**Section 132.58 Utilization Management by the Public Payer**

a) The recommendation by the provider's LPHA using the standards in Section 132.145 for determining medical necessity may be reviewed by an LPHA employed by the public payer, or an LPHA designee to confirm ongoing medical necessity for each prescribed service in each client record selected for review after the initiation of services. The public payer shall notify the provider of the findings of the medical necessity review within 7 days after the end of the review.

b) If there is a finding in the review that ongoing medical necessity is not demonstrated, the public payer may not pay for any service it determines is not medically necessary unless a request for reconsideration or an appeal is filed.

c) If the public payer and the LPHA of the provider do not concur on medical necessity, the provider may request reconsideration of the decision of the public payer in writing within 30 days after the review to the public payer specifying the grounds for the reconsideration. The provider may submit additional supporting evidence or documentation for the reconsideration. During the reconsideration, the client may continue to receive service that will be funded by the public payer.

1) The reconsideration request shall be reviewed by an LPHA, designated by the public payer, who has not been involved in the medical necessity review finding, within 14 days after receipt of the reconsideration request.

2) If the LPHA denies the reconsideration request of the provider, the provider may appeal in writing within 5 days after the date of the denial to the director/secretary of the public payer. No additional evidence or documentation may be provided for the appeal.

3) The appeal provisions in Section 132.44 are not applicable to appeals under this Section.

4) The director/secretary shall issue a final administrative decision regarding the appeal.

5) The final administrative decision shall be subject to judicial review exclusively as provided in the Administrative Review Law [735 ILCS 5/Art. III].

d) If an appeal is filed, the client may continue to receive service that will be funded by the public payer during the appeal process.

e) If the finding of the final appeal agrees that the service is not medically necessary, the provider must inform the client of the finding and work with the client to make an informed choice about continuing the service with non-public payer funding or receiving a different medically necessary Part 132 service.

(Source: Added at 35 Ill. Reg. 8860, effective May 26, 2011)