



96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB5079

Introduced 1/29/2010, by Rep. Greg Harris

SYNOPSIS AS INTRODUCED:

215 ILCS 180/35

Amends the Health Carrier External Review Act. In the provision concerning standard external review, provides that before a determination on an appeal relating to a determination based on treatment being experimental or investigational is made, a physician licensed under the Medical Practice Act of 1987 (instead of licensed to practice medicine in all its branches) shall certify that a certain situation is applicable. Contains a nonacceleration clause.

LRB096 18956 RPM 34344 b

1 AN ACT concerning insurance.

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

4 Section 5. The Health Carrier External Review Act is
5 amended by changing Section 35 as follows:

6 (215 ILCS 180/35)

7 (This Section may contain text from a Public Act with a
8 delayed effective date)

9 Sec. 35. Standard external review.

10 (a) Within 4 months after the date of receipt of a notice
11 of an adverse determination or final adverse determination, a
12 covered person or the covered person's authorized
13 representative may file a request for an external review with
14 the health carrier.

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

18 (1) the individual is or was a covered person in the
19 health benefit plan at the time the health care service was
20 requested or at the time the health care service was
21 provided;

22 (2) the health care service that is the subject of the
23 adverse determination or the final adverse determination

1 is a covered service under the covered person's health
2 benefit plan, but the health carrier has determined that
3 the health care service is not covered because it does not
4 meet the health carrier's requirements for medical
5 necessity, appropriateness, health care setting, level of
6 care, or effectiveness;

7 (3) the covered person has exhausted the health
8 carrier's internal grievance process as set forth in this
9 Act;

10 (4) for appeals relating to a determination based on
11 treatment being experimental or investigational, the
12 requested health care service or treatment that is the
13 subject of the adverse determination or final adverse
14 determination is a covered benefit under the covered
15 person's health benefit plan except for the health
16 carrier's determination that the service or treatment is
17 experimental or investigational for a particular medical
18 condition and is not explicitly listed as an excluded
19 benefit under the covered person's health benefit plan with
20 the health carrier and that the covered person's health
21 care provider, who is a physician licensed under the
22 Medical Practice Act of 1987 ~~to practice medicine in all~~
23 ~~its branches~~, has certified that one of the following
24 situations is applicable:

25 (A) standard health care services or treatments
26 have not been effective in improving the condition of

1 the covered person;

2 (B) standard health care services or treatments
3 are not medically appropriate for the covered person;

4 (C) there is no available standard health care
5 service or treatment covered by the health carrier that
6 is more beneficial than the recommended or requested
7 health care service or treatment;

8 (D) the health care service or treatment is likely
9 to be more beneficial to the covered person, in the
10 health care provider's opinion, than any available
11 standard health care services or treatments; or

12 (E) that scientifically valid studies using
13 accepted protocols demonstrate that the health care
14 service or treatment requested is likely to be more
15 beneficial to the covered person than any available
16 standard health care services or treatments; and

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

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

25 (1) is not complete, the health carrier shall inform
26 the covered person and, if applicable, the covered person's

1 authorized representative in writing and include in the
2 notice what information or materials are required by this
3 Act to make the request complete; or

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

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

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

23 (d) Whenever a request is eligible for external review the
24 health carrier shall, within 5 business days:

25 (1) assign an independent review organization from the
26 list of approved independent review organizations compiled

1 and maintained by the Director; and

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

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

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

23 (f) Upon assignment of an independent review organization,
24 the health carrier or its designee utilization review
25 organization shall, within 5 business days, provide to the
26 assigned independent review organization the documents and any

1 information considered in making the adverse determination or
2 final adverse determination; in such cases, the following
3 provisions shall apply:

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

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

15 (3) Within one business day after making the decision
16 to terminate the external review and make a decision to
17 reverse the adverse determination or final adverse
18 determination under item (2) of this subsection (f), the
19 independent review organization shall notify the health
20 carrier, the covered person and, if applicable, the covered
21 person's authorized representative, of its decision to
22 reverse the adverse determination.

23 (g) Upon receipt of the information from the health carrier
24 or its utilization review organization, the assigned
25 independent review organization shall review all of the
26 information and documents and any other information submitted

1 in writing to the independent review organization by the
2 covered person and the covered person's authorized
3 representative.

4 (h) Upon receipt of any information submitted by the
5 covered person or the covered person's authorized
6 representative, the independent review organization shall
7 forward the information to the health carrier within 1 business
8 day.

9 (1) Upon receipt of the information, if any, the health
10 carrier may reconsider its adverse determination or final
11 adverse determination that is the subject of the external
12 review.

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

16 (3) The external review may only be terminated if the
17 health carrier decides, upon completion of its
18 reconsideration, to reverse its adverse determination or
19 final adverse determination and provide coverage or
20 payment for the health care service that is the subject of
21 the adverse determination or final adverse determination.
22 In such cases, the following provisions shall apply:

23 (A) Within one business day after making the
24 decision to reverse its adverse determination or final
25 adverse determination, the health carrier shall notify
26 the covered person and if applicable, the covered

1 person's authorized representative, and the assigned
2 independent review organization in writing of its
3 decision.

4 (B) Upon notice from the health carrier that the
5 health carrier has made a decision to reverse its
6 adverse determination or final adverse determination,
7 the assigned independent review organization shall
8 terminate the external review.

9 (i) 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, the independent review organization,
13 to the extent the information or documents are available and
14 the independent review organization considers them
15 appropriate, shall consider the following in reaching a
16 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, the covered person, the covered person's
23 authorized representative, or the covered person's
24 treating provider;

25 (4) the terms of coverage under the covered person's
26 health benefit plan with the health carrier to ensure that

1 the independent review organization's decision is not
2 contrary to the terms of coverage under the covered
3 person's health benefit plan with the health carrier;

4 (5) the most appropriate practice guidelines, which
5 shall include applicable evidence-based standards and may
6 include any other practice guidelines developed by the
7 federal government, national or professional medical
8 societies, boards, and associations;

9 (6) any applicable clinical review criteria developed
10 and used by the health carrier or its designee utilization
11 review organization; and

12 (7) the opinion of the independent review
13 organization's clinical reviewer or reviewers after
14 considering items (1) through (6) of this subsection (i) to
15 the extent the information or documents are available and
16 the clinical reviewer or reviewers considers the
17 information or documents appropriate; and

18 (8) for a denial of coverage based on a determination
19 that the health care service or treatment recommended or
20 requested is experimental or investigational, whether and
21 to what extent:

22 (A) the recommended or requested health care
23 service or treatment has been approved by the federal
24 Food and Drug Administration, if applicable, for the
25 condition;

26 (B) medical or scientific evidence or

1 evidence-based standards demonstrate that the expected
2 benefits of the recommended or requested health care
3 service or treatment is more likely than not to be
4 beneficial to the covered person than any available
5 standard health care service or treatment 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; or

10 (C) the terms of coverage under the covered
11 person's health benefit plan with the health carrier to
12 ensure that the health care service or treatment that
13 is the subject of the opinion is experimental or
14 investigational would otherwise be covered under the
15 terms of coverage of the covered person's health
16 benefit plan with the health carrier.

17 (j) Within 5 days after the date of receipt of all
18 necessary information, the assigned independent review
19 organization shall provide written notice of its decision to
20 uphold or reverse the adverse determination or the final
21 adverse determination to the health carrier, the covered person
22 and, if applicable, the covered person's authorized
23 representative. In reaching a decision, the assigned
24 independent review organization is not bound by any claim
25 determinations reached prior to the submission of information
26 to the independent review organization. In such cases, the

1 following provisions shall apply:

2 (1) The independent review organization shall include
3 in the notice:

4 (A) a general description of the reason for the
5 request for external review;

6 (B) the date the independent review organization
7 received the assignment from the health carrier to
8 conduct the external review;

9 (C) the time period during which the external
10 review was conducted;

11 (D) references to the evidence or documentation,
12 including the evidence-based standards, considered in
13 reaching its decision;

14 (E) the date of its decision; and

15 (F) the principal reason or reasons for its
16 decision, including what applicable, if any,
17 evidence-based standards that were a basis for its
18 decision.

19 (2) For reviews of experimental or investigational
20 treatments, the notice shall include the following
21 information:

22 (A) a description of the covered person's medical
23 condition;

24 (B) a description of the indicators relevant to
25 whether there is sufficient evidence to demonstrate
26 that the recommended or requested health care service

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

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

11 (D) a description and analysis of any
12 evidence-based standards;

13 (E) whether the recommended or requested health
14 care service or treatment has been approved by the
15 federal Food and Drug Administration, for the
16 condition;

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

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

6 (3) In reaching a decision, the assigned independent
7 review organization is not bound by any decisions or
8 conclusions reached during the health carrier's
9 utilization review process or the health carrier's
10 internal grievance or appeals process.

11 (4) Upon receipt of a notice of a decision reversing
12 the adverse determination or final adverse determination,
13 the health carrier immediately shall approve the coverage
14 that was the subject of the adverse determination or final
15 adverse determination.

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

17 Section 95. No acceleration or delay. Where this Act makes
18 changes in a statute that is represented in this Act by text
19 that is not yet or no longer in effect (for example, a Section
20 represented by multiple versions), the use of that text does
21 not accelerate or delay the taking effect of (i) the changes
22 made by this Act or (ii) provisions derived from any other
23 Public Act.