a particular outcome, without the use of a control group.

2 "Clinical review criteria" has the same meaning given that
3 term in the Health Carrier Grievance Procedure Law ~~means the~~
4 ~~written screening procedures, decision abstracts, clinical~~
5 ~~protocols, and practice guidelines used by a health carrier to~~
6 ~~determine the necessity and appropriateness of health care~~
7 ~~services.~~

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

11 "Covered benefits" or "benefits" has the same meaning given
12 that term in the Health Carrier Grievance Procedure Law ~~means~~
13 ~~those health care services to which a covered person is~~
14 ~~entitled under the terms of a health benefit plan.~~

15 "Covered person" has the same meaning given that term in
16 the Health Carrier Grievance Procedure Law ~~means~~ a
17 ~~policyholder, subscriber, enrollee, or other individual~~
18 ~~participating in a health benefit plan.~~

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

21 "Emergency medical condition" has the same meaning given
22 that term in the Health Carrier Grievance Procedure Law. ~~means~~
23 ~~a medical condition manifesting itself by acute symptoms of~~
24 ~~sufficient severity, including, but not limited to, severe~~
25 ~~pain, such that a prudent layperson who possesses an average~~
26 ~~knowledge of health and medicine could reasonably expect the~~

1 ~~absence of immediate medical attention to result in:~~

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

5 ~~(2) serious impairment to bodily functions; or~~

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

7 "Emergency services" has the same meaning given that term
8 in the Health Carrier Grievance Procedure Law ~~means health care~~
9 ~~items and services furnished or required to evaluate and treat~~
10 ~~an emergency medical condition.~~

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

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

19 "Facility" has the same meaning given that term in the
20 Health Carrier Grievance Procedure Law ~~means an institution~~
21 ~~providing health care services or a health care setting.~~

22 "Final adverse determination" has the same meaning given
23 that term in the Health Carrier Grievance Procedure Law ~~means~~
24 ~~an adverse determination involving a covered benefit that has~~
25 ~~been upheld by a health carrier, or its designee utilization~~
26 ~~review organization, at the completion of the health carrier's~~

1 ~~internal grievance process procedures as set forth by the~~
2 ~~Managed Care Reform and Patient Rights Act.~~

3 "Health benefit plan" has the same meaning given that term
4 in the Health Carrier Grievance Procedure Law ~~means a policy,~~
5 ~~contract, certificate, plan, or agreement offered or issued by~~
6 ~~a health carrier to provide, deliver, arrange for, pay for, or~~
7 ~~reimburse any of the costs of health care services.~~

8 "Health care professional" has the same meaning given that
9 term in the Health Carrier Grievance Procedure Law.

10 "Health care provider" or "provider" has the same meaning
11 given that term in the Health Carrier Grievance Procedure Law
12 ~~means a physician, hospital facility, or other health care~~
13 ~~practitioner licensed, accredited, or certified to perform~~
14 ~~specified health care services consistent with State law,~~
15 ~~responsible for recommending health care services on behalf of~~
16 ~~a covered person.~~

17 "Health care services" has the same meaning given that term
18 in the Health Carrier Grievance Procedure Law ~~means services~~
19 ~~for the diagnosis, prevention, treatment, cure, or relief of a~~
20 ~~health condition, illness, injury, or disease.~~

21 "Health carrier" has the same meaning given that term in
22 the Health Carrier Grievance Procedure Law ~~means an entity~~
23 ~~subject to the insurance laws and regulations of this State, or~~
24 ~~subject to the jurisdiction of the Director, that contracts or~~
25 ~~offers to contract to provide, deliver, arrange for, pay for,~~
26 ~~or reimburse any of the costs of health care services,~~

1 ~~including a sickness and accident insurance company, a health~~
2 ~~maintenance organization, or any other entity providing a plan~~
3 ~~of health insurance, health benefits, or health care services.~~
4 ~~"Health carrier" also means Limited Health Service~~
5 ~~Organizations (LHSC) and Voluntary Health Service Plans.~~

6 "Health information" means information or data, whether
7 oral or recorded in any form or medium, and personal facts or
8 information about events or relationships that relate to:

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

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

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

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

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

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

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

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

12 (4) the following standard reference compendia:

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

15 (b) Drug Facts and Comparisons;

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

18 (d) The United States Pharmacopoeia-Drug
19 Information;

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

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

26 (b) the National Institutes of Health;

1 (c) the National Cancer Institute;

2 (d) the National Academy of Sciences;

3 (e) the Centers for Medicare & Medicaid Services;

4 (f) the federal Food and Drug Administration; and

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

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

10 "Person" has the same meaning given that term in the Health
11 Carrier Grievance Procedure Law.

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

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

23 "Retrospective review" has the same meaning given that term
24 in the Health Carrier Grievance Procedure Law ~~means a review of~~
25 ~~medical necessity conducted after services have been provided~~
26 ~~to a patient, but does not include the review of a claim that~~

1 ~~is limited to an evaluation of reimbursement levels, veracity~~
2 ~~of documentation, accuracy of coding, or adjudication for~~
3 ~~payment.~~

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

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

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

10 (215 ILCS 180/20)

11 Sec. 20. Notice of right to external review.

12 (a) At the same time the health carrier sends written
13 notice of a covered person's right to appeal a coverage
14 decision upon an adverse determination or a final adverse
15 determination ~~as provided by the Managed Care Reform and~~
16 ~~Patient Rights Act,~~ a health carrier shall notify a covered
17 person, the covered person's authorized representative, if
18 any, and a covered person's health care provider in writing of
19 the covered person's right to request an external review as
20 provided by this Act. The written notice required shall include
21 the following, or substantially equivalent, language: "We have
22 denied your request for the provision of or payment for a
23 health care service or course of treatment. You have the right
24 to have our decision reviewed by an independent review
25 organization not associated with us ~~if our decision involved~~

1 ~~making a judgment as to the medical necessity, appropriateness,~~
2 ~~health care setting, level of care, or effectiveness of the~~
3 ~~health care service or treatment you requested by submitting a~~
4 written request for an external review to the Department of
5 Insurance, Office of Consumer Health Information, 320 West
6 Washington Street, 4th Floor, Springfield, Illinois, 62767."
7 ~~us. Upon receipt of your request an independent review~~
8 ~~organization registered with the Department of Insurance will~~
9 ~~be assigned to review our decision.~~

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

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

18 (1) If the covered person has a medical condition where
19 the timeframe for completion of (A) an expedited internal
20 review of an appeal ~~a grievance~~ involving an adverse
21 determination, (B) a final adverse determination ~~as set~~
22 ~~forth in the Managed Care Reform and Patient Rights Act,~~ or
23 (C) a standard external review as established in this Act,
24 would seriously jeopardize the life or health of the
25 covered person or would jeopardize the covered person's
26 ability to regain maximum function, then the covered person

1 or the covered person's authorized representative may file
2 a request for an expedited external review.

3 (2) The covered person or the covered person's
4 authorized representative may file an appeal under the
5 health carrier's internal appeal process as set forth in
6 the Health Carrier Grievance Procedure Law, but if the
7 health carrier has not issued a written decision to the
8 covered person or the covered person's authorized
9 representative 30 days following the date the covered
10 person or the covered person's authorized representative
11 files an appeal of an adverse determination that involves a
12 prospective review request or 60 days following the date
13 the covered person or the covered person's authorized
14 representative files an appeal of an adverse determination
15 that involves a retrospective review request with the
16 health carrier and the covered person or the covered
17 person's authorized representative has not requested or
18 agreed to a delay, then the covered person or the covered
19 person's authorized representative may file a request for
20 external review and shall be considered to have exhausted
21 the health carrier's internal appeal process for purposes
22 of this Act. ~~The covered person or the covered person's~~
23 ~~authorized representative may file a request for an~~
24 ~~expedited external review at the same time the covered~~
25 ~~person or the covered person's authorized representative~~
26 ~~files a request for an expedited internal appeal involving~~

1 ~~an adverse determination as set forth in the Managed Care~~
2 ~~Reform and Patient Rights Act if the adverse determination~~
3 ~~involves a denial of coverage based on a determination that~~
4 ~~the recommended or requested health care service or~~
5 ~~treatment is experimental or investigational and the~~
6 ~~covered person's health care provider certifies in writing~~
7 ~~that the recommended or requested health care service or~~
8 ~~treatment that is the subject of the adverse determination~~
9 ~~would be significantly less effective if not promptly~~
10 ~~initiated. The independent review organization assigned to~~
11 ~~conduct the expedited external review will determine~~
12 ~~whether the covered person shall be required to complete~~
13 ~~the expedited review of the grievance prior to conducting~~
14 ~~the expedited external review.~~

15 (3) The covered person or the covered person's
16 authorized representative filed a request for an expedited
17 internal review of an adverse determination pursuant to the
18 Health Carrier Grievance Procedure Law and has not received
19 a decision on such request from the health carrier within
20 48 hours, except to the extent the covered person or the
21 covered person's authorized representative requested or
22 agreed to a delay.

23 (4) ~~(3)~~ If an adverse determination concerns a denial
24 of coverage based on a determination that the recommended
25 or requested health care service or treatment is
26 experimental or investigational and the covered person's

1 health care provider certifies in writing that the
2 recommended or requested health care service or treatment
3 that is the subject of the request would be significantly
4 less effective if not promptly initiated, then the covered
5 person or the covered person's authorized representative
6 may request an expedited external review at the same time
7 the covered person or the covered person's authorized
8 representative files a request for an expedited internal
9 appeal involving an adverse determination as set forth in
10 the Health Carrier Grievance Procedure Law. The
11 independent review organization assigned to conduct the
12 expedited external review shall determine whether the
13 covered person is required to complete the expedited review
14 of the appeal prior to conducting the expedited external
15 review.

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

22 (1) if the covered person has a medical condition where
23 the timeframe for completion of a standard external review
24 would seriously jeopardize the life or health of the
25 covered person or would jeopardize the covered person's
26 ability to regain maximum function, then the covered person

1 or the covered person's authorized representative may file
2 a request for an expedited external review; or

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

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

20 (d) In addition to the information to be provided pursuant
21 to subsections (a), (b), and (c) of this Section, the health
22 carrier shall include a copy of the description of both the
23 required standard and expedited external review procedures.
24 The description shall highlight the external review procedures
25 that give the covered person or the covered person's authorized
26 representative the opportunity to submit additional

1 information, including any forms used to process an external
2 review.

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

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

13 (215 ILCS 180/25)

14 Sec. 25. Request for external review. A covered person or
15 the covered person's authorized representative may make a
16 request for a standard external or expedited external review of
17 an adverse determination or final adverse determination.
18 Except as set forth in Sections 40 and 42 of this Act, all
19 requests for external review ~~Requests under this Section~~ shall
20 be made in writing to the Director ~~directly to the health~~
21 ~~carrier that made the adverse or final adverse determination.~~
22 ~~All requests for external review shall be in writing except for~~
23 ~~requests for expedited external reviews which may be made~~
24 ~~orally.~~ Health carriers must provide covered persons with forms
25 to request external reviews.

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

2 (215 ILCS 180/30)

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

4 (a) Except as provided in subsection (b) of this Section
5 ~~20~~, a request for an external review shall not be made until
6 the covered person has exhausted the health carrier's internal
7 appeal ~~grievance~~ process as set forth in the Health Carrier
8 Grievance Procedure Law ~~Managed Care Reform and Patient Rights~~
9 ~~Act~~.

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

13 (1) the covered person or the covered person's
14 authorized representative has filed an appeal under the
15 health carrier's internal appeal process as set forth in a
16 ~~request for an internal review of an adverse determination~~
17 ~~pursuant to the~~ Health Carrier Grievance Procedure Law
18 ~~Managed Care Reform and Patient Rights Act~~ and has not
19 received a written decision on the appeal 30 days following
20 the date the covered person or the covered person's
21 authorized representative files an appeal of an adverse
22 determination that involves a prospective review request
23 or 60 days following the date the covered person or the
24 covered person's authorized representative files an appeal
25 of an adverse determination that involves a retrospective

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

13 (2) the covered person or the covered person's
14 authorized representative filed a request for an expedited
15 internal review of an adverse determination pursuant to the
16 Health Carrier Grievance Procedure Law ~~Managed Care Reform~~
17 ~~and Patient Rights Act~~ and has not received a decision on
18 such request from the health carrier within 48 hours,
19 except to the extent the covered person or the covered
20 person's authorized representative requested or agreed to
21 a delay; ~~or~~

22 (3) the health carrier agrees to waive the exhaustion
23 requirement; ~~or~~

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

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

6 (5) an adverse determination concerns a denial of
7 coverage based on a determination that the recommended or
8 requested health care service or treatment is experimental
9 or investigational and the covered person's health care
10 provider certifies in writing that the recommended or
11 requested health care service or treatment that is the
12 subject of the request would be significantly less
13 effective if not promptly initiated; in such cases, the
14 covered person or the covered person's authorized
15 representative may request an expedited external review at
16 the same time the covered person or the covered person's
17 authorized representative files a request for an expedited
18 internal appeal involving an adverse determination as set
19 forth in the Health Carrier Grievance Procedure Law; the
20 independent review organization assigned to conduct the
21 expedited external review shall determine whether the
22 covered person is required to complete the expedited review
23 of the appeal prior to conducting the expedited external
24 review; or

25 (6) the health carrier has failed to comply with
26 Section 5-40 or 5-45 of the Utilization Review and Benefit

1 Determination Law, as set forth in subsection (d) of
2 Section 5-35 of that Law, or Section 10-30 or 10-40 of the
3 Health Carrier Grievance Procedure Law, as set forth in
4 subsection (b) of Section 10-25 of that Law.

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

6 (215 ILCS 180/35)

7 Sec. 35. Standard external review.

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

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

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

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

1 the health care service is not covered ~~because it does not~~
2 ~~meet the health carrier's requirements for medical~~
3 ~~necessity, appropriateness, health care setting, level of~~
4 ~~care, or effectiveness;~~

5 (3) the covered person has exhausted the health
6 carrier's internal appeal ~~grievance~~ process as set forth in
7 the Health Carrier Grievance Procedure Act unless the
8 covered person is not required to exhaust the health
9 carrier's internal appeal process pursuant to this Act;

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

25 ~~(A) standard health care services or treatments~~
26 ~~have not been effective in improving the condition of~~

1 ~~the covered person;~~

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

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

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

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

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

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

26 (1) is not complete, the health carrier shall inform

1 the Director and covered person and, if applicable, the
2 covered person's authorized representative in writing and
3 include in the notice what information or materials are
4 required by this Act to make the request complete; or

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

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

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

20 Notwithstanding a health carrier's initial determination
21 that the request is ineligible for external review, the
22 Director may determine that a request is eligible for external
23 review and require that it be referred for external review. In
24 making such determination, the Director's decision shall be in
25 accordance with the terms of the covered person's health
26 benefit plan, unless such terms are inconsistent with

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

3 (d) Whenever the Director receives notice that a request is
4 eligible for external review following the preliminary review
5 conducted pursuant to this Section ~~the health carrier shall,~~
6 within one 5 business day after the date of receipt of the
7 notice, the Director shall ~~days:~~

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

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

17 The Director ~~health carrier~~ shall include in the notice
18 provided to the covered person and, if applicable, the covered
19 person's authorized representative a statement that the
20 covered person or the covered person's authorized
21 representative may, within 5 business days following the date
22 of receipt of the notice provided pursuant to item (2) of this
23 subsection (d), submit in writing to the assigned independent
24 review organization additional information that the
25 independent review organization shall consider when conducting
26 the external review. The independent review organization is not

1 required to, but may, accept and consider additional
2 information submitted after 5 business days.

3 (e) The assignment by the Director of an approved
4 independent review organization to conduct an external review
5 in accordance with this Section shall be done on a random basis
6 among those independent review organizations approved by the
7 Director pursuant to this Act. ~~The assignment of an approved~~
8 ~~independent review organization to conduct an external review~~
9 ~~in accordance with this Section shall be made from those~~
10 ~~approved independent review organizations qualified to conduct~~
11 ~~external review as required by Sections 50 and 55 of this Act.~~

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

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

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

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

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

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

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

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

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

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

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

1 (i) In addition to the documents and information provided
2 by the health carrier or its utilization review organization
3 and the covered person and the covered person's authorized
4 representative, if any, the independent review organization,
5 to the extent the information or documents are available and
6 the independent review organization considers them
7 appropriate, shall consider the following in reaching a
8 decision:

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

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

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

17 (4) the terms of coverage under the covered person's
18 health benefit plan with the health carrier to ensure that
19 the independent review organization's decision is not
20 contrary to the terms of coverage under the covered
21 person's health benefit plan with the health carrier,
22 unless the terms are inconsistent with applicable law;

23 (5) the most appropriate practice guidelines, which
24 shall include applicable evidence-based standards and may
25 include any other practice guidelines developed by the
26 federal government, national or professional medical

1 societies, boards, and associations;

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

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

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

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

19 ~~(B) medical or scientific evidence or~~
20 ~~evidence-based standards demonstrate that the expected~~
21 ~~benefits of the recommended or requested health care~~
22 ~~service or treatment is more likely than not to be~~
23 ~~beneficial to the covered person than any available~~
24 ~~standard health care service or treatment and the~~
25 ~~adverse risks of the recommended or requested health~~
26 ~~care service or treatment would not be substantially~~

1 ~~increased over those of available standard health care~~
2 ~~services or treatments; or~~

3 ~~(C) the terms of coverage under the covered~~
4 ~~person's health benefit plan with the health carrier to~~
5 ~~ensure that the health care service or treatment that~~
6 ~~is the subject of the opinion is experimental or~~
7 ~~investigational would otherwise be covered under the~~
8 ~~terms of coverage of the covered person's health~~
9 ~~benefit plan with the health carrier.~~

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

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

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

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

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

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

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

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

14 (G) the rationale for its decision.

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

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

20 ~~(B) a description of the indicators relevant to~~
21 ~~whether there is sufficient evidence to demonstrate~~
22 ~~that the recommended or requested health care service~~
23 ~~or treatment is more likely than not to be more~~
24 ~~beneficial to the covered person than any available~~
25 ~~standard health care services or treatments and the~~
26 ~~adverse risks of the recommended or requested health~~

1 ~~care service or treatment would not be substantially~~
2 ~~increased over those of available standard health care~~
3 ~~services or treatments;~~

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

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

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

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

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

1 ~~reviewer's recommendation.~~

2 (3) (Blank). ~~In reaching a decision, the assigned~~
3 ~~independent review organization is not bound by any~~
4 ~~decisions or conclusions reached during the health~~
5 ~~carrier's utilization review process or the health~~
6 ~~carrier's internal grievance or appeals process.~~

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

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

13 (215 ILCS 180/40)

14 Sec. 40. Expedited external review.

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

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

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

25 (3) if a health carrier fails to provide a decision on

1 request for an expedited internal appeal within 48 hours as
2 provided by item (2) of Section 30 of this Act.

3 (b) Upon receipt of a request for an expedited external
4 review, the Director shall immediately send a copy of the
5 request to the health carrier. Immediately upon receipt of the
6 request for an expedited external review ~~as provided under~~
7 ~~subsections (b) and (c) of Section 20,~~ the health carrier shall
8 determine whether the request meets the reviewability
9 requirements set forth in ~~items (1), (2), and (4) of subsection~~
10 (b) of Section 35. In such cases, the following provisions
11 shall apply:

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

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

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

1 (4) In making a determination under item (3) of this
2 subsection (b), the Director's decision shall be made in
3 accordance with the terms of the covered person's health
4 benefit plan, unless such terms are inconsistent with
5 applicable law, and shall be subject to all applicable
6 provisions of this Act.

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

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

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

25 (2) The Director shall immediately notify the health
26 carrier of the name of the assigned independent review

1 organization. Immediately upon receipt from the Director
2 of the name of the independent review organization assigned
3 to conduct the external review ~~assigning an independent~~
4 ~~review organization to perform an expedited external~~
5 ~~review,~~ but in no case more than 24 hours after receiving
6 such notice ~~assigning the independent review organization,~~
7 the health carrier or its designee utilization review
8 organization shall provide or transmit all necessary
9 documents and information considered in making the adverse
10 determination or final adverse determination to the
11 assigned independent review organization electronically or
12 by telephone or facsimile or any other available
13 expeditious method.

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

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

1 decision to reverse the adverse determination or final
2 adverse determination.

3 (d) In addition to the documents and information provided
4 by the health carrier or its utilization review organization
5 and any documents and information provided by the covered
6 person and the covered person's authorized representative, the
7 independent review organization, to the extent the information
8 or documents are available and the independent review
9 organization considers them appropriate, shall consider
10 information as required by subsection (i) of Section 35 of this
11 Act in reaching a decision.

12 (e) As expeditiously as the covered person's medical
13 condition or circumstances requires, but in no event more than
14 72 hours after the date of receipt of the request for an
15 expedited external review ~~2 business days after the receipt of~~
16 ~~all pertinent information,~~ the assigned independent review
17 organization shall:

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

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

24 (f) In reaching a decision, the assigned independent review
25 organization is not bound by any decisions or conclusions
26 reached during the health carrier's utilization review process

1 or the health carrier's internal appeal ~~grievance~~ process as
2 set forth in the Health Carrier Grievance Procedure Law ~~Managed~~
3 ~~Care Reform and Patient Rights Act.~~

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

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

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

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

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

1 (215 ILCS 180/42 new)

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

4 (a) Within 4 months after the date of receipt of a notice
5 of an adverse determination or final adverse determination that
6 involves a denial of coverage based on a determination that the
7 health care service or treatment recommended or requested is
8 experimental or investigational, a covered person or the
9 covered person's authorized representative may file a request
10 for an external review with the Director.

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

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

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

25 (3) The following provisions apply concerning notice:

26 (A) Upon notice of the request for an expedited

1 external review, the health carrier shall immediately
2 determine whether the request meets the reviewability
3 requirements of subsection (d) of this Section. The
4 health carrier shall immediately notify the Director
5 and the covered person and, if applicable, the covered
6 person's authorized representative of its eligibility
7 determination.

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

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

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

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

26 (B) In making a determination under subdivision

1 (A) of this item (4), the Director's decision shall be
2 made in accordance with the terms of the covered
3 person's health benefit plan, unless such terms are
4 inconsistent with applicable law, and shall be subject
5 to all applicable provisions of this Act.

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

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

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

1 to the health carrier.

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

5 (1) the individual is or was a covered person in the
6 health benefit plan at the time the health care service was
7 recommended or requested or, in the case of a retrospective
8 review, at the time the health care service was provided;

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

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

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

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

26 or

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

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

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

11 (B) who is a licensed, board certified or board
12 eligible physician qualified to practice in the area of
13 medicine appropriate to treat the covered person's
14 condition, has certified in writing that
15 scientifically valid studies using accepted protocols
16 demonstrate that the health care service or treatment
17 requested by the covered person that is the subject of
18 the adverse determination or final adverse
19 determination is likely to be more beneficial to the
20 covered person than any available standard health care
21 services or treatments;

22 (5) the covered person has exhausted the health
23 carrier's internal appeal process as set forth in the
24 Health Carrier Grievance Procedure Act, unless the covered
25 person is not required to exhaust the health carrier's
26 internal appeal process pursuant to Section 30 of this Act;

1 and

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

5 (e) The following provisions apply concerning requests:

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

11 (2) If the request:

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

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

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

1 included in the notice.

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

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

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

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

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

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

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

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

24 (1) Within one business day after the receipt of the
25 notice of assignment to conduct the external review
26 pursuant to subsection (g) of this Section, the assigned

1 independent review organization shall select one or more
2 clinical reviewers, as it determines is appropriate,
3 pursuant to item (2) of this subsection (h) to conduct the
4 external review.

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

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

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

22 (3) In accordance with subsection (1) of this Section,
23 each clinical reviewer shall provide a written opinion to
24 the assigned independent review organization on whether
25 the recommended or requested health care service or
26 treatment should be covered.

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

5 (i) Within 5 business days after the date of receipt of the
6 notice provided pursuant to subsection (g) of this Section, the
7 health carrier or its designee utilization review organization
8 shall provide to the assigned independent review organization
9 the documents and any information considered in making the
10 adverse determination or final adverse determination; in such
11 cases, the following provisions shall apply:

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

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

23 (3) Immediately upon making the decision to terminate
24 the external review and make a decision to reverse the
25 adverse determination or final adverse determination under
26 item (2) of this subsection (i), the independent review

1 organization shall notify the Director, the health
2 carrier, the covered person, and, if applicable, the
3 covered person's authorized representative of its decision
4 to reverse the adverse determination.

5 (j) Upon receipt of the information from the health carrier
6 or its utilization review organization, each clinical reviewer
7 selected pursuant to subsection (h) of this Section shall
8 review all of the information and documents and any other
9 information submitted in writing to the independent review
10 organization by the covered person and the covered person's
11 authorized representative.

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

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

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

25 (3) The external review may be terminated only if the
26 health carrier decides, upon completion of its

1 reconsideration, to reverse its adverse determination or
2 final adverse determination and provide coverage or
3 payment for the health care service that is the subject of
4 the adverse determination or final adverse determination.

5 In such cases, the following provisions shall apply:

6 (A) Immediately upon making its decision to
7 reverse its adverse determination or final adverse
8 determination, the health carrier shall notify the
9 Director, the covered person and, if applicable, the
10 covered person's authorized representative, and the
11 assigned independent review organization in writing of
12 its decision.

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

18 (1) The following provisions apply concerning clinical
19 review opinions:

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

1 (2) Except for an opinion provided pursuant to item (3)
2 of this subsection (1), each clinical reviewer's opinion
3 shall be in writing and include the following information:

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

6 (B) a description of the indicators relevant to
7 determining whether there is sufficient evidence to
8 demonstrate that the recommended or requested health
9 care service or treatment is more likely than not to be
10 beneficial to the covered person than any available
11 standard health care services or treatments and the
12 adverse risks of the recommended or requested health
13 care service or treatment would not be substantially
14 increased over those of available standard health care
15 services or treatments;

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

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

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

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

26 (A) For an expedited external review, each

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

7 (B) If the opinion provided pursuant to
8 subdivision (A) of this item (3) was not in writing,
9 then within 48 hours following the date the opinion was
10 provided, the clinical reviewer shall provide written
11 confirmation of the opinion to the assigned
12 independent review organization and include the
13 information required under item (2) of this subsection
14 (1).

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

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

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

26 (3) consulting reports from appropriate health care

1 providers and other documents submitted by the health
2 carrier or its designee utilization review organization,
3 the covered person, the covered person's authorized
4 representative, or the covered person's treating physician
5 or health care professional;

6 (4) the terms of coverage under the covered person's
7 health benefit plan with the health carrier to ensure that,
8 but for the health carrier's determination that the
9 recommended or requested health care service or treatment
10 that is the subject of the opinion is experimental or
11 investigational, the reviewer's opinion is not contrary to
12 the terms of coverage under the covered person's health
13 benefit plan with the health carrier; and

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

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

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

5 (A) Except as provided in subdivision (B) of this
6 item (1), within 20 days after the date it receives the
7 opinion of each clinical reviewer, the assigned
8 independent review organization, in accordance with
9 item (2) of this subsection (n), shall make a decision
10 and provide written notice of the decision to the
11 Director, the health carrier, the covered person, and
12 the covered person's authorized representative, if
13 applicable.

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

1 person's authorized representative, if applicable.

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

4 (A) If a majority of the clinical reviewers
5 recommend that the recommended or requested health
6 care service or treatment should be covered, then the
7 independent review organization shall make a decision
8 to reverse the health carrier's adverse determination
9 or final adverse determination.

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

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

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

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

6 (iii) The selection of the additional clinical
7 reviewer under this subdivision (C) shall not
8 extend the time within which the assigned
9 independent review organization is required to
10 make a decision based on the opinions of the
11 clinical reviewers.

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

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

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

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

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

26 (5) the date of its decision;

1 (6) the principal reason or reasons for its decision;
2 and
3 (7) the rationale for its decision.

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

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

14 (215 ILCS 180/55)

15 Sec. 55. Minimum qualifications for independent review
16 organizations.

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

23 (1) a quality assurance mechanism that ensures that:

24 (A) external reviews are conducted within the
25 specified timeframes and required notices are provided

1 in a timely manner;

2 (B) selection of qualified and impartial clinical
3 reviewers to conduct external reviews on behalf of the
4 independent review organization and suitable matching
5 of reviewers to specific cases and that the independent
6 review organization employs or contracts with an
7 adequate number of clinical reviewers to meet this
8 objective;

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

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

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

25 (F) any person employed by or under contract with
26 the independent review organization adheres to the

1 requirements of this Act;

2 (2) a toll-free telephone service operating on a
3 24-hour-day, 7-day-a-week basis that accepts, receives,
4 and records information related to external reviews and
5 provides appropriate instructions; and

6 (3) an agreement to maintain and provide to the
7 Director the information set out in Section 70 of this Act.

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

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

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

19 (3) hold a non-restricted license in a state of the
20 United States and, for physicians, a current certification
21 by a recognized American medical specialty board in the
22 area or areas appropriate to the subject of the external
23 review; and

24 (4) have no history of disciplinary actions or
25 sanctions, including loss of staff privileges or
26 participation restrictions, that have been taken or are

1 pending by any hospital, governmental agency or unit, or
2 regulatory body that raise a substantial question as to the
3 clinical reviewer's physical, mental, or professional
4 competence or moral character.

5 (c) In addition to the requirements set forth in subsection
6 (a), an independent review organization may not own or control,
7 be a subsidiary of, or in any way be owned, or controlled by,
8 or exercise control with a health benefit plan, a national,
9 State, or local trade association of health benefit plans, or a
10 national, State, or local trade association of health care
11 providers.

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

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

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

26 (3) any officer, director or management employee of the

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

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

6 (5) the facility at which the recommended health care
7 service or treatment would be provided; or

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

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

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

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

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

2 (215 ILCS 180/65)

3 Sec. 65. External review reporting requirements.

4 (a) Each health carrier shall maintain written records in
5 the aggregate, by state, and for each type of health benefit
6 plan offered by the health carrier on all requests for external
7 review that the health carrier received notice from the
8 Director for each calendar year and submit a report to the
9 Director in the format specified by the Director by March 1 of
10 each year.

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

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

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

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

25 (3) the average length of time for resolution;

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

4 (5) the number of external reviews pursuant to Section
5 8G of this Act that were terminated as the result of a
6 reconsideration by the health carrier of its adverse
7 determination or final adverse determination after the
8 receipt of additional information from the covered person
9 or the covered person's authorized representative; and

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

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

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

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

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

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

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

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

1 adverse determination;

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

5 (C) the number of requests for expedited external
6 review resolved upholding the adverse determination or
7 final adverse determination; and

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

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

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

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

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

23 (B) denial of diagnostic procedure
24 (dissatisfaction regarding prospective
25 non-authorization of a request for a diagnostic
26 procedure recommended by a provider; partial approvals

1 are also considered to be denials);

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

5 (D) claims and utilization review (dissatisfaction
6 regarding the concurrent or retrospective evaluation
7 of the coverage, medical necessity, efficiency or
8 appropriateness of health care services or treatment
9 plans; prospective "Denials of care or treatment",
10 "Denials of diagnostic procedures" and "Denials of
11 referral requests" should not be classified in this
12 category, but the appropriate one above);

13 (8) the number of external reviews that were terminated
14 as the result of a reconsideration by the health carrier of
15 its adverse determination or final adverse determination
16 after the receipt of additional information from the
17 covered person or the covered person's authorized
18 representative; and

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

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

22 (215 ILCS 180/75)

23 Sec. 75. Disclosure requirements.

24 (a) Each health carrier shall include a description of the
25 external review procedures in, or attached to, the policy,

1 certificate, membership booklet, and outline of coverage or
2 other evidence of coverage it provides to covered persons.

3 (b) The description required under subsection (a) of this
4 Section shall include a statement that informs the covered
5 person of the right of the covered person to file a request for
6 an external review of an adverse determination or final adverse
7 determination with the Director ~~health carrier~~. The statement
8 shall explain that external review is available when the
9 adverse determination or final adverse determination involves
10 an issue of medical necessity, appropriateness, health care
11 setting, level of care, or effectiveness. The statement shall
12 include the toll-free telephone number and address of the
13 Office of Consumer Health Insurance within the Department of
14 Insurance.

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

16 (215 ILCS 180/80 new)

17 Sec. 80. Administration and enforcement.

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

20 (b) The Director is authorized to make use of any of the
21 powers established under the Illinois Insurance Code to enforce
22 the laws of this State. This includes but is not limited to,
23 the Director's administrative authority to investigate, issue
24 subpoenas, conduct depositions and hearings, issue orders,
25 including, without limitation, orders pursuant to Article XII

1 1/2 and Section 401.1 of the Illinois Insurance Code, and
2 impose penalties.

3 (215 ILCS 134/50 rep.)

4 Section 90-15. The Managed Care Reform and Patient Rights
5 Act is amended by repealing Section 50.

6 ARTICLE 99.

7 EFFECTIVE DATE

8 Section 99-99. Effective date. This Act takes effect upon
9 becoming law.