

**Bureau of Managed Care
Managed Care Organizations**

Policy/Procedures

Utilization Review Standardization and Transparency Requirements

Quality and Compliance Audits

Pursuant to 305 ILCS 5/5-30.1(g-13)(3) and 89 Ill. Adm. Code 140.76, the Department of Healthcare and Family Services (Department) has expanded the scope of audits conducted by its contracted External Quality Review Organization (EQRO) to assess Managed Care Organization (MCO) compliance with utilization review processes and service authorization determinations for services rendered in the hospital inpatient and outpatient settings.

The Department must annually submit to the Illinois General Assembly a report detailing the EQRO's findings, with the first report due April 7, 2026. As such:

1. Each MCO shall provide all data and documentation requested by the EQRO to audit MCO compliance with 305 ILCS 5/5-30.1(g-13)(3) and 89 Ill. Adm. Code 140.76.
2. The report compiled by the EQRO shall include:
 - A. An analysis of MCOs' compliance with nationally recognized clinical decision support criteria for inpatient admissions.
 - B. An analysis to evaluate whether service authorization determinations are being made consistently by all MCOs and to ensure that all individuals are being treated in accordance with equitable standards of care and all federal requirements enumerated at 42 CFR 438.210.
 - C. An analysis shall compare and contrast each MCO's service authorization determination outcomes to the outcomes of each MCO and the outcomes of the fee-for-service program; and
 - D. A report for each MCO providing the total number of prior authorization, concurrent authorization, and post authorization service authorization requests received from hospitals. The data shall be reported separately by hospital type, including but not limited to general acute, psychiatric, rehabilitation, long term acute care, and children's. [305 ILCS 5/5-30.1(g-13)(3)(A), (B) and (C)]
 - E. The report must provide, as a subset of the total requests reported in subsection (k)(1)(D):
 - i. Requests for which the final determination was an approval. Of those requests:

- The subset of approved requests which were initially denied but the denial was overturned through an enrollee appeal.
 - The subset of approved requests which were initially denied but the denial was overturned through a peer-to-peer review.
 - The subset of approved requests which were initially denied but the denial was overturned through a reconsideration or escalation process conducted by the service authorization program.
 - The subset of approved requests which were initially denied but the denial was overturned through the fair hearings process.
 - The subset of approved requests which were initially denied but the denial was overturned through the provider dispute process.
 - The subset of approved requests which were initially denied but the denial was overturned through the external quality review organization review process.
- ii. Requests for which the final determination was a denial.
- The subset of denied requests for which a peer-to-peer review was held, and the denial was upheld.
 - The subset of denied requests for which an enrollee appeal was submitted where the denial was upheld.
 - The subset of denied requests which were considered under a reconsideration or escalation process, but the denial was upheld
 - The subset of denied requests where the denial was upheld through the fair hearings process.
 - The subset of denied requests where the denial was upheld through the provider dispute process.
 - The subset of denied requests where the denial was upheld through the external quality review organization review process.
 - A single service authorization request may be reported in multiple categories listed in (ii).
- iii. The sum of (E)(i) and (E)(ii) must be equal to the total number of requests reported in (D). However, a single denied request may go through multiple post-denial processes resulting in reporting of a single request in multiple sub-categories in (E)(ii).

- F. Such analysis shall report separately and distinctly:
 - i. Outpatient services
 - ii. Inpatient, non-emergent initial admissions
 - iii. Emergent inpatient initial admissions.
 - iv. Continued inpatient stay.
 - v. Continued inpatient stays where some but not all requested days were approved shall be counted as two requests and the determination should count as one approval and one denial.
- 3. MCOs that do not comply with the timely and complete submission of data and documentation requested by the Department and its EQRO will be subject to sanctions as defined under each Managed Care Program Contract.

Policy History

Date	Action	Policy Originator
November 2025	UR Quality and Compliance Audit Clarification Policy	Helena Lefkow

Policy Revisions	Revisions Approved
[revision date]	[name of person who approved revisions]