1300.74.30 Independent Medical Review System

(a)

Plan enrollees may request independent medical review pursuant to this regulation for decisions that are eligible for independent medical review under Article 5.55 and section 1370.4 of the Act. The independent medical review process shall resolve decisions that deny, modify, or delay health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies. Specialized plans shall provide for independent medical reviews under this section if a covered service relates to the practice of medicine or is provided pursuant to a contract with a health plan providing medical, surgical and hospital services. The Department shall be the final arbiter when there is a question as to whether a dispute over a health care service is eligible for independent medical review, and whether extraordinary and compelling circumstances exist that waive the requirement that the enrollee first participate in the plan's grievance system.

(b)

An enrollee may apply for an independent medical review under the conditions specified in Section 1374.30(j) of the Act. The Department may waive the requirement that the enrollee participate in the plan's grievance process if the Department determines that extraordinary and compelling circumstances exist, which include, but are 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.

(c)

In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the independent medical review shall determine whether the services were emergency or urgent services necessary to screen and stabilize the enrollee's condition. For purposes of this section "emergency services" are services for emergency medical conditions as defined in section 1300.71.4 of title 28, and "urgent services" are all services, except emergency services, where the enrollee has obtained the services without prior authorization from the plan, or from a contracting provider.

(d)

Applications for independent medical review shall be submitted on a one-page form entitled Independent Medical Review Application (DMHC IMR 11/00), which is incorporated by reference, and shall be provided by the Department. The form shall contain a signed release from the enrollee, or a person authorized pursuant to law to act on behalf of the enrollee, authorizing release of medical and treatment information. Additionally, the enrollee may provide any relevant material or documentation with the application including, but not limited to: (1) A copy of the adverse determination by the plan or contracting provider notifying the enrollee that the request for health care services was denied, delayed or modified, in whole or in part, based on the determination that the service was not medically necessary; (2) Medical records, statements from the enrollee's provider or other documents establishing that the dispute is eligible for review; (3) A copy of the grievance requesting the health care service or benefit filed with the plan or any entity with delegated authority to resolve grievances, and the

response to the grievance, if any; (4) If expedited review is requested for a decision eligible for independent medical review pursuant to Article 5.55 of the Act, the application shall include, a certification from the enrollee's physician or provider indicating that an imminent and serious threat to the health of the enrollee exists. If expedited review is requested for a decision eligible for independent medical review pursuant to section 1370.4 of the Act, the application shall include a certification from the enrollee's physician that the proposed therapy would be significantly less effective if not promptly initiated.

(1)

A copy of the adverse determination by the plan or contracting provider notifying the enrollee that the request for health care services was denied, delayed or modified, in whole or in part, based on the determination that the service was not medically necessary;

(2)

Medical records, statements from the enrollee's provider or other documents establishing that the dispute is eligible for review;

(3)

A copy of the grievance requesting the health care service or benefit filed with the plan or any entity with delegated authority to resolve grievances, and the response to the grievance, if any;

(4)

If expedited review is requested for a decision eligible for independent medical review pursuant to Article 5.55 of the Act, the application shall include, a certification from the enrollee's physician or provider indicating that an imminent and serious threat to the health of the enrollee exists. If expedited review is requested for a decision eligible for independent medical review pursuant to section 1370.4 of the Act, the application

shall include a certification from the enrollee's physician that the proposed therapy would be significantly less effective if not promptly initiated.

(e)

If additional information is needed to complete an application or to determine the enrollee's eligibility for independent medical review, the Department shall advise the enrollee or the enrollee's representative, the enrollee's provider, the enrollee's health care plan or the enrollee's attending physician, as appropriate, by the most efficient means available.

(f)

The Department shall evaluate complaints received under subsection (b) of Section 1368 of the Act and applications submitted under this regulation and determine whether the enrollee is eligible for an independent medical review. The Department's determination will consider all information provided to the Department, the enrollee's medical condition and the disputed health care service. If the Department determines that the case should not be referred to independent medical review, the request shall be considered a complaint under subsection (b) of Section 1368 and sections 1300.68 and 1300.68.01. The enrollee or the enrollee's representative, health plan and any involved provider shall be advised of the Department's determination. (1) The request for independent medical review shall be filed with the Department within six months of the plan's written response to the enrollee's grievance. The six-month period does not begin to run until the enrollee, or the enrollee's representative, has been properly notified in writing of the plan's resolution of the grievance. Applications will not be rejected as untimely solely because the enrollee, the enrollee's provider, or the plan failed to submit supporting documentation. Requests for extensions or late applications shall be approved if a timely submission was

reasonably impaired by inadequate notice of the independent medical review process or by the applicant's medical circumstances. (2) An application will not be eligible for independent medical review if the enrollee's complaint has previously been submitted and reviewed by the Department. Exceptions may be approved if the application for independent medical review includes medical records and a statement from the enrollee's physician or provider demonstrating significant changes in the enrollee's medical condition or in medical therapies available have occurred since the Department's disposition of the complaint. (3) Enrollees of Medi-Cal health care service plans are eligible for an independent medical review if the enrollee has not presented the disputed health care service for resolution by the Medi-Cal fair hearing process. Reviews shall be conducted in accordance with the statutes and regulations of the Medi-Cal program. (4) This regulation applies to Medicare enrollees, to the extent the regulation does not conflict with federal law, including 42 USCS § 1395 w-26 (2004).

(1)

The request for independent medical review shall be filed with the Department within six months of the plan's written response to the enrollee's grievance. The six-month period does not begin to run until the enrollee, or the enrollee's representative, has been properly notified in writing of the plan's resolution of the grievance. Applications will not be rejected as untimely solely because the enrollee, the enrollee's provider, or the plan failed to submit supporting documentation. Requests for extensions or late applications shall be approved if a timely submission was reasonably impaired by inadequate notice of the independent medical review process or by the applicant's medical circumstances.

(2)

An application will not be eligible for independent medical review if the enrollee's

complaint has previously been submitted and reviewed by the Department. Exceptions may be approved if the application for independent medical review includes medical records and a statement from the enrollee's physician or provider demonstrating significant changes in the enrollee's medical condition or in medical therapies available have occurred since the Department's disposition of the complaint.

(3)

Enrollees of Medi-Cal health care service plans are eligible for an independent medical review if the enrollee has not presented the disputed health care service for resolution by the Medi-Cal fair hearing process. Reviews shall be conducted in accordance with the statutes and regulations of the Medi-Cal program.

(4)

This regulation applies to Medicare enrollees, to the extent the regulation does not conflict with federal law, including 42 USCS § 1395 w-26 (2004).

(g)

Except for Medi-Cal enrollees, and Medicare enrollees exempted by federal law, as described at subsection (f)(4), the independent medical review system established pursuant to this section shall be the exclusive independent medical review process offered to enrollees for disputes involving the medical necessity of covered health care services. Nothing in this section shall preclude a health plan from offering other independent review processes for disputes that do not involve medical necessity.

(h)

When the Department finds that a plan fails to advise an enrollee of the availability of independent medical review as required under Health and Safety Code section 1374.30(i), or engages in a practice of mischaracterizing determinations substantially based on medical necessity as coverage decisions, or

otherwise interferes with the rights of enrollees to obtain independent medical review, the Department shall impose administrative penalties on the plan in accordance with the Act.

(i)

The director shall notify the enrollee and the enrollee's health care plan if an application for independent medical review has been accepted within seven (7) calendar days of receipt of a completed application for a routine request and within 48 hours of receipt of a completed application for an expedited review. The notification shall identify the independent medical review organization, whether the review shall be conducted on an expedited or routine basis and other information deemed necessary by the Department. The director shall also transmit to the enrollee's health care plan a copy of the enrollee's signed release of medical and treatment information and copies of all other materials submitted with the enrollee's application.

(j)

Following receipt of the Department's notification that an application for independent medical review has been assigned to an independent medical review organization, the plan shall provide the organization with all information that was considered in relation to the disputed health care service, the enrollee's grievance and the plan's determination. The plan shall forward all information to the medical review organization within three (3) business days for a regular review and within one (1) calendar day in the case of an expedited review. (1) Unless otherwise advised in the notification or by the assigned review organization, the plan shall submit a complete set of the materials described below for the independent review organization. (A) A copy of all correspondence from and received by the plan concerning the disputed health care service, including but not limited to, any

enrollee grievance relating to the requested service; (B) A complete and legible copy of all medical records and other information used by the plan in making its decision regarding the disputed health care service. An additional copy of medical records shall be submitted for each reviewer. (C) A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted or underlined sections, if the evidence of coverage was referenced in the plan's resolution of the enrollee's grievance; (D) The plan's response to any additional issues raised in the enrollee's application for independent medical review. (2) The plan shall promptly provide the enrollee with an annotated list of all documents submitted to the independent medical review organization, together with information on how copies may be requested.

(1)

Unless otherwise advised in the notification or by the assigned review organization, the plan shall submit a complete set of the materials described below for the independent review organization. (A) A copy of all correspondence from and received by the plan concerning the disputed health care service, including but not limited to, any enrollee grievance relating to the requested service; (B) A complete and legible copy of all medical records and other information used by the plan in making its decision regarding the disputed health care service. An additional copy of medical records shall be submitted for each reviewer. (C) A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted or underlined sections, if the evidence of coverage was referenced in the plan's resolution of the enrollee's grievance; (D) The plan's response to any additional issues raised in the enrollee's application for independent medical review.

(A)

A copy of all correspondence from and received by the plan concerning the disputed health

care service, including but not limited to, any enrollee grievance relating to the requested service;

(B)

A complete and legible copy of all medical records and other information used by the plan in making its decision regarding the disputed health care service. An additional copy of medical records shall be submitted for each reviewer.

(C)

A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted or underlined sections, if the evidence of coverage was referenced in the plan's resolution of the enrollee's grievance;

(D)

The plan's response to any additional issues raised in the enrollee's application for independent medical review.

(2)

The plan shall promptly provide the enrollee with an annotated list of all documents submitted to the independent medical review organization, together with information on how copies may be requested.

(k)

Plans shall be responsible for providing additional information as follows: (1) Any medical records or other relevant matters not available at the time of the Department's initial notification, or that result from the enrollee's on-going medical care or treatment for the medical condition or disease under review. Such matters shall be forwarded as soon as possible upon receipt by the health plan, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases. (2) Additional medical records or other information requested by the IMR organization shall be sent within five (5) business days in routine cases or

one (1) calendar day in expedited cases. In expedited reviews, the health care plan shall immediately notify the enrollee and the enrollee's health care provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of the plan or its contracting providers.

(1)

Any medical records or other relevant matters not available at the time of the Department's initial notification, or that result from the enrollee's on-going medical care or treatment for the medical condition or disease under review. Such matters shall be forwarded as soon as possible upon receipt by the health plan, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases.

(2)

Additional medical records or other information requested by the IMR organization shall be sent within five (5) business days in routine cases or one (1) calendar day in expedited cases. In expedited reviews, the health care plan shall immediately notify the enrollee and the enrollee's health care provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of the plan or its contracting providers.

(l)

Each assigned reviewer shall issue a separate written analysis of the case, explaining the determination made, using plain English where possible. The analysis shall describe how the determination relates to the enrollee's medical condition and history, relevant medical records and other documents considered, and references to the specific medical and scientific evidence listed in Sections 1370.4(d) or 1374.33(b) of the Act, as applicable. For requests made pursuant to

Article 5.55 of the Act, reviewers shall determine whether the disputed service is medically necessary for the enrollee. For requests made pursuant to section 1370.4 of the Act, the reviewers shall determine whether the requested therapy is likely to be more beneficial for the enrollee then other available standard therapies, and whether the plan shall provide the requested therapy. Reviews based on section 1300.70.4 of these regulations shall also reference the medical and scientific evidence considered in assessing whether the requested health care service is likely to be more beneficial than other available standard therapies. The analysis may also discuss the risks and benefits considered by the reviewer in considering proposed and standard treatments.

(m)

The Department, the enrollee, or his/her representative may withdraw a case from the independent review system at any time. The plan may seek withdrawal of the case from the review system by providing the disputed health care service, subject to the concurrence of the enrollee.