

§ 1374.33. Analysis and determination

(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 upon request, at the department's cost and 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.

HISTORY:

Added Stats 2012 ch 872 § 6 (SB 1410), effective January 1, 2013, operative July 1, 2015.

§ 1374.34. Prompt implementation of decision; Review and audit [Effective until January 1, 2023]

(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 five thousand dollars (\$5,000) 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.

HISTORY:

Added Stats 1999 ch 542 § 10 (SB 189), operative January 1, 2001, as H & S C § 13933. Amended and renumbered by Stats 2000 ch

1067 § 17 (SB 2094); Amended Stats 2003 ch 579 § 1 (AB 1496); Stats 2008 ch 607 § 8 (SB 1379), effective September 30, 2008; Stats 2014 ch 40 § 1 (SB 870), effective June 20, 2014.

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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.

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(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.

HISTORY:

Added Stats 1999 ch 542 § 10 (SB 189), operative January 1, 2001, as H & S C § 13933. Amended and renumbered by Stats 2000 ch 1067 § 17 (SB 2094); Amended Stats 2003 ch

579 § 1 (AB 1496); Stats 2008 ch 607 § 8 (SB 1379), effective September 30, 2008; Stats 2014 ch 40 § 1 (SB 870), effective June 20, 2014; Stats 2022 ch 985 § 3 (SB 858), effective January 1, 2023.

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