1 AN ACT concerning health care utilization review.

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

4 Section 5. The Managed Care Reform and Patient Rights
5 Act is amended by changing Section 85 as follows:

6 (215 ILCS 134/85)
7 Sec. 85. Utilization review program registration.
8 (a) No person may conduct a utilization review program
9 in this State unless once every 2 years the person registers
10 the utilization review program with the Department and
11 certifies compliance with the Health Utilization Management
12 Standards of the American Accreditation Healthcare Commission
13 (URAC) sufficient to achieve American Accreditation
14 Healthcare Commission (URAC) accreditation or submits
15 evidence of accreditation by the American Accreditation
16 Healthcare Commission (URAC) for its Health Utilization
17 Management Standards. Nothing in this Act shall be construed
18 to require a health care plan or its subcontractors to become
19 American Accreditation Healthcare Commission (URAC)
20 accredited.
21 (b) In addition, the Director of the Department, in
22 consultation with the Director of the Department of Public
23 Health, may certify alternative utilization review standards
24 of national accreditation organizations or entities in order
25 for plans to comply with this Section. Any alternative
26 utilization review standards shall meet or exceed those
27 standards required under subsection (a).
28 (c) The provisions of this Section do not apply to:
29 (1) persons providing utilization review program
30 services only to the federal government;
31 (2) self-insured health plans under the federal

1 Employee Retirement Income Security Act of 1974, however,
2 this Section does apply to persons conducting a
3 utilization review program on behalf of these health
4 plans;
5 (3) hospitals and medical groups performing
6 utilization review activities for internal purposes
7 unless the utilization review program is conducted for
8 another person.
9 Nothing in this Act prohibits a health care plan or other
10 entity from contractually requiring an entity designated in
11 item (3) of this subsection to adhere to the utilization
12 review program requirements of this Act.
13 (d) This registration shall include submission of all of
14 the following information regarding utilization review
15 program activities:
16 (1) The name, address, and telephone number of the
17 utilization review programs.
18 (2) The organization and governing structure of the
19 utilization review programs.
20 (3) The number of lives for which utilization
21 review is conducted by each utilization review program.
22 (4) Hours of operation of each utilization review
23 program.
24 (5) Description of the grievance process for each
25 utilization review program.
26 (6) Number of covered lives for which utilization
27 review was conducted for the previous calendar year for
28 each utilization review program.
29 (7) Written policies and procedures for protecting
30 confidential information according to applicable State
31 and federal laws for each utilization review program.
32 (e) (1) A utilization review program shall have written
33 procedures for assuring that patient-specific information
34 obtained during the process of utilization review will be:

1 (A) kept confidential in accordance with applicable
2 State and federal laws; and
3 (B) shared only with the enrollee, the enrollee's
4 designee, the enrollee's health care provider, and those
5 who are authorized by law to receive the information.
6 Summary data shall not be considered confidential if it
7 does not provide information to allow identification of
8 individual patients or health care providers.
9 (2) Only a health care professional licensed in
10 this State may make determinations regarding the medical
11 necessity of health care services during the course of
12 utilization review.
13 (3) When making retrospective reviews, utilization
14 review programs shall base reviews solely on the medical
15 information available to the attending physician or
16 ordering provider at the time the health care services
17 were provided.
18 (4) When making prospective, concurrent, and
19 retrospective determinations, utilization review programs
20 shall collect only information that is necessary to make
21 the determination and shall not routinely require health
22 care providers to numerically code diagnoses or
23 procedures to be considered for certification, unless
24 required under State or federal Medicare or Medicaid
25 rules or regulations, but may request such code if
26 available, or routinely request copies of medical records
27 of all enrollees reviewed. During prospective or
28 concurrent review, copies of medical records shall only
29 be required when necessary to verify that the health care
30 services subject to review are medically necessary. In
31 these cases, only the necessary or relevant sections of
32 the medical record shall be required.
33 (f) If the Department finds that a utilization review
34 program is not in compliance with this Section, the

1 Department shall issue a corrective action plan and allow a
2 reasonable amount of time for compliance with the plan. If
3 the utilization review program does not come into compliance,
4 the Department may issue a cease and desist order. Before
5 issuing a cease and desist order under this Section, the
6 Department shall provide the utilization review program with
7 a written notice of the reasons for the order and allow a
8 reasonable amount of time to supply additional information
9 demonstrating compliance with requirements of this Section
10 and to request a hearing. The hearing notice shall be sent
11 by certified mail, return receipt requested, and the hearing
12 shall be conducted in accordance with the Illinois
13 Administrative Procedure Act.

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

17 (h) Any adverse determination made by a health care plan
18 or its subcontractors may be appealed in accordance with
19 subsection (f) of Section 45.

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

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

26 Section 99. Effective date. This Act takes effect upon
27 becoming law.