HB6837

LRB093 20734 SAS 46624 b

93RD GENERAL ASSEMBLY

State of Illinois

2003 and 2004

Introduced 02/09/04, by Mary E. Flowers

SYNOPSIS AS INTRODUCED:

215 ILCS 5/155.42 new

Amends the Illinois Insurance Code. Requires an insurer to establish and maintain a procedure for dealing with appeals of the insurer's administrative determinations and complaints regarding its administrative decisions. Provides that an appeal may be filed by an insured or his or her designee or guardian, physician, or health care provider. Requires an insurer to designate a clinical peer to review appeals. Provides that if an appeal is denied, the person who requested the appeal may request an external independent review of the denial. Provides procedures for external independent review.

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A BILL FOR

AN ACT concerning insurance.

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

Section 5. The Illinois Insurance Code is amended by adding Sections 155.42 as follows:

(215 ILCS 5/155.42 new)

Sec. 155.42. External independent review. Denial of coverage; appeals and external independent reviews.

(a) An insurer shall establish and maintain an appeals procedure as outlined in this Section. Compliance with this Section's appeals procedures shall satisfy an insurer's obligation to provide appeal procedures under any other State law or rules. All appeals of an insurer's administrative determinations and complaints regarding its administrative decisions shall be handled as required under this Section.

(b) When an appeal concerns a decision or action by an insurer, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an insured with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an insured's health, or (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an insured's health, the insurer must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, an insurer must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the insurer requires to evaluate the appeal. The insurer shall render a decision on the appeal within 24 hours after receipt of the required information. The insurer shall notify the party filing the appeal and the

insured, insured's physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an insured and not covered by subsection (b), the insurer shall establish a procedure for the filing of those appeals. Upon submission of an appeal under this subsection, an insurer must notify the party filing an appeal, within 3 business days, of all information that the insurer requires to evaluate the appeal. The insurer shall render a decision on the appeal within 15 business days after receipt of the required information. The insurer shall notify the party filing the appeal, the insured, the insured's physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed-up by a written notice of the determination.

(d) An appeal under subsection (b) or (c) may be filed by the insured, the insured's designee or guardian, the insured's physician, or the insured's health care provider. An insurer shall designate a clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review under subsection (f).

(e) If an appeal filed under subsection (b) or (c) is denied for a reason including, but not limited to, the service,

procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, or denial of hospitalization requests or length of stay requests, any involved party may request an external independent review under subsection (f) of the adverse determination.

(f) External independent review.

(1) The party seeking an external independent review shall so notify the insurer. The insurer shall seek to resolve all external independent reviews in the most expeditious manner and shall make a determination and provide notice of the determination no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to an insured's health or when extended health care services for an insured undergoing a course of treatment prescribed by a health care provider are at issue.

(2) Within 30 days after the insured receives written notice of an adverse determination, if the insured decides to initiate an external independent review, the insured shall send to the insurer a written request for an external independent review, including any information or documentation to support the insured's request for the covered service or claim for a covered service.

(3) Within 30 days after the insurer receives a request for an external independent review from an insured, the insurer shall:

(A) provide a mechanism for joint selection of an external independent reviewer by the insured, the insured's physician or other health care provider, and the insurer; and

(B) forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of the insurer's decision, the criteria used, and the medical and clinical reasons for that decision.

(4) Within 5 days after receipt of all necessary information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on whether or not the health care service or claim for the health care service is medically appropriate. The decision by the independent reviewer is final. If the external independent reviewer determines the health care service to be medically appropriate, the insurer shall pay for the health care service.

(5) The insurer shall be solely responsible for paying the fees of the external independent reviewer who is selected to perform the review.

(6) An external independent reviewer who acts in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review, unless the acts or omissions constitute wilful and wanton misconduct. For purposes of any proceeding, the good faith of the person participating shall be presumed.

(7) Future contractual or employment action by the insurer regarding the patient's physician or other health care provider shall not be based solely on the physician's or other health care provider's participation in this procedure.

(8) For the purposes of this Section, an external independent reviewer shall:

(A) be a clinical peer;

(B) have no direct financial interest in connection with the case; and

(C) have not been informed of the specific identity of the insured.

(g) Nothing in this Section shall be construed to require an insurer to pay for a health care service not covered under the insured's policy.

(h) For the purposes of this Section, an "insurer" offers a health care plan (plan) that establishes, operates, or

maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall not include the following:

(1) indemnity health insurance policies including those using a contracted provider network;

(2) health care plans that offer only dental or only vision coverage;

(3) preferred provider administrators, as defined in Section 370q(g) of the Illinois Insurance Code;

(4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974;

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

(6) not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.