



Sen. Jacqueline Y. Collins

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LRB096 10769 RPM 24366 a

1 AMENDMENT TO SENATE BILL 1506

2 AMENDMENT NO. _____. Amend Senate Bill 1506, AS AMENDED,
3 by replacing everything after the enacting clause with the
4 following:

5 "Section 1. Short title. This Act may be cited as the
6 Health Carrier External Review Act.

7 Section 5. Purpose and intent. The purpose of this Act is
8 to provide uniform standards for the establishment and
9 maintenance of external review procedures to assure that
10 covered persons have the opportunity for an independent review
11 of an adverse determination or final adverse determination, as
12 defined in this Act.

13 Section 10. Definitions. For the purposes of this Act:

14 "Adverse determination" means a determination by a health
15 carrier or its designee utilization review organization that an

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

8 "Authorized representative" means:

9 (1) a person to whom a covered person has given express
10 written consent to represent the covered person in an
11 external review;

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

14 (3) a family member of the covered person or the
15 covered person's health care provider only when the covered
16 person is unable to provide consent.

17 "Best evidence " means evidence based on:

18 (1) randomized clinical trials;

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

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

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

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

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

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

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

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

14 "Director" means the Director of the Division of Insurance
15 within the Illinois Department of Financial and Professional
16 Regulation.

17 "Emergency medical condition" means the sudden onset of a
18 health condition or illness that requires immediate medical
19 attention, where failure to provide medical attention would
20 result in a serious impairment to bodily functions, serious
21 dysfunction of a bodily organ or part, or would place the
22 person's health in serious jeopardy.

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

26 "Evidence-based standard" means the conscientious,

1 explicit, and judicious use of the current best evidence based
2 on an overall systematic review of the research in making
3 decisions about the care of individual patients.

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

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

10 "Final adverse determination" means an adverse
11 determination involving a covered benefit that has been upheld
12 by a health carrier, or its designee utilization review
13 organization, at the completion of the health carrier's
14 internal grievance process procedures as set forth by the
15 American Accreditation Health Care Commission.

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

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

25 "Health care services" means services for the diagnosis,
26 prevention, treatment, cure, or relief of a health condition,

1 illness, injury, or disease.

2 "Health carrier" means an entity subject to the insurance
3 laws and regulations of this State, or subject to the
4 jurisdiction of the Director, that contracts or offers to
5 contract to provide, deliver, arrange for, pay for, or
6 reimburse any of the costs of health care services, including a
7 sickness and accident insurance company, a health maintenance
8 organization, a nonprofit hospital and health service
9 corporation, or any other entity providing a plan of health
10 insurance, health benefits, or health care services. "Health
11 carrier" also means Limited Health Service Organizations
12 (LHSO) and Voluntary Health Service Plans.

13 "Health carrier" does not include a managed care plan as
14 defined in the Managed Care Reform and Patient Rights Act.

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

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

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

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

25 "Independent review organization" means an entity that
26 conducts independent external reviews of adverse

1 determinations and final adverse determinations.

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

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

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

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

21 (4) the following standard reference compendia:

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

24 (b) Drug Facts and Comparisons;

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

1 (d) The United States Pharmacopoeia-Drug
2 Information;

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

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

9 (b) the National Institutes of Health;

10 (c) the National Cancer Institute;

11 (d) the National Academy of Sciences;

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

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

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

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

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

24 "Retrospective review" means a review of medical necessity
25 conducted after services have been provided to a patient, but
26 does not include the review of a claim that is limited to an

1 evaluation of reimbursement levels, veracity of documentation,
2 accuracy of coding, or adjudication for payment.

3 "Utilization review" has the meaning provided by the
4 American Accreditation Health Care Commission.

5 "Utilization review organization" means a utilization
6 review program as defined by the American Accreditation Health
7 Care Commission.

8 Section 15. Applicability and scope.

9 (a) Except as provided in subsection (b) of this Section,
10 this Act shall apply to all health carriers.

11 (b) The provisions of this Act shall not apply to a policy
12 or certificate that provides coverage only for a specified
13 disease, specified accident or accident-only coverage, credit,
14 dental, disability income, hospital indemnity, long-term care
15 insurance as defined by Article XIXA of the Illinois Insurance
16 Code, vision care, or any other limited supplemental benefit; a
17 Medicare supplement policy of insurance as defined by the
18 Director by regulation; coverage under a plan through Medicare,
19 Medicaid, or the federal employees health benefits program; any
20 coverage issued under Chapter 55 of Title 10, U.S. Code and any
21 coverage issued as supplement to that coverage; any coverage
22 issued as supplemental to liability insurance, workers'
23 compensation, or similar insurance; automobile medical-payment
24 insurance or any insurance under which benefits are payable
25 with or without regard to fault, whether written on a group

1 blanket or individual basis; or any managed care plan as
2 defined in the Managed Care Reform and Patient Rights Act.

3 Section 20. Notice of right to external review.

4 (a) At the same time the health carrier sends written
5 notice of an adverse determination upon completion of the
6 health carrier's utilization review process as provided by the
7 American Accreditation Health Care Commission and a final
8 adverse determination, a health carrier shall notify a covered
9 person and a covered person's health care provider in writing
10 of the covered person's right to request an external review as
11 provided by this Act.

12 (1) The written notice required shall include the
13 following, or substantially equivalent, language: "We have
14 denied your request for the provision of or payment for a
15 health care service or course of treatment. You have the
16 right to have our decision reviewed by an independent
17 review organization not associated with us if our decision
18 involved making a judgment as to the medical necessity,
19 appropriateness, health care setting, level of care, or
20 effectiveness of the health care service or treatment you
21 requested by submitting a written request for an external
22 review to us. Upon receipt of your request an independent
23 review organization registered with the Department of
24 Financial and Professional Regulation, Division of
25 Insurance will be assigned to review our decision."

1 (2) The notice shall also include the appropriate
2 statements and information set forth in subsections (b) and
3 (c) of this Section.

4 (b) The health carrier shall include in the notice required
5 under subsection (a) of this Section for a notice related to an
6 adverse determination, a statement informing the covered
7 person that:

8 (1) if the covered person has a medical condition where
9 the timeframe for completion of an expedited internal
10 review of a grievance involving an adverse determination
11 would seriously jeopardize the life or health of the
12 covered person or would jeopardize the covered person's
13 ability to regain maximum function or if the adverse
14 determination involves a denial of coverage based on a
15 determination that the recommended or requested health
16 care service or treatment is experimental or
17 investigational and the covered person's treating
18 physician certifies in writing that the recommended or
19 requested health care service or treatment that is the
20 subject of the adverse determination would be
21 significantly less effective if not promptly initiated,
22 then the covered person or the covered person's authorized
23 representative may file a request for an expedited external
24 review at the same time the covered person or the covered
25 person's authorized representative files a request for an
26 expedited internal appeal involving an adverse

1 determination as set forth by the American Accreditation
2 Health Care Commission. The independent review
3 organization assigned to conduct the expedited external
4 review will determine whether the covered person shall be
5 required to complete the expedited review of the grievance
6 prior to conducting the expedited external review; and

7 (2) the covered person or the covered person's
8 authorized representative may file a grievance under the
9 health carrier's internal grievance process as set forth by
10 the American Accreditation Health Care Commission, but if
11 the health carrier has not issued a written decision to the
12 covered person or the covered person's authorized
13 representative within 30 days following the date the
14 covered person or the covered person's authorized
15 representative files the grievance with the health carrier
16 and the covered person or the covered person's authorized
17 representative has not requested or agreed to a delay, then
18 the covered person or the covered person's authorized
19 representative may file a request for external review and
20 shall be considered to have exhausted the health carrier's
21 internal grievance process.

22 (c) The health carrier shall include in the notice required
23 under subsection (a) of this Section for a notice related to a
24 final adverse determination, a statement informing the covered
25 person that:

26 (1) if the covered person has a medical condition where

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

7 (2) if a final adverse determination concerns:

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

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

24 (d) In addition to the information to be provided pursuant
25 to subsections (a), (b), and (c) of this Section, the health
26 carrier shall include a copy of the description of both the

1 required standard and expedited external review procedures.
2 The description shall highlight the external review procedures
3 that give the covered person or the covered person's authorized
4 representative the opportunity to submit additional
5 information, including any forms used to process an external
6 review.

7 Section 25. Request for external review. A covered person
8 or the covered person's authorized representative may make a
9 request for a standard external or expedited external review of
10 an adverse determination or final adverse determination.
11 Requests under this Section shall be made directly to the
12 health carrier that made the adverse or final adverse
13 determination. All requests for external review shall be in
14 writing except for requests for expedited external reviews
15 which may be made orally. Health carriers must provide covered
16 persons with forms to request external reviews.

17 Section 30. Exhaustion of internal grievance process.

18 (a) Except as provided in item (1) of subsection (b) of
19 Section 20 of this Act, a request for an external review shall
20 not be made until the covered person has exhausted the health
21 carrier's internal grievance process as set forth by the
22 American Accreditation Health Care Commission.

23 (b) A covered person shall be considered to have exhausted
24 the health carrier's internal grievance process for purposes of

1 this Section if the covered person or the covered person's
2 authorized representative filed a request for an internal
3 review of an adverse determination pursuant to the American
4 Accreditation Health Care Commission and has not received a
5 written decision on the request from the health carrier within
6 30 days after the request is filed, except to the extent the
7 covered person or the covered person's authorized
8 representative requested or agreed to a delay.

9 (c) Notwithstanding subsection (b) of this Section, a
10 covered person or the covered person's authorized
11 representative may not make a request for an external review of
12 an adverse determination involving a retrospective review
13 determination until the covered person has exhausted the health
14 carrier's internal grievance process.

15 (d) Upon request for an expedited external review pursuant
16 to item (1) of subsection (b) of Section 20 of this Act, the
17 independent review organization conducting the external review
18 shall determine whether the covered person shall be required to
19 complete the expedited review process set forth by the American
20 Accreditation Health Care Commission before it conducts the
21 expedited external review. Upon determination that the covered
22 person must first complete the expedited grievance review
23 process, the independent review organization immediately shall
24 notify the covered person and, if applicable, the covered
25 person's authorized representative of this determination and
26 that it will not proceed with the expedited external review

1 until completion of the expedited grievance review process and
2 that covered person's grievance at the completion of the
3 expedited grievance review process remains unresolved.

4 (e) A covered person need not exhaust a health carrier's
5 internal grievance procedures as set forth by the American
6 Accreditation Health Care Commission, if the health carrier
7 agrees to waive the exhaustion requirement.

8 Section 35. Standard external review.

9 (a) Within 4 months after the date of receipt of a notice
10 of an adverse determination or final adverse determination, a
11 covered person or the covered person's authorized
12 representative may file a request for an external review with
13 the health carrier.

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

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

21 (2) either of the following situations is applicable:

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

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

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

16 (3) the covered person's treating physician has
17 certified that one of the following situations is
18 applicable:

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

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

25 (C) there is no available standard health care
26 service or treatment covered by the health carrier that

1 is more beneficial than the recommended or requested
2 health care service or treatment described in item (4)
3 of this subsection (b);

4 (4) the covered person's treating physician:

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

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

21 (5) the covered person has exhausted the health
22 carrier's internal grievance process as set forth in
23 Section 30 of this Act; and

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

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

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

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

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

22 Notwithstanding a health carrier's initial determination
23 that the request is ineligible for external review, the
24 Director may determine that a request is eligible for external
25 review and require that it be referred for external review. In
26 making such determination, the Director's decision shall be in

1 accordance with the terms of the covered person's health
2 benefit plan and shall be subject to all applicable provisions
3 of this Act.

4 (d) Whenever a request is eligible for external review the
5 health carrier shall, within 5 business days:

6 (1) assign an independent review organization from the
7 list of approved independent review organizations compiled
8 and maintained by the Director; and

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

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

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

1 this Section shall be done on a random basis among those
2 approved independent review organizations qualified to conduct
3 external review except for instances of conflict of interest
4 concerns pursuant to this Act.

5 (f) Upon assignment of an independent review organization,
6 the health carrier or its designee utilization review
7 organization shall, within 5 business days, provide to the
8 assigned independent review organization the documents and any
9 information considered in making the adverse determination or
10 final adverse determination; in such cases, the following
11 provisions shall apply:

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

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

23 (3) Within one business day after making the decision
24 to terminate the external review and make a decision to
25 reverse the adverse determination or final adverse
26 determination under item (2) of this subsection (f), the

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

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

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

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

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

24 (3) The external review may only be terminated if the
25 health carrier decides, upon completion of its
26 reconsideration, to reverse its adverse determination or

1 final adverse determination and provide coverage or
2 payment for the health care service that is the subject of
3 the adverse determination or final adverse determination.
4 In such cases, the following provisions shall apply:

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

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

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

25 (1) for an adverse determination or final adverse
26 determination:

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

3 (B) the covered person's health care provider's
4 recommendation;

5 (C) consulting reports from appropriate health
6 care providers and other documents submitted by the
7 health carrier, the covered person, the covered
8 person's authorized representative, or the covered
9 person's treating provider;

10 (D) the terms of coverage under the covered
11 person's health benefit plan with the health carrier to
12 ensure that the independent review organization's
13 decision is not contrary to the terms of coverage under
14 the covered person's health benefit plan with the
15 health carrier;

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

22 (F) any applicable clinical review criteria
23 developed and used by the health carrier or its
24 designee utilization review organization; and

25 (G) the opinion of the independent review
26 organization's clinical reviewer or reviewers after

1 considering paragraphs (A) through (G) of this item (1)
2 of this subsection (i) to the extent the information or
3 documents are available and the clinical reviewer or
4 reviewers considers the information or documents
5 appropriate;

6 (2) for an adverse determination or final adverse
7 determination that involves a denial of coverage based on a
8 determination that the health care service or treatment
9 recommended or requested is experimental or
10 investigational:

11 (A) the covered person's pertinent medical
12 records;

13 (B) the covered person's health care provider's
14 recommendation;

15 (C) consulting reports from appropriate health
16 care providers and other documents submitted by the
17 health carrier, the covered person, the covered
18 person's authorized representative, or the covered
19 person's treating physician or health care
20 professional;

21 (D) the terms of coverage under the covered
22 person's health benefit plan with the health carrier to
23 ensure that, but for the health carrier's
24 determination that the recommended or requested health
25 care service or treatment that is the subject of the
26 opinion is experimental or investigational, the

1 independent review organization's opinion is not
2 contrary to the terms of coverage under the covered
3 person's health benefit plan with the health carrier;
4 and

5 (E) whether and to what extent:

6 (i) the recommended or requested health care
7 service or treatment has been approved by the
8 federal Food and Drug Administration, if
9 applicable, for the condition; or

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

21 (3) except for an expedited external review, for an
22 adverse determination or final adverse determination that
23 involves a denial of coverage based on a determination that
24 the health care service or treatment recommended or
25 requested is experimental or investigational, each
26 clinical reviewer selected by the independent review

1 organization shall provide its opinion to the independent
2 review organization in writing and include the following
3 information:

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

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

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

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

21 (E) information on whether the reviewer's
22 rationale for the opinion is based on paragraphs (i) or
23 (ii) of subitem (E) of item (2) of this subsection (i).

24 (j) Within 5 days after the date of receipt of all
25 necessary information, the assigned independent review
26 organization shall provide written notice of its decision to

1 uphold or reverse the adverse determination or the final
2 adverse determination to the health carrier, the covered person
3 and, if applicable, the covered person's authorized
4 representative. In reaching a decision, the assigned
5 independent review organization is not bound by any decisions
6 or conclusions reached during the health carrier's utilization
7 review process as set forth by the American Accreditation
8 Health Care Commission. In such cases, the following provisions
9 shall apply:

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

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

14 (B) the date the independent review organization
15 received the assignment from the health carrier to
16 conduct the external review;

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

19 (D) references to the evidence or documentation,
20 including the evidence-based standards, considered in
21 reaching its decision.

22 (E) the date of its decision; and

23 (F) the principal reason or reasons for its
24 decision, including what applicable, if any,
25 evidence-based standards that were a basis for its
26 decision.

1 (2) For reviews of experimental or investigational
2 treatments, the notice shall include the following
3 information:

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

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

11 (C) the date that the independent review
12 organization received assignment from the health
13 carrier to conduct the external review;

14 (D) the time period during which the external
15 review was conducted; and

16 (E) the principal reason or reasons for its
17 decision.

18 (3) Upon receipt of a notice of a decision reversing
19 the adverse determination or final adverse determination,
20 the health carrier immediately shall approve the coverage
21 that was the subject of the adverse determination or final
22 adverse determination.

23 Section 40. Expedited external review.

24 (a) A covered person or a covered person's authorized
25 representative may file a request for an expedited external

1 review with the health carrier either orally or in writing at
2 the time the covered person receives:

3 (1) an adverse determination, if:

4 (A) the adverse determination involves a medical
5 condition of the covered person for which the timeframe
6 for completion of an expedited internal review of a
7 grievance involving an adverse determination as set
8 forth by the American Accreditation Health Care
9 Commission would seriously jeopardize the life or
10 health of the covered person or would jeopardize the
11 covered person's ability to regain maximum function;
12 and

13 (B) the covered person or the covered person's
14 authorized representative has filed a request for an
15 expedited review of a grievance involving an adverse
16 determination as set forth by the American
17 Accreditation Health Care Commission; or

18 (2) a final adverse determination, if:

19 (A) the covered person has a medical condition
20 where the timeframe for completion of a standard
21 external review would seriously jeopardize the life or
22 health of the covered person or would jeopardize the
23 covered person's ability to regain maximum function;
24 or

25 (B) the final adverse determination concerns an
26 admission, availability of care, continued stay, or

1 health care service for which the covered person
2 received emergency services but has not been
3 discharged from a facility.

4 (b) Upon receipt of a request for an expedited external
5 review as provided in Section 20 of this Act, the health
6 carrier shall determine whether the request meets the
7 reviewability requirements set forth in subsection (b) of
8 Section 35 of this Act. The health carrier shall immediately
9 notify the covered person and, if applicable, the covered
10 person's authorized representative of its eligibility
11 determination. The notice of initial determination shall
12 include a statement informing the covered person and, if
13 applicable, the covered person's authorized representative
14 that a health carrier's initial determination that an external
15 review request is ineligible for review may be appealed to the
16 Director.

17 (c) The Director may determine that a request is eligible
18 for external review under subsection (b) of Section 35 of this
19 Act, notwithstanding a health carrier's initial determination
20 that the request is ineligible and require that it be referred
21 for external review. In making a determination, the Director's
22 decision shall be made in accordance with the terms of the
23 covered person's health benefit plan and shall be subject to
24 all applicable provisions of this Act.

25 (d) Whenever a request is eligible for external review, the
26 health carrier shall immediately assign an independent review

1 organization from the list of approved independent review
2 organizations compiled and maintained by the Director to
3 conduct the expedited review. In such cases, the following
4 provisions shall apply:

5 (1) The assignment by the health carrier of an approved
6 independent review organization to conduct an external
7 review in accordance with this Section shall be done on a
8 random basis among those approved independent review
9 organizations except as may be prohibited by conflict of
10 interest concerns pursuant to Section 60 of this Act.

11 (2) Immediately upon assigning an independent review
12 organization to perform an expedited external review, but
13 in no case less than 24 hours after assigning the
14 independent review organization, the health carrier or its
15 designee utilization review organization shall provide or
16 transmit all necessary documents and information
17 considered in making the final adverse determination to the
18 assigned independent review organization electronically or
19 by telephone or facsimile or any other available
20 expeditious method.

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

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

9 (e) 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 shall consider the following
14 in reaching a decision:

15 (1) for an adverse determination or final adverse
16 determination, the provisions included in subitems (A)
17 through (G) of item (1) of subsection (i) of Section 35 of
18 this Act; or

19 (2) for an adverse determination or final adverse
20 determination that involves a denial of coverage based on a
21 determination that the health care service or treatment
22 recommended or requested is experimental or
23 investigational, the provisions included in subitems (A)
24 through (E) of item (2) of subsection (i) of Section 35 of
25 this Act.

26 (f) As expeditiously as the covered person's medical

1 condition or circumstances requires, but in no event more than
2 72 hours after the receipt of all pertinent information, the
3 assigned independent review organization shall:

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

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

10 (g) In reaching a decision, the assigned independent review
11 organization is not bound by any decisions or conclusions
12 reached during the health carrier's utilization review process
13 or the health carrier's internal grievance process as set forth
14 by the American Accreditation Health Care Commission.

15 (h) Upon receipt of notice of a decision reversing the
16 final adverse determination, the health carrier shall
17 immediately approve the coverage that was the subject of the
18 final adverse determination. Within 48 hours after the date of
19 providing the notice required in this subsection (h), the
20 assigned independent review organization shall provide written
21 confirmation of the decision to the health carrier, the covered
22 person, and if applicable, the covered person's authorized
23 representative including the information set forth in
24 subsection (j) of Section 35 of this Act as applicable.

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

1 Section 45. Binding nature of external review decision. An
2 external review decision is binding on the health carrier. An
3 external review decision is binding on the covered person
4 except to the extent the covered person has other remedies
5 available under applicable federal or State law. A covered
6 person or the covered person's authorized representative may
7 not file a subsequent request for external review involving the
8 same adverse determination or final adverse determination for
9 which the covered person has already received an external
10 review decision pursuant to this Act.

11 Section 50. Approval of independent review organizations.

12 (a) The Director shall approve independent review
13 organizations eligible to be assigned to conduct external
14 reviews under this Act.

15 (b) In order to be eligible for approval by the Director
16 under this Section to conduct external reviews under this Act
17 an independent review organization:

18 (1) except as otherwise provided in this Section, shall
19 be accredited by a nationally recognized private
20 accrediting entity that the Director has determined has
21 independent review organization accreditation standards
22 that are equivalent to or exceed the minimum qualifications
23 for independent review; and

24 (2) shall submit an application for approval in

1 accordance with subsection (d) of this Section.

2 (c) The Director shall develop an application form for
3 initially approving and for reapproving independent review
4 organizations to conduct external reviews.

5 (d) Any independent review organization wishing to be
6 approved to conduct external reviews under this Act shall
7 submit the application form and include with the form all
8 documentation and information necessary for the Director to
9 determine if the independent review organization satisfies the
10 minimum qualifications established under this Act. The
11 Director may:

12 (1) approve independent review organizations that are
13 not accredited by a nationally recognized private
14 accrediting entity if there are no acceptable nationally
15 recognized private accrediting entities providing
16 independent review organization accreditation; and

17 (2) by rule establish an application fee that
18 independent review organizations shall submit to the
19 Director with an application for approval and renewing.

20 (e) An approval is effective for 2 years, unless the
21 Director determines before its expiration that the independent
22 review organization is not satisfying the minimum
23 qualifications established under this Act.

24 (f) Whenever the Director determines that an independent
25 review organization has lost its accreditation or no longer
26 satisfies the minimum requirements established under this Act,

1 the Director shall terminate the approval of the independent
2 review organization and remove the independent review
3 organization from the list of independent review organizations
4 approved to conduct external reviews under this Act that is
5 maintained by the Director.

6 (g) The Director shall maintain and periodically update a
7 list of approved independent review organizations.

8 (h) The Director may promulgate regulations to carry out
9 the provisions of this Section.

10 Section 55. Minimum qualifications for independent review
11 organizations.

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

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

19 (A) external reviews are conducted within the
20 specified time frames and required notices are
21 provided in a timely manner;

22 (B) selection of qualified and impartial clinical
23 reviewers to conduct external reviews on behalf of the
24 independent review organization and suitable matching
25 of reviewers to specific cases and that the independent

1 review organization employs or contracts with an
2 adequate number of clinical reviewers to meet this
3 objective;

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

9 (D) confidentiality of medical and treatment
10 records and clinical review criteria; and

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

14 (2) a toll-free telephone service operating on a
15 24-hour-day, 7-day-a-week basis that accepts, receives,
16 and records information related to external reviews and
17 provides appropriate instructions; and

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

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

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

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

5 (3) hold a non-restricted license in a state of the
6 United States and, for physicians, a current certification
7 by a recognized American medical specialty board in the
8 area or areas appropriate to the subject of the external
9 review;

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

17 (5) for purposes of conducting an external review of
18 experimental or investigational treatment adverse
19 determinations, through clinical experience in the past 3
20 years, be an expert in the treatment of the covered
21 person's condition and knowledgeable about the recommended
22 or requested health care service or treatment; neither the
23 covered person, the covered person's authorized
24 representative, if applicable, nor the health carrier
25 shall choose or control the choice of the physicians or
26 other health care professionals selected to conduct the

1 external review.

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

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

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

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

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

25 (4) the health care provider, the health care
26 provider's medical group or independent practice

1 association recommending the health care service or
2 treatment that is the subject of the external review;

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

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

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

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

20 Section 60. Hold harmless for independent review
21 organizations. No independent review organization or clinical
22 reviewer working on behalf of an independent review
23 organization or an employee, agent or contractor of an
24 independent review organization shall be liable for damages to
25 any person for any opinions rendered or acts or omissions

1 performed within the scope of the organization's or person's
2 duties under the law during or upon completion of an external
3 review conducted pursuant to this Act, unless the opinion was
4 rendered or act or omission performed in bad faith or involved
5 gross negligence.

6 Section 65. External review reporting requirements.

7 (a) Each health carrier shall maintain written records in
8 the aggregate on all requests for external review for each
9 calendar year and submit a report to the Director in the format
10 specified by the Director by March 1 of each year.

11 (b) The report shall include in the aggregate:

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

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

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

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

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

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

25 (C) the number of requests for expedited external

1 review resolved upholding the adverse determination or
2 final adverse determination; and

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

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

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

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

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

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

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

26 (D) claims and utilization review (dissatisfaction

1 regarding the concurrent or retrospective evaluation
2 of the coverage, medical necessity, efficiency or
3 appropriateness of health care services or treatment
4 plans; prospective "Denials of care or treatment,"
5 "Denials of diagnostic procedures" and "Denials of
6 referral requests" should not be classified in this
7 category, but the appropriate one above);

8 (8) the number of external reviews that were terminated
9 as the result of a reconsideration by the health carrier of
10 its adverse determination or final adverse determination
11 after the receipt of additional information from the
12 covered person or the covered person's authorized
13 representative; and

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

16 Section 70. Funding of external review. The health carrier
17 shall be solely responsible for paying the cost of external
18 reviews conducted by independent review organizations.

19 Section 75. Disclosure requirements.

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

24 (b) The description required under subsection (a) of this

1 Section shall include a statement that informs the covered
2 person of the right of the covered person to file a request for
3 an external review of an adverse determination or final adverse
4 determination with the health carrier. The statement shall
5 explain that external review is available when the adverse
6 determination or final adverse determination involves an issue
7 of medical necessity, appropriateness, health care setting,
8 level of care, or effectiveness. The statement shall include
9 the toll-free telephone number and address of the Office of
10 Consumer Health Insurance within the Division of Insurance.

11 Section 97. Severability. The provisions of this Act are
12 severable under Section 1.31 of the Statute on Statutes.

13 Section 99. Effective date. This Act takes effect January
14 1, 2010.".