**Rep. Mary E. Flowers**

# Filed: 3/4/2008



AMENDMENT TO HOUSE BILL 4223

AMENDMENT NO. _____. Amend House Bill 4223, on page 4, line 17, by deleting "or"; and

on page 4, line 20, after "health", by inserting ", or (iii) nonrenewal or termination of a policy or plan"; and

on page 15, immediately below line 8, by inserting the following:

"Section 37. The Managed Care Reform and Patient Rights Act is amended by changing Section 45 as follows:

(215 ILCS 134/45)

Sec. 45. Health care services appeals, complaints, and external independent reviews.

(a) A health care plan shall establish and maintain an appeals procedure as outlined in this Act. Compliance with this

Act's appeals procedures shall satisfy a health care plan's obligation to provide appeal procedures under any other State law or rules. All appeals of a health care plan's administrative determinations and complaints regarding its administrative decisions shall be handled as required under Section 50.

(b) When an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee'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 enrollee's health, or (iii) nonrenewal or termination of a plan, the health care plan must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, a health care plan 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 plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 24 hours after receipt of the required information. The health care plan shall notify the party filing the appeal and the enrollee, enrollee's primary care 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 enrollee and not covered by subsection (b) above, the health care plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a health care plan must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health care plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care 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 enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. A health care plan 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, denial of referral to specialist physicians 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 health care plan. The health care plan 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 enrollee's health or when extended health care services for an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.

(2) Within 30 days after the enrollee receives written

notice of an adverse determination, if the enrollee decides to initiate an external independent review, the enrollee shall send to the health care plan a written request for an external independent review, including any information or documentation to support the enrollee's request for the covered service or claim for a covered service.

(3) Within 30 days after the health care plan receives a request for an external independent review from an enrollee, the health care plan shall:

(A) provide a mechanism for joint selection of an external independent reviewer by the enrollee, the enrollee's physician or other health care provider, and the health care plan; 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 health care plan'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 health care plan shall pay for the health care service.

(5) The health care plan 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 health care plan 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 enrollee.

(g) Nothing in this Section shall be construed to require a health care plan to pay for a health care service not covered

under the enrollee's certificate of coverage or policy.

(h) Notwithstanding any other rulemaking authority that may exist, neither the Governor nor any agency or agency head under the jurisdiction of the Governor has any authority to make or promulgate rules to implement or enforce the provisions of this amendatory Act of the 95th General Assembly. If, however, the Governor believes that rules are necessary to implement or enforce the provisions of this amendatory Act of the 95th General Assembly, the Governor may suggest rules to the General Assembly by filing them with the Clerk of the House and the Secretary of the Senate and by requesting that the General Assembly authorize such rulemaking by law, enact those suggested rules into law, or take any other appropriate action in the General Assembly's discretion. Nothing contained in this amendatory Act of the 95th General Assembly shall be interpreted to grant rulemaking authority under any other Illinois statute where such authority is not otherwise explicitly given. For the purposes of this amendatory Act of the 95th General Assembly, "rules" is given the meaning contained in Section 1-70 of the Illinois Administrative Procedure Act, and "agency" and "agency head" are given the meanings contained in Sections 1-20 and 1-25 of the Illinois Administrative Procedure Act to the extent that such definitions apply to agencies or agency heads under the jurisdiction of the Governor.

(Source: P.A. 91-617, eff. 1-1-00.)".