

Effective:

Revised/Reviewed: August 2009, May 2011,
January 2012, February 2013, November 2013,
February 2014, February 2015, February 2016,
February 2017, February 2018, February 2019

Purpose:

To establish procedures that demonstrate the Plan's implementation of the DMHC's Independent Medical Review (IMR) program. The DMHC program allows enrollees to request that the DMHC obtain an impartial review of Plan decisions concerning:

- the medical necessity of a proposed treatment,
- experimental or investigational therapies for certain medical conditions,
- denied claims for out-of-plan emergency or urgent medical services.

Policy:

A member may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if the member believes that health care services have been improperly denied, modified, or delayed by the Plan. The Plan must provide a member with an IMR notification letter with any grievance disposition letter. The Plan must provide a member with Notification of IMR process with any provider referral or urgent/emergency room claim in which a health care service is denied, modified, or delayed in whole or in part by the plan for reasons of medical necessity.

The IMR process is in addition to VCHCP's Policy for Appeals. The member does not pay application or processing fees of any kind for IMR. The member has the right to provide information in support of the request for IMR. A decision not to participate in the IMR process may cause a member to forfeit any statutory right to pursue legal action against the Plan regarding the disputed health care service. A member must apply to the DMHC within six (6) months of meeting the eligibility criteria described below. The DMHC may extend the application deadline beyond six (6) months if the circumstances of a case warrant the extension.

Definitions:

Disputed Health Care Service means any health care service eligible for coverage and payment under a member's benefit plan that has been denied, modified, or pended by a decision of the VCHCP, 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.

Coverage Decision means the approval or denial of health care services by VCHCP, substantially based on a finding that the provisions of a particular service is included or excluded as a covered benefit under the terms and conditions of the Evidence of Coverage for the member's benefit plan. **Coverage decisions are not eligible for IMR.**

Eligibility Criteria:

A member may apply to the DMHC for an IMR when all the following conditions are met:

(1)

The member's provider has recommended a health care service as medically necessary, or

The member has received urgent care or emergency services that a provider determined was medically necessary, or

The member has been seen by a **contracted** VCHCP provider for the diagnosis or treatment of the medical condition for which the member seeks independent review;

(2) The disputed health care service has been denied, modified, or delayed by the Plan, based in whole or in part on a decision that the health care service is not medically necessary; and

(3) The member has filed an appeal with the Plan and the disputed decision is upheld or the appeal remains unresolved after 30 days. If the member's appeal requires Expedited review pursuant to the Plan's appeal's policy, the member shall not be required to participate in VCHCP's Appeals Process for more than three (3) days. The DMHC may waive the requirement that the member follow VCHCP's appeals process in extraordinary and compelling cases.

Notification to Members

The Plan will provide the Member with the following documentation advising the Member of the IMR Process and Procedures to follow:

- Letter from Plan explaining the IMR Process applicable forms and applications and contact information for DMHC.
- Independent Medical Review Application Instructions
- Authorization for Release of Medical Records and Declaration of Relationship.

Process

If the member's case is eligible for IMR, the DMHC will submit the dispute to DMHC, HMO Help Center. The DMHC will notify the member in writing as to whether the request for an IMR has been approved, in whole or in part, and, if not approved, the reasons therefore.

VCHCP shall provide to the IMR organization a copy of all of the following documents within three (3) business days of receipt of notice from the DMHC that an IMR has been requested:

1. A copy of all medical records in the possession of the plan related to the member's medical condition, the health care services being provided by the plan and its contracting providers for the condition, and the disputed health care services requested by the member for the condition.
2. A copy of all information provided to the member by the plan concerning plan decisions regarding the member's condition and care, and a copy of any material the member or the member's provider submitted to the plan in support of the member's request for disputed health care services. This documentation shall include the written response to the member's grievance.
3. A copy of any other relevant documents or information used by the plan 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. Any documents required by this paragraph that are legally privileged, including proprietary information, shall be clearly marked. The DMHC and the IMR organization shall maintain the confidentiality of legally privileged documents.

Assignment of Case

The IMR organization will assign the member's case to a medical specialist who will make an independent determination of whether or not the disputed services are medically necessary. Coverage decisions and other contractual issues shall not be considered by the reviewer. If DMHC determines that the member's dispute is not eligible for IMR, it is referred to the DMHC's internal complaint unit for resolution.

Documents to Member

VCHCP shall provide the member with an annotated list of the medical records and other documents submitted to the IMR organization and offer the member the opportunity to request personal copies and copies for his or her provider. The member is entitled to all documents provided to the IMR organization, except medical records prohibited by law and legally privileged documents.

Expedited Review

The plan's procedure for handling urgent grievances shall be followed when an expedited review of a disputed health care service is required by the DMHC because of an imminent and serious threat to the member's health. VCHCP shall provide to the IMR organization a copy of all of the required/requested documents within twenty-four (24) hours receipt of notice from the DMHC that an expedited review of an IMR has been requested.

Non-Urgent Care Review:

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of the member's application and supporting documents. For urgent cases involving imminent and serious threat to a member's health, 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 member's health, the IMR organization must provide its determination within three (3) business days.

Critical Timelines for Independent Medical Review

CASE TYPE	EXPEDITED (MEDICAL NECESSITY)	EXPEDITED (EXPERIMENTAL)	STANDARD
Department notifies enrollee, enrollee's physician and the health plan if application is eligible	Within 48 hours of application receipt	Within 48 hours of application receipt	Within 7 days of application receipt
Health Plan provides medical records/information to the Review Organization	Within 24 hours of DMHC notification	Within 24 hours of DMHC notification	Within 3 days of DMHC notification
Health Plan provides new records (not available at the time of the original submission) to the Review Organization	Within 1 day of receipt	Within 1 day of receipt	Within 1 day of receipt
Review organization renders determination	Within 3 days of receipt of records	Within 7 days of receipt of records	Within 21 days of receipt of records
Department adopts Review Organization determination and	Within 1 day of receipt of Review Organization determination	Within 1 day of receipt of Review Organization determination	Within 3 days of receipt of Review Organization determination



Utilization Management Policy & Procedure:
External Independent Medical Review Process Requirement:
 Effective: 2001
 Revised/Reviewed: August 2009, May 2011, January 2012, February 2013, November 2013, February 2015, February 2016, February 2017, February 2018

issues written decision			
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Additional Records:

Any newly developed or discovered relevant medical records or information in the possession of the Plan after initial documents are provided to the IMR organization shall be forwarded within one (1) day of receipt to the IMR organization.

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.

Decisions regarding prior authorization or for concurrent medical care services or care under way shall be communicated via telephone, email, or fax to the requesting physician within 24 hours of the Plan making the decision.

Decisions resulting in denial, delay, or modification of the requested services shall be made in writing via email, fax, or U.S. mail within 2 business days.

IMR Disposition:

The member will receive a copy of the assessment made in his or her case. If the IMR determines the service is medically necessary, VCHCP will provide the health care service. Coverage for the required services is provided subject to the terms and conditions generally applicable to other benefits under the member's benefit plan.

IMR decisions resulting in coverage for services for a member shall be authorized by the Plan in 5 business days or less. Such authorization shall be mailed in writing to the member and the provider that requested the services.

IMR decisions resulting in coverage for services for a member for services already rendered shall be paid to the provider, if not already reimbursed by member, or to the member if member has already paid the provider. Such payment shall be made within 5 business days or less.

A. Related Documents:

- California Legislation Information
- IMR Application and Instructions

- IMR Release of Medical Records and Declaration of Relationship
- IMR Physician Certification for Experimental/Investigational Denials, including Medicaid and Scientific References for Independent Medical Review Requests (H&S 1370.4(d))

B. References:

- Related Procedures:
 - i. Member Services: Grievance and Appeal Process
 - ii. Member Services: IMR Desk Procedure

Health & Safety Code Section 1374, et seq. Advisory No. 3 RE 1999 Legislation

28CCR 1300.68 (a)
28CCR 1300.68 (b)(2)
28CCR 1300.68 (f)(1)
28CCR 1300.68 (d)(4)
28CCR 1300.68 (d)(5)
28CCR 1300.68 (e)
28CCR 1300.70.4 (a)-(e)
28CCR 1300.74.30 (a) – (1) & (n)

A. Attachments: none

B. References:

C. Reviewers: Utilization Management Committee; Medical Director; QA Manager; Health Services Director

Reviewed/Revised by: Lita Catapang, RN & Albert Reeves, MD

- Committee Review:
 - UM: August 2009; QAC: August 2009

Reviewed/No Changes by: Faustine Dela Cruz, RN & Albert Reeves, MD

- Committee Review:
 - UM: August 11, 2011; QAC: August 23, 2011

Reviewed/No Changes by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD

- Committee Review:
 - UM: February 9, 2012; QAC: February 28, 2012

Reviewed/No Updates by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD

- Committee Review:
 - UM: February 14, 2013; QAC: February 26, 2013

- Committee Review:
 - UM: November 14, 2013; QAC: November 26, 2013

Reviewed/Revised by: Faustine Dela Cruz, RN, Mitch Craven, Compliance Officer & Albert Reeves, MD

Utilization Management Policy & Procedure:
External Independent Medical Review Process

Requirement:

Effective: 2001

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Reviewed/No Updates by: Faustine Dela Cruz, RN & Catherine Sanders, MD

- Committee Review:
 - UM: February 13, 2014; QAC February 25, 2014

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 - UM: February 12, 2015; QAC February 24, 2015

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Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/9/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review; removed some related policies
2/8/18	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/14/19	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review