



Sen. Heather A. Steans

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LRB097 05693 RPM 56047 a

1 AMENDMENT TO HOUSE BILL 224

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

4 "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

1 effectiveness or is determined to be experimental or  
2 investigational and the requested benefit is therefore  
3 denied, reduced, or terminated or payment is not provided  
4 or made, in whole or in part, for the benefit;

5 (2) the denial, reduction, or termination of or failure  
6 to provide or make payment, in whole or in part, for a  
7 benefit based on a determination by a health carrier or its  
8 designee utilization review organization that a  
9 preexisting condition was present before the effective  
10 date of coverage; or

11 (3) a rescission of coverage determination, which does  
12 not include a cancellation or discontinuance of coverage  
13 that is attributable to a failure to timely pay required  
14 premiums or contributions towards the cost of coverage.  
15 ~~means a determination by a health carrier or its designee~~  
16 ~~utilization review organization that an admission,~~  
17 ~~availability of care, continued stay, or other health care~~  
18 ~~service that is a covered benefit has been reviewed and,~~  
19 ~~based upon the information provided, does not meet the~~  
20 ~~health carrier's requirements for medical necessity,~~  
21 ~~appropriateness, health care setting, level of care, or~~  
22 ~~effectiveness, and the requested service or payment for the~~  
23 ~~service is therefore denied, reduced, or terminated.~~

24 "Authorized representative" means:

25 (1) a person to whom a covered person has given express  
26 written consent to represent the covered person for

1 purposes of this Law;

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

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

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

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

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

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

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

21 "Best evidence" means evidence based on:

22 (1) randomized clinical trials;

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

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

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

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

5 "Clinical review criteria" means the written screening  
6 procedures, decision abstracts, clinical protocols, and  
7 practice guidelines used by a health carrier to determine the  
8 necessity and appropriateness of health care services.

9 "Cohort study" means a prospective evaluation of 2 groups  
10 of patients with only one group of patients receiving specific  
11 intervention.

12 "Concurrent review" means a review conducted during a  
13 patient's stay or course of treatment in a facility, the office  
14 of a health care professional, or other inpatient or outpatient  
15 health care setting.

16 "Covered benefits" or "benefits" means those health care  
17 services to which a covered person is entitled under the terms  
18 of a health benefit plan.

19 "Covered person" means a policyholder, subscriber,  
20 enrollee, or other individual participating in a health benefit  
21 plan.

22 "Director" means the Director of the Department of  
23 Insurance.

24 "Emergency medical condition" means a medical condition  
25 manifesting itself by acute symptoms of sufficient severity,  
26 including, but not limited to, severe pain, such that a prudent

1 layperson who possesses an average knowledge of health and  
2 medicine could reasonably expect the absence of immediate  
3 medical attention to result in:

4 (1) placing the health of the individual or, with  
5 respect to a pregnant woman, the health of the woman or her  
6 unborn child, in serious jeopardy;

7 (2) serious impairment to bodily functions; or

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

9 "Emergency services" means health care items and services  
10 furnished or required to evaluate and treat an emergency  
11 medical condition.

12 "Evidence-based standard" means the conscientious,  
13 explicit, and judicious use of the current best evidence based  
14 on an overall systematic review of the research in making  
15 decisions about the care of individual patients.

16 "Expert opinion" means a belief or an interpretation by  
17 specialists with experience in a specific area about the  
18 scientific evidence pertaining to a particular service,  
19 intervention, or therapy.

20 "Facility" means an institution providing health care  
21 services or a health care setting.

22 "Final adverse determination" means an adverse  
23 determination involving a covered benefit that has been upheld  
24 by a health carrier, or its designee utilization review  
25 organization, at the completion of the health carrier's  
26 internal grievance process procedures as set forth by the

1 Managed Care Reform and Patient Rights Act.

2 "Health benefit plan" means a policy, contract,  
3 certificate, plan, or agreement offered or issued by a health  
4 carrier to provide, deliver, arrange for, pay for, or reimburse  
5 any of the costs of health care services.

6 "Health care provider" or "provider" means a physician,  
7 hospital facility, or other health care practitioner licensed,  
8 accredited, or certified to perform specified health care  
9 services consistent with State law, responsible for  
10 recommending health care services on behalf of a covered  
11 person.

12 "Health care services" means services for the diagnosis,  
13 prevention, treatment, cure, or relief of a health condition,  
14 illness, injury, or disease.

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

25 "Health information" means information or data, whether  
26 oral or recorded in any form or medium, and personal facts or

1 information about events or relationships that relate to:

2 (1) the past, present, or future physical, mental, or  
3 behavioral health or condition of an individual or a member  
4 of the individual's family;

5 (2) the provision of health care services to an  
6 individual; or

7 (3) payment for the provision of health care services  
8 to an individual.

9 "Independent review organization" means an entity that  
10 conducts independent external reviews of adverse  
11 determinations and final adverse determinations.

12 "Medical or scientific evidence" means evidence found in  
13 the following sources:

14 (1) peer-reviewed scientific studies published in or  
15 accepted for publication by medical journals that meet  
16 nationally recognized requirements for scientific  
17 manuscripts and that submit most of their published  
18 articles for review by experts who are not part of the  
19 editorial staff;

20 (2) peer-reviewed medical literature, including  
21 literature relating to therapies reviewed and approved by a  
22 qualified institutional review board, biomedical  
23 compendia, and other medical literature that meet the  
24 criteria of the National Institutes of Health's Library of  
25 Medicine for indexing in Index Medicus (Medline) and  
26 Elsevier Science Ltd. for indexing in Excerpta Medicus

1 (EMBASE);

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

5 (4) the following standard reference compendia:

6 (a) The American Hospital Formulary Service-Drug  
7 Information;

8 (b) Drug Facts and Comparisons;

9 (c) The American Dental Association Accepted  
10 Dental Therapeutics; and

11 (d) The United States Pharmacopoeia-Drug  
12 Information;

13 (5) findings, studies, or research conducted by or  
14 under the auspices of federal government agencies and  
15 nationally recognized federal research institutes,  
16 including:

17 (a) the federal Agency for Healthcare Research and  
18 Quality;

19 (b) the National Institutes of Health;

20 (c) the National Cancer Institute;

21 (d) the National Academy of Sciences;

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

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

24 (g) any national board recognized by the National  
25 Institutes of Health for the purpose of evaluating the  
26 medical value of health care services; or



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

3 "Person" means an individual, a corporation, a  
4 partnership, an association, a joint venture, a joint stock  
5 company, a trust, an unincorporated organization, any similar  
6 entity, or any combination of the foregoing.

7 "Prospective review" means a review conducted prior to an  
8 admission or the provision of a health care service or a course  
9 of treatment in accordance with a health carrier's requirement  
10 that the health care service or course of treatment, in whole  
11 or in part, be approved prior to its provision.

12 "Protected health information" means health information  
13 (i) that identifies an individual who is the subject of the  
14 information; or (ii) with respect to which there is a  
15 reasonable basis to believe that the information could be used  
16 to identify an individual.

17 "Randomized clinical trial" means a controlled prospective  
18 study of patients that have been randomized into an  
19 experimental group and a control group at the beginning of the  
20 study with only the experimental group of patients receiving a  
21 specific intervention, which includes study of the groups for  
22 variables and anticipated outcomes over time.

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

25 "Retrospective review" does not include the review of a claim  
26 that is limited to veracity of documentation or accuracy of

1 ~~coding. means a review of medical necessity conducted after~~  
2 ~~services have been provided to a patient, but does not include~~  
3 ~~the review of a claim that is limited to an evaluation of~~  
4 ~~reimbursement levels, veracity of documentation, accuracy of~~  
5 ~~coding, or adjudication for payment.~~

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

8 "Utilization review organization" means a utilization  
9 review program as defined in the Managed Care Reform and  
10 Patient Rights Act.

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

12 (215 ILCS 180/20)

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

14 (a) At the same time the health carrier sends written  
15 notice of a covered person's right to appeal a coverage  
16 decision upon an adverse determination or a final adverse  
17 determination ~~as provided by the Managed Care Reform and~~  
18 ~~Patient Rights Act,~~ a health carrier shall notify a covered  
19 person, the covered person's authorized representative, if  
20 any, and a covered person's health care provider in writing of  
21 the covered person's right to request an external review as  
22 provided by this Act. The written notice required shall include  
23 the following, or substantially equivalent, language: "We have  
24 denied your request for the provision of or payment for a  
25 health care service or course of treatment. You have the right

1 to have our decision reviewed by an independent review  
2 organization not associated with us ~~if our decision involved~~  
3 ~~making a judgment as to the medical necessity, appropriateness,~~  
4 ~~health care setting, level of care, or effectiveness of the~~  
5 ~~health care service or treatment you requested~~ by submitting a  
6 written request for an external review to the Department of  
7 Insurance, Office of Consumer Health Information, 320 West  
8 Washington Street, 4th Floor, Springfield, Illinois, 62767."  
9 us. ~~Upon receipt of your request an independent review~~  
10 ~~organization registered with the Department of Insurance will~~  
11 ~~be assigned to review our decision.~~

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

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

20 (1) If the covered person has a medical condition where  
21 the timeframe for completion of (A) an expedited internal  
22 review of an appeal ~~a grievance~~ involving an adverse  
23 determination, (B) a final adverse determination ~~as set~~  
24 ~~forth in the Managed Care Reform and Patient Rights Act,~~ or  
25 (C) a standard external review as established in this Act,  
26 would seriously jeopardize the life or health of the

1 covered person or would jeopardize the covered person's  
2 ability to regain maximum function, then the covered person  
3 or the covered person's authorized representative may file  
4 a request for an expedited external review.

5 (2) The covered person or the covered person's  
6 authorized representative may file an appeal under the  
7 health carrier's internal appeal process, but if the health  
8 carrier has not issued a written decision to the covered  
9 person or the covered person's authorized representative  
10 30 days following the date the covered person or the  
11 covered person's authorized representative files an appeal  
12 of an adverse determination that involves a concurrent or  
13 prospective review request or 60 days following the date  
14 the covered person or the covered person's authorized  
15 representative files an appeal of an adverse determination  
16 that involves a retrospective review request with the  
17 health carrier and the covered person or the covered  
18 person's authorized representative has not requested or  
19 agreed to a delay, then the covered person or the covered  
20 person's authorized representative may file a request for  
21 external review and shall be considered to have exhausted  
22 the health carrier's internal appeal process for purposes  
23 of this Act. ~~The covered person or the covered person's~~  
24 ~~authorized representative may file a request for an~~  
25 ~~expedited external review at the same time the covered~~  
26 ~~person or the covered person's authorized representative~~

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

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

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

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

24           (1) if the covered person has a medical condition where  
25 the timeframe for completion of a standard external review  
26 would seriously jeopardize the life or health of the

1 covered person or would jeopardize the covered person's  
2 ability to regain maximum function, then the covered person  
3 or the covered person's authorized representative may file  
4 a request for an expedited external review; or

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

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

22 (d) In addition to the information to be provided pursuant  
23 to subsections (a), (b), and (c) of this Section, the health  
24 carrier shall include a copy of the description of both the  
25 required standard and expedited external review procedures.  
26 The description shall highlight the external review procedures

1 that give the covered person or the covered person's authorized  
2 representative the opportunity to submit additional  
3 information, including any forms used to process an external  
4 review.

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

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

15 (215 ILCS 180/25)

16 Sec. 25. Request for external review. A covered person or  
17 the covered person's authorized representative may make a  
18 request for a standard external or expedited external review of  
19 an adverse determination or final adverse determination.  
20 Except as set forth in Sections 40 and 42 of this Act, all  
21 requests for external review ~~Requests under this Section~~ shall  
22 be made in writing to the Director ~~directly to the health~~  
23 ~~carrier that made the adverse or final adverse determination.~~  
24 ~~All requests for external review shall be in writing except for~~  
25 ~~requests for expedited external reviews which may be made~~



1 ~~orally~~. Health carriers must provide covered persons with forms  
2 to request external reviews.

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

4 (215 ILCS 180/30)

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

6 (a) Except as provided in subsection (b) of this Section  
7 ~~20~~, a request for an external review shall not be made until  
8 the covered person has exhausted the health carrier's internal  
9 appeal ~~grievance~~ process ~~as set forth in the Managed Care~~  
10 ~~Reform and Patient Rights Act.~~

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

14 (1) the covered person or the covered person's  
15 authorized representative has filed an appeal under the  
16 health carrier's internal appeal process ~~a request for an~~  
17 ~~internal review of an adverse determination pursuant to the~~  
18 ~~Managed Care Reform and Patient Rights Act~~ and has not  
19 received a written decision on the appeal 30 days following  
20 the date the covered person or the covered person's  
21 authorized representative files an appeal of an adverse  
22 determination that involves a concurrent or prospective  
23 review request or 60 days following the date the covered  
24 person or the covered person's authorized representative  
25 files an appeal of an adverse determination that involves a

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

14 (2) the covered person or the covered person's  
15 authorized representative filed a request for an expedited  
16 internal review of an adverse determination ~~pursuant to the~~  
17 ~~Managed Care Reform and Patient Rights Act~~ and has not  
18 received a decision on such request from the health carrier  
19 within 48 hours, except to the extent the covered person or  
20 the covered person's authorized representative requested  
21 or agreed to a delay; ~~or~~

22 (3) the health carrier agrees to waive the exhaustion  
23 requirement; ~~or~~

24 (4) the covered person has a medical condition in which  
25 the timeframe for completion of (A) an expedited internal  
26 review of a appeal involving an adverse determination, (B)

1 a final adverse determination, or (C) a standard external  
2 review as established in this Act would seriously  
3 jeopardize the life or health of the covered person or  
4 would jeopardize the covered person's ability to regain  
5 maximum function;

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

24 (6) the health carrier has failed to comply with  
25 applicable State and federal law governing internal claims  
26 and appeals procedures.

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

2 (215 ILCS 180/35)

3 Sec. 35. Standard external review.

4 (a) Within 4 months after the date of receipt of a notice  
5 of an adverse determination or final adverse determination, a  
6 covered person or the covered person's authorized  
7 representative may file a request for an external review with  
8 the Director. Within one business day after the date of receipt  
9 of a request for external review, the Director shall send a  
10 copy of the request to the health carrier.

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

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

18 (2) the health care service that is the subject of the  
19 adverse determination or the final adverse determination  
20 is a covered service under the covered person's health  
21 benefit plan, but the health carrier has determined that  
22 the health care service is not covered ~~because it does not~~  
23 ~~meet the health carrier's requirements for medical~~  
24 ~~necessity, appropriateness, health care setting, level of~~  
25 ~~care, or effectiveness;~~

1           (3) the covered person has exhausted the health  
2 carrier's internal appeal grievance process unless the  
3 covered person is not required to exhaust the health  
4 carrier's internal appeal process pursuant to as set forth  
5 in this Act;

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

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

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

26           ~~(C) there is no available standard health care~~

1 ~~service or treatment covered by the health carrier that~~  
2 ~~is more beneficial than the recommended or requested~~  
3 ~~health care service or treatment;~~

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

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

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

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

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

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

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

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

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

25          (d) Whenever the Director receives notice that a request is  
26 eligible for external review following the preliminary review

1 conducted pursuant to this Section ~~the health carrier shall,~~  
2 within one ~~5~~ business day ~~after the date of receipt of the~~  
3 notice, the Director shall ~~days:~~

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

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

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

25 (e) The assignment by the Director of an approved  
26 independent review organization to conduct an external review



1 in accordance with this Section shall be done on a random basis  
2 among those independent review organizations approved by the  
3 Director pursuant to this Act. ~~The assignment of an approved~~  
4 ~~independent review organization to conduct an external review~~  
5 ~~in accordance with this Section shall be made from those~~  
6 ~~approved independent review organizations qualified to conduct~~  
7 ~~external review as required by Sections 50 and 55 of this Act.~~

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

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

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

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

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

11 (g) Upon receipt of the information from the health carrier  
12 or its utilization review organization, the assigned  
13 independent review organization shall review all of the  
14 information and documents and any other information submitted  
15 in writing to the independent review organization by the  
16 covered person and the covered person's authorized  
17 representative.

18 (h) Upon receipt of any information submitted by the  
19 covered person or the covered person's authorized  
20 representative, the independent review organization shall  
21 forward the information to the health carrier within 1 business  
22 day.

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

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

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

10          In such cases, the following provisions shall apply:

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

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

23           (i) In addition to the documents and information provided  
24           by the health carrier or its utilization review organization  
25           and the covered person and the covered person's authorized  
26           representative, if any, the independent review organization,

1 to the extent the information or documents are available and  
2 the independent review organization considers them  
3 appropriate, shall consider the following in reaching a  
4 decision:

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

6 (2) the covered person's health care provider's  
7 recommendation;

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

13 (4) the terms of coverage under the covered person's  
14 health benefit plan with the health carrier to ensure that  
15 the independent review organization's decision is not  
16 contrary to the terms of coverage under the covered  
17 person's health benefit plan with the health carrier,  
18 unless the terms are inconsistent with applicable law;

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

24 (6) any applicable clinical review criteria developed  
25 and used by the health carrier or its designee utilization  
26 review organization; ~~and~~

1           (7) the opinion of the independent review  
2 organization's clinical reviewer or reviewers after  
3 considering items (1) through (6) of this subsection (i) to  
4 the extent the information or documents are available and  
5 the clinical reviewer or reviewers considers the  
6 information or documents appropriate; and

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

11           ~~(A) the recommended or requested health care~~  
12 ~~service or treatment has been approved by the federal~~  
13 ~~Food and Drug Administration, if applicable, for the~~  
14 ~~condition;~~

15           ~~(B) medical or scientific evidence or~~  
16 ~~evidence based standards demonstrate that the expected~~  
17 ~~benefits of the recommended or requested health care~~  
18 ~~service or treatment is more likely than not to be~~  
19 ~~beneficial to the covered person than any available~~  
20 ~~standard health care service or treatment and the~~  
21 ~~adverse risks of the recommended or requested health~~  
22 ~~care service or treatment would not be substantially~~  
23 ~~increased over those of available standard health care~~  
24 ~~services or treatments; or~~

25           ~~(C) the terms of coverage under the covered~~  
26 ~~person's health benefit plan with the health carrier to~~

1 ~~ensure that the health care service or treatment that~~  
2 ~~is the subject of the opinion is experimental or~~  
3 ~~investigational would otherwise be covered under the~~  
4 ~~terms of coverage of the covered person's health~~  
5 ~~benefit plan with the health carrier.~~

6 (j) Within 5 days after the date of receipt of all  
7 necessary information, but in no event more than 45 days after  
8 the date of receipt of the request for an external review, the  
9 assigned independent review organization shall provide written  
10 notice of its decision to uphold or reverse the adverse  
11 determination or the final adverse determination to the  
12 Director, the health carrier, the covered person, and, if  
13 applicable, the covered person's authorized representative. In  
14 reaching a decision, the assigned independent review  
15 organization is not bound by any claim determinations reached  
16 prior to the submission of information to the independent  
17 review organization. In such cases, the following provisions  
18 shall apply:

19 (1) The independent review organization shall include  
20 in the notice:

21 (A) a general description of the reason for the  
22 request for external review;

23 (B) the date the independent review organization  
24 received the assignment from the Director ~~health~~  
25 ~~carrier~~ to conduct the external review;

26 (C) the time period during which the external

1 review was conducted;

2 (D) references to the evidence or documentation,  
3 including the evidence-based standards, considered in  
4 reaching its decision;

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

6 (F) the principal reason or reasons for its  
7 decision, including what applicable, if any,  
8 evidence-based standards that were a basis for its  
9 decision; and.

10 (G) the rationale for its decision.

11 (2) (Blank). ~~For reviews of experimental or~~  
12 ~~investigational treatments, the notice shall include the~~  
13 ~~following information:~~

14 ~~(A) a description of the covered person's medical~~  
15 ~~condition;~~

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

26 ~~(C) a description and analysis of any medical or~~

1 ~~scientific evidence considered in reaching the~~  
2 ~~opinion;~~

3 ~~(D) a description and analysis of any~~  
4 ~~evidence-based standards;~~

5 ~~(E) whether the recommended or requested health~~  
6 ~~care service or treatment has been approved by the~~  
7 ~~federal Food and Drug Administration, for the~~  
8 ~~condition;~~

9 ~~(F) whether medical or scientific evidence or~~  
10 ~~evidence-based standards demonstrate that the expected~~  
11 ~~benefits of the recommended or requested health care~~  
12 ~~service or treatment is more likely than not to be more~~  
13 ~~beneficial to the covered person than any available~~  
14 ~~standard health care service or treatment 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; and~~

19 ~~(G) the written opinion of the clinical reviewer,~~  
20 ~~including the reviewer's recommendation as to whether~~  
21 ~~the recommended or requested health care service or~~  
22 ~~treatment should be covered and the rationale for the~~  
23 ~~reviewer's recommendation.~~

24 (3) (Blank). ~~In reaching a decision, the assigned~~  
25 ~~independent review organization is not bound by any~~  
26 ~~decisions or conclusions reached during the health~~



1 ~~carrier's utilization review process or the health~~  
2 ~~carrier's internal grievance or appeals process.~~

3 (4) Upon receipt of a notice of a decision reversing  
4 the adverse determination or final adverse determination,  
5 the health carrier immediately shall approve the coverage  
6 that was the subject of the adverse determination or final  
7 adverse determination.

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

9 (215 ILCS 180/40)

10 Sec. 40. Expedited external review.

11 (a) A covered person or a covered person's authorized  
12 representative may file a request for an expedited external  
13 review with the Director ~~health carrier~~ either orally or in  
14 writing:

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

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

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

24 (b) Upon receipt of a request for an expedited external  
25 review, the Director shall immediately send a copy of the

1 request to the health carrier. Immediately upon receipt of the  
2 request for an expedited external review ~~as provided under~~  
3 ~~subsections (b) and (c) of Section 20,~~ the health carrier shall  
4 determine whether the request meets the reviewability  
5 requirements set forth in ~~items (1), (2), and (4) of~~ subsection  
6 (b) of Section 35. In such cases, the following provisions  
7 shall apply:

8 (1) The health carrier shall immediately notify the  
9 Director, the covered person, and, if applicable, the  
10 covered person's authorized representative of its  
11 eligibility determination.

12 (2) The notice of initial determination shall include a  
13 statement informing the covered person and, if applicable,  
14 the covered person's authorized representative that a  
15 health carrier's initial determination that an external  
16 review request is ineligible for review may be appealed to  
17 the Director.

18 (3) The Director may determine that a request is  
19 eligible for expedited external review notwithstanding a  
20 health carrier's initial determination that the request is  
21 ineligible and require that it be referred for external  
22 review.

23 (4) In making a determination under item (3) of this  
24 subsection (b), the Director's decision shall be made in  
25 accordance with the terms of the covered person's health  
26 benefit plan, unless such terms are inconsistent with

1       applicable law, and shall be subject to all applicable  
2       provisions of this Act.

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

7       (c) Upon receipt of the notice that the request meets the  
8       reviewability requirements, ~~determining that a request meets~~  
9       ~~the requirements of subsections (b) and (c) of Section 20,~~ the  
10      Director ~~health carrier~~ shall immediately assign an  
11      independent review organization from the list of approved  
12      independent review organizations compiled and maintained by  
13      the Director to conduct the expedited review. In such cases,  
14      the following provisions shall apply:

15              (1) The assignment of an approved independent review  
16              organization to conduct an external review in accordance  
17              with this Section shall be made from those approved  
18              independent review organizations qualified to conduct  
19              external review as required by Sections 50 and 55 of this  
20              Act.

21              (2) The Director shall immediately notify the health  
22              carrier of the name of the assigned independent review  
23              organization. Immediately upon receipt from the Director  
24              of the name of the independent review organization assigned  
25              to conduct the external review ~~assigning an independent~~  
26              ~~review organization to perform an expedited external~~

1 ~~review~~, but in no case more than 24 hours after receiving  
2 such notice ~~assigning the independent review organization~~,  
3 the health carrier or its designee utilization review  
4 organization shall provide or transmit all necessary  
5 documents and information considered in making the adverse  
6 determination or final adverse determination to the  
7 assigned independent review organization electronically or  
8 by telephone or facsimile or any other available  
9 expeditious method.

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

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

25 (d) In addition to the documents and information provided  
26 by the health carrier or its utilization review organization

1 and any documents and information provided by the covered  
2 person and the covered person's authorized representative, the  
3 independent review organization, to the extent the information  
4 or documents are available and the independent review  
5 organization considers them appropriate, shall consider  
6 information as required by subsection (i) of Section 35 of this  
7 Act in reaching a decision.

8 (e) As expeditiously as the covered person's medical  
9 condition or circumstances requires, but in no event more than  
10 72 hours after the date of receipt of the request for an  
11 expedited external review ~~2 business days after the receipt of~~  
12 ~~all pertinent information,~~ the assigned independent review  
13 organization shall:

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

16 (2) notify the Director, the health carrier, the  
17 covered person, the covered person's health care provider,  
18 and, if applicable, the covered person's authorized  
19 representative, of the decision.

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

25 (g) Upon receipt of notice of a decision reversing the  
26 adverse determination or final adverse determination, the

1 health carrier shall immediately approve the coverage that was  
2 the subject of the adverse determination or final adverse  
3 determination.

4 (h) If the notice provided pursuant to subsection (e) of  
5 this Section was not in writing, then within ~~Within~~ 48 hours  
6 after the date of providing that ~~the~~ notice ~~required in item~~  
7 ~~(2) of subsection (e)~~, the assigned independent review  
8 organization shall provide written confirmation of the  
9 decision to the Director, the health carrier, the covered  
10 person, and, if applicable, the covered person's authorized  
11 representative including the information set forth in  
12 subsection (j) of Section 35 of this Act as applicable.

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

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

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

21 (215 ILCS 180/42 new)

22 Sec. 42. External review of experimental or  
23 investigational treatment adverse determinations.

24 (a) Within 4 months after the date of receipt of a notice  
25 of an adverse determination or final adverse determination that

1 involves a denial of coverage based on a determination that the  
2 health care service or treatment recommended or requested is  
3 experimental or investigational, a covered person or the  
4 covered person's authorized representative may file a request  
5 for an external review with the Director.

6 (b) The following provisions apply to cases concerning  
7 expedited external reviews:

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

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

20 (3) The following provisions apply concerning notice:

21 (A) Upon notice of the request for an expedited  
22 external review, the health carrier shall immediately  
23 determine whether the request meets the reviewability  
24 requirements of subsection (d) of this Section. The  
25 health carrier shall immediately notify the Director  
26 and the covered person and, if applicable, the covered

1 person's authorized representative of its eligibility  
2 determination.

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

7 (C) The notice of initial determination under  
8 subdivision (A) of this item (3) shall include a  
9 statement informing the covered person and, if  
10 applicable, the covered person's authorized  
11 representative that a health carrier's initial  
12 determination that the external review request is  
13 ineligible for review may be appealed to the Director.

14 (4) The following provisions apply concerning the  
15 Director's determination:

16 (A) The Director may determine that a request is  
17 eligible for external review under subsection (d) of  
18 this Section notwithstanding a health carrier's  
19 initial determination that the request is ineligible  
20 and require that it be referred for external review.

21 (B) In making a determination under subdivision  
22 (A) of this item (4), the Director's decision shall be  
23 made in accordance with the terms of the covered  
24 person's health benefit plan, unless such terms are  
25 inconsistent with applicable law, and shall be subject  
26 to all applicable provisions of this Act.



1           (5) Upon receipt of the notice that the expedited  
2 external review request meets the reviewability  
3 requirements of subsection (d) of this Section, the  
4 Director shall immediately assign an independent review  
5 organization to review the expedited request from the list  
6 of approved independent review organizations compiled and  
7 maintained by the Director and notify the health carrier of  
8 the name of the assigned independent review organization.

9           (6) At the time the health carrier receives the notice  
10 of the assigned independent review organization, the  
11 health carrier or its designee utilization review  
12 organization shall provide or transmit all necessary  
13 documents and information considered in making the adverse  
14 determination or final adverse determination to the  
15 assigned independent review organization electronically or  
16 by telephone or facsimile or any other available  
17 expeditious method.

18           (c) Except for a request for an expedited external review  
19 made pursuant to subsection (b) of this Section, within one  
20 business day after the date of receipt of a request for  
21 external review, the Director shall send a copy of the request  
22 to the health carrier.

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

26           (1) the individual is or was a covered person in the

1 health benefit plan at the time the health care service was  
2 recommended or requested or, in the case of a retrospective  
3 review, at the time the health care service was provided;

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

13 (3) the covered person's health care provider has  
14 certified that one of the following situations is  
15 applicable:

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

19 (B) standard health care services or treatments  
20 are not medically appropriate for the covered person;  
21 or

22 (C) there is no available standard health care  
23 service or treatment covered by the health carrier that  
24 is more beneficial than the recommended or requested  
25 health care service or treatment;

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

1           (A) has recommended a health care service or  
2           treatment that the physician certifies, in writing, is  
3           likely to be more beneficial to the covered person, in  
4           the physician's opinion, than any available standard  
5           health care services or treatments; or

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

17           (5) the covered person has exhausted the health  
18           carrier's internal appeal process, unless the covered  
19           person is not required to exhaust the health carrier's  
20           internal appeal process pursuant to Section 30 of this Act;  
21           and

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

25           (e) The following provisions apply concerning requests:

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

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

5           (2) If the request:

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

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

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

22           (4) The notice of initial determination of  
23           ineligibility shall include a statement informing the  
24           covered person and, if applicable, the covered person's  
25           authorized representative that a health carrier's initial  
26           determination that the external review request is

1 ineligible for review may be appealed to the Director by  
2 filing a complaint with the Director.

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

13 (f) Whenever a request for external review is determined  
14 eligible for external review, the health carrier shall notify  
15 the Director and the covered person and, if applicable, the  
16 covered person's authorized representative.

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

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

26 (2) notify in writing the covered person and, if

1 applicable, the covered person's authorized representative  
2 of the request's eligibility and acceptance for external  
3 review and the name of the independent review organization.

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

16 (h) The following provisions apply concerning assignments  
17 and clinical reviews:

18 (1) Within one business day after the receipt of the  
19 notice of assignment to conduct the external review  
20 pursuant to subsection (g) of this Section, the assigned  
21 independent review organization shall select one or more  
22 clinical reviewers, as it determines is appropriate,  
23 pursuant to item (2) of this subsection (h) to conduct the  
24 external review.

25 (2) The provisions of this item (2) apply concerning  
26 the selection of reviewers:

1           (A) In selecting clinical reviewers pursuant to  
2           item (1) of this subsection (h), the assigned  
3           independent review organization shall select  
4           physicians or other health care professionals who meet  
5           the minimum qualifications described in Section 55 of  
6           this Act and, through clinical experience in the past 3  
7           years, are experts in the treatment of the covered  
8           person's condition and knowledgeable about the  
9           recommended or requested health care service or  
10           treatment.

11           (B) Neither the covered person, the covered  
12           person's authorized representative, if applicable, nor  
13           the health carrier shall choose or control the choice  
14           of the physicians or other health care professionals to  
15           be selected to conduct the external review.

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

21           (4) In reaching an opinion, clinical reviewers are not  
22           bound by any decisions or conclusions reached during the  
23           health carrier's utilization review process or the health  
24           carrier's internal appeal process.

25           (i) Within 5 business days after the date of receipt of the  
26           notice provided pursuant to subsection (g) of this Section, the

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

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

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

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

25 (j) Upon receipt of the information from the health carrier  
26 or its utilization review organization, each clinical reviewer



1 selected pursuant to subsection (h) of this Section shall  
2 review all of the information and documents and any other  
3 information submitted in writing to the independent review  
4 organization by the covered person and the covered person's  
5 authorized representative.

6 (k) Upon receipt of any information submitted by the  
7 covered person or the covered person's authorized  
8 representative, the independent review organization shall  
9 forward the information to the health carrier within one  
10 business day. In such cases, the following provisions shall  
11 apply:

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 be terminated only 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) Immediately upon making its decision to

1           reverse its adverse determination or final adverse  
2           determination, the health carrier shall notify the  
3           Director, the covered person and, if applicable, the  
4           covered person's authorized representative, and the  
5           assigned independent review organization in writing of  
6           its 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          (1) The following provisions apply concerning clinical  
13          review opinions:

14           (1) Except as provided in item (3) of this subsection  
15           (1), within 20 days after being selected in accordance with  
16           subsection (h) of this Section to conduct the external  
17           review, each clinical reviewer shall provide an opinion to  
18           the assigned independent review organization on whether  
19           the recommended or requested health care service or  
20           treatment should be covered.

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

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

26           (B) a description of the indicators relevant to

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

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

13 (D) a description and analysis of any  
14 evidence-based standard; and

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

18 (3) The provisions of this item (3) apply concerning  
19 the timing of opinions:

20 (A) For an expedited external review, each  
21 clinical reviewer shall provide an opinion orally or in  
22 writing to the assigned independent review  
23 organization as expeditiously as the covered person's  
24 medical condition or circumstances requires, but in no  
25 event more than 5 calendar days after being selected in  
26 accordance with subsection (h) of this Section.

1           (B) If the opinion provided pursuant to  
2           subdivision (A) of this item (3) was not in writing,  
3           then within 48 hours following the date the opinion was  
4           provided, the clinical reviewer shall provide written  
5           confirmation of the opinion to the assigned  
6           independent review organization and include the  
7           information required under item (2) of this subsection  
8           (1).

9           (m) In addition to the documents and information provided  
10          by the health carrier or its utilization review organization  
11          and the covered person and the covered person's authorized  
12          representative, if any, each clinical reviewer selected  
13          pursuant to subsection (h) of this Section, to the extent the  
14          information or documents are available and the clinical  
15          reviewer considers appropriate, shall consider the following  
16          in reaching a decision:

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

18               (2) the covered person's health care provider's  
19               recommendation;

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

26               (4) the terms of coverage under the covered person's

1 health benefit plan with the health carrier to ensure that,  
2 but for the health carrier's determination that the  
3 recommended or requested health care service or treatment  
4 that is the subject of the opinion is experimental or  
5 investigational, the reviewer's opinion is not contrary to  
6 the terms of coverage under the covered person's health  
7 benefit plan with the health carrier; and

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

21 (n) The following provisions apply concerning decisions,  
22 notices, and recommendations:

23 (1) The provisions of this item (1) apply concerning  
24 decisions and notices:

25 (A) Except as provided in subdivision (B) of this  
26 item (1), within 20 days after the date it receives the

1           opinion of each clinical reviewer, the assigned  
2           independent review organization, in accordance with  
3           item (2) of this subsection (n), shall make a decision  
4           and provide written notice of the decision to the  
5           Director, the health carrier, the covered person, and  
6           the covered person's authorized representative, if  
7           applicable.

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

22           (2) The provisions of this item (2) apply concerning  
23           recommendations:

24           (A) If a majority of the clinical reviewers  
25           recommend that the recommended or requested health  
26           care service or treatment should be covered, then the

1 independent review organization shall make a decision  
2 to reverse the health carrier's adverse determination  
3 or final adverse determination.

4 (B) If a majority of the clinical reviewers  
5 recommend that the recommended or requested health  
6 care service or treatment should not be covered, the  
7 independent review organization shall make a decision  
8 to uphold the health carrier's adverse determination  
9 or final adverse determination.

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

12 (i) If the clinical reviewers are evenly split  
13 as to whether the recommended or requested health  
14 care service or treatment should be covered, then  
15 the independent review organization shall obtain  
16 the opinion of an additional clinical reviewer in  
17 order for the independent review organization to  
18 make a decision based on the opinions of a majority  
19 of the clinical reviewers pursuant to subdivision  
20 (A) or (B) of this item (2).

21 (ii) The additional clinical reviewer selected  
22 under clause (i) of this subdivision (C) shall use  
23 the same information to reach an opinion as the  
24 clinical reviewers who have already submitted  
25 their opinions.

26 (iii) The selection of the additional clinical

1 reviewer under this subdivision (C) shall not  
2 extend the time within which the assigned  
3 independent review organization is required to  
4 make a decision based on the opinions of the  
5 clinical reviewers.

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

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

10 (2) the written opinion of each clinical reviewer,  
11 including the recommendation of each clinical reviewer as  
12 to whether the recommended or requested health care service  
13 or treatment should be covered and the rationale for the  
14 reviewer's recommendation;

15 (3) the date the independent review organization  
16 received the assignment from the Director to conduct the  
17 external review;

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

20 (5) the date of its decision;

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

22 and

23 (7) the rationale for its decision.

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



1 the subject of the adverse determination or final adverse  
2 determination.

3 (q) The assignment by the Director of an approved  
4 independent review organization to conduct an external review  
5 in accordance with this Section shall be done on a random basis  
6 among those independent review organizations approved by the  
7 Director pursuant to this Act.

8 (215 ILCS 180/55)

9 Sec. 55. Minimum qualifications for independent review  
10 organizations.

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

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

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

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

1           adequate number of clinical reviewers to meet this  
2           objective;

3           (C) for adverse determinations involving  
4           experimental or investigational treatments, in  
5           assigning clinical reviewers, the independent review  
6           organization selects physicians or other health care  
7           professionals who, through clinical experience in the  
8           past 3 years, are experts in the treatment of the  
9           covered person's condition and knowledgeable about the  
10          recommended or requested health care service or  
11          treatment;

12          (D) the health carrier, the covered person, and the  
13          covered person's authorized representative shall not  
14          choose or control the choice of the physicians or other  
15          health care professionals to be selected to conduct the  
16          external review;

17          (E) confidentiality of medical and treatment  
18          records and clinical review criteria; and

19          (F) any person employed by or under contract with  
20          the independent review organization adheres to the  
21          requirements of this Act;

22          (2) a toll-free telephone service operating on a  
23          24-hour-day, 7-day-a-week basis that accepts, receives,  
24          and records information related to external reviews and  
25          provides appropriate instructions; and

26          (3) an agreement to maintain and provide to the

1 Director the information set out in Section 70 of this Act.

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

6 (1) be an expert in the treatment of the covered  
7 person's medical condition that is the subject of the  
8 external review;

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

13 (3) hold a non-restricted license in a state of the  
14 United States and, for physicians, a current certification  
15 by a recognized American medical specialty board in the  
16 area or areas appropriate to the subject of the external  
17 review; and

18 (4) have no history of disciplinary actions or  
19 sanctions, including loss of staff privileges or  
20 participation restrictions, that have been taken or are  
21 pending by any hospital, governmental agency or unit, or  
22 regulatory body that raise a substantial question as to the  
23 clinical reviewer's physical, mental, or professional  
24 competence or moral character.

25 (c) In addition to the requirements set forth in subsection  
26 (a), an independent review organization may not own or control,

1 be a subsidiary of, or in any way be owned, or controlled by,  
2 or exercise control with a health benefit plan, a national,  
3 State, or local trade association of health benefit plans, or a  
4 national, State, or local trade association of health care  
5 providers.

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

15 (1) the health carrier that is the subject of the  
16 external review;

17 (2) the covered person whose treatment is the subject  
18 of the external review or the covered person's authorized  
19 representative;

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

22 (4) the health care provider, the health care  
23 provider's medical group or independent practice  
24 association recommending the health care service or  
25 treatment that is the subject of the external review;

26 (5) the facility at which the recommended health care

1 service or treatment would be provided; or

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

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

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

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

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

22 (215 ILCS 180/65)

23 Sec. 65. External review reporting requirements.

24 (a) Each health carrier shall maintain written records in  
25 the aggregate, by state, and for each type of health benefit

1 plan offered by the health carrier on all requests for external  
2 review that the health carrier received notice from the  
3 Director for each calendar year and submit a report to the  
4 Director in the format specified by the Director by March 1 of  
5 each year.

6 (a-5) An independent review organization assigned pursuant  
7 to this Act to conduct an external review shall maintain  
8 written records in the aggregate by state and by health carrier  
9 on all requests for external review for which it conducted an  
10 external review during a calendar year and submit a report in  
11 the format specified by the Director by March 1 of each year.

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

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

15 (2) the number of requests for external review resolved  
16 and, of those resolved, the number resolved upholding the  
17 adverse determination or final adverse determination and  
18 the number resolved reversing the adverse determination or  
19 final adverse determination;

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

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

24 (5) the number of external reviews that were terminated  
25 as the result of a reconsideration by the health carrier of  
26 its adverse determination or final adverse determination

1 after the receipt of additional information from the  
2 covered person or the covered person's authorized  
3 representative; and

4 (6) any other information the Director may request or  
5 require.

6 (a-15) The independent review organization shall retain  
7 the written records required pursuant to this Section for at  
8 least 3 years.

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

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

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

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

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

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

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

25 (C) the number of requests for expedited external  
26 review resolved upholding the adverse determination or

1 final adverse determination; and

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

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

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

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

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

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

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

25 (D) claims and utilization review (dissatisfaction  
26 regarding the concurrent or retrospective evaluation



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

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

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

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

16 (215 ILCS 180/75)

17 Sec. 75. Disclosure requirements.

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

22 (b) The description required under subsection (a) of this  
23 Section shall include a statement that informs the covered  
24 person of the right of the covered person to file a request for  
25 an external review of an adverse determination or final adverse

1 determination with the Director ~~health carrier~~. The statement  
2 shall explain that external review is available when the  
3 adverse determination or final adverse determination involves  
4 an issue of medical necessity, appropriateness, health care  
5 setting, level of care, or effectiveness. The statement shall  
6 include the toll-free telephone number and address of the  
7 Office of Consumer Health Insurance within the Department of  
8 Insurance.

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

10 (215 ILCS 180/80 new)

11 Sec. 80. Administration and enforcement.

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

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

22 Section 99. Effective date. This Act takes effect on July  
23 1, 2011."