

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 Sections 10, 20, 25, 30, 35, 40, 55, 65,
6 and 75 and by adding Sections 42 and 80 as follows:

7 (215 ILCS 180/10)

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

9 "Adverse determination" means:

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

21 (2) the denial, reduction, or termination of or failure
22 to provide or make payment, in whole or in part, for a
23 benefit based on a determination by a health carrier or its

1 designee utilization review organization that a
2 preexisting condition was present before the effective
3 date of coverage; or

4 (3) a recission of coverage determination, which does
5 not include a cancellation or discontinuance of coverage
6 that is attributable to a failure to timely pay required
7 premiums or contributions towards the cost of coverage.

8 ~~means a determination by a health carrier or its designee~~
9 ~~utilization review organization that an admission,~~
10 ~~availability of care, continued stay, or other health care~~
11 ~~service that is a covered benefit has been reviewed and,~~
12 ~~based upon the information provided, does not meet the~~
13 ~~health carrier's requirements for medical necessity,~~
14 ~~appropriateness, health care setting, level of care, or~~
15 ~~effectiveness, and the requested service or payment for the~~
16 ~~service is therefore denied, reduced, or terminated.~~

17 "Authorized representative" means:

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

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

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

26 (4) a health care provider when the covered person's

1 health benefit plan requires that a request for a benefit
2 under the plan be initiated by the health care provider; or

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

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

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

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

14 "Best evidence" means evidence based on:

15 (1) randomized clinical trials;

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

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

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

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

24 "Clinical review criteria" means the written screening
25 procedures, decision abstracts, clinical protocols, and
26 practice guidelines used by a health carrier to determine the

1 necessity and appropriateness of health care services.

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

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

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

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

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

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

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

26 (2) serious impairment to bodily functions; or

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

2 "Emergency services" means health care items and services
3 furnished or required to evaluate and treat an emergency
4 medical condition.

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

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

13 "Facility" means an institution providing health care
14 services or a health care setting.

15 "Final adverse determination" means an adverse
16 determination involving a covered benefit that has been upheld
17 by a health carrier, or its designee utilization review
18 organization, at the completion of the health carrier's
19 internal grievance process procedures as set forth by the
20 Managed Care Reform and Patient Rights Act.

21 "Health benefit plan" means a policy, contract,
22 certificate, plan, or agreement offered or issued by a health
23 carrier to provide, deliver, arrange for, pay for, or reimburse
24 any of the costs of health care services.

25 "Health care provider" or "provider" means a physician,
26 hospital facility, or other health care practitioner licensed,

1 accredited, or certified to perform specified health care
2 services consistent with State law, responsible for
3 recommending health care services on behalf of a covered
4 person.

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

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

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

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

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

26 (3) payment for the provision of health care services

1 to an individual.

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

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

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

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

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

24 (4) the following standard reference compendia:

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

- 1 (b) Drug Facts and Comparisons;
- 2 (c) The American Dental Association Accepted
3 Dental Therapeutics; and
- 4 (d) The United States Pharmacopoeia-Drug
5 Information;
- 6 (5) findings, studies, or research conducted by or
7 under the auspices of federal government agencies and
8 nationally recognized federal research institutes,
9 including:
- 10 (a) the federal Agency for Healthcare Research and
11 Quality;
- 12 (b) the National Institutes of Health;
- 13 (c) the National Cancer Institute;
- 14 (d) the National Academy of Sciences;
- 15 (e) the Centers for Medicare & Medicaid Services;
- 16 (f) the federal Food and Drug Administration; and
- 17 (g) any national board recognized by the National
18 Institutes of Health for the purpose of evaluating the
19 medical value of health care services; or
- 20 (6) any other medical or scientific evidence that is
21 comparable to the sources listed in items (1) through (5).
- 22 "Person" means an individual, a corporation, a
23 partnership, an association, a joint venture, a joint stock
24 company, a trust, an unincorporated organization, any similar
25 entity, or any combination of the foregoing.
- 26 "Prospective review" means a review conducted prior to an

1 admission or the provision of a health care service or a course
2 of treatment in accordance with a health carrier's requirement
3 that the health care service or course of treatment, in whole
4 or in part, be approved prior to its provision.

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

10 "Randomized clinical trial" means a controlled prospective
11 study of patients that have been randomized into an
12 experimental group and a control group at the beginning of the
13 study with only the experimental group of patients receiving a
14 specific intervention, which includes study of the groups for
15 variables and anticipated outcomes over time.

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

18 "Retrospective review" does not include the review of a claim
19 that is limited to veracity of documentation or accuracy of
20 coding. ~~means a review of medical necessity conducted after~~
21 ~~services have been provided to a patient, but does not include~~
22 ~~the review of a claim that is limited to an evaluation of~~
23 ~~reimbursement levels, veracity of documentation, accuracy of~~
24 ~~coding, or adjudication for payment.~~

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

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

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

5 (215 ILCS 180/20)

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

7 (a) At the same time the health carrier sends written
8 notice of a covered person's right to appeal a coverage
9 decision upon an adverse determination or a final adverse
10 determination ~~as provided by the Managed Care Reform and~~
11 ~~Patient Rights Act,~~ a health carrier shall notify a covered
12 person, the covered person's authorized representative, if
13 any, and a covered person's health care provider in writing of
14 the covered person's right to request an external review as
15 provided by this Act. The written notice required shall include
16 the following, or substantially equivalent, language: "We have
17 denied your request for the provision of or payment for a
18 health care service or course of treatment. You have the right
19 to have our decision reviewed by an independent review
20 organization not associated with us ~~if our decision involved~~
21 ~~making a judgment as to the medical necessity, appropriateness,~~
22 ~~health care setting, level of care, or effectiveness of the~~
23 ~~health care service or treatment you requested~~ by submitting a
24 written request for an external review to the Department of
25 Insurance, Office of Consumer Health Information, 320 West

1 Washington Street, 4th Floor, Springfield, Illinois, 62767."
2 ~~us. Upon receipt of your request an independent review~~
3 ~~organization registered with the Department of Insurance will~~
4 ~~be assigned to review our decision.~~

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

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

13 (1) If the covered person has a medical condition where
14 the timeframe for completion of (A) an expedited internal
15 review of an appeal ~~a grievance~~ involving an adverse
16 determination, (B) a final adverse determination ~~as set~~
17 ~~forth in the Managed Care Reform and Patient Rights Act,~~ or
18 (C) a standard external review as established in this Act,
19 would seriously jeopardize the life or health of the
20 covered person or would jeopardize the covered person's
21 ability to regain maximum function, then the covered person
22 or the covered person's authorized representative may file
23 a request for an expedited external review.

24 (2) The covered person or the covered person's
25 authorized representative may file an appeal under the
26 health carrier's internal appeal process, but if the health

1 carrier has not issued a written decision to the covered
2 person or the covered person's authorized representative
3 30 days following the date the covered person or the
4 covered person's authorized representative files an appeal
5 of an adverse determination that involves a concurrent or
6 prospective review request or 60 days following the date
7 the covered person or the covered person's authorized
8 representative files an appeal of an adverse determination
9 that involves a retrospective review request with the
10 health carrier and the covered person or the covered
11 person's authorized representative has not requested or
12 agreed to a delay, then the covered person or the covered
13 person's authorized representative may file a request for
14 external review and shall be considered to have exhausted
15 the health carrier's internal appeal process for purposes
16 of this Act. ~~The covered person or the covered person's~~
17 ~~authorized representative may file a request for an~~
18 ~~expedited external review at the same time the covered~~
19 ~~person or the covered person's authorized representative~~
20 ~~files a request for an expedited internal appeal involving~~
21 ~~an adverse determination as set forth in the Managed Care~~
22 ~~Reform and Patient Rights Act if the adverse determination~~
23 ~~involves a denial of coverage based on a determination that~~
24 ~~the recommended or requested health care service or~~
25 ~~treatment is experimental or investigational and the~~
26 ~~covered person's health care provider certifies in writing~~

1 ~~that the recommended or requested health care service or~~
2 ~~treatment that is the subject of the adverse determination~~
3 ~~would be significantly less effective if not promptly~~
4 ~~initiated. The independent review organization assigned to~~
5 ~~conduct the expedited external review will determine~~
6 ~~whether the covered person shall be required to complete~~
7 ~~the expedited review of the grievance prior to conducting~~
8 ~~the expedited external review.~~

9 (3) If the covered person or the covered person's
10 authorized representative filed a request for an expedited
11 internal review of an adverse determination and has not
12 received a decision on such request from the health carrier
13 within 48 hours, except to the extent the covered person or
14 the covered person's authorized representative requested
15 or agreed to a delay, then the covered person or the
16 covered person's authorized representative may file a
17 request for external review and shall be considered to have
18 exhausted the health carrier's internal appeal process for
19 the purposes of this Act.

20 (4) ~~(3)~~ If an adverse determination concerns a denial
21 of coverage based on a determination that the recommended
22 or requested health care service or treatment is
23 experimental or investigational and the covered person's
24 health care provider certifies in writing that the
25 recommended or requested health care service or treatment
26 that is the subject of the request would be significantly

1 less effective if not promptly initiated, then the covered
2 person or the covered person's authorized representative
3 may request an expedited external review at the same time
4 the covered person or the covered person's authorized
5 representative files a request for an expedited internal
6 appeal involving an adverse determination. The independent
7 review organization assigned to conduct the expedited
8 external review shall determine whether the covered person
9 is required to complete the expedited review of the appeal
10 prior to conducting the expedited external review.

11 (c) ~~This subsection (c) shall apply to an expedited review~~
12 ~~upon final adverse determination.~~ In addition to the notice
13 required in subsection (a), ~~for the health carrier shall~~
14 ~~include~~ a notice related to a final adverse determination, the
15 health carrier shall include a statement informing the covered
16 person of all of the following:

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

24 (2) if a final adverse determination concerns an
25 admission, availability of care, continued stay, or health
26 care service for which the covered person received

1 emergency services, but has not been discharged from a
2 facility, then the covered person, or the covered person's
3 authorized representative, may request an expedited
4 external review; or

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

15 (d) In addition to the information to be provided pursuant
16 to subsections (a), (b), and (c) of this Section, the health
17 carrier shall include a copy of the description of both the
18 required standard and expedited external review procedures.
19 The description shall highlight the external review procedures
20 that give the covered person or the covered person's authorized
21 representative the opportunity to submit additional
22 information, including any forms used to process an external
23 review.

24 (e) As part of any forms provided under subsection (d) of
25 this Section, the health carrier shall include an authorization
26 form, or other document approved by the Director, by which the

1 covered person, for purposes of conducting an external review
2 under this Act, authorizes the health carrier and the covered
3 person's treating health care provider to disclose protected
4 health information, including medical records, concerning the
5 covered person that is pertinent to the external review, as
6 provided in the Illinois Insurance Code.

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

8 (215 ILCS 180/25)

9 Sec. 25. Request for external review. A covered person or
10 the covered person's authorized representative may make a
11 request for a standard external or expedited external review of
12 an adverse determination or final adverse determination.
13 Except as set forth in Sections 40 and 42 of this Act, all
14 requests for external review ~~Requests under this Section~~ shall
15 be made in writing to the Director ~~directly to the health~~
16 ~~carrier that made the adverse or final adverse determination.~~
17 ~~All requests for external review shall be in writing except for~~
18 ~~requests for expedited external reviews which may be made~~
19 ~~orally.~~ Health carriers must provide covered persons with forms
20 to request external reviews.

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

22 (215 ILCS 180/30)

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

24 (a) Except as provided in subsection (b) of this Section

1 ~~20~~, a request for an external review shall not be made until
2 the covered person has exhausted the health carrier's internal
3 appeal grievance process ~~as set forth in the Managed Care~~
4 ~~Reform and Patient Rights Act.~~

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

8 (1) the covered person or the covered person's
9 authorized representative has filed an appeal under the
10 health carrier's internal appeal process ~~a request for an~~
11 ~~internal review of an adverse determination pursuant to the~~
12 ~~Managed Care Reform and Patient Rights Act~~ and has not
13 received a written decision on the appeal 30 days following
14 the date the covered person or the covered person's
15 authorized representative files an appeal of an adverse
16 determination that involves a concurrent or prospective
17 review request or 60 days following the date the covered
18 person or the covered person's authorized representative
19 files an appeal of an adverse determination that involves a
20 retrospective review request ~~request from the health~~
21 ~~carrier within 15 days after receipt of the required~~
22 ~~information but not more than 30 days after the request was~~
23 ~~filed by the covered person or the covered person's~~
24 ~~authorized representative,~~ except to the extent the
25 covered person or the covered person's authorized
26 representative requested or agreed to a delay; ~~however, a~~

1 ~~covered person or the covered person's authorized~~
2 ~~representative may not make a request for an external~~
3 ~~review of an adverse determination involving a~~
4 ~~retrospective review determination until the covered~~
5 ~~person has exhausted the health carrier's internal~~
6 ~~grievance process;~~

7 (2) the covered person or the covered person's
8 authorized representative filed a request for an expedited
9 internal review of an adverse determination ~~pursuant to the~~
10 ~~Managed Care Reform and Patient Rights Act~~ and has not
11 received a decision on such request from the health carrier
12 within 48 hours, except to the extent the covered person or
13 the covered person's authorized representative requested
14 or agreed to a delay; ~~or~~

15 (3) the health carrier agrees to waive the exhaustion
16 requirement; ~~or~~

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

25 (5) an adverse determination concerns a denial of
26 coverage based on a determination that the recommended or

1 requested health care service or treatment is experimental
2 or investigational and the covered person's health care
3 provider certifies in writing that the recommended or
4 requested health care service or treatment that is the
5 subject of the request would be significantly less
6 effective if not promptly initiated; in such cases, the
7 covered person or the covered person's authorized
8 representative may request an expedited external review at
9 the same time the covered person or the covered person's
10 authorized representative files a request for an expedited
11 internal appeal involving an adverse determination; the
12 independent review organization assigned to conduct the
13 expedited external review shall determine whether the
14 covered person is required to complete the expedited review
15 of the appeal prior to conducting the expedited external
16 review; or

17 (6) the health carrier has failed to comply with
18 applicable State and federal law governing internal claims
19 and appeals procedures.

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

21 (215 ILCS 180/35)

22 Sec. 35. Standard external review.

23 (a) Within 4 months after the date of receipt of a notice
24 of an adverse determination or final adverse determination, a
25 covered person or the covered person's authorized

1 representative may file a request for an external review with
2 the Director. Within one business day after the date of receipt
3 of a request for external review, the Director shall send a
4 copy of the request to the health carrier.

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

8 (1) the individual is or was a covered person in the
9 health benefit plan at the time the health care service was
10 requested or at the time the health care service was
11 provided;

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

20 (3) the covered person has exhausted the health
21 carrier's internal appeal ~~grievance~~ process unless the
22 covered person is not required to exhaust the health
23 carrier's internal appeal process pursuant to as set forth
24 ~~in~~ this Act;

25 (4) (blank); and ~~for appeals relating to a~~
26 ~~determination based on treatment being experimental or~~

1 ~~investigational, the requested health care service or~~
2 ~~treatment that is the subject of the adverse determination~~
3 ~~or final adverse determination is a covered benefit under~~
4 ~~the covered person's health benefit plan except for the~~
5 ~~health carrier's determination that the service or~~
6 ~~treatment is experimental or investigational for a~~
7 ~~particular medical condition and is not explicitly listed~~
8 ~~as an excluded benefit under the covered person's health~~
9 ~~benefit plan with the health carrier and that the covered~~
10 ~~person's health care provider, who ordered or provided the~~
11 ~~services in question and who is licensed under the Medical~~
12 ~~Practice Act of 1987, has certified that one of the~~
13 ~~following situations is applicable:~~

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

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

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

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

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

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

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

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

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

25 The Department may specify the form for the health
26 carrier's notice of initial determination under this

1 subsection (c) and any supporting information to be included in
2 the notice.

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

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

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

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

1 independent review organization; and

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

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

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

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

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

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

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

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

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

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

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

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

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

1 payment for the health care service that is the subject of
2 the adverse determination or final adverse determination.

3 In such cases, the following provisions shall apply:

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

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

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

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

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

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

6 (4) the terms of coverage under the covered person's
7 health benefit plan with the health carrier to ensure that
8 the independent review organization's decision is not
9 contrary to the terms of coverage under the covered
10 person's health benefit plan with the health carrier,
11 unless the terms are inconsistent with applicable law;

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

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

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

26 (8) (blank). ~~for a denial of coverage based on a~~

1 ~~determination that the health care service or treatment~~
2 ~~recommended or requested is experimental or~~
3 ~~investigational, whether and to what extent:~~

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

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

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

25 (j) Within 5 days after the date of receipt of all
26 necessary information, but in no event more than 45 days after

1 the date of receipt of the request for an external review, the
2 assigned independent review organization shall provide written
3 notice of its decision to uphold or reverse the adverse
4 determination or the final adverse determination to the
5 Director, the health carrier, the covered person, and, if
6 applicable, the covered person's authorized representative. In
7 reaching a decision, the assigned independent review
8 organization is not bound by any claim determinations reached
9 prior to the submission of information to the independent
10 review organization. In such cases, the following provisions
11 shall apply:

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

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

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

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

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

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

25 (F) the principal reason or reasons for its
26 decision, including what applicable, if any,

1 evidence-based standards that were a basis for its
2 decision; and;

3 (G) the rationale for its decision.

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

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

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

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

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

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

1 ~~condition;~~

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

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

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

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

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

2 (215 ILCS 180/40)

3 Sec. 40. Expedited external review.

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

8 (1) immediately after the date of receipt of a notice
9 prior to a final adverse determination as provided by
10 subsection (b) of Section 20 of this Act;

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

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

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

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

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

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

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

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

26 (c) Upon receipt of the notice that the request meets the

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

8 (1) The assignment of an approved independent review
9 organization to conduct an external review in accordance
10 with this Section shall be made from those approved
11 independent review organizations qualified to conduct
12 external review as required by Sections 50 and 55 of this
13 Act.

14 (2) The Director shall immediately notify the health
15 carrier of the name of the assigned independent review
16 organization. Immediately upon receipt from the Director
17 of the name of the independent review organization assigned
18 to conduct the external review ~~assigning an independent~~
19 ~~review organization to perform an expedited external~~
20 ~~review,~~ but in no case more than 24 hours after receiving
21 such notice ~~assigning the independent review organization,~~
22 the 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 (3) If the health carrier or its utilization review
4 organization fails to provide the documents and
5 information within the specified timeframe, the assigned
6 independent review organization may terminate the external
7 review and make a decision to reverse the adverse
8 determination or final adverse determination.

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

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

1 (e) As expeditiously as the covered person's medical
2 condition or circumstances requires, but in no event more than
3 72 hours after the date of receipt of the request for an
4 expedited external review ~~2 business days after the receipt of~~
5 ~~all pertinent information~~, the assigned independent review
6 organization shall:

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

9 (2) notify the Director, the health carrier, the
10 covered person, the covered person's health care provider,
11 and, if applicable, the covered person's authorized
12 representative, of the decision.

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

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

23 (h) If the notice provided pursuant to subsection (e) of
24 this Section was not in writing, then within ~~Within~~ 48 hours
25 after the date of providing that the notice ~~required in item~~
26 ~~(2) of subsection (e)~~, the assigned independent review

1 organization shall provide written confirmation of the
2 decision to the Director, the health carrier, the covered
3 person, and, if applicable, the covered person's authorized
4 representative including the information set forth in
5 subsection (j) of Section 35 of this Act as applicable.

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

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

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

14 (215 ILCS 180/42 new)

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

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

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

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

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

13 (3) The following provisions apply concerning notice:

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

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

26 (C) The notice of initial determination under

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

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

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

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

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

1 the name of the assigned independent review organization.

2 (6) At the time the health carrier receives the notice
3 of the assigned independent review organization, the
4 health carrier or its designee utilization review
5 organization shall provide or transmit all necessary
6 documents and information considered in making the adverse
7 determination or final adverse determination to the
8 assigned independent review organization electronically or
9 by telephone or facsimile or any other available
10 expeditious method.

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

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

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

23 (2) the recommended or requested health care service or
24 treatment that is the subject of the adverse determination
25 or final adverse determination is a covered benefit under
26 the covered person's health benefit plan except for the

1 health carrier's determination that the service or
2 treatment is experimental or investigational for a
3 particular medical condition and is not explicitly listed
4 as an excluded benefit under the covered person's health
5 benefit plan with the health carrier;

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

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

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

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

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

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

25 (B) who is a licensed, board certified or board
26 eligible physician qualified to practice in the area of

1 medicine appropriate to treat the covered person's
2 condition, has certified in writing that
3 scientifically valid studies using accepted protocols
4 demonstrate that the health care service or treatment
5 requested by the covered person that is the subject of
6 the adverse determination or final adverse
7 determination is likely to be more beneficial to the
8 covered person than any available standard health care
9 services or treatments;

10 (5) the covered person has exhausted the health
11 carrier's internal appeal process, unless the covered
12 person is not required to exhaust the health carrier's
13 internal appeal process pursuant to Section 30 of this Act;
14 and

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

18 (e) The following provisions apply concerning requests:

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

24 (2) If the request:

25 (A) is not complete, then the health carrier shall
26 inform the Director and the covered person and, if

1 applicable, the covered person's authorized
2 representative in writing and include in the notice
3 what information or materials are required by this Act
4 to make the request complete; or

5 (B) is not eligible for external review, then the
6 health carrier shall inform the Director and the
7 covered person and, if applicable, the covered
8 person's authorized representative in writing and
9 include in the notice the reasons for its
10 ineligibility.

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

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

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

1 determination, the Director's decision shall be in
2 accordance with the terms of the covered person's health
3 benefit plan, unless such terms are inconsistent with
4 applicable law, and shall be subject to all applicable
5 provisions of this Act.

6 (f) Whenever a request for external review is determined
7 eligible for external review, the health carrier shall notify
8 the Director and the covered person and, if applicable, the
9 covered person's authorized representative.

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

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 shall include in the notice provided to the
24 covered person and, if applicable, the covered person's
25 authorized representative a statement that the covered person
26 or the covered person's authorized representative may, within 5

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

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

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

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

20 (A) In selecting clinical reviewers pursuant to
21 item (1) of this subsection (h), the assigned
22 independent review organization shall select
23 physicians or other health care professionals who meet
24 the minimum qualifications described in Section 55 of
25 this Act and, through clinical experience in the past 3
26 years, are experts in the treatment of the covered

1 person's condition and knowledgeable about the
2 recommended or requested health care service or
3 treatment.

4 (B) Neither the covered person, the covered
5 person's authorized representative, if applicable, nor
6 the health carrier shall choose or control the choice
7 of the physicians or other health care professionals to
8 be selected to conduct the external review.

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

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

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

25 (1) Except as provided in item (2) of this subsection
26 (i), failure by the health carrier or its utilization

1 review organization to provide the documents and
2 information within the specified time frame shall not delay
3 the conduct of the external review.

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

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

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

25 (k) Upon receipt of any information submitted by the
26 covered person or the covered person's authorized

1 representative, the independent review organization shall
2 forward the information to the health carrier within one
3 business day. In such cases, the following provisions shall
4 apply:

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

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

12 (3) The external review may be terminated only if the
13 health carrier decides, upon completion of its
14 reconsideration, to reverse its adverse determination or
15 final adverse determination and provide coverage or
16 payment for the health care service that is the subject of
17 the adverse determination or final adverse determination.

18 In such cases, the following provisions shall apply:

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

26 (B) Upon notice from the health carrier that the

1 health carrier has made a decision to reverse its
2 adverse determination or final adverse determination,
3 the assigned independent review organization shall
4 terminate the external review.

5 (1) The following provisions apply concerning clinical
6 review opinions:

7 (1) Except as provided in item (3) of this subsection
8 (1), within 20 days after being selected in accordance with
9 subsection (h) of this Section to conduct the external
10 review, each clinical reviewer shall provide an opinion to
11 the assigned independent review organization on whether
12 the recommended or requested health care service or
13 treatment should be covered.

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

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

19 (B) a description of the indicators relevant to
20 determining whether there is sufficient evidence to
21 demonstrate that the recommended or requested health
22 care service or treatment is more likely than not to be
23 beneficial to the covered person than any available
24 standard health care services or treatments 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;

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

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

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

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

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

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

1 (1).

2 (m) In addition to the documents and information provided
3 by the health carrier or its utilization review organization
4 and the covered person and the covered person's authorized
5 representative, if any, each clinical reviewer selected
6 pursuant to subsection (h) of this Section, to the extent the
7 information or documents are available and the clinical
8 reviewer considers appropriate, shall consider the following
9 in reaching a decision:

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

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

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

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

1 (5) whether (A) the recommended or requested health
2 care service or treatment has been approved by the federal
3 Food and Drug Administration, if applicable, for the
4 condition or (B) medical or scientific evidence or
5 evidence-based standards demonstrate that the expected
6 benefits of the recommended or requested health care
7 service or treatment is more likely than not to be
8 beneficial to the covered person than any available
9 standard health care service or treatment and the adverse
10 risks of the recommended or requested health care service
11 or treatment would not be substantially increased over
12 those of available standard health care services or
13 treatments.

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

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

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

1 (B) For an expedited external review, within 48
2 hours after the date it receives the opinion of each
3 clinical reviewer, the assigned independent review
4 organization, in accordance with item (2) of this
5 subsection (n), shall make a decision and provide
6 notice of the decision orally or in writing to the
7 Director, the health carrier, the covered person, and
8 the covered person's authorized representative, if
9 applicable. If such notice is not in writing, within 48
10 hours after the date of providing that notice, the
11 assigned independent review organization shall provide
12 written confirmation of the decision to the Director,
13 the health carrier, the covered person, and the covered
14 person's authorized representative, if applicable.

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

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

23 (B) If a majority of the clinical reviewers
24 recommend that the recommended or requested health
25 care service or treatment should not be covered, the
26 independent review organization shall make a decision

1 to uphold the health carrier's adverse determination
2 or final adverse determination.

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

5 (i) If the clinical reviewers are evenly split
6 as to whether the recommended or requested health
7 care service or treatment should be covered, then
8 the independent review organization shall obtain
9 the opinion of an additional clinical reviewer in
10 order for the independent review organization to
11 make a decision based on the opinions of a majority
12 of the clinical reviewers pursuant to subdivision
13 (A) or (B) of this item (2).

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

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

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

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

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

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

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

13 (5) the date of its decision;

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

15 and

16 (7) the rationale for its decision.

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

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

1 (215 ILCS 180/55)

2 Sec. 55. Minimum qualifications for independent review
3 organizations.

4 (a) To be approved to conduct external reviews, an
5 independent review organization shall have and maintain
6 written policies and procedures that govern all aspects of both
7 the standard external review process and the expedited external
8 review process set forth in this Act that include, at a
9 minimum:

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

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

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

21 (C) for adverse determinations involving
22 experimental or investigational treatments, in
23 assigning clinical reviewers, the independent review
24 organization selects physicians or other health care
25 professionals who, through clinical experience in the

1 past 3 years, are experts in the treatment of the
2 covered person's condition and knowledgeable about the
3 recommended or requested health care service or
4 treatment;

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

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

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

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

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

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

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

1 external review;

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

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

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

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

25 (d) Conflicts of interest prohibited. In addition to the
26 requirements set forth in subsections (a), (b), and (c) of this

1 Section, to be approved pursuant to this Act to conduct an
2 external review of a specified case, neither the independent
3 review organization selected to conduct the external review nor
4 any clinical reviewer assigned by the independent organization
5 to conduct the external review may have a material
6 professional, familial or financial conflict of interest with
7 any of the following:

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

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

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

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

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

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

25 (e) An independent review organization that is accredited
26 by a nationally recognized private accrediting entity that has

1 independent review accreditation standards that the Director
2 has determined are equivalent to or exceed the minimum
3 qualifications of this Section shall be presumed to be in
4 compliance with this Section and shall be eligible for approval
5 under this Act.

6 (f) An independent review organization shall be unbiased.
7 An independent review organization shall establish and
8 maintain written procedures to ensure that it is unbiased in
9 addition to any other procedures required under this Section.

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

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

15 (215 ILCS 180/65)

16 Sec. 65. External review reporting requirements.

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

24 (a-5) An independent review organization assigned pursuant
25 to this Act to conduct an external review shall maintain

1 written records in the aggregate by state and by health carrier
2 on all requests for external review for which it conducted an
3 external review during a calendar year and submit a report in
4 the format specified by the Director by March 1 of each year.

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

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

8 (2) the number of requests for external review resolved
9 and, of those resolved, the number resolved upholding the
10 adverse determination or final adverse determination and
11 the number resolved reversing the adverse determination or
12 final adverse determination;

13 (3) the average length of time for resolution;

14 (4) a summary of the types of coverages or cases for
15 which an external review was sought, as provided in the
16 format required by the Director;

17 (5) the number of external reviews that were terminated
18 as the result of a reconsideration by the health carrier of
19 its adverse determination or final adverse determination
20 after the receipt of additional information from the
21 covered person or the covered person's authorized
22 representative; and

23 (6) any other information the Director may request or
24 require.

25 (a-15) The independent review organization shall retain
26 the written records required pursuant to this Section for at

1 least 3 years.

2 (b) The report required under subsection (a) of this
3 Section shall include in the aggregate, by state, and by type
4 of health benefit plan:

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

6 (2) the total number of requests for expedited external
7 review;

8 (3) the total number of requests for external review
9 denied;

10 (4) the number of requests for external review
11 resolved, including:

12 (A) the number of requests for external review
13 resolved upholding the adverse determination or final
14 adverse determination;

15 (B) the number of requests for external review
16 resolved reversing the adverse determination or final
17 adverse determination;

18 (C) the number of requests for expedited external
19 review resolved upholding the adverse determination or
20 final adverse determination; and

21 (D) the number of requests for expedited external
22 review resolved reversing the adverse determination or
23 final adverse determination;

24 (5) the average length of time for resolution for an
25 external review;

26 (6) the average length of time for resolution for an

1 expedited external review;

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

4 (A) denial of care or treatment (dissatisfaction
5 regarding prospective non-authorization of a request
6 for care or treatment recommended by a provider
7 excluding diagnostic procedures and referral requests;
8 partial approvals and care terminations are also
9 considered to be denials);

10 (B) denial of diagnostic procedure
11 (dissatisfaction regarding prospective
12 non-authorization of a request for a diagnostic
13 procedure recommended by a provider; partial approvals
14 are also considered to be denials);

15 (C) denial of referral request (dissatisfaction
16 regarding non-authorization of a request for a
17 referral to another provider recommended by a PCP);

18 (D) claims and utilization review (dissatisfaction
19 regarding the concurrent or retrospective evaluation
20 of the coverage, medical necessity, efficiency or
21 appropriateness of health care services or treatment
22 plans; prospective "Denials of care or treatment",
23 "Denials of diagnostic procedures" and "Denials of
24 referral requests" should not be classified in this
25 category, but the appropriate one above);

26 (8) the number of external reviews that were terminated

1 as the result of a reconsideration by the health carrier of
2 its adverse determination or final adverse determination
3 after the receipt of additional information from the
4 covered person or the covered person's authorized
5 representative; and

6 (9) any other information the Director may request or
7 require.

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

9 (215 ILCS 180/75)

10 Sec. 75. Disclosure requirements.

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

15 (b) The description required under subsection (a) of this
16 Section shall include a statement that informs the covered
17 person of the right of the covered person to file a request for
18 an external review of an adverse determination or final adverse
19 determination with the Director ~~health carrier~~. The statement
20 shall explain that external review is available when the
21 adverse determination or final adverse determination involves
22 an issue of medical necessity, appropriateness, health care
23 setting, level of care, or effectiveness. The statement shall
24 include the toll-free telephone number and address of the
25 Office of Consumer Health Insurance within the Department of

1 Insurance.

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

3 (215 ILCS 180/80 new)

4 Sec. 80. Administration and enforcement.

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

7 (b) The Director is authorized to make use of any of the
8 powers established under the Illinois Insurance Code to enforce
9 the laws of this State. This includes but is not limited to,
10 the Director's administrative authority to investigate, issue
11 subpoenas, conduct depositions and hearings, issue orders,
12 including, without limitation, orders pursuant to Article XII
13 1/2 and Section 401.1 of the Illinois Insurance Code, and
14 impose penalties.

15 Section 99. Effective date. This Act takes effect on July
16 1, 2011.