

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 ordered or provided the services in  
22 question and who is licensed under the Medical Practice Act  
23 of 1987 ~~is a physician licensed to practice medicine in all~~  
24 ~~its branches~~, has certified that one of the following  
25 situations is applicable:

26 (A) standard health care services or treatments

1           have not been effective in improving the condition of  
2           the covered person;

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

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

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

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

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

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

26                 (1) is not complete, the health carrier shall inform

1 the covered person and, if applicable, the covered person's  
2 authorized representative in writing and include in the  
3 notice what information or materials are required by this  
4 Act to make the request complete; or

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

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 and shall be subject to all applicable provisions  
23 of this Act.

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

26 (1) assign an independent review organization from the

1 list of approved independent review organizations compiled  
2 and maintained by the Director; and

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

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

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

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

1 assigned independent review organization the documents and any  
2 information considered in making the adverse determination or  
3 final adverse determination; in such cases, the following  
4 provisions shall apply:

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

10 (2) If the health carrier or its utilization review  
11 organization fails to provide the documents and  
12 information within the specified time frame, 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 (3) 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 (2) of this subsection (f), the  
20 independent review organization shall notify the health  
21 carrier, the covered person and, if applicable, the covered  
22 person's authorized representative, of its decision to  
23 reverse the adverse determination.

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

1 information and documents and any other information submitted  
2 in writing to the independent review organization by the  
3 covered person and the covered person's authorized  
4 representative.

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

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

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

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

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

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

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

10 (i) In addition to the documents and information provided  
11 by the health carrier or its utilization review organization  
12 and the covered person and the covered person's authorized  
13 representative, if any, the independent review organization,  
14 to the extent the information or documents are available and  
15 the independent review organization considers them  
16 appropriate, shall consider the following in reaching a  
17 decision:

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

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

21 (3) consulting reports from appropriate health care  
22 providers and other documents submitted by the health  
23 carrier, the covered person, the covered person's  
24 authorized representative, or the covered person's  
25 treating provider;

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



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

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

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

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

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

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

1 (B) medical or scientific evidence or  
2 evidence-based standards demonstrate that the expected  
3 benefits of the recommended or requested health care  
4 service or treatment is more likely than not to be  
5 beneficial to the covered person than any available  
6 standard health care service or treatment and the  
7 adverse risks of the recommended or requested health  
8 care service or treatment would not be substantially  
9 increased over those of available standard health care  
10 services or treatments; or

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

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

1 to the independent review organization. In such cases, the  
2 following provisions shall apply:

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

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

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

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

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

15 (E) the date of its decision; and

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

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

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

25 (B) a description of the indicators relevant to  
26 whether there is sufficient evidence to demonstrate

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

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

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

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

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

1 services or treatments; and

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

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

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

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

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