Rep. Mary E. Flowers

Filed: 4/4/2011

AMENDMENT TO HOUSE BILL 224

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

"ARTICLE 5.
UTILIZATION REVIEW AND
BENEFIT DETERMINATION

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

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

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

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

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

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

"Case management" has the same meaning given that term in the Health Carrier Grievance Procedure Law.

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

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

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

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

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

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

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

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

"Emergency medical condition" has the same meaning given

that term in the Health Carrier Grievance Procedure Law.

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

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

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

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

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

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

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

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

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

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

"Person" has the same meaning given that term in the Health

Carrier Grievance Procedure Law.

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

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

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

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

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

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

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

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

Section 5-15. Applicability and scope. This Law shall apply to a health carrier offering a health benefit plan that provides or performs utilization review services. The requirements of this Law also shall apply to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf. This Law also shall apply to a health carrier or its designee

utilization review organization that provides or performs concurrent review, prospective review, or retrospective review benefit determinations.

Section 5-20. Corporate oversight of utilization review program. A health carrier shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of this Law and applicable regulations are met. The health carrier also shall ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

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

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

(a) A health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected

to utilization review shall implement a written utilization review program that describes all review activities and procedures, both delegated and non-delegated, for the following:

(1) the filing of benefit requests;

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

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

(b) The program document shall describe the following:

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

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

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

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

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

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

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

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

(d) A health carrier shall maintain records for a minimum of 6 years of all benefit requests and claims and notices associated with utilization review and benefit determinations made in accordance with Sections 5-40 and 5-45 of this Law. The health carrier shall make the records available for examination by covered persons and the Department upon request.

Section 5-35. Operational requirements.

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

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

(c) A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the

requirements of Sections 5-40 and 5-45 of this Law.

(d) The following provisions shall apply:

(1) Whenever a health carrier fails to strictly adhere to the requirements of Sections 5-40 or 5-45 of this Law with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of this Law and may take action under paragraph (2) of this subsection (d) regardless of whether the health carrier asserts that it substantially complied with the requirements of Sections 5-40 or 5-45 of this Law, as applicable, or that any error it committed was de minimus.

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

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

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

(g) A health carrier's data systems shall be sufficient to

support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

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

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

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

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

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

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

(k) When conducting utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review

or benefit determination.

(l) In conducting utilization review, the health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination. In ensuring the independence and impartially of individuals involved in making the utilization review or benefit determination, the health carrier shall not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

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

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

(b) Subject to subsection (d) of this Section, for prospective review determinations, a health carrier shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of

the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than 15 days after the date the health carrier receives the request.

(c) Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with subsection (q) of this Section.

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

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

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

(e) If the extension under subsection (d) of this Section is necessary due to the failure of the covered person or the covered person's authorized representative to submit

information necessary to reach a determination on the request, then the notice of extension shall:

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

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

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

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

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

(1) is a communication by a covered person or the covered person's authorized representative that is

received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

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

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

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

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

(3) the health care service or treatment that is the

subject of the adverse determination shall be continued without liability to the covered person with respect to the internal review request made pursuant to Health Carrier Grievance Procedure Law.

(j) For retrospective review determinations, a health carrier shall make the determination within a reasonable period of time, but in no event later than 30 days after the date of receiving the benefit request.

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

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

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

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

determination.

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

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

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

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

(o) If the time period for making the determination under this Section is extended due to the covered person's or, if applicable, the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination

shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of:

(1) the date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information; or

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

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

(q) Notice requirements are as follows:

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

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

(B) the specific reasons or reasons for the adverse determination, including the denial code and its

corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

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

(D) a description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

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

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

(G) if the adverse determination is based on a medical necessity or experimental or investigational

treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

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

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

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

(2) A health carrier shall provide the notice required under this Section in a culturally and linguistically

appropriate manner if required in accordance with federal regulations. If a health carrier is required to provide the notice required under this Section in a culturally and linguistically appropriate manner in accordance with federal regulations, then the health carrier shall:

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

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

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

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

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

(B) an explanation as to why the act, practice, or omission was fraudulent or was an intentional

misrepresentation of a material fact;

(C) notice that the covered person or the covered person's authorized representative, prior to the effective date of the proposed rescission, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to Health Carrier Grievance Procedure Law;

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

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

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

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

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

(b) As part of the procedures required under subsection (a) of this Section, a health carrier shall provide that, in the case of a failure by a covered person or the covered person's authorized representative to follow the health carrier's procedures for filing an urgent care request, the covered person or the covered person's authorized representative shall be notified of the failure and the proper procedures to be following for filing the request.

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

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

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

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

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

(2) is a communication that refers to a specific covered person, a specific medical condition or symptom,

and a specific health care service, treatment or provider for which approval is being requested.

(e) For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than 24 hours after the receipt of the request by the health carrier.

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

(g) If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, then the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in

writing of this failure and state what specific information is needed as soon as possible, but in no event later than 24 hours after receipt of the request.

(h) The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than 48 hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in subsection (g) of this Section.

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

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

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

(j) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in subsection (h) of this Section, then the health carrier may

deny the certification of the requested benefit.

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

(l) For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, then the health carrier shall make a determination with respect to the request and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than 24 hours after the health carrier's receipt of the request.

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

(n) For purposes of calculating the time periods within which a determination is required to be made under this Section, the time period within which the determination is required to be made shall begin on the date the request is

filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 5-30 of this Law for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(o) Notice requirements are as follows:

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

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

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

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

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

the request;

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

(F) a description of the health carrier's expedited review procedures established pursuant to Section 10-40 of the Health Carrier Grievance Procedure Law;

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

(H) if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will

be provided to the covered person free of charge upon request;

(I) if applicable, instructions for requesting:

(i) a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with subparagraph (G) of this paragraph (1); or

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

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

(2) A health carrier shall provide the notice required under this Section in a culturally and linguistically appropriate manner if required in accordance with federal regulations. If a health carrier is required to provide the notice required under this Section in a culturally and

linguistically appropriate manner in accordance with federal regulations, the health carrier shall do the following:

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

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

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

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

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

(B) an explanation as to why the act, practice or omission was fraudulent or was an intentional

misrepresentation of a material fact;

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

(D) the effective date of the proposed rescission.

(4) A health carrier may provide the notice required under this Section orally or in writing. If notice of the adverse determination is provided orally, then the health carrier shall provide written notice of the adverse determination within 3 days following the oral notification.

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

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

Section 5-60. Disclosure requirements.

(a) In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review

procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures.

(b) A health carrier shall include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons.

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

Section 5-65. Administration and enforcement.

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

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

ARTICLE 10. HEALTH CARRIER GRIEVANCE PROCEDURES

"Section 10-1. Short title. This Article may be cited as

the Health Carrier Grievance Procedure Law.

Section 10-5. Purpose and intent. The purpose of this Law is to provide standards for the establishment and maintenance of procedures by health carriers to ensure that covered persons have the opportunity for the appropriate resolution of grievances, as defined in this Law.

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

"Adverse determination" means:

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

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

carrier's health benefit plan;

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

(4) a rescission of coverage determination.

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

"Authorized representative" means:

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

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

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

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

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

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

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

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

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

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

"Director" means the Director of Insurance.

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

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

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

plan.

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

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

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

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

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

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

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

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

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

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

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

"Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier

to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and policies that pay on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include:

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

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

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

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

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

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

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

(1) limited scope dental or vision benefits;

(2) benefits for long-term care, nursing home care,

home health care, community-based care, or any combination thereof; or

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

"Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(2) hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

"Managed care plan" means a health benefit plan that requires a covered person to use or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or

employed by the health carrier. "Managed care plan" includes:

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

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

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

"Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

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

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

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

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

(2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to

a failure to timely pay required premiums or contributions towards the cost of coverage.

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

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

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

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

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

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

Except as provided in item (2) of this definition of

"urgent care request", in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request shall be treated as an urgent care request.

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

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

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

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

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

(b) Notwithstanding the provisions under subsections (g) and (h) of this Section, a health carrier shall maintain the records required under subsection (a) of this Section for at

least 6 years related to the notices provided under subsection (g) of Section 10-30 and subsection (h) of Section 10-40 of this Law.

(c) The health carrier shall make the records available for examination by covered persons and the Director upon request, and shall annually file a copy of the register with the Department. The Department shall make a summary of all data collected available upon request and shall publish the summary on the World Wide Web. No Department publication or release of information shall identify any enrollee, health care provider, or individual complainant.

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

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

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

(A) a consumer or enrollee;

(B) a provider; or

(C) any other individual;

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

(A) denial of care or treatment;

(B) denial of a diagnostic procedure;

(C) denial of a referral request;

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

(E) underwriting;

(F) marketing and sales;

(G) claims and utilization review;

(H) member services;

(I) provider relations; and

(J) miscellaneous;

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

(4) the date received;

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

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

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

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

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

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

contains a review of the register for that calendar year.

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

(1) the certificate of compliance required by Section 10-25 of this Law;

(2) the number of covered lives;

(3) the total number of grievances;

(4) the number of grievances resolved at each level, if applicable, and their resolution;

(5) the number of grievances appealed to the Director of which the health carrier has been informed;

(6) the number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(7) a synopsis of actions being taken to correct problems identified.

Section 10-25. Grievance review procedures.

(a) Except as specified in Section 10-40 of this Law, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in Sections 10-30 and 10-35 of this Law.

(b) The following provisions shall apply:

(1) Whenever a health carrier fails to strictly adhere

to the requirements of Section 10-30 or Section 10-40 of this Law with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this Law and may take action under paragraph (2) of this subsection (b) regardless of whether the health carrier asserts that it substantially complied with the requirements of Section 10-30 or Section 10-40, as applicable, or that any error it committed was de minimus.

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

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

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

(e) A health carrier shall file annually with the Director,

as part of its annual report required by Section 10-20 of this Law, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this Law.

(f) A description of the grievance procedures required under this Section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

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

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

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

(b) The health carrier shall provide the covered person with the name, address, and telephone number of a person or

organizational unit designated to coordinate the review on behalf of the health carrier.

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

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

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

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

(g) In conducting a review under this Section, the reviewer

or reviewers shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person or the covered person's authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

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

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

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

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

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

(2) was submitted, considered, or generated in the course of making the adverse determination, without regard

to whether the document, record, or other information was relied upon in making the benefit determination;

(3) demonstrates that, in making the benefit determination, the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

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

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

(k) For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsections (l), (m), and (n) of this Section, the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 10-25 of this Law for filing a request

without regard to whether all of the information necessary to make the determination accompanies the filing.

(l) A health carrier shall notify and issue a decision in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the time frames provided in subsections (m) or (n) of this Section.

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

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

(o) Prior to issuing a decision in accordance with the timeframes provided in subsections (m) or (n) of this Section, the health carrier shall provide free of charge to the covered person, or the covered person's authorized representative, any

new or additional evidence relied upon or generated by the health carrier or at the direction of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

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

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

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

(2) information sufficient to identify the claim

involved with respect to the grievance, including the date of service, the health care provider, if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

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

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

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

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

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

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

(C) a statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant, as the term "relevant" is

defined in subsection (i) of this Section, to the covered person's benefit request;

(D) if the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

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

(F) if applicable, instructions for requesting:

(i) a copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination, as provided in subparagraph (D) of paragraph (6) of subsection

(q) of this Section; and

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

(G) If applicable, a statement indicating:

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

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

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

(r) A health carrier shall provide the notice required under subsection (q) of this Section in a culturally and linguistically appropriate manner if required in accordance with federal regulations. If a health carrier is required to provide the notice in a culturally and linguistically appropriate manner in accordance with federal regulations,

then the health carrier shall:

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

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

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

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

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

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

(c) A covered person does not have the right to attend or to have a representative in attendance at the standard review,

but the covered person or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the carrier pursuant to subsection (e) of this Section to consider when conducting the review.

(d) The health carrier shall make the provisions of subsection (c) of this Section known to the covered person or, if applicable, the covered person's authorized representative within 3 business days after the date of receiving the grievance.

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

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

(g) Subject to subsection (h) of this Section, if, due to

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

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

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

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

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

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

(4) Reference to the evidence or documentation used as

the basis for the decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) the specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of

the health carrier's standard, if any, that was used in reaching the denial;

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

(C) a description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

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

(E) if the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, then either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will

be provided to the covered person free of charge upon request;

(F) If applicable, instructions for requesting:

(i) a copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with subparagraph (4) of paragraph (F) of subsection (h) of this Section; or

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

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

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

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

(i) A health carrier shall provide the notice required

under this Section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

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

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

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

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

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

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

Section 10-45. Administration and enforcement.

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

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

ARTICLE 90. AMENDATORY PROVISIONS

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

(215 ILCS 134/10)

Sec. 10. Definitions:

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

"Clinical peer" means a health care professional who is in

the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

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

"Department" means the Department of Insurance.

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

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

(2) serious impairment to bodily functions; or

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

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

"Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including but not

limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

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

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

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

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

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

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

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

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

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

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

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

"Health care services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or

healing human illness or injury including home health and pharmaceutical services and products.

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

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

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

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

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

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

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

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

"Stabilization" means, with respect to an emergency medical condition, to provide such medical treatment of the

condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.

"Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate ~~the evaluation of~~ the medical necessity, appropriateness, efficacy, or ~~and~~ efficiency of, ~~the use of~~ health care services, procedures, settings or ~~and~~ facilities.

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

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

(215 ILCS 134/45)

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

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

(b) (Blank). ~~When an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not~~

~~limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, the health care plan must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, a health care plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 24 hours after receipt of the required information. The health care plan shall notify the party filing the appeal and the enrollee, enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed up by a written notice of the determination.~~

(c) (Blank). ~~For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the health care plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a health care plan must notify the party filing an appeal, within 3 business days, of all information that the~~

~~plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health care plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed up by a written notice of the determination.~~

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

(e) (Blank). ~~If an appeal filed under subsection (b) or (c)~~

~~is denied for a reason including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization requests or length of stay requests, any involved party may request an external independent review as provided by the Illinois Health Carrier External Review Act.~~

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

(g) Future contractual or employment action by the health care plan regarding the patient's physician or other health

care provider shall not be based solely on the physician's or other health care provider's participation in health care services appeals, complaints, or external independent reviews under the Illinois Health Carrier External Review Act.

(h) Nothing in this Section shall be construed to require a health care plan to pay for a health care service not covered under the terms of the enrollee's certificate of coverage or policy, unless the terms are inconsistent with applicable law. (Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 134/85)

Sec. 85. Utilization review program registration.

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

(b) In addition, the Director of the Department, in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Only a health care professional may make

determinations regarding the medical necessity of health care services during the course of utilization review.

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

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

(f) If the Department finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department

may issue a cease and desist order. Before issuing a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.

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

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

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

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

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

(215 ILCS 180/10)

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

"Adverse determination" has the same meaning given that term in the Health Carrier Grievance Procedure Law ~~means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated~~.

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

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

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

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

"Best evidence" means evidence based on:

(1) randomized clinical trials;

(2) if randomized clinical trials are not available,

then cohort studies or case-control studies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Facility" has the same meaning given that term in the Health Carrier Grievance Procedure Law ~~means an institution~~

~~providing health care services or a health care setting~~.

"Final adverse determination" has the same meaning given that term in the Health Carrier Grievance Procedure Law ~~means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) the following standard reference compendia:

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

(b) Drug Facts and Comparisons;

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

(d) The United States Pharmacopoeia-Drug Information;

(5) findings, studies, or research conducted by or

under the auspices of federal government agencies and nationally recognized federal research institutes, including:

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

(b) the National Institutes of Health;

(c) the National Cancer Institute;

(d) the National Academy of Sciences;

(e) the Centers for Medicare & Medicaid Services;

(f) the federal Food and Drug Administration; and

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

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

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

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

"Randomized clinical trial" means a controlled prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a

specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

"Retrospective review" has the same meaning given that term in the Health Carrier Grievance Procedure Law ~~means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment~~.

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

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

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

(215 ILCS 180/20)

Sec. 20. Notice of right to external review.

(a) At the same time the health carrier sends written notice of a covered person's right to appeal a coverage decision upon an adverse determination or a final adverse determination ~~as provided by the Managed Care Reform and Patient Rights Act~~, a health carrier shall notify a covered person, the covered person's authorized representative, if any, and a covered person's health care provider in writing of the covered person's right to request an external review as

provided by this Act. The written notice required shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by an independent review organization not associated with us ~~if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested~~ by submitting a written request for an external review to the Department of Insurance, Office of Consumer Health Information, 320 West Washington Street, 4th Floor, Springfield, Illinois, 62767." ~~us~~. ~~Upon receipt of your request an independent review organization registered with the Department of Insurance will be assigned to review our decision.~~

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

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

(1) If the covered person has a medical condition where the timeframe for completion of (A) an expedited internal review of an appeal ~~a grievance~~ involving an adverse

determination, (B) a final adverse determination ~~as set forth in the Managed Care Reform and Patient Rights Act~~, or (C) a standard external review as established in this Act, would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review.

(2) The covered person or the covered person's authorized representative may file an appeal under the health carrier's internal appeal process as set forth in the Health Carrier Grievance Procedure Law, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative 30 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a prospective review request or 60 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a retrospective review request with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, then the covered person or the covered person's authorized representative may file a request for external review and shall be considered to have exhausted

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

(3) The covered person or the covered person's authorized representative filed a request for an expedited internal review of an adverse determination pursuant to the Health Carrier Grievance Procedure Law and has not received a decision on such request from the health carrier within 48 hours, except to the extent the covered person or the

covered person's authorized representative requested or agreed to a delay.

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

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

person of all of the following:

(1) if the covered person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review; or

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

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

(d) In addition to the information to be provided pursuant

to subsections (a), (b), and (c) of this Section, the health carrier shall include a copy of the description of both the required standard and expedited external review procedures. The description shall highlight the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information, including any forms used to process an external review.

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

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

(215 ILCS 180/25)

Sec. 25. Request for external review. A covered person or the covered person's authorized representative may make a request for a standard external or expedited external review of an adverse determination or final adverse determination. Except as set forth in Sections 40 and 42 of this Act, all requests for external review ~~Requests under this Section~~ shall

be made in writing to the Director ~~directly to the health carrier that made the adverse or final adverse determination. All requests for external review shall be in writing except for requests for expedited external reviews which may me made orally~~. Health carriers must provide covered persons with forms to request external reviews.

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

(215 ILCS 180/30)

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

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

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

(1) the covered person or the covered person's authorized representative has filed an appeal under the health carrier's internal appeal process as set forth in ~~a request for an internal review of an adverse determination pursuant to~~ the Health Carrier Grievance Procedure Law ~~Managed Care Reform and Patient Rights Act~~ and has not received a written decision on the appeal 30 days following

the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a prospective review request or 60 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a retrospective review request ~~request from the health carrier within 15 days after receipt of the required information but not more than 30 days after the request was filed by the covered person or the covered person's authorized representative~~, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay; ~~however, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination until the covered person has exhausted the health carrier's internal grievance process;~~

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

a delay; ~~or~~

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

(4) the covered person has a medical condition in which the timeframe for completion of (A) an expedited internal review of a appeal involving an adverse determination, (B) a final adverse determination, or (C) a standard external review as established in this Act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

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

expedited external review shall determine whether the covered person is required to complete the expedited review of the appeal prior to conducting the expedited external review; or

(6) the health carrier has failed to comply with Section 5-40 or 5-45 of the Utilization Review and Benefit Determination Law, as set forth in subsection (d) of Section 5-35 of that Law, or Sections 10-30 or 10-40 of the Health Carrier Grievance Procedure Law, as set forth in subsection (b) of Section 10-25 of that Law.

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

(215 ILCS 180/35)

Sec. 35. Standard external review.

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

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

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

requested or at the time the health care service was provided;

(2) the health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but the health carrier has determined that the health care service is not covered ~~because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness~~;

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

(4) (blank); and ~~for appeals relating to a determination based on treatment being experimental or investigational, the requested health care service or treatment that is the subject of the adverse determination or final adverse determination is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier and that the covered~~

~~person's health care provider, who ordered or provided the services in question and who is licensed under the Medical Practice Act of 1987, has certified that one of the following situations is applicable:~~

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

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

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

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

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

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

(c) Within one business day after completion of the

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

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

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

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

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

Notwithstanding a health carrier's initial determination

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

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

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

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

The Director ~~health carrier~~ shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized

representative may, within 5 business days following the date of receipt of the notice provided pursuant to item (2) of this subsection (d), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

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

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

provisions shall apply:

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

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

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

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

representative.

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

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

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

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

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

writing of its decision.

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

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

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

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

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

(4) the terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered

person's health benefit plan with the health carrier, unless the terms are inconsistent with applicable law;

(5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

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

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

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

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

~~(B) medical or scientific evidence or evidence based standards demonstrate that the expected~~

~~benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments; or~~

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

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

review organization. In such cases, the following provisions shall apply:

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

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

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

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

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

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

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

(G) the rationale for its decision.

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

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

~~(B) a description of the indicators relevant to~~

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

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

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

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

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

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

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

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

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

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

(215 ILCS 180/40)

Sec. 40. Expedited external review.

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

(1) immediately after the date of receipt of a notice

prior to a final adverse determination as provided by subsection (b) of Section 20 of this Act;

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

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

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

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

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

the Director.

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

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

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

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

(1) The assignment of an approved independent review organization to conduct an external review in accordance

with this Section shall be made from those approved independent review organizations qualified to conduct external review as required by Sections 50 and 55 of this Act.

(2) The Director shall immediately notify the health carrier of the name of the assigned independent review organization. Immediately upon receipt from the Director of the name of the independent review organization assigned to conduct the external review ~~assigning an independent review organization to perform an expedited external review~~, but in no case more than 24 hours after receiving such notice ~~assigning the independent review organization~~, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

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

(4) Within one business day after making the decision

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

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

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

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

(2) notify the Director, the health carrier, the

covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative, of the decision.

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

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

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

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

(j) The assignment by the Director of an approved

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

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

(215 ILCS 180/42 new)

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

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

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

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

promptly initiated.

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

(3) The following provisions apply concerning notice:

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

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

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

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

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

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

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

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

by telephone or facsimile or any other available expeditious method.

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

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

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

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

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

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

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

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

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

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

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

services or treatments;

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

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

(e) The following provisions apply concerning requests:

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

(2) If the request:

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

(B) is not eligible for external review, then the health carrier shall inform the Director and the covered person and, if applicable, the covered

person's authorized representative in writing and include in the notice the reasons for its ineligibility.

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

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

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

(f) Whenever a request for external review is determined eligible for external review, the health carrier shall notify

the Director and the covered person and, if applicable, the covered person's authorized representative.

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

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

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

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

after 5 business days.

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

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

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

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

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

be selected to conduct the external review.

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

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

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

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

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

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

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

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

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

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

review.

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

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

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

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

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

(1) Except as provided in item (3) of this subsection

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

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

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

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

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

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

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

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

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

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

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

reviewer considers appropriate, shall consider the following in reaching a decision:

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

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

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

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

(5) whether (A) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition or (B) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be

beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

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

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

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

(B) For an expedited external review, within 48 hours after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, in accordance with item (2) of this subsection (n), shall make a decision and provide notice of the decision orally or in writing to the Director, the health carrier, the covered person, and

the covered person's authorized representative, if applicable. If such notice is not in writing, within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, the health carrier, the covered person, and the covered person's authorized representative, if applicable.

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

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

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

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

(i) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, then

the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subdivision (A) or (B) of this item (2).

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

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

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

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

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

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

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

(5) the date of its decision;

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

(7) the rationale for its decision.

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

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

(215 ILCS 180/55)

Sec. 55. Minimum qualifications for independent review organizations.

(a) To be approved to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both

the standard external review process and the expedited external review process set forth in this Act that include, at a minimum:

(1) a quality assurance mechanism that ensures that:

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

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

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

(D) the health carrier, the covered person, and the covered person's authorized representative shall not choose or control the choice of the physicians or other

health care professionals to be selected to conduct the external review;

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

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

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

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

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

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

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

(3) hold a non-restricted license in a state of the United States and, for physicians, a current certification

by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

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

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

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

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

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

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

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

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

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

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

(f) An independent review organization shall be unbiased. An independent review organization shall establish and

maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this Section.

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

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

(215 ILCS 180/65)

Sec. 65. External review reporting requirements.

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

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

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

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

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

(3) the average length of time for resolution;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) denial of care or treatment (dissatisfaction regarding prospective non-authorization of a request for care or treatment recommended by a provider excluding diagnostic procedures and referral requests;

partial approvals and care terminations are also considered to be denials);

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

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

(D) claims and utilization review (dissatisfaction regarding the concurrent or retrospective evaluation of the coverage, medical necessity, efficiency or appropriateness of health care services or treatment plans; prospective "Denials of care or treatment", "Denials of diagnostic procedures" and "Denials of referral requests" should not be classified in this category, but the appropriate one above);

(8) the number of external reviews that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

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

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

(215 ILCS 180/75)

Sec. 75. Disclosure requirements.

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

(b) The description required under subsection (a) of this Section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the Director ~~health carrier~~. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the toll-free telephone number and address of the Office of Consumer Health Insurance within the Department of Insurance.

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

(215 ILCS 180/80 new)

Sec. 80. Administration and enforcement.

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

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

(215 ILCS 134/50 rep.)

Section 90-15. The Managed Care Reform and Patient Rights Act is amended by repealing Section 50.

ARTICLE 99.

EFFECTIVE DATE

Section 99-99. Effective date. This Act takes effect upon becoming law.".