



Rep. Mary E. Flowers

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1 AMENDMENT TO HOUSE BILL 224

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

4 "ARTICLE 5.
5 UTILIZATION REVIEW AND
6 BENEFIT DETERMINATION

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

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

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

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

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

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

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

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

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

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

15 "Department" means the Department of Insurance.

16 "Director" means the Director of Insurance.

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

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

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

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

26 "Emergency medical condition" has the same meaning given

1 that term in the Health Carrier Grievance Procedure Law.

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

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

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

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

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

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

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

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

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

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

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

1 Carrier Grievance Procedure Law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (1) the filing of benefit requests;

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

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

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

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

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

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

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

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

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

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

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

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

12 Section 5-35. Operational requirements.

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

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

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

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

2 (d) The following provisions shall apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

1 or benefit determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 determination.

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

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

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

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

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

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

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

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

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

15 (q) Notice requirements are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 misrepresentation of a material fact;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 deny the certification of the requested benefit.

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

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

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

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

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

6 (o) Notice requirements are as follows:

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

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

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

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

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

1 the request;

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

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

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

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

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

3 (I) if applicable, instructions for requesting:

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

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

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

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

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

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

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

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

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

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

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

1 misrepresentation of a material fact;

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

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

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

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

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

20 Section 5-60. Disclosure requirements.

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

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

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

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

11 Section 5-65. Administration and enforcement.

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

14 (b) The Director is authorized to make use of any of the
15 powers established under the Illinois Insurance Code to enforce
16 the laws of this State. This includes but is not limited to,
17 the Director's administrative authority to investigate, issue
18 subpoenas, conduct depositions and hearings, issue orders,
19 including, without limitation, orders pursuant to Article XII
20 1/2 and Section 401.1 of the Illinois Insurance Code, and
21 impose penalties.

22 ARTICLE 10. HEALTH CARRIER GRIEVANCE PROCEDURES

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

1 the Health Carrier Grievance Procedure Law.

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

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

8 "Adverse determination" means:

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

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

1 carrier's health benefit plan;

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

6 (4) a rescission of coverage determination.

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

9 "Authorized representative" means:

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

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

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

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

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

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

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

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

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

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

17 "Director" means the Director of Insurance.

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

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

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

1 plan.

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

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

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

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

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

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

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

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

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

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

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

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

1 to provide, deliver, arrange for, pay for, or reimburse any of
2 the costs of health care services. "Health benefit plan"
3 includes short-term and catastrophic health insurance
4 policies, and policies that pay on a cost-incurred basis,
5 except as otherwise specifically exempted in this definition.

6 "Health benefit plan" does not include:

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

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

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

13 (4) workers' compensation or similar insurance;

14 (5) automobile medical payment insurance;

15 (6) credit-only insurance;

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

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

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

25 (1) limited scope dental or vision benefits;

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

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

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

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

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

16 (2) hospital indemnity or other fixed indemnity
17 insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 "Retrospective review" does not include the review of a claim
6 that is limited to veracity of documentation or accuracy of
7 coding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (A) a consumer or enrollee;

21 (B) a provider; or

22 (C) any other individual;

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

25 (A) denial of care or treatment;

26 (B) denial of a diagnostic procedure;

1 (C) denial of a referral request;

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

4 (E) underwriting;

5 (F) marketing and sales;

6 (G) claims and utilization review;

7 (H) member services;

8 (I) provider relations; and

9 (J) miscellaneous;

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

12 (4) the date received;

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

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

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

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

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

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

1 contains a review of the register for that calendar year.

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

6 (1) the certificate of compliance required by Section
7 10-25 of this Law;

8 (2) the number of covered lives;

9 (3) the total number of grievances;

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

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

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

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

19 Section 10-25. Grievance review procedures.

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

24 (b) The following provisions shall apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (2) information sufficient to identify the claim

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

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

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

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

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

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

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

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

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

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

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

22 (F) if applicable, instructions for requesting:

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

1 (q) of this Section; and

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

6 (G) If applicable, a statement indicating:

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

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

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

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

1 then the health carrier shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (4) Reference to the evidence or documentation used as

1 the basis for the decision.

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

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

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

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

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

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

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

7 (f) An expedited review decision shall be made and the
8 covered person or, if applicable, the covered person's
9 authorized representative shall be notified of the decision in
10 accordance with this Section as expeditiously as the covered
11 person's medical condition requires, but in no event more than
12 48 hours after the receipt of the request for the expedited
13 review. If the expedited review is of a grievance involving an
14 adverse determination with respect to a concurrent review
15 urgent care request, the service shall be continued without
16 liability to the covered person until the covered person has
17 been notified of the determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (F) If applicable, instructions for requesting:

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

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

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

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

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

26 (i) A health carrier shall provide the notice required

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

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

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

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

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

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

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

1 Section 10-45. Administration and enforcement.

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

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

12 ARTICLE 90. AMENDATORY PROVISIONS

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

15 (215 ILCS 134/10)

16 Sec. 10. Definitions:

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

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

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

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

6 "Department" means the Department of Insurance.

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

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

16 (2) serious impairment to bodily functions; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (215 ILCS 134/45)

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

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

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

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

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

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

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

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

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

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

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

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

5 (h) Nothing in this Section shall be construed to require a
6 health care plan to pay for a health care service not covered
7 under the terms of the enrollee's certificate of coverage or
8 policy, unless the terms are inconsistent with applicable law.

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

10 (215 ILCS 134/85)

11 Sec. 85. Utilization review program registration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (2) Only a health care professional may make

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

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

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

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

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

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

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

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

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

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

1 (215 ILCS 180/10)

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

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

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

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

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

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

23 "Best evidence" means evidence based on:

24 (1) randomized clinical trials;

25 (2) if randomized clinical trials are not available,

1 then cohort studies or case-control studies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (4) the following standard reference compendia:

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

21 (b) Drug Facts and Comparisons;

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

24 (d) The United States Pharmacopoeia-Drug
25 Information;

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

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

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

6 (b) the National Institutes of Health;

7 (c) the National Cancer Institute;

8 (d) the National Academy of Sciences;

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

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

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

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

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

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

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

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

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

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

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

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

16 (215 ILCS 180/20)

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

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

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

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

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

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

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

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

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

21 (3) The covered person or the covered person's
22 authorized representative filed a request for an expedited
23 internal review of an adverse determination pursuant to the
24 Health Carrier Grievance Procedure Law and has not received
25 a decision on such request from the health carrier within
26 48 hours, except to the extent the covered person or the

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

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

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

1 person of all of the following:

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

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

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

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

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

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

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

19 (215 ILCS 180/25)

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

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

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

8 (215 ILCS 180/30)

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

10 (a) Except as provided in subsection (b) of this Section
11 ~~20~~, a request for an external review shall not be made until
12 the covered person has exhausted the health carrier's internal
13 appeal ~~grievance~~ process as set forth in the Health Carrier
14 Grievance Procedure Law ~~Managed Care Reform and Patient Rights~~
15 ~~Act.~~

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

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

1 the date the covered person or the covered person's
2 authorized representative files an appeal of an adverse
3 determination that involves a prospective review request
4 or 60 days following the date the covered person or the
5 covered person's authorized representative files an appeal
6 of an adverse determination that involves a retrospective
7 review request ~~request from the health carrier within 15~~
8 ~~days after receipt of the required information but not more~~
9 ~~than 30 days after the request was filed by the covered~~
10 ~~person or the covered person's authorized representative,~~
11 except to the extent the covered person or the covered
12 person's authorized representative requested or agreed to
13 a delay; ~~however, a covered person or the covered person's~~
14 ~~authorized representative may not make a request for an~~
15 ~~external review of an adverse determination involving a~~
16 ~~retrospective review determination until the covered~~
17 ~~person has exhausted the health carrier's internal~~
18 ~~grievance process;~~

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

1 a delay; ~~or~~

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

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

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

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

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

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

12 (215 ILCS 180/35)

13 Sec. 35. Standard external review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (c) Within one business day after completion of the

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

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

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

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

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

26 Notwithstanding a health carrier's initial determination

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

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

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

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

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

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

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

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

1 provisions shall apply:

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

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

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

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

1 representative.

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

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

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

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

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

1 writing of its decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (G) the rationale for its decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (215 ILCS 180/40)

20 Sec. 40. Expedited external review.

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

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

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

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

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

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

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

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

1 the Director.

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

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

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

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

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

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

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

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

26 (4) Within one business day after making the decision

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

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

18 (e) As expeditiously as the covered person's medical
19 condition or circumstances requires, but in no event more than
20 72 hours after the date of receipt of the request for an
21 expedited external review ~~2 business days after the receipt of~~
22 ~~all pertinent information,~~ the assigned independent review
23 organization shall:

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

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

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

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

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

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

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

26 (j) The assignment by the Director of an approved

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

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

6 (215 ILCS 180/42 new)

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

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

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

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

1 promptly initiated.

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

5 (3) The following provisions apply concerning notice:

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

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

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

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

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

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

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

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

1 by telephone or facsimile or any other available
2 expeditious method.

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

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

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

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

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

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

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

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

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

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

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

1 services or treatments;

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

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

11 (e) The following provisions apply concerning requests:

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

17 (2) If the request:

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

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

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

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

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

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

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

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

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

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

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

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

1 after 5 business days.

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

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

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

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

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

1 be selected to conduct the external review.

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

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

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

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

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

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

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

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

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

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

1 review.

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

5 (3) The external review may be terminated only if the
6 health carrier decides, upon completion of its
7 reconsideration, to reverse its adverse determination or
8 final adverse determination and provide coverage or
9 payment for the health care service that is the subject of
10 the adverse determination or final adverse determination.

11 In such cases, the following provisions shall apply:

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

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

24 (1) The following provisions apply concerning clinical
25 review opinions:

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

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

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

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

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

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

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

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

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

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

13 (B) If the opinion provided pursuant to
14 subdivision (A) of this item (3) was not in writing,
15 then within 48 hours following the date the opinion was
16 provided, the clinical reviewer shall provide written
17 confirmation of the opinion to the assigned
18 independent review organization and include the
19 information required under item (2) of this subsection
20 (1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 (5) the date of its decision;

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

8 and

9 (7) the rationale for its decision.

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

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

20 (215 ILCS 180/55)

21 Sec. 55. Minimum qualifications for independent review
22 organizations.

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

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

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

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

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

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

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

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

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

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

8 (2) a toll-free telephone service operating on a
9 24-hour-day, 7-day-a-week basis that accepts, receives,
10 and records information related to external reviews and
11 provides appropriate instructions; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (215 ILCS 180/65)

9 Sec. 65. External review reporting requirements.

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

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

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

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

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

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

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

10 (5) the number of external reviews pursuant to section
11 8G of this Act that were terminated as the result of a
12 reconsideration by the health carrier of its adverse
13 determination or final adverse determination after the
14 receipt of additional information from the covered person
15 or the covered person's authorized representative; and

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

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

21 (b) The report required under subsection (a) of this
22 Section shall include in the aggregate, by state, and by type
23 of health benefit plan:

24 (1) the total number of requests for external review;

25 (2) the total number of requests for expedited external
26 review;

1 (3) the total number of requests for external review
2 denied;

3 (4) the number of requests for external review
4 resolved, including:

5 (A) the number of requests for external review
6 resolved upholding the adverse determination or final
7 adverse determination;

8 (B) the number of requests for external review
9 resolved reversing the adverse determination or final
10 adverse determination;

11 (C) the number of requests for expedited external
12 review resolved upholding the adverse determination or
13 final adverse determination; and

14 (D) the number of requests for expedited external
15 review resolved reversing the adverse determination or
16 final adverse determination;

17 (5) the average length of time for resolution for an
18 external review;

19 (6) the average length of time for resolution for an
20 expedited external review;

21 (7) a summary of the types of coverages or cases for
22 which an external review was sought, as specified below:

23 (A) denial of care or treatment (dissatisfaction
24 regarding prospective non-authorization of a request
25 for care or treatment recommended by a provider
26 excluding diagnostic procedures and referral requests;

1 partial approvals and care terminations are also
2 considered to be denials);

3 (B) denial of diagnostic procedure
4 (dissatisfaction regarding prospective
5 non-authorization of a request for a diagnostic
6 procedure recommended by a provider; partial approvals
7 are also considered to be denials);

8 (C) denial of referral request (dissatisfaction
9 regarding non-authorization of a request for a
10 referral to another provider recommended by a PCP);

11 (D) claims and utilization review (dissatisfaction
12 regarding the concurrent or retrospective evaluation
13 of the coverage, medical necessity, efficiency or
14 appropriateness of health care services or treatment
15 plans; prospective "Denials of care or treatment",
16 "Denials of diagnostic procedures" and "Denials of
17 referral requests" should not be classified in this
18 category, but the appropriate one above);

19 (8) the number of external reviews that were terminated
20 as the result of a reconsideration by the health carrier of
21 its adverse determination or final adverse determination
22 after the receipt of additional information from the
23 covered person or the covered person's authorized
24 representative; and

25 (9) any other information the Director may request or
26 require.

1 (Source: P.A. 96-857, eff. 7-1-10.)

2 (215 ILCS 180/75)

3 Sec. 75. Disclosure requirements.

4 (a) Each health carrier shall include a description of the
5 external review procedures in, or attached to, the policy,
6 certificate, membership booklet, and outline of coverage or
7 other evidence of coverage it provides to covered persons.

8 (b) The description required under subsection (a) of this
9 Section shall include a statement that informs the covered
10 person of the right of the covered person to file a request for
11 an external review of an adverse determination or final adverse
12 determination with the Director ~~health carrier~~. The statement
13 shall explain that external review is available when the
14 adverse determination or final adverse determination involves
15 an issue of medical necessity, appropriateness, health care
16 setting, level of care, or effectiveness. The statement shall
17 include the toll-free telephone number and address of the
18 Office of Consumer Health Insurance within the Department of
19 Insurance.

20 (Source: P.A. 96-857, eff. 7-1-10.)

21 (215 ILCS 180/80 new)

22 Sec. 80. Administration and enforcement.

23 (a) The Director of Insurance may adopt rules necessary to
24 implement the Department's responsibilities under this Act.

1 (b) The Director is authorized to make use of any of the
2 powers established under the Illinois Insurance Code to enforce
3 the laws of this State. This includes but is not limited to,
4 the Director's administrative authority to investigate, issue
5 subpoenas, conduct depositions and hearings, issue orders,
6 including, without limitation, orders pursuant to Article XII
7 1/2 and Section 401.1 of the Illinois Insurance Code, and
8 impose penalties.

9 (215 ILCS 134/50 rep.)

10 Section 90-15. The Managed Care Reform and Patient Rights
11 Act is amended by repealing Section 50.

12 ARTICLE 99.

13 EFFECTIVE DATE

14 Section 99-99. Effective date. This Act takes effect upon
15 becoming law."