§ 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.