HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874] *(Chapter 2.2 added by Stats. 1975, Ch. 941.)*

ARTICLE 5.55. Appeals Seeking Independent Medical Reviews [1374.30 - 1374.36] *(Article 5.55 added by Stats. 1999, Ch. 533, Sec. 1.)*

1374.30. (a) Commencing January 1, 2001, there is hereby established in the department the Independent Medical Review System.

(b) For the purposes of this chapter, “disputed health care service” means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. A disputed health care service does not include services provided by a specialized health care service plan, except to the extent that the service (1) involves the practice of medicine, or (2) is provided pursuant to a contract with a health care service plan that covers hospital, medical, or surgical benefits. If a plan, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the statement of decision shall clearly specify the provision in the contract that excludes that coverage.

(c) For the purposes of this chapter, “coverage decision” means the approval or denial of health care services by a plan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A “coverage decision” does not encompass a plan or contracting provider decision regarding a disputed health care service.

(d) (1) All enrollee grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this article are met. If the department finds that an enrollee grievance involving a disputed health care service does not meet the requirements of this article for review under the Independent Medical Review System, the enrollee request for review shall be treated as a request for the department to review the grievance pursuant to subdivision (b) of Section 1368. All other enrollee grievances, including grievances involving coverage decisions, remain eligible for review by the department pursuant to subdivision (b) of Section 1368.

(2) In any case in which an enrollee or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.

(3) The department shall be the final arbiter when there is a question as to whether an enrollee grievance is a disputed health care service or a coverage decision. The department shall establish a process to complete an initial screening of an enrollee grievance. If there appears to be any medical necessity issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.

(e) Every health care service plan contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. For purposes of this article, an enrollee may designate an agent to act on his or her behalf, as described in paragraph (2) of subdivision (b) of Section 1368. The provider may join with or otherwise assist the enrollee in seeking an independent medical review, and may advocate on behalf of the enrollee.

(f) Medi-Cal beneficiaries enrolled in a health care service plan shall not be excluded from participation. Medicare beneficiaries enrolled in a health care service plan shall not be excluded unless expressly preempted by federal law. Reviews of cases for Medi-Cal enrollees shall be conducted in accordance with statutes and regulations for the Medi-Cal program.

(g) The department may seek to integrate the quality of care and consumer protection provisions, including remedies, of the Independent Medical Review System with related dispute resolution procedures of other health care agency programs, including the Medicare and Medi-Cal programs, in a way that minimizes the potential for duplication, conflict, and added costs. Nothing in this subdivision shall be construed to limit any rights conferred upon enrollees under this chapter.

(h) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available.

(i) Every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.

(j) An enrollee may apply to the department for an independent medical review when all of the following conditions are met:

(1) (A) The enrollee's provider has recommended a health care service as medically necessary, or

(B) The enrollee has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.

For purposes of this article, the enrollee's provider may be an out-of-plan provider. However, the plan shall have no liability for payment of services provided by an out-of-plan provider, except as provided pursuant to subdivision (c) of Section 1374.34.

(2) The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.

(3) The enrollee has filed a grievance with the plan or its contracting provider pursuant to Section 1368, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the plan's grievance process for more than 30 days. In the case of a grievance that requires expedited review pursuant to Section 1368.01, the enrollee shall not be required to participate in the plan's grievance process for more than three days.

(k) An enrollee may apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six months of any of the qualifying periods or events under subdivision (j). The director may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(l) The enrollee shall pay no application or processing fees of any kind.

(m) As part of its notification to the enrollee regarding a disposition of the enrollee's grievance that denies, modifies, or delays health care services, the plan shall provide the enrollee with a one- or two-page application form approved by the department, and an addressed envelope, which the enrollee may return to initiate an independent medical review. The plan shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the enrollee's diagnosis or condition, the nature of the disputed health care service sought by the enrollee, a means to identify the enrollee's case, and any other material information. The form shall also include the following:

(1) Notice that a decision not to participate in the independent medical review process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

(2) A statement indicating the enrollee's consent to obtain any necessary medical records from the plan, any of its contracting providers, and any out-of-plan provider the enrollee may have consulted on the matter, to be signed by the enrollee.

(3) Notice of the enrollee's right to provide information or documentation, either directly or through the enrollee's provider, regarding any of the following:

(A) A provider recommendation indicating that the disputed health care service is medically necessary for the enrollee's medical condition.

(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the enrollee's medical condition.

(C) Reasonable information supporting the enrollee's position that the disputed health care service is or was medically necessary for the enrollee's medical condition, including all information provided to the enrollee by the plan or any of its contracting providers, still in the possession of the enrollee, concerning a plan or provider decision regarding disputed health care services, and a copy of any materials the enrollee submitted to the plan, still in the possession of the enrollee, in support of the grievance, as well as any additional material that the enrollee believes is relevant.

(4) A section designed to collect information on the enrollee's ethnicity, race, and primary language spoken that includes both of the following:

(A) A statement of intent indicating that the information is used for statistics only, in order to ensure that all enrollees get the best care possible.

(B) A statement indicating that providing this information is optional and will not affect the independent medical review process in any way.

(n) Upon notice from the department that the health care service plan's enrollee has applied for an independent medical review, the plan or its contracting providers shall provide to the independent medical review organization designated by the department a copy of all of the following documents within three business days of the plan's receipt of the department's notice of a request by an enrollee for an independent review:

(1) (A) A copy of all of the enrollee's medical records in the possession of the plan or its contracting providers relevant to each of the following:

(i) The enrollee's medical condition.

(ii) The health care services being provided by the plan and its contracting providers for the condition.

(iii) The disputed health care services requested by the enrollee for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the plan or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The plan shall concurrently provide a copy of medical records required by this subparagraph to the enrollee or the enrollee's provider, if authorized by the enrollee, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the enrollee by the plan and any of its contracting providers concerning plan and provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the plan and to the plan's contracting providers in support of the enrollee's request for disputed health care services. This documentation shall include the written response to the enrollee's grievance, required by paragraph (4) of subdivision (a) of Section 1368. The confidentiality of any enrollee medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The plan shall concurrently provide a copy of documents required by this paragraph, except for any information found by the director to be legally privileged information, to the enrollee and the enrollee's provider. The department and the independent medical review organization shall maintain the confidentiality of any information found by the director to be the proprietary information of the plan.

(o) This section shall become operative on July 1, 2015.

(Repealed (in Sec. 1) and added by Stats. 2012, Ch. 872, Sec. 2. (SB 1410) Effective January 1, 2013. Section operative July 1, 2015, by its own provisions.)

1374.31. (a) If there is an imminent and serious threat to the health of the enrollee, as specified in subdivision (c) of Section 1374.33, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the department may waive the requirement that the enrollee follow the plan's grievance process in extraordinary and compelling cases, where the director finds that the enrollee has acted reasonably.

(b) The department shall expeditiously review requests and immediately notify the enrollee in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. The plan shall promptly issue a notification to the enrollee, after submitting all of the required material to the independent medical review organization, that includes an annotated list of documents submitted and offer the enrollee the opportunity to request copies of those

documents from the plan. The department shall promptly approve enrollee requests whenever the enrollee's plan has agreed that the case is eligible for an independent medical review. The department shall not refer coverage decisions for independent review. To the extent an enrollee request for independent review is not approved by the department, the enrollee request shall be treated as an immediate request for the department to review the grievance pursuant to subdivision (b) of Section 1368.

(c) An independent medical review organization, specified in Section 1374.32, shall conduct the review in accordance with Section 1374.33 and any regulations or orders of the director adopted pursuant thereto. The organization's review shall be limited to an examination of the medical necessity of the disputed health care services and shall not include any consideration of coverage decisions or other contractual issues.

(Added by Stats. 1999, Ch. 533, Sec. 1. Effective January 1, 2000.)

1374.32. (a) The department shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this article. The independent medical review organizations shall be independent of any health care service plan doing business in this state. The director may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall be required to meet in order to qualify for participation in the Independent Medical Review System and to assist the department in carrying out its responsibilities.

(b) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.

(c) The independent medical review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the director, with any of the following:

(1) The plan.

(2) Any officer, director, or employee of the plan.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the plan, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the enrollee whose treatment is under review, or the alternative therapy, if any, recommended by the plan.

(6) The enrollee or the enrollee's immediate family.

(d) In order to contract with the department for purposes of this article, an independent medical review organization shall meet all of the following requirements:

(1) The organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a health plan or a trade association of health plans. A board member, director, officer, or employee of the independent medical review organization shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health plan or a trade association of health plans shall not serve as a board member, director, officer, or employee of an independent medical review organization.

(2) The organization shall submit to the department the following information upon initial application to contract for purposes of this article and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars ($100,000), if any.

(C) The names of all corporations and organizations that the independent medical review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent medical review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care organization, provider group, or board or committee of a plan, managed care organization, or provider group.

(E) (i) The percentage of revenue the independent medical review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, and utilization reviews.

(ii) The names of any health care service plan or provider group for which the independent medical review organization provides review services, including, but not limited to, utilization review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.

(H) A description of how the independent medical review organization ensures compliance with the conflict-of-interest provisions of this section.

(3) The organization shall demonstrate that it has a quality assurance mechanism in place that does the following:

(A) Ensures that the medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts of interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall be physicians or other appropriate providers who meet the following minimum requirements:

(A) The medical professional shall be a clinician expert in the treatment of the enrollee's medical condition and knowledgeable about the proposed treatment through recent or current actual clinical experience treating patients with the same or a similar medical condition as the enrollee.

(B) Notwithstanding any other provision of law, the medical professional shall hold a nonrestricted license in any state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer, except when training and experience with the issue under review reasonably requires the use of an out-of-state reviewer.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(5) Neither the expert reviewer, nor the independent medical review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The plan or a provider group of the plan, except that an academic medical center under contract to the plan to provide services to enrollees may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the plan.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the enrollee whose condition is under review.

(F) The enrollee or the enrollee's immediate family.

(6) For purposes of this section, the following terms shall have the following meanings:

(A) “Material familial affiliation” means any relationship as a spouse, child, parent, sibling, spouse’s parent, or child’s spouse.

(B) “Material professional affiliation” means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent medical review organization. “Material professional affiliation” does not include affiliations that are limited to staff privileges at a health facility.

(C) “Material financial affiliation” means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent medical review organization or individual to which this subdivision applies. “Material financial affiliation” does not include payment by the plan to the independent medical review organization for the services required by this section, nor does “material financial affiliation” include an expert’s participation as a contracting plan provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(e) The department shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the director, filed with it by an independent medical review organization seeking to contract under this article. The department may charge a nominal fee to the interested person for photocopying the requested information.

(f) This section shall become operative on July 1, 2015.

(Repealed (in Sec. 3) and added by Stats. 2012, Ch. 872, Sec. 4. (SB 1410) Effective January 1, 2013. Section operative July 1, 2015, by its own provisions.)

1374.33. (a) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the enrollee, provider reports, as well as any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b).

(b) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee and any of the following:

(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(2) Nationally recognized professional standards.

(3) Expert opinion.

(4) Generally accepted standards of medical practice.

(5) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(c) The organization shall complete its review and make its determination in writing, and in layperson’s terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the director. If the disputed health care service has not been provided and the enrollee’s provider or the department certifies in writing that an imminent and serious threat to the health of the enrollee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the enrollee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the department, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the director for up to three days in extraordinary circumstances or for good cause.

(d) The medical professionals’ analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the enrollee’s medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (b) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(e) The independent medical review organization shall provide the director, the plan, the enrollee, and the enrollee’s provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in cases where the reviewer is called to testify and in response to court orders. If more than one medical professional reviewed the case and the result was

differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(f) The director shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the plan.

(g) After removing the names of the parties, including, but not limited to, the enrollee, all medical providers, the plan, and any of the plan's employees or contractors, director decisions adopting a determination of an independent medical review organization shall be made available by the department to the public in a searchable database on the department's Internet Web site, after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.

(h) (1) Information regarding each director decision provided by the database referenced in subdivision (g) shall include all of the following:

(A) Enrollee demographic profile information, including age and gender.

(B) The enrollee diagnosis and disputed health care service.

(C) Whether the independent medical review was for medically necessary services pursuant to this article or for experimental or investigational therapies pursuant to Section 1370.4.

(D) Whether the independent medical review was standard or expedited.

(E) Length of time from the receipt by the independent medical review organization of the application for review and supporting documentation to the rendering of a determination by the independent medical review organization in writing.

(F) Length of time from receipt by the department of the independent medical review application to the issuance of the director's determination in writing to the parties that is binding on the health care service plan.

(G) Credentials and qualifications of the reviewer or reviewers.

(H) The nature of the statutory criteria set forth in subdivision (b) that the reviewer or reviewers used to make the case decision.

(I) The final result of the determination.

(J) The year the determination was made.

(K) A detailed case summary that includes the specific standards, criteria, and medical and scientific evidence, if any, that led to the case decision.

(2) The database referenced in subdivision (g) shall be accompanied by all of the following:

(A) The annual rate of independent medical review among the total enrolled population.

(B) The annual rate of independent medical review cases by health care service plan.

(C) The number, type, and resolution of independent medical review cases by health care service plan.

(D) The number, type, and resolution of independent medical review cases by ethnicity, race, and primary language spoken.

(i) This section shall become operative on July 1, 2015.

(Repealed (in Sec. 5) and added by Stats. 2012, Ch. 872, Sec. 6. (SB 1410) Effective January 1, 2013. Section operative July 1, 2015, by its own provisions.)

1374.34. (a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

(b) A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than ten thousand dollars ($10,000) for each day that the decision is not implemented. The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(c) The director shall require the plan to promptly reimburse the enrollee for any reasonable costs associated with those services when the director finds that the disputed health care services were a covered benefit under the terms and conditions of the health care service plan contract, and the services are found by the independent medical review organization to have been medically necessary pursuant to Section 1374.33, and either the enrollee's decision to secure the services outside of the plan provider network was reasonable under the emergency or urgent medical circumstances, or the health care service plan contract does not require or provide prior authorization before the health care services are provided to the enrollee.

(d) In addition to requiring plan compliance regarding subdivisions (a), (b), and (c) the director shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where substantial harm, as defined in Section 3428 of the Civil Code, to an enrollee has already occurred because of the decision of a plan, or one of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically necessary pursuant to Section 1374.33, the director shall impose penalties.

(e) Pursuant to Section 1368.04, the director shall perform an annual audit of independent medical review cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably to resolve grievances associated with a delay, denial, or modification of medically necessary health care services when the obligation of the plan to provide those health care services to enrollees or subscribers is reasonably clear.

(f) A plan's provision of prescription drugs to a Medi-Cal beneficiary pursuant to paragraph (5) of subdivision (b) of Section 14105.33 of the Welfare and Institutions Code and in accordance with the State Department of Health Care Services coverage policies shall not be a ground for an enforcement action. Nothing in this article is intended to limit a plan's responsibility to provide medically necessary health care services pursuant to this chapter.

(g) Commencing January 1, 2028, and every five years thereafter, the penalty amount specified in this section shall be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.

(Amended by Stats. 2022, Ch. 985, Sec. 3. (SB 858) Effective January 1, 2023.)

1374.35. (a) After considering the results of a competitive bidding process and any other relevant information on program costs, the director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(b) The costs of the independent medical review system for enrollees shall be borne by health care service plans pursuant to an assessment fee system established by the director. In determining the amount to be assessed, the director shall consider all appropriations available for the support of this chapter, and existing fees paid to the department. The director may adjust fees upward or downward, on a schedule set by the department, to address shortages or overpayments, and to reflect utilization of the independent review process.

(Added by Stats. 1999, Ch. 533, Sec. 1. Effective January 1, 2000.)

1374.36. (a) The director shall submit to the Legislature by March 1, 2002, a report on the initial implementation of this article. The report shall include a description of assessments imposed on plans to implement this article, increased staffing and other resources attributable to these new responsibilities, and any redirection of existing staff and resources to carry out these responsibilities. A single copy of the report shall be made available at no cost to members of the public upon request. The department may recover the cost of additional copies that are requested.

(b) This section shall become operative on January 1, 2001, and then only if Assembly Bill 55 of the 1999–2000 Regular Session is enacted.

(Added by Stats. 1999, Ch. 542, Sec. 11. Effective January 1, 2000. Section operative January 1, 2001, by its own provisions.)