

The Health Carrier External Review Act does not apply to:

- 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**. The Department of Insurance and the U.S. Department of Health and Human Services will provide guidance for self-insured employers on the appeals procedures required by the Affordable Care Act.

For more information on the Affordable Care Act, please visit the Department’s Health Insurance Reform Information Center at: insurance.illinois.gov/HIRIC.

How do patients request an external independent review?

The health insurance company or HMO must provide the insured with information about the right to request an external review, including an explanation of how to submit the request. This information must be included in the policy or certificate, membership booklet, and outline of coverage (or other similar document). In addition, beginning July 1, 2010, the insurance company or HMO must inform the patient in writing of their right to request an external review every time the company denies a pre-certification request or claim submitted by the patient or their doctor based on a determination as to the medical necessity of the recommended treatment.

The insurance company or HMO will provide a form for the patient to submit a written request for an external review. In urgent cases (see below), a patient may also file a request over the telephone.

The patient must file their request for an external review within **four (4) months** after receiving notice from the insurance company or HMO that the treatment recommended or provided by the patient’s doctor has been denied. If a patient submits an internal appeal to the insurance company or HMO and the appeal is denied, the patient must file their request

for an external review within 4 months after receiving notice that their appeal has been denied.

NOTE: An “authorized representative” may file a request for an external review on behalf of the patient. An authorized representative must be: i) someone to whom the patient has given express written consent to represent the patient in an external review; ii) a person authorized by law to provide substituted consent for the patient; or iii) the patient’s health care provider, if the patient is unable to give consent.

Which requests are eligible for external independent review?

Once the patient has submitted a request for an external review, their insurance company or HMO has **five (5) business days** to determine if the request is eligible. In general, the patient’s request will be eligible for external review if:

1. The patient was covered by the insurance policy or HMO contract at the time the treatment was requested or provided;
2. The treatment is covered by the patient’s policy or contract, but their insurance company or HMO has determined the treatment does not meet its requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
3. The patient has first filed an internal appeal to their insurance company or HMO, and the company has upheld its decision to deny payment for the treatment in question;
 - In certain urgent cases, the patient may be eligible for an “expedited” external review even if s/he has not filed an internal appeal with their insurance company or HMO;
 - In addition, the patient may be eligible for an external review if they filed an internal appeal but have not received a decision from their insurance company or HMO within 15 days after the company receives all required information (in no case longer than 30 days after s/he has first filed the appeal), or within 48 hours if the patient has 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 of Insurance’s fact sheet on Medical Necessity at insurance.illinois.gov/HealthInsurance/Medical_Necessity.asp.

4. If the treatment is considered “experimental” or “investigational” by the insurance company or HMO, the patient’s health care provider (who must be a licensed physician) has certified that other “standard” treatments are not appropriate for their condition due to one of several reasons;
5. The patient has provided all required information and forms.

If the patient’s insurance company or HMO determines that their request is ineligible for an external review, it must give the patient a written explanation of why their request is ineligible or incomplete within one (1) business day. The patient may appeal the company’s determination by [filing a complaint](#) with the Department.

How will the independent reviewer make its decision?

1. Once the patient's insurance company determines that the patient's request is eligible for an external review, it has **five (5) business days** to assign a qualified Independent Review Organization ("IRO"), from a [list of IROs](#) approved by the Department of Insurance, to review the case.

The IRO must assign a qualified clinical reviewer—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—to review their case.

2. Within **five (5) business days** of assigning the IRO, the patient's insurance company or HMO must submit to the IRO all the information the company used in making its decision to deny the patient's treatment, including any information it may have received from the patient or their health care provider. The patient also has **five (5) business days**, from the date they receive notice from their insurance company or HMO that the patient's request is eligible for an external review, to submit any additional information 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 the patient and their insurance company or HMO, the IRO must consider information including: the patient's relevant medical records, their provider's recommendation, and the most appropriate practice guidelines for the patient's 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. After receiving all necessary information, the IRO has **five (5) calendar days** to provide written notice of its decision to the patient and their insurance company or HMO. If the IRO makes a decision reversing the original denial of treatment, the patient's insurance company or HMO 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 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 the patient appeal the decision of an independent reviewer?

Yes. The IRO's decision can be appealed by [filing a complaint](#) 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 the patient's case—the Department can overturn the IRO's decision and require the insurance company or HMO to pay for the treatment in question.

If the patient's insurance company or HMO appeals the Department's decision, the Department must assign a new IRO to reconsider the patient's case. The new IRO must make its decision using all of the information described above.

NOTE: The decision of an IRO, and any subsequent appeal, does not prevent the patient from pursuing any other remedy available under federal or State law.

What if I have an urgent medical condition?

In certain urgent circumstances, the patient 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 within **72 to 120 hours** after the patient files the request:

- The patient's insurance company or HMO must **immediately** determine whether the patient's request is eligible for an expedited external review;
- The patient's insurance company or HMO must **immediately** assign a qualified IRO from the list of approved IROs as described above;
- The patient's insurance company or HMO must **immediately** submit all necessary information to the IRO, but in no case more than **24 hours** after assigning the IRO;
- The IRO must notify the patient and their insurance company or HMO of its decision "as expeditiously as [the patient's] medical condition or circumstances requires," but in no event more than **two (2) business days** after the IRO receives all necessary information.

If the patient has already filed an internal appeal with their insurance company or HMO, and their appeal was denied (or if the patient has not received a decision within 48 hours), the patient may request an expedited external review—by telephone or in writing—if:

1. The patient has a medical condition in which the time it would take to complete a standard external review (15 business days + 5 calendar days, as described above) would seriously jeopardize the patient's life or health, or would jeopardize the patient's ability to regain maximum function;

2. The recommended treatment involves an admission, availability of care, continued stay, or health care service for which the patient has received emergency services but have not yet been released; or
3. For a treatment considered by the patient's insurance company or HMO to be experimental or investigational, the patient's health care provider certifies that the treatment would be significantly less effective if it is delayed.

If the patient has not yet filed an internal appeal, they may request an expedited external review—by telephone or in writing—if:

1. The patient has a medical condition in which the time it would take to complete an expedited internal appeal (48 hours) would seriously jeopardize the patient's life or health, or would jeopardize the patient's ability to regain maximum function; or
2. For a treatment considered by the patient's insurance company or HMO to be experimental or investigational, their health care provider certifies that the treatment would be significantly less effective if it is delayed.

To be eligible for an expedited external review, the patient's request must also meet the eligibility requirements of items (1), (2), and (4) described on pages 2-3 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 insurance company or HMO 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 the patient's 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 insurance company or HMO.
- 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 insurance company or HMO, any trade association of insurance companies or HMOs, 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 insurance company or HMO;
 - any officer, director or management employee of the insurance company or HMO;

- 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 Department of Insurance Consumer Services Section at (312) 814-2427 or the Office of Consumer Health Insurance toll free at (877) 527-9431 or visit them on their website at <http://insurance.illinois.gov>