

Updated January 9, 2017

External Review Notice Requirements Checklist

215 ILCS 180/15 Applicability	Applies to all health carriers policies except to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by Article XIXA of the Illinois Insurance Code, vision care, or any other limited supplemental benefit; a Medicare supplement policy of insurance as defined by the Director by regulation; coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program; any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage; any coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance; automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.
215 ILCS 180/20(a)	All health denial letters that involve medical necessity, experimental/investigational, pre-existing conditions or rescissions must include notice of the covered person's right to appeal a coverage decision. The following language is required: <i>"We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by an independent review organization not associated with us by submitting a written request for an external review to the Department of Insurance, Office of Consumer Health Information, 320 West Washington Street, 4th Floor, Springfield, Illinois, 62767."</i> The written notice shall include a copy of the Department's Request for External Review form.
215 ILCS 180/20(b)	The notice must contain information regarding: (1) ability to skip internal appeals and standard review and file expedited for urgent situations; (2) ability to file an external review if the internal appeal has been delayed by carrier 30 days for concurrent or prospective and 60 days for retrospective; (3) ability to file for external review if an expedited internal appeal has been delayed by carrier - 48 hours (4) for experimental/investigational - ability to file for an expedited external review if delay of the recommended health service would be significantly less effective if delayed.
215 ILCS 180/20(c)	The notice must contain the three provisions in this section which explain when an expedited external review may be filed.
215 ILCS 180/20(d)	The notice must include a copy of the description of the standard and expedited external review procedures and highlight that additional information may accompany the request. The notice must include the External Review Request Form.
215 ILCS 180/20(c)	The notice must include the External Review Request form, the Authorized Representative Form and the Health Care Provider Certification form for expedited and experimental requests.
In addition, all Notices and forms must	
50 IL ADM Code 5430.40 (b)(1)(A)	Prominently display name, address, toll-free phone number, toll-free phone number, fax number and appeal email address of the carrier or administrator that handles appeals.
50 IL ADM Code 5430.40 (b)(1)(B)	shall be specific and limited to information regarding appeals and external review procedures for the member's plan.

All Notices	
50 IL ADM Code 5430.40 (b)(1)(C)	shall state the number of levels of appeals available (no more than two levels for group and one level for individual) under the plan and will state which level of appeal is applicable to the adverse determination within the notice. (See below code reference)
50 IL ADM Code 5430.40 (b)(1)(D)	All notices shall include the date, including month, day and year, of the adverse determination and, if applicable, the date of the final adverse determination, including month, day and year;
50 IL ADM Code 5430.40 (b)(1)(E)	shall inform covered persons that the deadlines for filing an appeal or external review request are not postponed or delayed by health care provider appeals UNLESS the health care provider is acting as an authorized representative for the covered person, i.e., the covered person should be filing internal appeals independently and concurrently unless the health care provider has been designated in writing as the authorized representative.
50 IL ADM Code 5430.40 (b)(1)(F)	shall indicate whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care provider) or a PROVIDER appeal (pursuant to the provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a provider appeal.
50 IL ADM Code 5430.40 (b)(1)(I)	shall include the following contact information for the Department of Insurance: Illinois Department of Insurance Office of Consumer Health Insurance External Review Unit 320 W. Washington Street Springfield, IL 62767 (877) 850-4740 Toll-free phone (217) 557-8495 Fax number Doi.externalreview@illinois.gov Email address https://mc.insurance.illinois.gov/messagecenter.nsf
Provider Appeal Exhaustion Notice	
50 IL ADM Code 5430.40 (b)(1)(G)	Upon exhaustion of provider appeals , the notice (which is copied to the member) shall specify timeframes from the date of the adverse determination for the member to file an appeal or file an external review.
Member Notice when internal appeals are exhausted	
50 IL ADM Code 5430.40 (b)(1)(H)	Upon exhaustion of internal appeals by the member , the final adverse determination notice shall clearly state that it is the final adverse determination, that all internal appeals have been exhausted, and that the member has 4 months from the date of the letter to file an external review.

Special Rules for Multi-State Plans

<p>50 IL ADM Code 5430.40 (b)(5)</p>	<p>Pursuant to the U.S. Office of Personnel Management’s (OPM) Multi-State Plan Program regulation at 45 C.F.R. §800.5023, OPM administers the External Review Process for disputed adverse benefit determinations submitted by enrollees in Multi-State Plan health insurance options.</p>
<p>215 ILCS 180/20c</p>	<p>(1) if the covered person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review; or</p> <p>(2) if a final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, then the covered person, or the covered person's authorized representative, may request an expedited external review; or</p> <p>(3) if a final adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and the covered person's health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, then the covered person or the covered person's authorized representative may request an expedited external review.</p>