



# Illinois Insurance Facts

Illinois Department of Insurance

## Independent Review of Denied Health Insurance Claims

July 1, 2010

**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.

Whether you submit a claim after receiving medical treatment or attempt to pre-certify a treatment recommended by your doctor, health insurance companies and HMOs will review the claim or pre-certification request to determine if the treatment is “medically necessary.” If the insurance company or HMO determines the treatment is not medically necessary, it will deny the pre-certification request, or deny or reduce payment for the claim.

Effective beginning **July 1, 2010**, the [Health Carrier External Review Act](#) (the “Act;” P.A. 96-857) grants all Illinoisans with health insurance the right to an external, independent review of denied health insurance claims.

- External reviews will be conducted by unbiased and qualified physicians, selected by nationally-accredited independent review organizations approved by the Department of Insurance.
- The entire cost of an external review will be paid for by the health insurance company or HMO.

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

All fully insured individual and group major medical health insurance policies and HMO contracts must provide for an external independent review in accordance with the Health Carrier External Review Act.

### 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**. If you receive coverage through 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.

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: [www.insurance.illinois.gov/HIRIC](http://www.insurance.illinois.gov/HIRIC).

## **How do I request an external independent review?**

Your health insurance company or HMO 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, beginning July 1, 2010, your insurance company or HMO 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.

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

You must file your request for an external review within **four (4) months** after you receive notice from your insurance company or HMO that the treatment recommended or provided by your doctor has been denied. If you submit an internal appeal to your insurance company or HMO 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; or iii) your health care provider, if you are unable to give consent.

## **Which requests are eligible for external independent review?**

Once you submit a request for an external review, your insurance company or HMO has **five (5) business days** to determine if your request is eligible. In general, your request will be eligible for external review if:

- 1) You were covered by the insurance policy or HMO contract at the time the treatment was requested or provided;
- 2) The treatment is covered by your policy or contract, but your 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) You have first filed an internal appeal to your insurance company or HMO, 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 insurance company or HMO;
  - In addition, you may be eligible for an external review if you filed an internal appeal but have not received a decision from your insurance company or HMO within 15 days after the company receives all required information (in no case longer than 30 days after you first file the appeal), 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](http://www.insurance.illinois.gov/HealthInsurance/Medical_Necessity.asp).

- 4) If the treatment is considered “experimental” or “investigational” by the insurance company or HMO, 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;
- 5) You have provided all required information and forms.

If your insurance company or HMO 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 (1) business day. You may appeal the company’s determination by [filing a complaint](#) with the Department.

### **How will the independent reviewer make its decision?**

- 1) Once your insurance company determines that your 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 your 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 your case.

- 2) Within **five (5) business days** of assigning the IRO, your insurance company or HMO 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 also have **five (5) business days**, from the date you receive notice from your insurance company or HMO that your 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 you and your insurance company or HMO, 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) After receiving all necessary information, the IRO has **five (5) calendar days** to provide written notice of its decision to you and your insurance company or HMO. If the IRO makes a decision reversing the original denial of treatment, your 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 I appeal the decision of an independent reviewer?**

Yes. You can appeal the decision of an IRO 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 your case—the Department can overturn the IRO's decision and require the insurance company or HMO to pay for the treatment in question.

If your insurance company or HMO 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.

**NOTE:** The decision of an IRO, and any subsequent appeal, 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 within **72 to 120 hours** after you file the request:

- Your insurance company or HMO must **immediately** determine whether your request is eligible for an expedited external review;
- Your insurance company or HMO must **immediately** assign a qualified IRO from the list of approved IROs as described above;
- Your 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 you and your insurance company or HMO of its decision “as expeditiously as [your] medical condition or circumstances requires,” but in no event more than **two (2) business days** after the IRO receives all necessary information.

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

- 1) You have 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 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 insurance company or HMO 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, you may request an expedited external review—by telephone or 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 insurance company or HMO 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 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 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 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 our Office of Consumer Health Insurance toll free at (877) 527-9431 or visit us on our website at <http://insurance.illinois.gov>