



## 97TH GENERAL ASSEMBLY

### State of Illinois

2011 and 2012

HB0224

Introduced 01/21/11, by Rep. Mary E. Flowers

#### SYNOPSIS AS INTRODUCED:

215 ILCS 180/35

Amends the Health Carrier External Review Act in the provision concerning standard external review. Provides that whenever a request is eligible for external review (1) the health carrier shall, within 2 (instead of 5) business days, request the Director of Insurance to assign an independent review organization (now, from the list of approved independent review organizations compiled and maintained by the Director) and (2) within 3 business days after receiving the health carrier's request, the Director shall assign, on a rotating basis, an independent review organization from the list of approved independent review organizations compiled and maintained by the Director. Includes the health carrier among those to be notified in writing by the Director of the request's eligibility and acceptance for external review. Effective immediately.

LRB097 05693 RPM 45756 b

1 AN ACT concerning insurance.

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

4 Section 5. The Health Carrier External Review Act is  
5 amended by changing Section 35 as follows:

6 (215 ILCS 180/35)

7 Sec. 35. Standard external review.

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

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

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

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

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

5 (3) the covered person has exhausted the health  
6 carrier's internal grievance process as set forth in this  
7 Act;

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

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

26 (B) standard health care services or treatments

1 are not medically appropriate for the covered person;

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

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

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

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

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

23 (1) is not complete, the health carrier shall inform  
24 the covered person and, if applicable, the covered person's  
25 authorized representative in writing and include in the  
26 notice what information or materials are required by this

1 Act to make the request complete; or

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

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

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

21 (d) Whenever a request is eligible for external review:

22 (1) the health carrier shall, within 2 5 business days,  
23 request the Director to ~~:(1) assign an independent review~~  
24 ~~organization from the list of approved independent review~~  
25 ~~organizations compiled and maintained by the Director; and~~

26 (2) within 3 business days after receiving the health

1       carrier's request, the Director shall assign, on a rotating  
2       basis, an independent review organization from the list of  
3       approved independent review organizations compiled and  
4       maintained by the Director and notify in writing the health  
5       carrier, covered person, and, if applicable, the covered  
6       person's authorized representative of the request's  
7       eligibility and acceptance for external review and the name  
8       of the independent review organization.

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

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

26      (f) Upon assignment of an independent review organization,

1 the health carrier or its designee utilization review  
2 organization shall, within 5 business days, provide to the  
3 assigned independent review organization the documents and any  
4 information considered in making the adverse determination or  
5 final adverse determination; in such cases, the following  
6 provisions shall apply:

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

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

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

26 (g) Upon receipt of the information from the health carrier

1 or its utilization review organization, the assigned  
2 independent review organization shall review all of the  
3 information and documents and any other information submitted  
4 in writing to the independent review organization by the  
5 covered person and the covered person's authorized  
6 representative.

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

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

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

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

26 (A) Within one business day after making the



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

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

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

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

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

23 (3) consulting reports from appropriate health care  
24 providers and other documents submitted by the health  
25 carrier, the covered person, the covered person's  
26 authorized representative, or the covered person's

1 treating provider;

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

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

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

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

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

25 (A) the recommended or requested health care  
26 service or treatment has been approved by the federal

1 Food and Drug Administration, if applicable, for the  
2 condition;

3 (B) medical or scientific evidence or  
4 evidence-based standards demonstrate that the expected  
5 benefits of the recommended or requested health care  
6 service or treatment is more likely than not to be  
7 beneficial to the covered person than any available  
8 standard health care service or treatment and the  
9 adverse risks of the recommended or requested health  
10 care service or treatment would not be substantially  
11 increased over those of available standard health care  
12 services or treatments; or

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

20 (j) Within 5 days after the date of receipt of all  
21 necessary information, the assigned independent review  
22 organization shall provide written notice of its decision to  
23 uphold or reverse the adverse determination or the final  
24 adverse determination to the health carrier, the covered person  
25 and, if applicable, the covered person's authorized  
26 representative. In reaching a decision, the assigned

1 independent review organization is not bound by any claim  
2 determinations reached prior to the submission of information  
3 to the independent review organization. In such cases, the  
4 following provisions shall apply:

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

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

9 (B) the date the independent review organization  
10 received the assignment from the health carrier to  
11 conduct the external review;

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

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

17 (E) the date of its decision; and

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

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

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

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

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

14 (D) a description and analysis of any  
15 evidence-based standards;

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

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

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

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

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

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

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

20 Section 99. Effective date. This Act takes effect upon  
21 becoming law.