

AMENDED IN SENATE AUGUST 24, 1998  
AMENDED IN SENATE JULY 6, 1998  
AMENDED IN ASSEMBLY MAY 22, 1998  
AMENDED IN ASSEMBLY APRIL 27, 1998  
AMENDED IN ASSEMBLY FEBRUARY 24, 1998

CALIFORNIA LEGISLATURE—1997–98 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1667**

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**Introduced by Assembly Members Migden, Baugh, and  
Richter**

January 14, 1998

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An act to amend Sections 1368, 1368.01, 1368.03, and 1368.04 of, and to add Article 12 (commencing with Section 1399.80) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 2.55 (commencing with Section 10145.80) to Chapter 1 of Part 2 of Division 2 of the Insurance Code, relating to health insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 1667, as amended, Migden. Health care service plans: disability insurers: ~~appeals~~ *independent medical reviews*.

*Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Corporations.*

*Existing law requires every health care service plan to establish and maintain a grievance system approved by the department under which enrollees and subscribers may*

*submit their grievances to the plan. Under existing law, after participating for at least 60 days in, or completing, the plan's grievance process, an enrollee or subscriber may submit the grievance or complaint to the department for review.*

*Existing law requires every health care service plan and disability insurer to establish a reasonable external, independent review process to examine coverage decisions regarding experimental or investigational therapies for individual enrollees or insureds who have a terminal condition and meet certain specified criteria.*

*This bill would require health care service plans to provide subscribers and enrollees with written responses to grievances, as specified, and would provide that a grievance may be submitted to the department by an enrollee or subscriber after participating in the plan's grievance process for 30 days. The bill would require the department to respond to each grievance in writing within 30 days.*

*This bill would also, on and after January 1, 2000, require every health care service plan to provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, terminated, or otherwise limited by the plan or by one of its contracting providers. The bill would require the Department of Corporations to establish an independent medical review system whereby requests for reviews are assigned to an independent medical review organization, as specified. An enrollee would in most cases be required to pay to the department a processing fee of \$25, which would be refunded if the enrollee prevails in the review, and the remaining costs would be paid by an assessment on health care service plans imposed by the department. The bill would enact other related provisions.*

*The bill would also provide for a similar but unspecified independent medical review system to be established in the Department of Insurance for review of similar decisions by disability insurers.*

*This bill would also require the Commissioner of Corporations to submit a report to the Legislature by March 1, 2001, on the implementation of the independent medical review system.*



*Under existing law, a willful violation of the provisions governing health care service plans is a crime. By changing the definition of the crime applicable to these plans, this bill would impose a state-mandated local program.*

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that no reimbursement is required by this act for a specified reason.*

~~(1) Under existing law, the Knox Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Corporations.~~

~~Existing law requires every health care service plan to establish and maintain a grievance system approved by the department under which enrollees and subscribers may submit their grievances to the plan. Under existing law, after participating for at least 60 days in, or completing, the plan's grievance process, an enrollee or subscriber may submit the grievance or complaint to the department for review.~~

~~This bill would require health care service plans to provide subscribers and enrollees with written responses to grievances, as specified, and would provide that a grievance may be submitted to the department by an enrollee or subscriber after participating in the plan's grievance process for 45 days. The bill would require the department to respond to each grievance in writing within 45 days.~~

~~(2) Existing law requires every health care service plan and disability insurer to establish a reasonable external, independent review process to examine coverage decisions regarding experimental or investigational therapies for individual enrollees or insureds who have a terminal condition and meet certain specified criteria.~~

~~This bill would, on and after January 1, 2000, require the Commissioner of Corporations and the Insurance Commissioner to contract with one or more independent review organizations to conduct independent medical reviews, as specified. The bill would require the Commissioner of Corporations and the Insurance Commissioner to contract, by July 1, 1999, with a private,~~



~~nonprofit accrediting organization to accredit the independent medical review entities that are to conduct these independent reviews. The bill would enact other related provisions.~~

~~(3) Under existing law, a willful violation of the provisions governing health care service plans is a crime.~~

~~By changing the definition of the crime applicable to these plans, this bill would impose a state-mandated local program.~~

~~(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

~~(5) This bill would also provide that it shall not become operative unless SB 1504 and SB 1653 are also enacted and become operative.~~

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

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

1 SECTION 1. ~~This act shall be known as the Patient's~~  
2 SECTION 1. *This act shall be known as the Patient's*  
3 *Independent Medical Review Act of 1998.*

4 SEC. 2. *Section 1368 of the Health and Safety Code is*  
5 *amended to read:*

6 1368. (a) Every plan shall do all of the following:

7 (1) Establish and maintain a grievance system  
8 approved by the department under which enrollees may  
9 submit their grievances to the plan. Each system shall  
10 provide reasonable procedures in accordance with  
11 department regulations that shall ensure adequate  
12 consideration of enrollee grievances and rectification  
13 when appropriate.

14 (2) Inform its subscribers and enrollees upon  
15 enrollment in the plan and annually thereafter of the  
16 procedure for processing and resolving grievances. The  
17 information shall include the location and telephone  
18 number where grievances may be submitted.



1 (3) Provide forms for ~~complaints~~ *grievances* to be  
2 given to subscribers and enrollees who wish to register  
3 written ~~complaints~~ *grievances*. The forms used by plans  
4 licensed pursuant to Section 1353 shall be approved by  
5 the commissioner in advance as to format.

6 (4) *Provide subscribers and enrollees with written*  
7 *responses to grievances, with a clear and concise*  
8 *explanation of the reasons for the plan's response. For*  
9 *grievances involving the denial, termination, or the*  
10 *imposition of other limits on health care services, the plan*  
11 *response shall describe the criteria used and the clinical*  
12 *reasons for its decision, including all criteria and clinical*  
13 *reasons related to medical necessity or medical*  
14 *appropriateness.*

15 (5) Keep in its files all copies of ~~complaints~~ *grievances*,  
16 and the responses thereto, for a period of five years.

17 (b) (1) (A) After either completing the grievance  
18 process described in subdivision (a), or participating in  
19 the process for at least ~~60~~ 30 days, a subscriber or enrollee  
20 may submit the grievance ~~or—complaint~~ to the  
21 department for review. In any case determined by the  
22 department to be a case involving an imminent and  
23 serious threat to the health of the patient, including, but  
24 not limited to, *severe pain*, the potential loss of life, limb,  
25 or major bodily function, or in any other case where the  
26 department determines that an earlier review is  
27 warranted, a subscriber or enrollee shall not be required  
28 to complete the grievance process or participate in the  
29 process for at least ~~60~~ 30 days *before submitting a*  
30 *grievance to the department for review.*

31 (B) A grievance ~~or—complaint~~ may be submitted to the  
32 department for review and resolution prior to any  
33 arbitration.

34 (C) Notwithstanding subparagraphs (A) and (B), the  
35 department may refer any grievance ~~or—complaint~~ *issue*  
36 *that does not pertain to compliance with this chapter* to  
37 the State Department of Health Services, the  
38 Department of Aging, the federal Health Care Financing  
39 Administration, or any other appropriate governmental  
40 entity for investigation and resolution.



1 (2) If the subscriber or enrollee is a minor, or is  
 2 incompetent or incapacitated, the parent, guardian,  
 3 conservator, relative, or other designee of the subscriber  
 4 or enrollee, as appropriate, may submit the grievance ~~or~~  
 5 ~~complaint~~ to the department as the agent of the  
 6 subscriber or enrollee. Further, a provider may join with,  
 7 or otherwise assist, a subscriber or enrollee, or the agent,  
 8 to submit the grievance ~~or complaint~~ to the department.  
 9 In addition, following submission of the grievance ~~or~~  
 10 ~~complaint~~ to the department, the subscriber or enrollee,  
 11 or the agent, may authorize the provider to assist,  
 12 including advocating on behalf of the subscriber or  
 13 enrollee. For purposes of this section, a “relative”  
 14 includes the parent, stepparent, spouse, adult son or  
 15 daughter, grandparent, brother, sister, uncle, or aunt of  
 16 the subscriber or enrollee.

17 ~~(3) Every health care service plan regulated by the~~  
 18 ~~department shall prominently display in every plan~~  
 19 ~~contract, on enrollee and subscriber evidence of~~  
 20 ~~coverage forms, on the complaint forms required under~~  
 21 ~~paragraph (3) of subdivision (a), and on all written~~  
 22 ~~responses to grievances and complaints, a notice of the~~  
 23 ~~right to submit unresolved grievances and complaints to~~  
 24 ~~the department for review.~~

25 ~~(4) The department shall review the written~~  
 26 ~~documents submitted with the subscriber’s or the~~  
 27 ~~enrollee’s request for review, or submitted by the agent~~  
 28 ~~on behalf of the subscriber or enrollee. The department~~  
 29 ~~may ask for additional information, and may hold an~~  
 30 ~~informal meeting with the involved parties, including~~  
 31 ~~providers who have joined in submitting the grievance ~~or~~~~  
 32 ~~~~complaint~~, or who are otherwise assisting or advocating~~  
 33 ~~on behalf of the subscriber or enrollee. ~~The~~ *If after*~~  
 34 ~~*reviewing the record, the department concludes that the*~~  
 35 ~~*grievance, in whole or in part, is eligible for review under*~~  
 36 ~~*the independent medical review system established*~~  
 37 ~~*pursuant to Article 12 (commencing with Section*~~  
 38 ~~*1399.80), the department shall immediately notify the*~~  
 39 ~~*subscriber or enrollee, or agent, of that option and shall,*~~  
 40 ~~*if requested orally or in writing, assist the subscriber or*~~



1 enrollee in participating in the independent medical  
2 review system.

3 (4) If after reviewing the record of a grievance, the  
4 department concludes that a health care service eligible  
5 for coverage and payment under a health care service  
6 plan contract has been denied, terminated, or otherwise  
7 limited by a plan, or by one of its contracting providers,  
8 substantially due to a determination that the service is not  
9 medically necessary or medically appropriate for the  
10 enrollee's medical condition, and that determination was  
11 not communicated to the enrollee in writing along with  
12 a notice of the enrollee's potential right to participate in  
13 the independent medical review system, as required by  
14 this chapter, the commissioner shall impose a penalty.

15 (5) The department shall send a written notice of the  
16 final disposition of the grievance ~~or complaint~~, and the  
17 reasons therefor, to the subscriber or enrollee, the agent,  
18 to any provider that has joined with or is otherwise  
19 assisting the subscriber or enrollee, and to the plan,  
20 within ~~60~~ 30 calendar days of receipt of the request for  
21 review unless the commissioner, in his or her discretion,  
22 determines that additional time is reasonably necessary  
23 to fully and fairly evaluate the relevant grievance ~~or~~  
24 ~~complaint~~. ~~Distribution.~~ In any decision not eligible for  
25 the independent medical review system established  
26 pursuant to Article 12 (commencing with Section  
27 1399.80), the department's written notice shall include, at  
28 a minimum, the following:

29 (A) A summary of its findings and the reasons why the  
30 department found the plan to be, or not to be, in  
31 compliance with any applicable laws, regulations, or  
32 orders of the commissioner.

33 (B) A discussion of the department's contact with any  
34 medical provider, or any other independent expert relied  
35 on by the department, along with a summary of the views  
36 and qualifications of that provider or expert.

37 (C) If the enrollee's grievance is sustained in whole or  
38 part, information about any corrective action taken.

39 (6) In any department review of a grievance involving  
40 a disputed health care service, as defined in subdivision



1 (b) of Section 1399.80, that is not eligible for the  
2 independent medical review system established  
3 pursuant to Article 12 (commencing with Section  
4 1399.80), in which the department finds that the plan has  
5 denied, terminated, or otherwise limited health care  
6 services that are medically necessary or medically  
7 appropriate, and those services are a covered benefit  
8 under the terms and conditions of the health care service  
9 plan contract, the department's written notice shall  
10 either:

11 (A) Order the plan to promptly offer and provide  
12 those health care services to the enrollee, or

13 (B) Order the plan to promptly reimburse the  
14 enrollee for any reasonable costs associated with urgent  
15 care or emergency services, or other extraordinary and  
16 compelling health care services, when the department  
17 finds that the enrollee's decision to secure those services  
18 outside of the plan network was reasonable under the  
19 circumstances.

20 The department's order shall be binding on the plan.

21 (7) Distribution of the written notice shall not be  
22 deemed a waiver of any exemption or privilege under  
23 existing law, including, but not limited to, Section 6254.5  
24 of the Government Code, for any information in  
25 connection with and including the written notice, nor  
26 shall any person employed or in any way retained by the  
27 department be required to testify as to that information  
28 or notice.

29 (8) On or before January 1, ~~1997~~ 1999, the  
30 commissioner shall establish and maintain a system of  
31 aging of ~~complaints~~ grievances that are pending and  
32 unresolved for ~~60~~ 30 days or more, that shall include a  
33 brief explanation of the reasons each ~~complaint~~ grievance  
34 is pending and unresolved for ~~60~~ 30 days or more.

35 ~~(5)~~

36 (9) A subscriber or enrollee, or the agent acting on  
37 behalf of a subscriber or enrollee, may also request  
38 voluntary mediation with the plan prior to exercising the  
39 right to submit a grievance ~~or—complaint~~ to the  
40 department. The use of mediation services shall not



1 preclude the right to submit a grievance ~~or complaint~~ to  
2 the department upon completion of mediation. In order  
3 to initiate mediation, the subscriber or enrollee, or the  
4 agent acting on behalf of the subscriber or enrollee, and  
5 the plan shall voluntarily agree to mediation. Expenses  
6 for mediation shall be borne equally by both sides. The  
7 department shall have no administrative or enforcement  
8 responsibilities in connection with the voluntary  
9 mediation process authorized by this paragraph.

10 (c) The plan's grievance system shall include a system  
11 of aging of ~~complaints~~ *grievances* that are pending and  
12 unresolved for 30 days or more. On or before January 1,  
13 1997, the plan shall provide a quarterly report to the  
14 commissioner of ~~complaints~~ *grievances* pending and  
15 unresolved for 30 or more days with separate categories  
16 of ~~complaints~~ *grievances* for Medicare enrollees and  
17 Medi-Cal enrollees. The plan shall include with the report  
18 a brief explanation of the reasons each ~~complaint~~  
19 *grievance* is pending and unresolved for 30 days or more.  
20 The plan may include the following statement in the  
21 quarterly report that is made available to the public by  
22 the commissioner:

23  
24 "Under Medicare and Medi-Cal law, Medicare  
25 enrollees and Medi-Cal enrollees each have separate  
26 avenues of appeal that are not available to other  
27 enrollees. Therefore, ~~complaints~~ *grievances* pending  
28 and unresolved may reflect enrollees pursuing their  
29 Medicare or Medi-Cal appeal rights."  
30

31 If requested by a plan, the commissioner shall include this  
32 statement in a written report made available to the public  
33 and prepared by the commissioner that describes or  
34 compares ~~complaints~~ *grievances* that are pending and  
35 unresolved with the plan for 30 days or more.  
36 Additionally, the commissioner shall, if requested by a  
37 plan, append to that written report a brief explanation,  
38 provided in writing by the plan, of the reasons why  
39 ~~complaints~~ *grievances* described in that written report  
40 are pending and unresolved for 30 days or more. The

1 commissioner shall not be required to include a statement  
2 or append a brief explanation to a written report that the  
3 commissioner is required to prepare under this chapter,  
4 including Sections 1380 and 1397.5.

5 (d) Subject to subparagraph (C) of paragraph (1) of  
6 subdivision (b), the grievance, ~~complaint~~, or resolution  
7 procedures authorized by this section shall be in addition  
8 to any other procedures that may be available to any  
9 person, and failure to pursue, exhaust, or engage in the  
10 procedures described in this section shall not preclude  
11 the use of any other remedy provided by law.

12 (e) Nothing in this section shall be construed to allow  
13 the submission to the department of any provider  
14 ~~complaint~~ or grievance under this section. However, as  
15 part of a provider's duty to advocate for medically  
16 appropriate health care for his or her patients pursuant  
17 to Sections 510 and 2056 of the Business and Professions  
18 Code, nothing in this subdivision shall be construed to  
19 prohibit a provider from contacting and informing the  
20 department about any concerns he or she has regarding  
21 compliance with or enforcement of this chapter.

22 *SEC. 3. Section 1368.01 of the Health and Safety Code*  
23 *is amended to read:*

24 1368.01. (a) The grievance system shall require the  
25 plan to resolve grievances within 30 days ~~whenever~~  
26 ~~possible~~ and shall require the plan to provide enrollees  
27 and subscribers with a written statement on the  
28 disposition or pending status of the grievance within ~~30~~  
29 *15* days of the plan's receipt of the grievance.

30 (b) The grievance system shall include a requirement  
31 for expedited plan review of grievances for cases  
32 involving an imminent and serious threat to the health of  
33 the patient, including, but not limited to, *severe pain*,  
34 potential loss of life, limb, or major bodily function. When  
35 the plan has notice of a case requiring expedited review,  
36 the grievance system shall require the plan to  
37 immediately inform enrollees and subscribers in writing  
38 of their right to notify the department of the grievance.  
39 The grievance system shall also require the plan to  
40 provide enrollees, subscribers, and the department with



1 a written statement on the disposition or pending status  
2 of the grievance no later than ~~five~~ *three* days from receipt  
3 of the grievance.

4 *SEC. 4. Section 1368.03 of the Health and Safety Code*  
5 *is amended to read:*

6 1368.03. (a) The department may require enrollees  
7 and subscribers to participate in a plan's grievance  
8 process for up to ~~60~~ 30 days before pursuing a ~~complaint~~  
9 *grievance* through the department. However, the  
10 department may not impose this waiting period—~~in for~~  
11 *expedited review* cases covered by subdivision (b) of  
12 Section 1368.01 or in any other case where the  
13 department determines that an earlier review is  
14 warranted.

15 (b) Notwithstanding subdivision (a), the department  
16 may refer any grievance ~~or complaint issue that does not~~  
17 *pertain to compliance with this chapter* to the State  
18 Department of Health Services, the Department of  
19 Aging, the federal Health Care Financing  
20 Administration, or any other appropriate governmental  
21 entity for investigation and resolution.

22 *SEC. 5. Section 1368.04 of the Health and Safety Code*  
23 *is amended to read:*

24 1368.04. (a) The commissioner shall, ~~as appropriate,~~  
25 investigate and take enforcement action against plans  
26 regarding ~~complaints by enrollees and subscribers~~  
27 *grievances reviewed and found by the department to*  
28 *involve plan noncompliance with the requirements of*  
29 *this chapter, including grievances that have been*  
30 *reviewed pursuant to the independent medical review*  
31 *system established pursuant to Article 12 (commencing*  
32 *with Section 1399.80). Where harm to an enrollee has*  
33 *occurred as a result of plan noncompliance, the*  
34 *commissioner shall impose penalties. The commissioner*  
35 *shall periodically evaluate ~~complaints~~ grievances to*  
36 *determine if any audit, investigative, or enforcement*  
37 *actions should be undertaken by the department.*

38 (b) The commissioner may, after appropriate notice  
39 and opportunity for hearing, levy an administrative  
40 penalty, by order, in an amount not to exceed two



1 hundred fifty thousand dollars (\$250,000) if the  
2 commissioner determines that a health care service plan  
3 has knowingly committed, or has performed with ~~such a~~  
4 frequency as to indicate a general business practice, any  
5 of the following:

6 (1) Repeated failure to act promptly and reasonably to  
7 investigate and resolve grievances in accordance with  
8 Section 1368.01.

9 (2) Repeated failure to act promptly and reasonably to  
10 resolve grievances when the obligation of the plan to the  
11 enrollee or subscriber is reasonably clear.

12 (c) The administrative penalties available to the  
13 commissioner pursuant to this section are not exclusive,  
14 and may be sought and employed in any combination  
15 with civil, criminal, and other administrative remedies  
16 deemed warranted by the commissioner to enforce this  
17 chapter.

18 (d) The administrative penalties authorized pursuant  
19 to this section shall be paid to the State Corporations  
20 Fund.

21 *SEC. 6. Article 12 (commencing with Section*  
22 *1399.80) is added to Chapter 2.2 of Division 2 of the Health*  
23 *and Safety Code, to read:*

24

25 *Article 12. Appeals Seeking Independent Medical*  
26 *Reviews*

27

28 *1399.80. (a) Commencing January 1, 2000, there is*  
29 *established in the department the Independent Medical*  
30 *Review System.*

31 *(b) For the purposes of this chapter, "disputed health*  
32 *care service" means any health care service eligible for*  
33 *coverage and payment under a health care service plan*  
34 *contract that has been denied, terminated, or otherwise*  
35 *limited by a decision of the plan, or by one of its*  
36 *contracting providers, substantially due to a finding that*  
37 *the service is not medically necessary or medically*  
38 *appropriate for the enrollee's medical condition. A*  
39 *decision regarding a "disputed health care service"*



1 *relates to the practice of medicine and is not a “coverage*  
2 *decision.”*

3 *(c) For the purposes of this chapter, “coverage*  
4 *decision” means the approval or denial of health care*  
5 *services by a plan, or by one of its contracting entities,*  
6 *based, in whole or in part, on a finding that the provision*  
7 *of a particular service is included or excluded as a covered*  
8 *benefit under the terms and conditions of the health care*  
9 *service plan contract. A “coverage decision” does not*  
10 *encompass a plan or contracting provider decision*  
11 *regarding a “disputed health care service.”*

12 *(d) All enrollee grievances involving a disputed health*  
13 *care service are eligible for review under the*  
14 *Independent Medical Review System if the requirements*  
15 *of this chapter are met. If the department finds that an*  
16 *enrollee grievance involving a disputed health care*  
17 *service does not meet the requirements of this chapter for*  
18 *review under the Independent Medical Review System,*  
19 *the enrollee request for review shall be treated as a*  
20 *request for the department to review the grievance*  
21 *pursuant to subdivision (b) of Section 1368. All other*  
22 *enrollee grievances, including grievances involving*  
23 *coverage decisions, remain eligible for review by the*  
24 *department pursuant to subdivision (b) of Section 1368.*

25 *(e) No later than January 1, 2000, every health care*  
26 *service plan shall provide an enrollee with the*  
27 *opportunity to seek an independent medical review*  
28 *whenever health care services have been denied,*  
29 *terminated, or otherwise limited by the plan, or by one*  
30 *of its contracting providers, if the decision was based, in*  
31 *whole or in part, on a finding that the proposed health*  
32 *care services are not medically necessary or medically*  
33 *appropriate. For purposes of this article, “enrollee” shall*  
34 *include a subscriber or designee as described in*  
35 *paragraph (2) of subdivision (b) of Section 1368, and an*  
36 *enrollee’s provider with the consent of the enrollee or the*  
37 *designee. The provider may join with or otherwise assist*  
38 *the enrollee to seek an independent medical review, and*  
39 *may advocate on behalf of the enrollee.*



1 (f) Every health care service plan contract that is  
2 issued, amended, renewed, or delivered in this state on or  
3 after January 1, 2000, shall authorize enrollee  
4 participation in the Independent Medical Review  
5 System. Medi-Cal beneficiaries enrolled in a health care  
6 service plan shall not be excluded from participation.  
7 Medicare beneficiaries shall not be excluded unless the  
8 federal Health Care Financing Administration issues a  
9 finding that federal law preempts their participation.

10 (g) The department shall seek to integrate the quality  
11 of care and consumer protection provisions, including  
12 remedies, of the Independent Medical Review System  
13 with related dispute resolution procedures of other  
14 health care agency programs, including the medicare and  
15 Medi-Cal programs, in a way that minimizes the potential  
16 for duplication, conflict, and added costs. Nothing in this  
17 subdivision shall be construed to limit any rights  
18 conferred upon enrollees under this chapter.

19 (h) The independent medical review process  
20 authorized by this article is in addition to any other  
21 procedures or remedies that may be available. The  
22 enrollee's election to either pursue or not pursue,  
23 exhaust, or engage in the procedures described in this  
24 article does not preclude the use of any other remedy  
25 provided by law.

26 (i) No later than January 1, 2000, every health care  
27 service plan shall prominently display in every plan  
28 contract, on enrollee and subscriber evidence of  
29 coverage forms, on copies of plan procedures for  
30 resolving grievances, on the grievance forms required  
31 under Section 1368, and on all written responses to  
32 grievances, information concerning the right of an  
33 enrollee to request an independent medical review in  
34 cases where the enrollee believes that health care  
35 services have been improperly denied, terminated, or  
36 otherwise limited by the plan, or by one of its contracting  
37 providers.

38 (j) An enrollee may apply to the department for an  
39 independent medical review when all of the following  
40 conditions are met:



1 (1) (A) The enrollee's provider has recommended a  
2 health care service as medically necessary or medically  
3 appropriate for the enrollee's medical conditions, or

4 (B) The enrollee has received urgent care or  
5 emergency services that a provider determined was  
6 medically necessary or medically appropriate for the  
7 enrollee's medical condition, or

8 (C) The enrollee, in the absence of a provider  
9 recommendation under subparagraph (A) or the receipt  
10 of urgent care or emergency services by a provider under  
11 subparagraph (B), has been seen by an in-plan provider  
12 for the diagnosis or treatment of the medical condition for  
13 which the enrollee seeks independent review.

14 For purposes of this article, the enrollee's provider may  
15 be an out-of-plan provider. However, the plan shall have  
16 no liability for payment of services provided by an  
17 out-of-plan provider, except as provided in subdivision  
18 (b) of Section 1399.84.

19 (2) The disputed health care service has been denied,  
20 terminated, or otherwise limited by the plan, or by one  
21 of its contracting providers, substantially due to a decision  
22 that the health care service is not medically necessary or  
23 medically appropriate.

24 (3) The enrollee has filed a grievance with the plan or  
25 its contracting provider pursuant to Section 1368, and the  
26 disputed decision is upheld or the grievance remains  
27 unresolved after 30 days. The enrollee shall not be  
28 required to participate in the plan's grievance process for  
29 more than 30 days. In the case of a grievance that requires  
30 expedited review pursuant to Section 1368.01, the  
31 enrollee shall not be required to participate in the plan's  
32 grievance process for more than three days.

33 (k) An enrollee may apply to the department for an  
34 independent medical review of a decision to deny,  
35 terminate, or otherwise limit health care services,  
36 substantially due to a finding that the disputed health  
37 care services are not medically necessary or medically  
38 appropriate, within 60 days of any of the qualifying  
39 periods or events under subdivision (j). The  
40 commissioner may extend the application deadline



1 beyond 60 days if the circumstances of a case warrant the  
2 extension.

3 (l) The enrollee shall pay to the department an  
4 application processing fee of twenty-five dollars (\$25),  
5 which shall be refunded if the enrollee prevails, in whole  
6 or in part, in the review. Medi-Cal beneficiaries shall be  
7 exempt from the fee. The commissioner shall reduce or  
8 waive the fee in other cases involving low-income  
9 individuals, according to a schedule established by the  
10 commissioner. The remaining costs of the Independent  
11 Medical Review System shall be borne by the plans as  
12 provided in Section 1399.85.

13 (m) As part of the application for an independent  
14 medical review, the enrollee shall provide the  
15 department with all of the following:

16 (1) A brief description of the enrollee's medical  
17 condition for which health care services were denied,  
18 terminated, or otherwise limited.

19 (2) Documentation showing any of the following:

20 (A) A provider recommendation indicating that the  
21 disputed health care service is medically necessary or  
22 medically appropriate for the enrollee's medical  
23 condition.

24 (B) The enrollee has received the disputed health care  
25 service, on an urgent care or emergency basis, from a  
26 provider who determined it was medically necessary or  
27 medically appropriate for the enrollee's medical  
28 condition.

29 (C) Reasonable information supporting the enrollee's  
30 position that the disputed health care service is or was  
31 medically necessary or medically appropriate for the  
32 enrollee's medical condition.

33 The enrollee shall be encouraged to also provide a copy  
34 of all information provided to the enrollee by the plan or  
35 any of its contracting providers, still in the possession of  
36 the enrollee, concerning a plan or provider decision  
37 regarding disputed health care services, and a copy of any  
38 materials the enrollee submitted to the plan, still in the  
39 possession of the enrollee, in support of the grievance, as



1 well as any additional material that the enrollee believes  
2 is relevant.

3 (3) A written consent to obtain any necessary medical  
4 records from the plan, any of its contracting providers,  
5 and any out-of-plan provider the enrollee may have  
6 consulted on the matter.

7 (n) Upon notice from the department that the health  
8 care service plan's enrollee has applied for an  
9 independent medical review, the plan or its contracting  
10 providers shall provide to the department, or to the  
11 independent medical review organization if requested by  
12 the department, a copy of all of the following documents  
13 within three business days of the plan's receipt of the  
14 department's notice of a request by an enrollee for an  
15 independent review:

16 (1) A copy of all of the enrollee's medical records in the  
17 possession of the plan or its contracting providers  
18 relevant to each of the following:

19 (A) The enrollee's medical condition.

20 (B) The health care services being provided by the  
21 plan and its contracting providers for the condition.

22 (C) The disputed health care services requested by  
23 the enrollee for the condition.

24 Any newly developed or discovered relevant medical  
25 records in the possession of the plan or its contracting  
26 providers after the initial documents are provided to the  
27 department shall be forwarded immediately to the  
28 department, or to the independent medical review  
29 organization if requested by the department. The plan  
30 shall concurrently provide a copy of medical records  
31 required by this subparagraph to the enrollee or the  
32 enrollee's provider unless the offer of medical records is  
33 declined or otherwise prohibited by law. The  
34 confidentiality of all medical record information shall be  
35 maintained pursuant to applicable state and federal laws.

36 (2) A copy of all information provided to the enrollee  
37 by the plan and any of its contracting providers  
38 concerning plan and provider decisions regarding the  
39 enrollee's condition and care, and a copy of any materials  
40 the enrollee or the enrollee's provider submitted to the



1 plan and to the plan's contracting providers in support of  
2 the enrollee's request for disputed health care services.  
3 This documentation shall include the written response to  
4 the enrollee's grievance, required by paragraph (4) of  
5 subdivision (a) of Section 1368. The confidentiality of any  
6 enrollee medical information shall be maintained  
7 pursuant to applicable state and federal laws.

8 (3) A copy of any other relevant documents or  
9 information used by the plan or its contracting providers  
10 in determining whether disputed health care services  
11 should have been provided, and any statements by the  
12 plan and its contracting providers explaining the reasons  
13 for the decision not to provide disputed health care  
14 services on the basis of medical necessity or medical  
15 appropriateness. The plan shall concurrently provide a  
16 copy of documents required by this subparagraph, except  
17 for any information found by the commissioner to be  
18 legally privileged information, to the enrollee and the  
19 enrollee's provider. The department and the  
20 independent review organization shall maintain the  
21 confidentiality of any information found by the  
22 commissioner to be the proprietary information of the  
23 plan.

24 1399.81. (a) Upon receipt of an enrollee's request for  
25 an independent medical review, the commissioner shall  
26 assign the request in whole or in part to an independent  
27 medical review organization as described in Section  
28 1399.82 when all of the following conditions are satisfied:

29 (1) The enrollee has provided an executed release to  
30 obtain necessary medical records.

31 (2) The enrollee has submitted payment for the  
32 application fee, unless the fee is reduced or waived.

33 (3) The commissioner finds that the decision to deny,  
34 terminate, or otherwise limit disputed health care  
35 services was substantially due to a determination that the  
36 proposed health care services are not medically necessary  
37 or medically appropriate. The commissioner shall  
38 consider the entire record submitted by the enrollee, the  
39 plan, and providers when making this finding.



1 (4) The enrollee has followed the plan's grievance  
2 process pursuant to Section 1368. However, the  
3 commissioner may waive this requirement in  
4 extraordinary and compelling cases, where the  
5 commissioner finds that the enrollee has acted  
6 reasonably.

7 (5) The enrollee has submitted documentation  
8 satisfying the requirements of paragraph (1) of  
9 subdivision (j) of Section 1399.80.

10 (b) The department shall expeditiously review  
11 requests and immediately notify the enrollee in writing  
12 as to whether the request for an independent medical  
13 review has been approved, in whole or in part, and, if not  
14 approved, the reasons therefor. The department shall  
15 issue a notification to the enrollee no later than two  
16 business days after receiving all of the material required  
17 under subdivision (a). The department shall approve in  
18 one business day enrollee requests whenever the  
19 enrollee's plan has agreed that the case is eligible for an  
20 independent medical review. The department shall not  
21 certify coverage decisions for independent review. To  
22 the extent an enrollee request for independent review is  
23 not approved by the department, the enrollee request  
24 shall be treated as an immediate request for the  
25 department to review the grievance pursuant to  
26 subdivision (b) of Section 1368.

27 (c) If the request for review is approved, the  
28 department shall immediately arrange for delivery by the  
29 plan, and its contracting providers or directly provide the  
30 independent medical review organization with all  
31 necessary information and documents related to the case  
32 submitted by the enrollee, the enrollee's provider, the  
33 health care service plan, and its contracting providers. If  
34 there is an imminent and serious threat to the health of  
35 the enrollee, as defined in subdivision (c) of Section  
36 1399.83, all necessary information and documents shall be  
37 delivered within 24 hours of approval of the request. In  
38 other cases, information and documents shall be provided  
39 to the independent medical review organization no later  
40 than two business days after approval of the request.

1 (d) *The organization shall conduct the review in*  
2 *accordance with Section 1399.83 and any regulations or*  
3 *orders of the commissioner adopted pursuant thereto.*  
4 *The organization's review shall be limited to an*  
5 *examination of the medical necessity or appropriateness*  
6 *of the disputed health care services and shall not include*  
7 *any consideration of coverage decisions or other*  
8 *contractual issues.*

9 1399.82. (a) *By January 1, 2000, the commissioner*  
10 *shall contract with one or more independent medical*  
11 *review organizations in the state to conduct reviews for*  
12 *purposes of this article. The independent medical review*  
13 *organizations shall be independent of any health care*  
14 *service plans doing business in this state. The*  
15 *commissioner may establish additional requirements,*  
16 *including conflict-of-interest standards, consistent with*  
17 *the purposes of this article, that an organization shall be*  
18 *required to meet in order to qualify for participation in*  
19 *the Independent Medical Review System.*

20 (b) (1) *The independent medical review*  
21 *organization, any experts it designates to conduct a*  
22 *review, or any officer, director, or employee of the*  
23 *independent medical review organization shall not have*  
24 *any material professional, familial, or financial affiliation,*  
25 *as determined by the commissioner, with any of the*  
26 *following:*

27 (A) *The plan.*

28 (B) *Any officer, director, or employee of the plan.*

29 (C) *A physician, the physician's medical group, or the*  
30 *independent practice association either denying or*  
31 *proposing the health care service in dispute.*

32 (D) *The institution at which either the proposed*  
33 *health care service, or the alternative service, if any,*  
34 *recommended by the plan, would be provided.*

35 (E) *The development or manufacture of the principal*  
36 *drug, device, procedure, or other therapy proposed by*  
37 *the enrollee whose treatment is under review, or the*  
38 *alternative therapy, if any, recommended by the plan.*

39 (c) *The commissioner shall, by July 1, 1999, contract*  
40 *with a private, nonprofit accrediting organization to*



1 *accredit the independent medical review organizations*  
2 *described in subdivision (a). The accrediting*  
3 *organization may grant and revoke accreditation, and*  
4 *shall develop, apply, and enforce accreditation standards*  
5 *that ensure the independence of the independent*  
6 *medical review organization, the confidentiality of the*  
7 *medical records, and the qualifications and*  
8 *independence of the health care professionals providing*  
9 *the analyses and recommendations requested of them.*  
10 *The accrediting organization shall demonstrate the*  
11 *ability to objectively evaluate the performance of*  
12 *independent medical review organizations and shall*  
13 *demonstrate that it has no conflict of interest, including*  
14 *any material professional, familial, or financial affiliation,*  
15 *as provided in subdivision (b), with any independent*  
16 *medical review organization or plan, in accrediting those*  
17 *organizations for the purpose of reviewing medical*  
18 *treatment and treatment recommendation decisions*  
19 *made by health care service plans.*

20 *(d) In order to receive accreditation for the purposes*  
21 *of this section, an independent medical review*  
22 *organization shall meet all of the following requirements:*

23 *(1) An independent medical review organization shall*  
24 *not be an affiliate or a subsidiary of, nor in any way be*  
25 *owned or controlled by, a health plan or a trade*  
26 *association of health plans. A board member, director,*  
27 *officer, or employee of the independent medical review*  
28 *organization shall not serve as a board member, director,*  
29 *or employee of a health care service plan. A board*  
30 *member, director, or officer of a health plan or a trade*  
31 *association of health plans shall not serve as a board*  
32 *member, director, officer, or employee of an*  
33 *independent medical review organization.*

34 *(2) The independent medical review organization*  
35 *shall submit to the accrediting organization and to the*  
36 *department the following information upon initial*  
37 *application for accreditation and, except as otherwise*  
38 *provided, annually thereafter upon any change to any of*  
39 *the following information:*

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

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

6 (C) The names of all corporations and organizations  
7 that the independent medical review organization  
8 controls or is affiliated with, and the nature and extent of  
9 any ownership or control, including the affiliated  
10 organization's type of business.

11 (D) The names and biographical sketches of all  
12 directors, officers, and executives of the independent  
13 medical review organization, as well as a statement  
14 regarding any past or present relationships the directors,  
15 officers, and executives may have with any health care  
16 service plan, disability insurer, managed care  
17 organization, provider group, or board or committee of  
18 a plan, managed care organization, or provider group.

19 (E) (i) The percentage of revenue the independent  
20 medical review organization receives from expert  
21 reviews, including, but not limited to, external medical  
22 reviews, quality assurance reviews, and utilization  
23 reviews.

24 (ii) The names of any health care service plan or  
25 provider group for which the independent medical  
26 review organization provides review services, including,  
27 but not limited to, utilization review, quality assurance  
28 review, and external medical review. Any change in this  
29 information shall be reported to the department within  
30 five business days of the change.

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

34 (G) A description of the system the independent  
35 medical review organization uses to identify and recruit  
36 medical professionals to review treatment and treatment  
37 recommendation decisions, the number of medical  
38 professionals credentialed, and the types of cases and  
39 areas of expertise which the medical professionals are  
40 credentialed to review.



1 (H) A description of how the independent medical  
2 review organization ensures compliance with the  
3 conflict-of-interest provisions of this section.

4 (3) The independent medical review organization  
5 shall demonstrate that it has a quality assurance  
6 mechanism in place that does the following:

7 (A) Ensures that the medical professionals retained  
8 are appropriately credentialed and privileged.

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

12 (C) Ensures that the method of selecting medical  
13 professionals for individual cases achieves a fair and  
14 impartial panel of medical professionals who are qualified  
15 to render recommendations regarding the clinical  
16 conditions and the medical necessity of treatments or  
17 therapies in question.

18 (D) Ensures the confidentiality of medical records  
19 and the review materials, consistent with the  
20 requirements of this section and applicable state and  
21 federal law.

22 (E) Ensures the independence of the medical  
23 professionals retained to perform the reviews through  
24 conflict-of-interest policies and prohibitions, and ensures  
25 adequate screening for conflicts-of-interest, pursuant to  
26 paragraph (5).

27 (4) Medical professionals selected by independent  
28 medical review organizations to review medical  
29 treatment decisions shall be physicians or other  
30 appropriate providers who meet the following minimum  
31 requirements:

32 (A) The medical professional shall be a clinician  
33 knowledgeable in the treatment of the enrollee's medical  
34 condition, knowledgeable about the proposed treatment,  
35 and familiar with guidelines and protocols in the area of  
36 treatment under review.

37 (B) The medical professional shall hold a  
38 nonrestricted license in the State of California, and for  
39 physicians, a current certification by a recognized  
40 American medical specialty board in the area or areas



1 *appropriate to the condition or treatment under review.*  
2 *For good cause shown, such as the unavailability of*  
3 *licensed qualified medical professionals in California or*  
4 *the availability of uniquely qualified clinics outside of*  
5 *California, the independent medical review organization*  
6 *may utilize a medical professional who holds a*  
7 *nonrestricted license in any state of the United States,*  
8 *provided that the out-of-state medical professional is*  
9 *knowledgeable about the treatment standards in*  
10 *California and applies those standards.*

11 *(C) The medical professional shall have no history of*  
12 *disciplinary action or sanctions, including, but not limited*  
13 *to, loss of staff privileges or participation restrictions,*  
14 *taken or pending by any hospital, government, or*  
15 *regulatory body.*

16 *(5) Neither the expert reviewer, nor the independent*  
17 *medical review organization, shall have any material*  
18 *professional, material familial, or material financial*  
19 *affiliation with any of the following:*

20 *(A) The plan or a provider group of the plan, except*  
21 *that an academic medical center under contract to the*  
22 *plan to provide services to enrollees may qualify as an*  
23 *independent medical review organization provided it*  
24 *will not provide the service and provided the center is not*  
25 *the developer or manufacturer of the proposed*  
26 *treatment.*

27 *(B) Any officer, director, or management employee of*  
28 *the plan.*

29 *(C) The physician, the physician's medical group, or*  
30 *the independent practice association (IPA) proposing*  
31 *the treatment.*

32 *(D) The institution at which the treatment would be*  
33 *provided.*

34 *(E) The development or manufacture of the*  
35 *treatment proposed for the enrollee whose condition is*  
36 *under review.*

37 *(F) The enrollee or the enrollee's immediate family.*

38 *(6) For purposes of this section, the following terms*  
39 *shall have the following meanings:*



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

4 (B) “Material professional affiliation” means any  
5 physician-patient relationship, any partnership or  
6 employment relationship, a shareholder or similar  
7 ownership interest in a professional corporation, or any  
8 independent contractor arrangement that constitutes a  
9 material financial affiliation with any expert or any officer  
10 or director of the independent medical review  
11 organization. “Material professional affiliation” does not  
12 include affiliations that are limited to staff privileges at a  
13 health facility.

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

26 (e) The accrediting organization shall provide, upon  
27 the request of any interested person, a copy of all  
28 nonproprietary information, as determined by the  
29 commissioner, filed with it by an independent medical  
30 review organization seeking accreditation under this  
31 article. The accrediting organization may charge a  
32 nominal fee to the interested person for photocopying the  
33 requested information.

34 (f) The independent review process established by  
35 this section shall be required on and after January 1, 2000.

36 1399.83. (a) Upon receipt of information and  
37 documents related to a case pursuant to subdivision (c)  
38 of Section 1399.81, the medical professional reviewer or  
39 reviewers selected to conduct the review by the  
40 independent medical review organization shall promptly



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

11 (b) Following its review, the reviewer or reviewers  
12 shall determine whether the disputed health care service  
13 was medically necessary or medically appropriate based  
14 on generally accepted practice guidelines developed by  
15 federal agencies, nationally recognized federal research  
16 institutes, national professional medical specialty  
17 societies, or relevant medical or scientific evidence or  
18 generally accepted standards of medical practice.

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

39 (d) The medical professionals' analyses and  
40 determinations shall state whether the disputed health



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

12 (e) The independent medical review organization  
13 shall provide the commissioner, the plan, the enrollee,  
14 and the enrollee's provider with the analyses and  
15 determinations of the medical professionals reviewing  
16 the case, a description of the qualifications of the medical  
17 professionals, and the names of the reviewers. If more  
18 than one medical professional reviewed the case and the  
19 result was differing determinations, the independent  
20 medical review organization shall provide each of the  
21 separate reviewer's analyses and determinations.

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

26 (g) (1) Subject to provisions of the Evidence Code,  
27 the opinion of a medical professional reviewer on  
28 whether the disputed health care service was medically  
29 necessary or medically appropriate may be offered for  
30 admissibility solely on that issue by a party to the medical  
31 review who calls the medical professional as his or her  
32 expert witness in any subsequent administrative or civil  
33 proceeding. Any opinion evidence of the medical  
34 professional reviewer that is admitted shall be considered  
35 only as the testimony of the party's expert witness, and  
36 not as the testimony of the medical professional  
37 conducting the medical review. Any opinion evidence of  
38 the medical professional reviewer that is admitted shall  
39 be accorded the same weight as other expert opinion



1 *evidence and shall be subject to the same rules, including*  
2 *cross-examination.*

3 *(2) A medical professional reviewer opinion of*  
4 *medical necessity or medical appropriateness shall not be*  
5 *based in whole or in part on a determination that the*  
6 *disputed health care service is excluded from or covered*  
7 *under the terms and conditions of the health care service*  
8 *plan contract, and that coverage determination shall be*  
9 *inadmissible.*

10 *(h) After removing the names of the parties,*  
11 *including, but not limited to, the enrollee, all medical*  
12 *providers, the plan, and any of its employees or*  
13 *contractors, commissioner decisions adopting a*  
14 *determination of an independent medical review*  
15 *organization shall be made available by the department*  
16 *to the public upon request, at the department's cost.*

17 *1399.84. (a) Upon receiving the decision adopted by*  
18 *the commissioner pursuant to Section 1399.83 that a*  
19 *disputed health care service is medically necessary or*  
20 *medically appropriate, the plan shall immediately*  
21 *contact the enrollee and offer to promptly implement the*  
22 *decision.*

23 *(b) In any case where an enrollee secured urgent care,*  
24 *emergency services, or other extraordinary and*  
25 *compelling health care services outside of the plan*  
26 *provider network, which services are later found by the*  
27 *independent medical review organization to have been*  
28 *medically necessary or medically appropriate, the*  
29 *commissioner shall require the plan to promptly*  
30 *reimburse the enrollee for any reasonable costs associated*  
31 *with those services when the commissioner finds that the*  
32 *enrollee's decision to secure the services outside of the*  
33 *plan provider network prior to completing the plan*  
34 *grievance process or seeking an independent medical*  
35 *review was reasonable under the circumstances and the*  
36 *disputed health care services were a covered benefit*  
37 *under the terms and conditions of the health care service*  
38 *plan contract.*

39 *(c) In addition to requiring plan compliance*  
40 *regarding subdivisions (a) and (b), the commissioner*



1 shall review individual cases submitted for independent  
2 medical review to determine whether any enforcement  
3 actions, including penalties, may be appropriate. In  
4 particular, where harm to an enrollee has already  
5 occurred because of the decision of a plan, or one of its  
6 contracting providers, to deny, terminate, or otherwise  
7 limit covered health care services that an independent  
8 medical review determines to be medically necessary or  
9 medically appropriate, the commissioner shall impose  
10 penalties.

11 (d) Pursuant to Section 1368.04, the commissioner  
12 shall periodically evaluate independent medical review  
13 cases to determine if any audit, investigative, or  
14 enforcement actions should be undertaken by the  
15 department, particularly if a plan repeatedly fails to act  
16 promptly and reasonably to resolve grievances associated  
17 with a denial, termination, or the imposition of other  
18 limits on medically necessary or medically appropriate  
19 health care services when the obligation of the plan to  
20 provide those health care services to enrollees or  
21 subscribers is reasonably clear.

22 1399.85. (a) After considering the results of a  
23 competitive bidding process and any other relevant  
24 information on program costs, the commissioner shall  
25 establish a reasonable, per-case reimbursement schedule  
26 to pay the costs of independent medical review  
27 organization reviews, which may vary depending on the  
28 type of medical condition under review and on other  
29 relevant factors.

30 (b) Aside from the application fee of twenty-five  
31 dollars (\$25), the costs of the independent medical  
32 review system for enrollees shall be borne by health care  
33 service plans pursuant to an assessment fee system  
34 established by the commissioner. Every health care  
35 service plan shall pay annually to the department, on the  
36 date or dates set by the department, its prorated share of  
37 fees, as determined by the commissioner, to pay for the  
38 estimated annual costs associated with carrying out,  
39 overseeing, and evaluating the independent medical  
40 review system. In determining the amount to be assessed,



1 the commissioner shall consider all appropriations  
2 available for the support of this chapter. The  
3 commissioner may adjust fees upward or downward, on  
4 a schedule set by the department, to address shortages or  
5 overpayments.

6 (c) These funds shall be used for all costs reasonably  
7 incurred in the administration of this chapter, including,  
8 but not limited to, start-up costs, overhead, department  
9 administration, contracting with an accrediting  
10 organization, contracts with independent medical  
11 review organizations, payments to medical professional  
12 reviewers, and program evaluation.

13 (d) The commissioner shall submit to the Legislature  
14 by March 1, 2001, a report on the initial implementation  
15 of this article. The report shall include a description of  
16 assessments imposed on plans to implement this article,  
17 increased staffing and other resources attributable to  
18 these new responsibilities, and any redirection of existing  
19 staff and resources to carry out these responsibilities. A  
20 single copy of the report shall be made available at no cost  
21 to members of the public upon request. The department  
22 may recover the cost of additional copies that are  
23 requested.

24 SEC. 7. Article 2.55 (commencing with Section  
25 10145.80) is added to Chapter 1 of Part 2 of Division 2 of  
26 the Insurance Code, to read:

27

28 Article 2.55. Appeals Seeking Independent Medical  
29 Review

30

31 10145.80. Commencing January 1, 2000, there is  
32 established in the department the Independent Medical  
33 Review System pursuant to the Patient's Independent  
34 Medical Review Act of 1998.

35 SEC. 8. No reimbursement is required by this act  
36 pursuant to Section 6 of Article XIII B of the California  
37 Constitution because the only costs that may be incurred  
38 by a local agency or school district will be incurred  
39 because this act creates a new crime or infraction,  
40 eliminates a crime or infraction, or changes the penalty



1 *for a crime or infraction, within the meaning of Section*  
2 *17556 of the Government Code, or changes the definition*  
3 *of a crime within the meaning of Section 6 of Article*  
4 *XIII B of the California Constitution.*

5 *Notwithstanding Section 17580 of the Government*  
6 *Code, unless otherwise specified, the provisions of this act*  
7 *shall become operative on the same date that the act*  
8 *takes effect pursuant to the California Constitution.*

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**All matter omitted in this version of the  
bill appears in the bill as amended in the  
Senate, July 6, 1998 (JR 11)**

O

