

215 ILCS 134/70 Post-Stabilization Medical Services

Sec. 70. Post-stabilization medical services.

(a) If prior authorization for covered post-stabilization services is required by the health care plan, the plan shall provide access 24 hours a day, 7 days a week to persons designated by the plan to make such determinations, provided that any determination made under this Section must be made by a health care professional. The review shall be resolved in accordance with the provisions of Section 85 and the time requirements of this Section.

(b) The treating physician licensed to practice medicine in all its branches or health care provider shall contact the health care plan or delegated health care provider as designated on the enrollee's health insurance card to obtain authorization, denial, or arrangements for an alternate plan of treatment or transfer of the enrollee.

(c) The treating physician licensed to practice medicine in all its branches or health care provider shall document in the enrollee's medical record the enrollee's presenting symptoms; emergency medical condition; and time, phone number dialed, and result of the communication for request for authorization of post-stabilization medical services. The health care plan shall provide reimbursement for covered post-stabilization medical services if:

(1) authorization to render them is received from the health care plan or its delegated health care provider, or

(2) after 2 documented good faith efforts, the treating health care provider has attempted to contact the enrollee's health care plan or its delegated health care provider, as designated on the enrollee's health insurance card, for prior authorization of post-stabilization medical services and neither the plan nor designated persons were accessible or the authorization was not denied within 60 minutes of the request. "Two documented good faith efforts" means the health care provider has called the telephone number on the enrollee's health insurance card or other available number either 2 times or one time and an additional call to any referral number provided. "Good faith" means honesty of purpose, freedom from intention to defraud, and being faithful to one's duty or obligation. For the purpose of this Act, good faith shall be presumed.

(d) After rendering any post-stabilization medical services, the treating physician licensed to practice medicine in all its branches or health care provider shall continue to make every reasonable effort to contact the health care plan or its delegated health care provider regarding authorization, denial, or arrangements for an alternate plan of treatment or transfer of the enrollee until the treating health care provider receives instructions from the health care plan or delegated health care provider for continued care or the care is transferred to another health care provider or the patient is discharged.

(e) Payment for covered post-stabilization services may be denied:

(1) if the treating health care provider does not meet the conditions outlined in subsection (c);

(2) upon determination that the post-stabilization services claimed were not performed;

(3) upon timely determination that the post-stabilization services rendered were contrary to the instructions of the health care plan or its delegated health care provider if contact was made between those parties prior to the service being rendered;

(4) upon determination that the patient receiving such services was not an enrollee of the health care plan; or

(f) Nothing in this Section prohibits a health care plan from delegating tasks associated with the responsibilities enumerated in this Section to the health care plan's contracted health care providers

or another entity. Only a clinical peer may make an adverse determination. However, the ultimate responsibility for coverage and payment decisions may not be delegated.

(g) Coverage and payment for post-stabilization medical services for which prior authorization or deemed approval is received shall not be retrospectively denied.

(h) Nothing in this Section shall prohibit the imposition of deductibles, copayments, and co-insurance. Nothing in this Section alters the prohibition on billing enrollees contained in the Health Maintenance Organization Act.

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