[215 Ill. Comp. Stat. § 134/65.]

§ 134/65. Emergency services prior to stabilization: Managed Care Reform and Patient Rights Act

(a) A health care plan that provides or that is required by law to provide coverage for emergency services shall provide coverage such that payment under this coverage is not dependent upon whether the services are performed by a plan or non-plan health care provider and without regard to prior authorization. This coverage shall be at the same benefit level as if the services or treatment had been rendered by the health care plan physician licensed to practice medicine in all its branches or health care provider.

(b) Prior authorization or approval by the plan shall not be required for emergency services.

(c) Coverage and payment shall only be retrospectively denied under the following circumstances:

(1) upon reasonable determination that the emergency services claimed were never performed;

(2) upon timely determination that the emergency evaluation and treatment were rendered to an enrollee who sought emergency services and whose circumstance did not meet the definition of emergency medical condition;

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

(4) upon material misrepresentation by the enrollee or health care provider; "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(d) When an enrollee presents to a hospital seeking emergency services, the determination as to whether the need for those services exists shall be made for purposes of treatment by a physician licensed to practice medicine in all its branches or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches. The physician or other appropriate personnel shall indicate in the patient's chart the results of the emergency medical screening examination.

(e) The appropriate use of the 911 emergency telephone system or its local equivalent shall not be discouraged or penalized by the health care plan when an emergency medical condition exists. This provision shall not imply that the use of 911 or its local equivalent is a factor in determining the existence of an emergency medical condition.

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(f) The medical director's or his or her designee's determination of whether the enrollee meets the standard of an emergency medical condition shall be based solely upon the presenting symptoms documented in the medical record at the time care was sought. Only a clinical peer may make an adverse determination.
(g) 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.

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