



Illinois Insurance Facts

Illinois Department of Insurance

External Review (for adverse determinations on or after August 26th 2011)

August 2011

Note: This information was developed to provide consumers with general information and guidance about insurance coverage and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

House Bill 224 gives you the right under specific circumstances to apply for an External Review for the denial, reduction, termination or failure to make payment, in whole or in part, under the health carrier's health benefit plan on the basis that:

- 1) The request for benefits does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service; or
- 2) The health carrier considers the drug, procedure or therapy to be experimental and or/investigational; or
- 3) The health carrier has determined that the request for benefit involves a pre-existing health condition; or
- 4) The health carrier has rescinded coverage due to a reason other than failure to timely pay required premiums or contributions towards the cost of coverage.

Before you may apply for this review, you must have completed the grievance process outlined under your plan.

To guide you through this process, we have provided a brief overview of the grievance process.

DENIAL OF CLAIM

Under the terms of your health benefit plan, your health carrier (insurance company, HMO, Limited Health Service Organization, Voluntary Health Service Plan) or its respective utilization review company are permitted to make decisions involving medical judgments which may result in the reduction or denial of a requested benefit. The health carrier may decline to authorize a benefit for you because it has determined that benefit is not medically necessary based on an evaluation of the medical information submitted; because it has determined that the drug, procedure or therapy is considered experimental and/or investigational; because it has determined the benefit is for a preexisting condition; or because it has rescinded your health coverage for reasons other than nonpayment of premiums or contributions.

Members have the right to appeal any of these decisions as outlined below.

INTERNAL APPEALS THROUGH YOUR HEALTH CARRIER

Covered persons who are denied a benefit by a health carrier or whose coverage has been rescinded have the right to appeal that denial or rescission through the carrier's internal grievance process.

In addition, covered persons may be eligible for an expedited appeal for urgent care requests if:

- The time frame for making a standard determination could seriously jeopardize the life or health of the covered person, or their ability to regain maximum function; or
- The request involves an admission, availability of care, continued stay or health care service for which the covered person received emergency services and has not been discharged from a facility; or
- The request involves an experimental or investigation determination and the health care provider certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

Notice of the internal grievance procedure must be included with all denial letters sent by a health carrier. Members should follow these procedures when appealing a denial. The notice must also provide information regarding your right to an external review.

NOTE: If your requested benefit is denied because it is not a covered benefit under your plan, or your benefits for this service have reached its limit, then the grievance process is concluded after your final internal appeal and no further appeal or review is allowed under the plan.

Which health insurance policies must provide for an external independent review?

All fully insured individual and group health insurance policies, HMO contracts, Voluntary Health Services Plans contracts, and Limited Health Service Organization contracts must provide for an external independent review in accordance with the Health Carrier External Review Act **EXCEPT:**

- Health insurance policies that provide coverage *only for* a specified disease (for example, a cancer-only policy); specified accident or accident-only coverage; credit; dental; disability income; hospital indemnity; long-term care insurance; vision; or other limited supplemental benefits;
- Coverage through Medicare, Medicaid, or the Federal Employees Health Benefits Program;
- Self-insured employer plans;
- Self-insured health and welfare plans, such as union plans;
- Insurance policies or trusts issued in other states.
 - For HMOs, the Act does apply to contracts written outside of Illinois, if the HMO member is an Illinois resident and the HMO has established a provider network in Illinois. To determine if your HMO plan must comply with the Act, contact your HMO or check your certificate of coverage.

NOTE: The federal Patient Protection and Affordable Care Act (the “Affordable Care Act”) requires all individual and group health plans—including [self-insured plans](#)—to provide appeals procedures similar to those required by the Health Carrier External Review Act. This requirement is effective for plan years beginning on or after **September 23, 2010**. If you are covered by a self-insured plan, please contact your employer for more information on when the appeals procedures required by the Affordable Care Act will be effective for your plan.

How do I request an external independent review?

Your health carrier must provide you information about your right to request an external review, including an explanation of how to submit the request. This information must be included in your

policy or certificate, membership booklet, and outline of coverage (or other similar document). In addition, your health carrier must inform you in writing of your right to request an external review every time the company denies a pre-certification request or claim submitted by you or your doctor based on a determination as to the medical necessity of the recommended treatment, experimental/investigation status of the recommended treatment, the condition being considered pre-existing, or a health care coverage rescission. Generally, you must exhaust the internal appeal process of your health plan prior to requesting an external review. This requirement is waived for expedited external review requests (see below).

Beginning August 26th 2011 external review requests must be submitted to the Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 (toll-free phone number)
(217) 557-8495 (fax)
DOI.externalreview@illinois.gov

The cost of an external review will be paid for by the health carrier.

Your health carrier must provide a form for you to submit a written request for an external review. This form is also available on the Department's website at <http://insurance.illinois.gov/externalreview>.

You must file a request for an external review within **four (4) months** after you receive notice from your health carrier that the treatment recommended or provided by your doctor has been denied. If you submit an internal appeal to your insurance health carrier and your appeal is denied, you must file your request for an external review within 4 months after you receive notice that your appeal has been denied.

NOTE: An "authorized representative" may file a request for an external review on your behalf. An authorized representative must be: i) someone to whom you have given express written consent to represent you in an external review; ii) a person authorized by law to provide substituted consent for you; iii) a family member or your treating health care provider if you are unable to consent; iv) your health care provider when your plan requires that the request be initiated by the health care provider; or v) in the case of an urgent care request, your health care provider who has knowledge of your medical condition.

Which requests are eligible for external independent review?

Once you submit a request for an external review, the Department will send the request to your health carrier within one business day to determine if your request is eligible. The health carrier has five business days to make an initial eligibility determination.

In general, your request will be eligible for external review if:

- 1) You were covered by the health carrier policy or contract at the time the treatment was requested or provided;
- 2) The treatment is covered by your policy or contract, but health carrier has denied it due to medical necessity, experimental/investigational; pre-existing condition; or rescission of health care coverage;
- 3) You have exhausted the internal appeals to your health carrier, and the company has upheld its decision to deny payment for the treatment in question;
 - In certain urgent cases, you may be eligible for an “expedited” external review even if you have not filed an internal appeal with your health carrier;
 - In addition, you may be eligible for an external review if you filed an internal appeal but have not received a decision from your health carrier within 30 days for concurrent or prospective review or within 60 days for retrospective, or within 48 hours if you have filed a request for an expedited internal appeal;

NOTE: For more information about filing an internal appeal with your insurance company or HMO, please see the Department’s fact sheet on Medical Necessity at www.insurance.illinois.gov/HealthInsurance/Medical_Necessity.asp.

- 4) If the treatment is considered “experimental” or “investigational” by the health carrier and your health care provider (who must be a licensed physician) has certified that other “standard” treatments are not appropriate for your condition due to one of several reasons; and
- 5) You have provided all required information and forms.

If your health carrier determines that your request is ineligible for an external review, it must give you a written explanation of why your request is ineligible or incomplete within one business day. You may appeal the company’s determination by [filing a complaint](#) with the Department.

What happens if my request is eligible for external review?

Once your request is determined to be eligible for an external review, the Department will randomly assign a qualified Independent Review Organization (“IRO”), from a [list of IROs](#) approved by the Department of Insurance, to review your case.

How will a decision on my request for external review be reached?

- 1) After your case is assigned to an IRO by the Department, that IRO must assign a qualified clinical reviewer to review your case. A qualified clinical reviewer is a physician or other appropriate health care provider who is an expert in the treatment of your medical condition, with recent or current actual clinical experience treating patients with the same or similar condition and, for physicians, a current specialty certification appropriate to your condition. For cases involving experimental/investigational determinations, more than one clinical reviewer may be assigned.

- 2) Within **five business days** after the IRO assignment, your health carrier must submit to the IRO all the information the company used in making its decision to deny your treatment, including any information it may have received from you or your health care provider. You or your authorized representative also have **five business days**, from the date you receive notice from the Department of the name of the assigned IRO, to submit any additional information directly to the IRO. The IRO must maintain a 24-hour-a-day, 7-day-a-week system to receive and process such information.
- 3) In addition to the information provided by you, your authorized representative and your health carrier, the IRO must consider information including: your relevant medical records, your provider's recommendation, and the most appropriate practice guidelines for your condition, which must include any applicable evidence-based standards.

For external reviews involving experimental or investigational treatments, the IRO must also consider additional medical and scientific evidence to determine whether the treatment recommended by your provider is likely to be more beneficial to you than any other available "standard" treatment(s), and whether the adverse risks of the recommended treatment would be substantially increased compared to the available standard treatment(s).

- 4) Within 5 days, but in no event more than 45 days after receiving all necessary information, the IRO must provide written notice of its decision to you, your health carrier, the Department, and to your authorized representative, if you have one. If the IRO makes a decision reversing the original denial of treatment, your health carrier must immediately approve the coverage.

The written notice from the IRO must include basic information about the external review, including the date the review was initiated and the time period during which it was conducted, a description of the documentation and evidence considered, and the principal reason for the decision, including any applicable evidence-based standards.

For reviews involving experimental or investigational treatments, the notice must also include a description and analysis of all medical and scientific evidence considered, and the written opinion of the clinical reviewer(s) as to whether the evidence demonstrates that the recommended treatment would be more beneficial to you than other available standard treatment(s), and whether the adverse risks of the recommended treatment would be substantially increased compared to the available standard treatment(s).

Can I appeal the decision of an IRO?

Yes. Until July 2013, you can appeal the decision of an IRO by filing an appeal with the Department. If the Department, in consultation with a licensed medical professional, finds that the IRO's decision was "arbitrary and capricious"—for example, if the decision entirely failed to consider an important aspect of your case—the Department can overturn the IRO's decision and require the health carrier to pay for the treatment in question.

If your health carrier appeals the Department's decision, the Department must assign a new IRO to reconsider your case. The new IRO must make its decision using all of the information described above. This determination will be binding except that it does not prevent you from pursuing any other remedy available under federal or State law.

What if I have an urgent medical condition?

In certain urgent circumstances, you may have the right to an “expedited” external review. An expedited external review is similar to the standard external review described above, except that the review must be completed more expeditiously (depending on the reason for denial).

Specifically, the IRO must notify you, your authorized representative if you have one, the Department and your health carrier of its decision “as expeditiously as [your] medical condition or circumstances require,” but in no event more than **72 hours** after the IRO receives all necessary information for all cases **EXCEPT** experimental/investigational determinations, which must be made no later than **7 calendar days** after the date the request is received by the IRO.

If you have already filed an expedited internal appeal with your health carrier, and your appeal was denied (or if you have not received a decision within 48 hours), you may request an expedited external review if:

- 1) You have a medical condition in which the time it would take to complete a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function;
- 2) The recommended treatment involves an admission, availability of care, continued stay, or health care service for which you have received emergency services but have not yet been released; or
- 3) For a treatment considered by your health carrier to be experimental or investigational, your health care provider certifies that the treatment would be significantly less effective if it is delayed.

If you have not yet filed an internal appeal or an expedited internal appeal, you may request an expedited external review in writing if:

- 1) You have a medical condition in which the time it would take to complete an expedited internal appeal (48 hours) would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or
- 2) For a treatment considered by your health carrier to be experimental or investigational, your health care provider certifies that the treatment would be significantly less effective if it is delayed.

To be eligible for an expedited external review, your request must also meet the eligibility requirements of items (1), (2), and (4) described on pages 3-4 above.

NOTE: A request is not eligible for expedited external review if the request relates to a “retrospective” denial, or a case in which the health carrier has denied or reduced payment for a treatment after the treatment has already been provided.

How do I know that the independent reviewer assigned to my case is truly independent?

To be approved by the Department, an IRO must satisfy numerous requirements of the Health Carrier External Review Act designed to ensure that both the IRO and the clinical reviewer assigned to your case by the IRO are unbiased and free from conflicts of interest. For example:

- An IRO must establish and maintain written procedures to ensure the selection of “qualified and impartial” clinical reviewers, and to ensure that the IRO’s assignment of a particular clinical reviewer is not made or controlled by either the person requesting the external review or the person’s health carrier.
- An IRO may not own or control, be a subsidiary of, or in any way be owned, or controlled by, or exercise control with a health carrier, any trade association of a health carrier, or any trade association of health care providers.
- An IRO may not be assigned to review a specific case if the IRO or the clinical reviewer assigned by the IRO has any material professional, familial, or financial conflict of interest with:
 - the health carrier;
 - any officer, director or management employee of the health carrier;
 - the person requesting the review (or the person’s authorized representative, if applicable);
 - the health care provider, or the health care provider’s medical group or independent practice association;
 - the facility at which the recommended treatment would be provided; or
 - the developer or manufacturer of the primary drug, device, procedure, or other therapy that is the subject of the external review.
- An IRO must establish and maintain written procedures to ensure it is unbiased.

An IRO must renew its approval with the Department every two years. The Department may revoke the approval of an IRO at any time if it finds the IRO is not satisfying the minimum requirements of the Act, including the conflict of interest standards described above.

For a current list of the IROs approved by the Department, please click [here](#).

For More Information

Call the Office of Consumer Health Insurance toll free at (877) 850-4740
or visit us on our website at <http://insurance.illinois.gov/externalreview>