

AMENDED IN ASSEMBLY APRIL 15, 1999

AMENDED IN ASSEMBLY APRIL 12, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL

No. 55

**Introduced by Assembly Members Migden and
Strom-Martin
(Coauthor: Assembly Member Wayne)**

December 7, 1998

An act to add Title 7 (commencing with Section 3428) to Part 1 of Division 4 of the Civil Code, 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.

LEGISLATIVE COUNSEL'S DIGEST

AB 55, as amended, Migden. Health care service plans.

(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.

This bill would require a health care service plan or managed care entity, for services rendered on or after January 1, 2000, to be legally responsible to patients to ensure that health care providers, rather than the plan, shall be in charge of patient care.

The bill would provide that a health care service plan or managed care entity shall have a duty of ordinary care to provide medically appropriate health care service to its members, subscribers, or enrollees where the health care service is a benefit generally provided under the plan.

The bill would make a health care service plan or managed care entity liable for any and all harm resulting from the failure to exercise ordinary care in the provision, approval, or denial of health care services.

The bill would set forth prohibitions regarding health care service plans or managed care entities seeking indemnity from the requirements of this provision and would make any provisions to the contrary in a contract with providers void and unenforceable. The bill would make any waiver of certain provisions in the bill contrary to public policy, unenforceable, and void.

(2) Existing law provides for the regulation of insurance, administered by the Commissioner of Insurance. Existing law provides that the business of insurance is subject to the laws of California applicable to any other business, including, but not limited to, the Unruh Civil Rights Act in the Civil Code and the antitrust and unfair business practices laws in the Business and Professions Code.

This bill would provide that all persons or entities engaged in the business of insurance, as defined in the bill, in this state shall be held accountable in a civil action for all harm legally caused by the wrongful or unreasonable denial or delay of health care or disability benefits or services.

This bill would provide that health care service plans and managed care entities shall be subject to the laws of California applicable to any other business or business practice, including those applicable to the business of insurance.

(3) Existing law provides that for the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by the Civil Code, is the amount that will compensate for all the detriment approximately caused thereby, whether it could have been anticipated or not.



This bill would provide that damages shall be recoverable, including under this provision, for certain violations of the provisions of the bill.

(4) 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, 2001, 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, significantly delayed, *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~~ *Under this bill, an enrollee would not pay any application or processing fee. The bill would require that the costs of the independent medical review process 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.

It would further require the Commissioner of Corporations to submit a report to the Legislature by March 1, 2002, on the implementation of the independent medical review system.

(5) 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.

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. Title 7 (commencing with Section 3428)
2 is added to Part 1 of Division 4 of the Civil Code, to read:

3
4 TITLE 7. DUTY OF HEALTH CARE SERVICE
5 PLANS AND MANAGED CARE ENTITIES

6
7 3428. (a) For services rendered on or after January 1,
8 2000, a health care service plan or managed care entity,
9 as described in subdivision (f) of Section 1345 of the
10 Health and Safety Code or managed care entity, shall be
11 legally responsible to patients to ensure that health care
12 providers, rather than the health care service plan, are in
13 charge of patient care.

14 (b) (1) A health care service plan or managed care
15 entity shall have a duty of ordinary care to provide a
16 medically appropriate health care service to its members,



1 subscribers, or enrollees where the health care service is
2 a benefit generally provided under the plan.

3 (2) A health care service plan or managed care entity
4 shall be liable for any and all harm resulting from the
5 failure to exercise ordinary care in the provision,
6 approval, or denial of health care services, including but
7 not limited to, where the failure to provide those services
8 resulted from the fact that the health care service plan or
9 managed care entity interfered with, delayed, or
10 otherwise influenced the quality of medical care
11 provided.

12 (c) Nothing in this section shall cause a health care
13 service plan or managed care entity to be defined as a
14 health care provider under any provision of law,
15 including, but not limited to, Section 6146 of the Business
16 and Professions Code, Sections 3333.1 or 3333.2 of this
17 code, or Sections 340.5, 364, 425.13, 667.7, or 1295 of the
18 Code of Civil Procedure.

19 (d) A health care service plan or managed care entity
20 shall not seek indemnity, whether contractual or
21 equitable, from a provider for liability imposed under
22 subdivision (b). Any provision to the contrary in a
23 contract with providers is void and unenforceable.

24 (e) This section shall not create any liability on the
25 part of an employer or an employer group purchasing
26 organization that purchases coverage or assumes risk on
27 behalf of its employees or on behalf of self-funded
28 employee benefit plans.

29 (f) Any waiver by a member, subscriber, or enrollee of
30 the provisions of this section is contrary to public policy
31 and shall be unenforceable and void.

32 (g) This section does not create any new or additional
33 liability on the part of a health care service plan for the
34 sole medical negligence of a treating physician. “Sole
35 medical negligence” means that negligent provision of
36 medical care that is based on a decision unrelated to
37 financial or medical coverage issues.

38 (h) This section does not abrogate or limit any other
39 theory of liability otherwise available at law.



1 (i) If any provision of this section or the application
2 thereof to any person or circumstance is held to be
3 unconstitutional or otherwise invalid or unenforceable,
4 the remainder of the section and the application of those
5 provisions to other persons or circumstances shall not be
6 affected thereby.

7 3428.1. (a) All persons or entities engaged in the
8 business of insurance in this state shall be held
9 accountable in a civil action for all harm legally caused by
10 the wrongful or unreasonable denial or delay of health
11 care or disability benefits or services.

12 (b) For purposes of this section, “persons or entities
13 engaged in the business of insurance” are the following:

14 (1) Any and all entities regulated under the Insurance
15 Code to the extent those entities provide insurance for
16 life, health, medical, or disability risks.

17 (2) Any and all entities subject to regulation under
18 Chapter 2.2 (commencing with Section 1340) of Division
19 2 of the Health and Safety Code or any subsequent
20 legislation that replaces those provisions.

21 (c) Notwithstanding any other law, health care service
22 plans and managed care entities shall be subject to the
23 laws of California applicable to any other business or
24 business practice, including, but not limited to, those
25 specified in Section 1861.03 of the Insurance Code.

26 (d) Damages recoverable for violation of this section
27 include, but are not limited to, those set forth in Section
28 3333.

29 (e) Any waiver by a member, subscriber, or enrollee
30 of the provisions of this section is contrary to public policy
31 and shall be unenforceable and void.

32 (f) This section does not abrogate or limit any other
33 theory of liability otherwise available at law.

34 (g) If any provision of this section or the application
35 thereof to any person or circumstances is held to be
36 unconstitutional or otherwise invalid or unenforceable,
37 the remainder of the section and the application of those
38 provisions to other persons or circumstances shall not be
39 affected thereby.



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

3 1368. (a) Every plan shall do all of the following:

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

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

16 (3) Provide forms for grievances to be given to
17 subscribers and enrollees who wish to register written
18 grievances. The forms used by plans licensed pursuant to
19 Section 1353 shall be approved by the commissioner in
20 advance as to format.

21 (4) Provide subscribers and enrollees with written
22 responses to grievances, with a clear and concise
23 explanation of the reasons for the plan's response. For
24 grievances involving the denial, ~~termination, or the~~
25 *significant delay, termination, or* imposition of other
26 limits on health care services, the plan response shall
27 describe the criteria used and the clinical reasons for its
28 decision, including all criteria and clinical reasons related
29 to medical necessity or medical appropriateness.

30 (5) Keep in its files all copies of grievances, and the
31 responses thereto, for a period of five years.

32 (b) (1) (A) After either completing the grievance
33 process described in subdivision (a), or participating in
34 the process for at least 30 days, a subscriber or enrollee
35 may submit the grievance to the department for review.
36 In any case determined by the department to be a case
37 involving an imminent and serious threat to the health of
38 the patient, including, but not limited to, severe pain, the
39 potential loss of life, limb, or major bodily function, or in
40 any other case where the department determines that an



1 earlier review is warranted, a subscriber or enrollee shall
2 not be required to complete the grievance process or
3 participate in the process for at least 30 days before
4 submitting a grievance to the department for review.

5 (B) A grievance may be submitted to the department
6 for review and resolution prior to any arbitration.

7 (C) Notwithstanding subparagraphs (A) and (B), the
8 department may refer any grievance issue that does not
9 pertain to compliance with this chapter to the State
10 Department of Health Services, the California
11 Department of Aging, the federal Health Care Financing
12 Administration, or any other appropriate governmental
13 entity for investigation and resolution.

14 (2) If the subscriber or enrollee is a minor, or is
15 incompetent or incapacitated, the parent, guardian,
16 conservator, relative, or other designee of the subscriber
17 or enrollee, as appropriate, may submit the grievance to
18 the department as the agent of the subscriber or enrollee.
19 Further, a provider may join with, or otherwise assist, a
20 subscriber or enrollee, or the agent, to submit the
21 grievance to the department. In addition, following
22 submission of the grievance to the department, the
23 subscriber or enrollee, or the agent, may authorize the
24 provider to assist, including advocating on behalf of the
25 subscriber or enrollee. For purposes of this section, a
26 “relative” includes the parent, stepparent, spouse, adult
27 son or daughter, grandparent, brother, sister, uncle, or
28 aunt of the subscriber or enrollee.

29 (3) The department shall review the written
30 documents submitted with the subscriber’s or the
31 enrollee’s request for review, or submitted by the agent
32 on behalf of the subscriber or enrollee. The department
33 may ask for additional information, and may hold an
34 informal meeting with the involved parties, including
35 providers who have joined in submitting the grievance,
36 or who are otherwise assisting or advocating on behalf of
37 the subscriber or enrollee. If after reviewing the record,
38 the department concludes that the grievance, in whole or
39 in part, is eligible for review under the independent
40 medical review system established pursuant to Article 12



1 (commencing with Section 1399.80), the department
2 shall immediately notify the subscriber or enrollee, or
3 agent, of that option and shall, if requested orally or in
4 writing, assist the subscriber or enrollee in participating
5 in the independent medical review system.

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

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

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

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



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

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

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

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

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

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

33 (8) On or before January 1, 1999, the commissioner
34 shall establish and maintain a system of aging of
35 grievances that are pending and unresolved for 30 days
36 or more, that shall include a brief explanation of the
37 reasons each grievance is pending and unresolved for 30
38 days or more.

39 (9) A subscriber or enrollee, or the agent acting on
40 behalf of a subscriber or enrollee, may also request



1 voluntary mediation with the plan prior to exercising the
2 right to submit a grievance to the department. The use of
3 mediation services shall not preclude the right to submit
4 a grievance to the department upon completion of
5 mediation. In order to initiate mediation, the subscriber
6 or enrollee, or the agent acting on behalf of the subscriber
7 or enrollee, and the plan shall voluntarily agree to
8 mediation. Expenses for mediation shall be borne equally
9 by both sides. The department shall have no
10 administrative or enforcement responsibilities in
11 connection with the voluntary mediation process
12 authorized by this paragraph.

13 (c) The plan's grievance system shall include a system
14 of aging of grievances that are pending and unresolved
15 for 30 days or more. On or before January 1, 1999, the plan
16 shall provide a quarterly report to the commissioner of
17 grievances pending and unresolved for 30 or more days
18 with separate categories of grievances for Medicare
19 enrollees and Medi-Cal enrollees. The plan shall include
20 with the report a brief explanation of the reasons each
21 grievance is pending and unresolved for 30 days or more.
22 The plan may include the following statement in the
23 quarterly report that is made available to the public by
24 the commissioner:

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

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



1 written report are pending and unresolved for 30 days or
2 more. The commissioner shall not be required to include
3 a statement or append a brief explanation to a written
4 report that the commissioner is required to prepare
5 under this chapter, including Sections 1380 and 1397.5.

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

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

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

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

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



1 provide enrollees, subscribers, and the department with
2 a written statement on the disposition or pending status
3 of the grievance no later than three days from receipt of
4 the grievance.

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

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

15 (b) Notwithstanding subdivision (a), the department
16 may refer any grievance issue that does not pertain to
17 compliance with this chapter to the State Department of
18 Health Services, the Department of Aging, the federal
19 Health Care Financing Administration, or any other
20 appropriate governmental entity for investigation and
21 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 investigate and
25 take enforcement action against plans regarding
26 grievances reviewed and found by the department to
27 involve plan noncompliance with the requirements of
28 this chapter, including grievances that have been
29 reviewed pursuant to the independent medical review
30 system established pursuant to Article 12 (commencing
31 with Section 1399.80). Where harm to an enrollee has
32 occurred as a result of plan noncompliance, the
33 commissioner shall impose penalties. The commissioner
34 shall periodically evaluate grievances to determine if any
35 audit, investigative, or enforcement actions should be
36 undertaken by the department.

37 (b) The commissioner may, after appropriate notice
38 and opportunity for hearing, levy an administrative
39 penalty, by order, in an amount not to exceed two
40 hundred fifty thousand dollars (\$250,000) if the



1 commissioner determines that a health care service plan
2 has knowingly committed, or has performed with a
3 frequency that indicates a general business practice, any
4 of the following:

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

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

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

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

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

23

24 Article 12. Appeals Seeking Independent Medical
25 Reviews

26

27 1399.80. (a) Commencing January 1, 2001, there is
28 established in the department the Independent Medical
29 Review System.

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



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

10 (d) (1) All enrollee grievances involving a disputed
11 health care service are eligible for review under the
12 Independent Medical Review System if the requirements
13 of this chapter are met. If the department finds that an
14 enrollee grievance involving a disputed health care
15 service does not meet the requirements of this chapter for
16 review under the Independent Medical Review System,
17 the enrollee request for review shall be treated as a
18 request for the department to review the grievance
19 pursuant to subdivision (b) of Section 1368. All other
20 enrollee grievances, including grievances involving
21 coverage decisions, remain eligible for review by the
22 department pursuant to subdivision (b) of Section 1368.

23 (2) In any case in which an enrollee or provider asserts
24 that a decision to deny ~~care~~, *significantly delay*,
25 *terminate*, or *otherwise limit health care services* was
26 based, in whole or in part, on ~~the basis~~ *consideration* of
27 medical necessity or appropriateness, the department
28 shall have the final authority to determine whether the
29 grievance is more properly resolved pursuant to an
30 independent medical review as provided under this
31 article or pursuant to subdivision (a) of Section 1368.

32 (e) No later than January 1, 2001, every health care
33 service plan shall provide an enrollee with the
34 opportunity to seek an independent medical review
35 whenever health care services have been denied,
36 significantly delayed, *terminated*, or otherwise limited
37 by the plan, or by one of its contracting providers, if the
38 decision was ~~substantially due to~~ *based in whole or in part*
39 *on* a finding that the proposed health care services are not
40 medically necessary or medically appropriate. For



1 purposes of this article, “enrollee” shall include a
2 subscriber or designee as described in paragraph (2) of
3 subdivision (b) of Section 1368, and an enrollee’s provider
4 with the consent of the enrollee or the designee. The
5 provider may join with or otherwise assist the enrollee to
6 seek an independent medical review, and may advocate
7 on behalf of the enrollee.

8 (f) Every health care service plan contract that is
9 issued, amended, renewed, or delivered in this state on or
10 after January 1, 2001, shall authorize enrollee
11 participation in the Independent Medical Review
12 System. Medi-Cal beneficiaries enrolled in a health care
13 service plan shall not be excluded from participation.
14 Medicare beneficiaries shall not be excluded unless the
15 federal Health Care Financing Administration issues a
16 finding that federal law preempts their participation.
17 *excluded. However, the application of this subdivision to*
18 *a Medicare beneficiary shall not apply in the event, and*
19 *to the extent, that application is judicially determined to*
20 *be preempted by federal law.*

21 (g) The department shall seek to integrate the quality
22 of care and consumer protection provisions, including
23 remedies, of the Independent Medical Review System
24 with related dispute resolution procedures of other
25 health care agency programs, including the medicare and
26 Medi-Cal programs, in a way that minimizes the potential
27 for duplication, conflict, and added costs. Nothing in this
28 subdivision shall be construed to limit any rights
29 conferred upon enrollees under this chapter.

30 (h) The independent medical review process
31 authorized by this article is in addition to any other
32 procedures or remedies that may be available. The
33 enrollee’s election to either pursue or not pursue,
34 exhaust, or engage in the procedures described in this
35 article does not preclude the use of any other remedy
36 provided by law.

37 (i) No later than January 1, 2001, every health care
38 service plan shall prominently display in every plan
39 contract, on enrollee and subscriber evidence of
40 coverage forms, on copies of plan procedures for



1 resolving grievances, on the grievance forms required
2 under Section 1368, and on all written responses to
3 grievances, information concerning the right of an
4 enrollee to request an independent medical review in
5 cases where the enrollee believes that health care
6 services have been improperly denied, *significantly*
7 *delayed*, terminated, or otherwise limited by the plan, or
8 by one of its contracting providers.

9 (j) An enrollee may apply to the department for an
10 independent medical review when all of the following
11 conditions are met:

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

15 (B) The enrollee has received urgent care or
16 emergency services that a provider determined was
17 medically necessary or medically appropriate for the
18 enrollee's medical condition, or

19 (C) The enrollee, in the absence of a provider
20 recommendation under subparagraph (A) or the receipt
21 of urgent care or emergency services by a provider under
22 subparagraph (B), has been seen by an in-plan provider
23 for the diagnosis or treatment of the medical condition for
24 which the enrollee seeks independent review. *The plan*
25 *shall expedite access to an in-plan provider upon request*
26 *of an enrollee. The in-plan provider need not recommend*
27 *the disputed health care service as a condition for the*
28 *enrollee to be eligible for an independent review.*

29 For purposes of this article, the enrollee's provider may
30 be an out-of-plan provider. However, the plan shall have
31 no liability for payment of services provided by an
32 out-of-plan provider, except as provided in subdivision
33 (b) of Section 1399.84.

34 (2) The disputed health care service has been denied,
35 significantly delayed, *terminated*, or otherwise limited by
36 the plan, or by one of its contracting providers,
37 ~~substantially due to~~ *based in whole or in part on* a decision
38 that the health care service is not medically necessary or
39 medically appropriate.



1 (3) The enrollee has filed a grievance with the plan or
2 its contracting provider pursuant to Section 1368, and the
3 disputed decision is upheld or the grievance remains
4 unresolved after 30 days. The enrollee shall not be
5 required to participate in the plan's grievance process for
6 more than 30 days. In the case of a grievance that requires
7 expedited review pursuant to Section 1368.01, the
8 enrollee shall not be required to participate in the plan's
9 grievance process for more than three days.

10 (k) An enrollee may apply to the department for an
11 independent medical review of a decision to deny,
12 *significantly delay*, terminate, or otherwise limit health
13 care services, ~~substantially due to~~ *based in whole or in*
14 *part on* a finding that the disputed health care services are
15 not medically necessary or medically appropriate, within
16 60 days of any of the qualifying periods or events under
17 subdivision (j). The commissioner may extend the
18 application deadline beyond 60 days if the circumstances
19 of a case warrant the extension.

20 ~~(l) The enrollee shall pay to the department an~~
21 ~~application processing fee of twenty-five dollars (\$25),~~
22 ~~which shall be refunded if the enrollee prevails, in whole~~
23 ~~or in part, in the review. Medi-Cal beneficiaries shall be~~
24 ~~exempt from the fee. The commissioner shall establish a~~
25 ~~reduced fee schedule for low-income persons, including~~
26 ~~all individuals in families with incomes below 250 percent~~
27 ~~of the federal poverty level. An individual's certification~~
28 ~~of his or her income level shall be deemed sufficient~~
29 ~~documentation of the enrollee's qualification for a~~
30 ~~reduced or waived fee. The remaining costs of the~~
31 ~~Independent Medical Review System shall be borne by~~
32 ~~the plans as provided in Section 1399.85.~~

33 *(l) The enrollee shall pay no application or processing*
34 *fees of any kind.*

35 (m) As part of the application for an independent
36 medical review, the enrollee shall provide the
37 department with all of the following:

38 (1) A brief description of the enrollee's medical
39 condition for which health care services were denied,
40 *significantly delayed*, terminated, or otherwise limited.



1 (2) Documentation showing any of the following:

2 (A) A provider recommendation indicating that the
3 disputed health care service is medically necessary or
4 medically appropriate for the enrollee's medical
5 condition.

6 (B) The enrollee has received the disputed health care
7 service, on an urgent care or emergency basis, from a
8 provider who determined it was medically necessary or
9 medically appropriate for the enrollee's medical
10 condition.

11 (C) Reasonable information supporting the enrollee's
12 position that the disputed health care service is or was
13 medically necessary or medically appropriate for the
14 enrollee's medical condition.

15 The enrollee shall be encouraged to also provide a copy
16 of all information provided to the enrollee by the plan or
17 any of its contracting providers, still in the possession of
18 the enrollee, concerning a plan or provider decision
19 regarding disputed health care services, and a copy of any
20 materials the enrollee submitted to the plan, still in the
21 possession of the enrollee, in support of the grievance, as
22 well as any additional material that the enrollee believes
23 is relevant.

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

28 (n) Upon notice from the department that the health
29 care service plan's enrollee has applied for an
30 independent medical review, the plan or its contracting
31 providers shall provide to the department, or to the
32 independent medical review organization if requested by
33 the department, a copy of all of the following documents
34 within three business days of the plan's receipt of the
35 department's notice of a request by an enrollee for an
36 independent review:

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

40 (A) The enrollee's medical condition.



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

3 (C) The disputed health care services requested by
4 the enrollee for the condition.

5 Any newly developed or discovered relevant medical
6 records in the possession of the plan or its contracting
7 providers after the initial documents are provided to the
8 department shall be forwarded immediately to the
9 department, or to the independent medical review
10 organization if requested by the department. The plan
11 shall concurrently provide a copy of medical records
12 required by this subparagraph to the enrollee or the
13 enrollee's provider unless the offer of medical records is
14 declined or otherwise prohibited by law. The
15 confidentiality of all medical record information shall be
16 maintained pursuant to applicable state and federal laws.

17 (2) A copy of all information provided to the enrollee
18 by the plan and any of its contracting providers
19 concerning plan and provider decisions regarding the
20 enrollee's condition and care, and a copy of any materials
21 the enrollee or the enrollee's provider submitted to the
22 plan and to the plan's contracting providers in support of
23 the enrollee's request for disputed health care services.
24 This documentation shall include the written response to
25 the enrollee's grievance, required by paragraph (4) of
26 subdivision (a) of Section 1368. The confidentiality of any
27 enrollee medical information shall be maintained
28 pursuant to applicable state and federal laws.

29 (3) A copy of any other relevant documents or
30 information used by the plan or its contracting providers
31 in determining whether disputed health care services
32 should have been provided, and any statements by the
33 plan and its contracting providers explaining the reasons
34 for the decision not to provide disputed health care
35 services on the basis of medical necessity or medical
36 appropriateness. The plan shall concurrently provide a
37 copy of documents required by this subparagraph, except
38 for any information found by the commissioner to be
39 legally privileged information, to the enrollee and the
40 enrollee's provider. The department and the



1 independent review organization shall maintain the
2 confidentiality of any information found by the
3 commissioner to be the proprietary information of the
4 plan.

5 1399.81. (a) Upon receipt of an enrollee's request for
6 an independent medical review, the commissioner shall
7 assign the request in whole or in part to an independent
8 medical review organization as described in Section
9 1399.82 when all of the following conditions are satisfied:

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

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

14 (3) The commissioner finds that the decision to deny,
15 significantly delay, *terminate*, or otherwise limit disputed
16 health care services was ~~substantially due to~~ *based in*
17 *whole or in part on* a determination that the proposed
18 health care services are not medically necessary or
19 medically appropriate. The commissioner shall consider
20 the entire record submitted by the enrollee, the plan, and
21 providers when making this finding.

22 (4) The enrollee has followed the plan's grievance
23 process pursuant to Section 1368. However, the
24 commissioner may waive this requirement in
25 extraordinary and compelling cases, where the
26 commissioner finds that the enrollee has acted
27 reasonably.

28 (5) The enrollee has submitted documentation
29 satisfying the requirements of paragraph (1) of
30 subdivision (j) of Section 1399.80.

31 (b) The department shall expeditiously review
32 requests and immediately notify the enrollee in writing
33 as to whether the request for an independent medical
34 review has been approved, in whole or in part, and, if not
35 approved, the reasons therefor. The department shall
36 issue a notification to the enrollee no later than two
37 business days after receiving all of the material required
38 under subdivision (a). The department shall approve in
39 one business day enrollee requests whenever the
40 enrollee's plan has agreed that the case is eligible for an



1 independent medical review. The department shall not
2 certify coverage decisions for independent review. To
3 the extent an enrollee request for independent review is
4 not approved by the department, the enrollee request
5 shall be treated as an immediate request for the
6 department to review the grievance pursuant to
7 subdivision (b) of Section 1368.

8 (c) If the request for review is approved, the
9 department shall immediately arrange for delivery by the
10 plan, and its contracting providers or directly provide the
11 independent medical review organization with all
12 necessary information and documents related to the case
13 submitted by the enrollee, the enrollee's provider, the
14 health care service plan, and its contracting providers. If
15 there is an imminent and serious threat to the health of
16 the enrollee, as defined in subdivision (c) of Section
17 1399.83, all necessary information and documents shall be
18 delivered within 24 hours of approval of the request. In
19 other cases, information and documents shall be provided
20 to the independent medical review organization no later
21 than two business days after approval of the request.

22 (d) The organization shall conduct the review in
23 accordance with Section 1399.83 and any regulations or
24 orders of the commissioner adopted pursuant thereto.
25 The organization's review shall be limited to an
26 examination of the medical necessity or appropriateness
27 of the disputed health care services and shall not include
28 any consideration of coverage decisions or other
29 contractual issues.

30 1399.82. (a) By January 1, 2000, the commissioner
31 shall contract with one or more independent medical
32 review organizations in the state to conduct reviews for
33 purposes of this article. The independent medical review
34 organizations shall be independent of any health care
35 service plans doing business in this state. The
36 commissioner may establish additional requirements,
37 including conflict-of-interest standards, consistent with
38 the purposes of this article, that an organization shall be
39 required to meet in order to qualify for participation in
40 the Independent Medical Review System.



1 (b) The independent medical review organization,
2 any experts it designates to conduct a review, or any
3 officer, director, or employee of the independent medical
4 review organization shall not have any material
5 professional, familial, or financial affiliation, as
6 determined by the commissioner, with any of the
7 following:

8 (1) The plan.

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

10 (3) A physician, the physician's medical group, or the
11 independent practice association either denying or
12 proposing the health care service in dispute.

13 (4) The institution at which either the proposed health
14 care service, or the alternative service, if any,
15 recommended by the plan, would be provided.

16 (5) The development or manufacture of the principal
17 drug, device, procedure, or other therapy proposed by
18 the enrollee whose treatment is under review, or the
19 alternative therapy, if any, recommended by the plan.

20 (c) The commissioner shall, by July 1, 1999, contract
21 with a private, nonprofit accrediting organization to
22 accredit the independent medical review organizations
23 described in subdivision (a). The accrediting
24 organization may grant and revoke accreditation, and
25 shall develop, apply, and enforce accreditation standards
26 that ensure the independence of the independent
27 medical review organization, the confidentiality of the
28 medical records, and the qualifications and
29 independence of the health care professionals providing
30 the analyses and recommendations requested of them.
31 The accrediting organization shall demonstrate the
32 ability to objectively evaluate the performance of
33 independent medical review organizations and shall
34 demonstrate that it has no conflict of interest, including
35 any material professional, familial, or financial affiliation,
36 as provided in subdivision (b), with any independent
37 medical review organization or plan, in accrediting those
38 organizations for the purpose of reviewing medical
39 treatment and treatment recommendation decisions
40 made by health care service plans.



1 (d) In order to receive accreditation for the purposes
2 of this section, an independent medical review
3 organization shall meet all of the following requirements:

4 (1) An independent medical review organization shall
5 not be an affiliate or a subsidiary of, nor in any way be
6 owned or controlled by, a health plan or a trade
7 association of health plans. A board member, director,
8 officer, or employee of the independent medical review
9 organization shall not serve as a board member, director,
10 or employee of a health care service plan. A board
11 member, director, or officer of a health plan or a trade
12 association of health plans shall not serve as a board
13 member, director, officer, or employee of an
14 independent medical review organization.

15 (2) The independent medical review organization
16 shall submit to the accrediting organization and to the
17 department the following information upon initial
18 application for accreditation and, except as otherwise
19 provided, annually thereafter upon any change to any of
20 the following information:

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

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

26 (C) The names of all corporations and organizations
27 that the independent medical review organization
28 controls or is affiliated with, and the nature and extent of
29 any ownership or control, including the affiliated
30 organization's type of business.

31 (D) The names and biographical sketches of all
32 directors, officers, and executives of the independent
33 medical review organization, as well as a statement
34 regarding any past or present relationships the directors,
35 officers, and executives may have with any health care
36 service plan, disability insurer, managed care
37 organization, provider group, or board or committee of
38 a plan, managed care organization, or provider group.

39 (E) (i) The percentage of revenue the independent
40 medical review organization receives from expert



1 reviews, including, but not limited to, external medical
2 reviews, quality assurance reviews, and utilization
3 reviews.

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

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

14 (G) A description of the system the independent
15 medical review organization uses to identify and recruit
16 medical professionals to review treatment and treatment
17 recommendation decisions, the number of medical
18 professionals credentialed, and the types of cases and
19 areas of expertise which the medical professionals are
20 credentialed to review.

21 (H) A description of how the independent medical
22 review organization ensures compliance with the
23 conflict-of-interest provisions of this section.

24 (3) The independent medical review organization
25 shall demonstrate that it has a quality assurance
26 mechanism in place that does the following:

27 (A) Ensures that the medical professionals retained
28 are appropriately credentialed and privileged.

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

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

38 (D) Ensures the confidentiality of medical records
39 and the review materials, consistent with the



1 requirements of this section and applicable state and
2 federal law.

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

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

13 (A) The medical professional shall be a clinician
14 knowledgeable in the treatment of the enrollee's medical
15 condition, knowledgeable about the proposed treatment,
16 and familiar with guidelines and protocols in the area of
17 treatment under review.

18 (B) The medical professional shall hold a
19 nonrestricted license in the State of California, and for
20 physicians, a current certification by a recognized
21 American medical specialty board in the area or areas
22 appropriate to the condition or treatment under review.
23 For good cause shown, such as the unavailability of
24 licensed qualified medical professionals in California or
25 the availability of uniquely qualified clinics outside of
26 California, the independent medical review organization
27 may utilize a medical professional who holds a
28 nonrestricted license in any state of the United States,
29 provided that the out-of-state medical professional is
30 knowledgeable about the treatment standards in
31 California and applies those standards.

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

37 (5) Neither the expert reviewer, nor the independent
38 medical review organization, shall have any material
39 professional, material familial, or material financial
40 affiliation with any of the following:



1 (A) The plan or a provider group of the plan, except
2 that an academic medical center under contract to the
3 plan to provide services to enrollees may qualify as an
4 independent medical review organization provided it
5 will not provide the service and provided the center is not
6 the developer or manufacturer of the proposed
7 treatment.

8 (B) Any officer, director, or management employee of
9 the plan.

10 (C) The physician, the physician's medical group, or
11 the independent practice association (IPA) proposing
12 the treatment.

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

15 (E) The development or manufacture of the
16 treatment proposed for the enrollee whose condition is
17 under review.

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

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

21 (A) "Material familial affiliation" means any
22 relationship as a spouse, child, parent, sibling, spouse's
23 parent, or child's spouse.

24 (B) "Material professional affiliation" means any
25 physician-patient relationship, any partnership or
26 employment relationship, a shareholder or similar
27 ownership interest in a professional corporation, or any
28 independent contractor arrangement that constitutes a
29 material financial affiliation with any expert or any officer
30 or director of the independent medical review
31 organization. "Material professional affiliation" does not
32 include affiliations that are limited to staff privileges at a
33 health facility.

34 (C) "Material financial affiliation" means any financial
35 interest of more than 5 percent of total annual revenue
36 or total annual income of an independent medical review
37 organization or individual to which this subdivision
38 applies. "Material financial affiliation" does not include
39 payment by the plan to the independent medical review
40 organization for the services required by this section, nor



1 does “material financial affiliation” include an expert’s
2 participation as a contracting plan provider where the
3 expert is affiliated with an academic medical center or a
4 National Cancer Institute-designated clinical cancer
5 research center.

6 (e) The accrediting organization shall provide, upon
7 the request of any interested person, a copy of all
8 nonproprietary information, as determined by the
9 commissioner, filed with it by an independent medical
10 review organization seeking accreditation under this
11 article. The accrediting organization may charge a
12 nominal fee to the interested person for photocopying the
13 requested information.

14 (f) The independent review process established by
15 this section shall be required on and after January 1, 2001.

16 1399.83. (a) Upon receipt of information and
17 documents related to a case pursuant to subdivision (c)
18 of Section 1399.81, the medical professional reviewer or
19 reviewers selected to conduct the review by the
20 independent medical review organization shall promptly
21 review all pertinent medical records of the enrollee,
22 provider reports, as well as any other information
23 submitted to the organization as authorized by the
24 department or requested from any of the parties to the
25 dispute by the reviewers. If reviewers request
26 information from any of the parties, a copy of the request
27 and the response shall be provided to all of the parties.
28 The reviewer or reviewers shall also review relevant
29 information related to the criteria set forth in subdivision
30 (b).

31 (b) Following its review, the reviewer or reviewers
32 shall determine whether the disputed health care service
33 was medically necessary or medically appropriate based
34 on any of the following:

35 (1) Generally accepted practice guidelines developed
36 by federal agencies, nationally recognized federal
37 research institutes, or national professional medical
38 specialty societies.



1 (2) Relevant medical or scientific evidence, if any
2 exists, regarding the clinical value of the disputed health
3 care service.

4 (3) Generally accepted standards of medical practice.

5 (4) *Treatments that are likely to provide a benefit to*
6 *a patient for conditions for which other treatments are*
7 *not clinically efficacious.*

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

28 (d) The medical professionals' analyses and
29 determinations shall state whether the disputed health
30 care service is medically necessary or medically
31 appropriate. Each analysis shall cite the enrollee's
32 medical condition, the relevant documents in the record,
33 and the relevant findings associated with the provisions
34 of subdivision (b) to support the determination. If more
35 than one medical professional reviews the case, the
36 recommendation of the majority shall prevail. If the
37 medical professionals reviewing the case are evenly split
38 as to whether the disputed health care service should be
39 provided, the decision shall be in favor of providing the
40 service.



1 (e) The independent medical review organization
2 shall provide the commissioner, the plan, the enrollee,
3 and the enrollee's provider with the analyses and
4 determinations of the medical professionals reviewing
5 the case, a description of the qualifications of the medical
6 professionals, and the names of the reviewers. If more
7 than one medical professional reviewed the case and the
8 result was differing determinations, the independent
9 medical review organization shall provide each of the
10 separate reviewer's analyses and determinations.

11 (f) The commissioner shall immediately adopt the
12 determination of the independent medical review
13 organization, and shall promptly issue a written decision
14 to the parties, which decision shall be binding on the plan.

15 ~~(g) (1) Subject to the provisions of the Evidence~~
16 ~~Code, the opinion of a medical professional reviewer on~~
17 ~~whether the disputed health care service was medically~~
18 ~~necessary or medically appropriate may be offered for~~
19 ~~admissibility by a party to the medical reviewer who calls~~
20 ~~the medical professional as an expert witness in any~~
21 ~~subsequent administrative or civil proceeding. In the~~
22 ~~event a party in a subsequent administrative or civil~~
23 ~~proceeding calls the reviewer as an expert witness, it shall~~
24 ~~be stipulated and presented to the court that all of the~~
25 ~~following applies to the reviewer:~~

26 ~~(A) The reviewer does not have any material or~~
27 ~~financial relationship with either party in the proceeding~~
28 ~~and did not at the time of the review.~~

29 ~~(B) The reviewer does not have any professional~~
30 ~~conflict of interest related to the review under any~~
31 ~~conflict-of-interest provisions of state law.~~

32 ~~(C) The reviewer was not selected by either party in~~
33 ~~the proceeding to conduct the medical review.~~

34 ~~(2) Any opinion evidence of the medical reviewer that~~
35 ~~is admitted shall be subject to the same rules as all other~~
36 ~~expert witness opinion evidence, including~~
37 ~~cross-examination.~~

38 *(g) After removing the names of the parties,*
39 *including, but not limited to, the enrollee, all medical*
40 *providers, the plan, and any of the plan's employees or*



1 *contractors, commissioner decisions adopting a*
2 *determination of an independent medical review*
3 *organization shall be made available by the department*
4 *to the public upon request, at the department's cost.*

5 (h) The relationship of the reviewer with the state,
6 including the reviewer's selection and remuneration by
7 the department for purposes of conducting the review,
8 shall not be admissible in any subsequent administrative
9 or civil proceeding.

10 1399.84. (a) Upon receiving the decision adopted by
11 the commissioner pursuant to Section 1399.83 that a
12 disputed health care service is medically necessary or
13 medically appropriate, the plan shall immediately
14 contact the enrollee and offer to promptly implement the
15 decision.

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

32 (c) In addition to requiring plan compliance
33 regarding subdivisions (a) and (b), the commissioner
34 shall review individual cases submitted for independent
35 medical review to determine whether any enforcement
36 actions, including penalties, may be appropriate. In
37 particular, where harm to an enrollee has already
38 occurred because of the decision of a plan, or one of its
39 contracting providers, to deny, terminate, or otherwise
40 limit covered health care services that an independent



1 medical review determines to be medically necessary or
2 medically appropriate, the commissioner shall impose
3 penalties.

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

15 1399.85. (a) After considering the results of a
16 competitive bidding process and any other relevant
17 information on program costs, the commissioner shall
18 establish a reasonable, per-case reimbursement schedule
19 to pay the costs of independent medical review
20 organization reviews, which may vary depending on the
21 type of medical condition under review and on other
22 relevant factors.

23 (b) Aside from the application fee of twenty-five
24 dollars (\$25), the costs of the independent medical
25 review system for enrollees shall be borne by health care
26 service plans pursuant to an assessment fee system
27 established by the commissioner. Every health care
28 service plan shall pay annually to the department, on the
29 date or dates set by the department, its prorated share of
30 fees, as determined by the commissioner, to pay for the
31 estimated annual costs associated with carrying out,
32 overseeing, and evaluating the independent medical
33 review system. In determining the amount to be assessed,
34 the commissioner shall consider all appropriations
35 available for the support of this chapter. The
36 commissioner may adjust fees upward or downward, on
37 a schedule set by the department, to address shortages or
38 overpayments.

39 (c) These funds shall be used for all costs reasonably
40 incurred in the administration of this chapter, including,



1 but not limited to, startup costs, overhead, department
2 administration, contracting with an accrediting
3 organization, contracts with independent medical
4 review organizations, payments to medical professional
5 reviewers, and program evaluation.

6 (d) The commissioner shall submit to the Legislature
7 by March 1, 2002, a report on the initial implementation
8 of this article. The report shall include a description of
9 assessments imposed on plans to implement this article,
10 increased staffing and other resources attributable to
11 these new responsibilities, and any redirection of existing
12 staff and resources to carry out these responsibilities. A
13 single copy of the report shall be made available at no cost
14 to members of the public upon request. The department
15 may recover the cost of additional copies that are
16 requested.

17 SEC. 7. Article 2.55 (commencing with Section
18 10145.80) is added to Chapter 1 of Part 2 of Division 2 of
19 the Insurance Code, to read:

20

21 Article 2.55. Appeals Seeking Independent Medical
22 Review

23

24 10145.80. Commencing January 1, 2001, there is
25 established in the department the Independent Medical
26 Review System pursuant to the Patient's Independent
27 Medical Review Act of 1998.

28 SEC. 8. No reimbursement is required by this act
29 pursuant to Section 6 of Article XIII B of the California
30 Constitution because the only costs that may be incurred
31 by a local agency or school district will be incurred
32 because this act creates a new crime or infraction,
33 eliminates a crime or infraction, or changes the penalty
34 for a crime or infraction, within the meaning of Section
35 17556 of the Government Code, or changes the definition
36 of a crime within the meaning of Section 6 of Article
37 XIII B of the California Constitution.

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