

Introduced by Senator HernandezFebruary 24, 2012

An act to amend Sections 1374.32 and 1374.33 of the Health and Safety Code, and to amend Sections 10169.2 and 10169.3 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1410, as introduced, Hernandez. Independent medical review.

Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires the department and the commissioner to establish an independent medical review system under which a patient may seek an independent medical review whenever health care services have been denied, modified, or delayed by a health care service plan or health insurer and the patient has previously filed a grievance that remains unresolved after 30 days. Existing law requires medical professionals selected by an independent medical review organization to review medical treatment decisions to meet certain minimum requirements, including that the medical professional be a clinician knowledgeable in the treatment of the patient's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

This bill would instead require the medical professional to 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 similar condition.

Existing law requires the Director of Managed Health Care and the Insurance Commissioner to adopt the determination of an independent medical review organization as a director or commissioner decision. Existing law requires the decisions to be made available, on request, to the public at cost. Existing law requires certain information to be removed from the decision, including the name of the health plan.

This bill would require the decisions to be made available at no charge on the Internet Web site of the Department of Managed Health Care or Department of Insurance, as applicable. The bill would delete the requirement to remove the name of the health plan.

This bill would also require the 2 departments to consult with each other regarding the establishment of a common searchable database for these decisions, and would specify the information that is to be made available in that regard.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1374.32 of the Health and Safety Code
2 is amended to read:

3 1374.32. (a) ~~By January 1, 2001, the~~ *The* department shall
4 contract with one or more independent medical review
5 organizations in the state to conduct reviews for purposes of this
6 article. The independent medical review organizations shall be
7 independent of any health care service plan doing business in this
8 state. The director may establish additional requirements, including
9 conflict-of-interest standards, consistent with the purposes of this
10 article, that an organization shall be required to meet in order to
11 qualify for participation in the Independent Medical Review System
12 and to assist the department in carrying out its responsibilities.

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

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

1 (1) The plan.

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

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

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

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

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

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

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

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

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

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

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

38 (D) The names and biographical sketches of all directors,
39 officers, and executives of the independent medical review
40 organization, as well as a statement regarding any past or present

1 relationships the directors, officers, and executives may have with
2 any health care service plan, disability insurer, managed care
3 organization, provider group, or board or committee of a plan,
4 managed care organization, or provider group.

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

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

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

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

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

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

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

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

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

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

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

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

12 (A) The medical professional shall be a clinician ~~knowledgeable~~
13 *expert* in the treatment of the enrollee's medical condition, *and*
14 ~~knowledgeable about the proposed treatment, and familiar with~~
15 ~~guidelines and protocols in the area of treatment under review~~
16 *through recent or current actual clinical experience treating*
17 *patients with the same or a similar medical condition as the*
18 *enrollee.*

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

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

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

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

- 1 (B) Any officer, director, or management employee of the plan.
- 2 (C) The physician, the physician’s medical group, or the
- 3 independent practice association (IPA) proposing the treatment.
- 4 (D) The institution at which the treatment would be provided.
- 5 (E) The development or manufacture of the treatment proposed
- 6 for the enrollee whose condition is under review.
- 7 (F) The enrollee or the enrollee’s immediate family.

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

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

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

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

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

37 SEC. 2. Section 1374.33 of the Health and Safety Code is
 38 amended to read:

39 1374.33. (a) Upon receipt of information and documents
 40 related to a case, the medical professional reviewer or reviewers

1 selected to conduct the review by the independent medical review
2 organization shall promptly review all pertinent medical records
3 of the enrollee, provider reports, as well as any other information
4 submitted to the organization as authorized by the department or
5 requested from any of the parties to the dispute by the reviewers.
6 If reviewers request information from any of the parties, a copy
7 of the request and the response shall be provided to all of the
8 parties. The reviewer or reviewers shall also review relevant
9 information related to the criteria set forth in subdivision (b).

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

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

16 (2) Nationally recognized professional standards.

17 (3) Expert opinion.

18 (4) Generally accepted standards of medical practice.

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

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

38 (d) The medical professionals' analyses and determinations
39 shall state whether the disputed health care service is medically
40 necessary. Each analysis shall cite the enrollee's medical condition,

1 the relevant documents in the record, and the relevant findings
2 associated with the provisions of subdivision (b) to support the
3 determination. If more than one medical professional reviews the
4 case, the recommendation of the majority shall prevail. If the
5 medical professionals reviewing the case are evenly split as to
6 whether the disputed health care service should be provided, the
7 decision shall be in favor of providing the service.

8 (e) The independent medical review organization shall provide
9 the director, the plan, the enrollee, and the enrollee's provider with
10 the analyses and determinations of the medical professionals
11 reviewing the case, and a description of the qualifications of the
12 medical professionals. The independent medical review
13 organization shall keep the names of the reviewers confidential in
14 all communications with entities or individuals outside the
15 independent medical review organization, except in cases where
16 the reviewer is called to testify and in response to court orders. If
17 more than one medical professional reviewed the case and the
18 result was differing determinations, the independent medical review
19 organization shall provide each of the separate reviewer's analyses
20 and determinations.

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

25 (g) After removing the ~~names~~ *name* of the ~~parties, including,~~
26 ~~but not limited to, the enrollee, the names of all medical providers,~~
27 ~~the plan, and any of the insurer's~~ *the names of the health care*
28 *service plan's* employees or contractors, *and the name of any other*
29 *party, other than the plan,* director decisions adopting a
30 determination of an independent medical review organization shall
31 be made available by the department to the public ~~upon request,~~
32 ~~at the department's cost and on the department's Internet Web site,~~
33 after considering applicable laws governing disclosure of public
34 records, confidentiality, and personal privacy. *Pursuant to this*
35 *requirement, the department shall consult with and coordinate*
36 *with the Department of Insurance in the planning and*
37 *implementation of a common, searchable database that contains*
38 *information about each director and Insurance Commissioner*
39 *decision pursuant to subdivision (h).*

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

4 (A) Enrollee or insured demographic profile information,
5 including age, gender, and ethnicity.

6 (B) The department that contracted the independent medical
7 review organization that made the determination.

8 (C) Length of time to complete the independent medical review.

9 (D) Credentials and qualifications of the reviewer.

10 (E) The nature of the statutory criteria set forth in subdivision
11 (b) that the reviewer used to make the case decision.

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

15 (2) The database referenced in subdivision (g) shall also include
16 both of the following:

17 (A) The annual rate of independent medical review among the
18 total insured population.

19 (B) The number, type, and resolution of independent medical
20 review cases by health plan.

21 SEC. 3. Section 10169.2 of the Insurance Code is amended to
22 read:

23 10169.2. (a) ~~By January 1, 2001, the~~ The department shall
24 contract with one or more independent medical review
25 organizations in the state to conduct reviews for purposes of this
26 article. The independent medical review organizations shall be
27 independent of any disability insurer doing business in this state.
28 The commissioner may establish additional requirements, including
29 conflict-of-interest standards, consistent with the purposes of this
30 article, that an organization shall be required to meet in order to
31 qualify for participation in the Independent Medical Review System
32 and to assist the department in carrying out its responsibilities.

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

37 (c) The independent medical review organization, any experts
38 it designates to conduct a review, or any officer, director, or
39 employee of the independent medical review organization shall

1 not have any material professional, familial, or financial affiliation,
2 as determined by the commissioner, with any of the following:

3 (1) The insurer.

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

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

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

11 (5) The development or manufacture of the principal drug,
12 device, procedure, or other therapy proposed by the insured whose
13 treatment is under review, or the alternative therapy, if any,
14 recommended by the insurer.

15 (6) The insured or the insured's immediate family.

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

19 (1) The organization shall not be an affiliate or a subsidiary of,
20 nor in any way be owned or controlled by, a disability insurer or
21 a trade association of insurers. A board member, director, officer,
22 or employee of the independent medical review organization shall
23 not serve as a board member, director, or employee of a disability
24 insurer. A board member, director, or officer of a disability insurer
25 or a trade association of insurers shall not serve as a board member,
26 director, officer, or employee of an independent medical review
27 organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (C) Ensures that the method of selecting medical professionals
38 for individual cases achieves a fair and impartial panel of medical
39 professionals who are qualified to render recommendations

1 regarding the clinical conditions and the medical necessity of
2 treatments or therapies in question.

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

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

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

14 (A) The medical professional shall be a clinician ~~knowledgeable~~
15 *expert* in the treatment of the insured’s medical condition; *and*
16 knowledgeable about the proposed treatment; ~~and familiar with~~
17 ~~guidelines and protocols in the area of treatment under review~~
18 *through recent or current actual clinical experience treating*
19 *patients with the same or a similar medical condition as the*
20 *insured.*

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

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

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

37 (A) The disability insurer or a provider group of the insurer,
38 except that an academic medical center under contract to the insurer
39 to provide services to insureds may qualify as an independent
40 medical review organization provided it will not provide the service

1 and provided the center is not the developer or manufacturer of
2 the proposed treatment.

3 (B) Any officer, director, or management employee of the
4 insurer.

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

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

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

10 (F) The insured or the insured’s immediate family.

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

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

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

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

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

1 (f) The commissioner may contract with the Department of
2 Managed Health Care to administer the independent medical review
3 process established by this article.

4 SEC. 4. Section 10169.3 of the Insurance Code is amended to
5 read:

6 10169.3. (a) Upon receipt of information and documents
7 related to a case, the medical professional reviewer or reviewers
8 selected to conduct the review by the independent medical review
9 organization shall promptly review all pertinent medical records
10 of the insured, provider reports, as well as any other information
11 submitted to the organization as authorized by the department or
12 requested from any of the parties to the dispute by the reviewers.
13 If reviewers request information from any of the parties, a copy
14 of the request and the response shall be provided to all of the
15 parties. The reviewer or reviewers shall also review relevant
16 information related to the criteria set forth in subdivision (b).

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

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

23 (B) Nationally recognized professional standards.

24 (C) Expert opinion.

25 (D) Generally accepted standards of medical practice.

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

29 (c) The organization shall complete its review and make its
30 determination in writing, and in layperson's terms to the maximum
31 extent practicable, within 30 days of the receipt of the application
32 for review and supporting documentation, or within less time as
33 prescribed by the commissioner. If the disputed health care service
34 has not been provided and the insured's provider or the department
35 certifies in writing that an imminent and serious threat to the health
36 of the insured may exist, including, but not limited to, serious pain,
37 the potential loss of life, limb, or major bodily function, or the
38 immediate and serious deterioration of the health of the insured,
39 the analyses and determinations of the reviewers shall be expedited
40 and rendered within three days of the receipt of the information.

1 Subject to the approval of the department, the deadlines for
2 analyses and determinations involving both regular and expedited
3 reviews may be extended by the commissioner for up to three days
4 in extraordinary circumstances or for good cause.

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

15 (e) The independent medical review organization shall provide
16 the director, the insurer, the insured, and the insured's provider
17 with the analyses and determinations of the medical professionals
18 reviewing the case, and a description of the qualifications of the
19 medical professionals. The independent medical review
20 organization shall keep the names of the reviewers confidential in
21 all communications with entities or individuals outside the
22 independent medical review organization, except in cases where
23 the reviewer is called to testify and in response to court orders. If
24 more than one medical professional reviewed the case and the
25 result was differing determinations, the independent medical review
26 organization shall provide each of the separate reviewer's analyses
27 and determinations.

28 (f) The commissioner shall immediately adopt the determination
29 of the independent medical review organization, and shall promptly
30 issue a written decision to the parties that shall be binding on the
31 insurer.

32 (g) After removing the ~~names~~ *name* of the parties, including,
33 ~~but not limited to,~~ the insured, *the names of* all medical providers,
34 ~~the insurer, and any~~ *names* of the insurer's employees or
35 contractors, *and the name of any other party, other than the health*
36 *plan*, commissioner decisions adopting a determination of an
37 independent medical review organization shall be made available
38 by the department ~~to the public upon request, at the department's~~
39 ~~cost~~ *and on the department's Internet Web site*, after considering
40 applicable laws governing disclosure of public records,

1 confidentiality, and personal privacy. Pursuant to this requirement,
2 the department shall consult with and coordinate with the
3 Department of Managed Health Care in the planning and
4 implementation of a common, searchable database that contains
5 information about each commissioner and Director of Managed
6 Health Care decision pursuant to subdivision (h).

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

10 (A) Insured or enrollee demographic profile information,
11 including age, gender, and ethnicity.

12 (B) The department that contracted the independent medical
13 review organization that made the determination.

14 (C) Length of time to complete the independent medical review.

15 (D) Credentials and qualifications of the reviewer.

16 (E) The nature of the statutory criteria set forth in subdivision
17 (b) that the reviewer used to make the case decision.

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

21 (2) The database referenced in subdivision (g) shall also include
22 both of the following:

23 (A) The annual rate of independent medical review among the
24 total insured population.

25 (B) The number, type, and resolution of independent medical
26 review cases by health plan.