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AMENDED IN ASSEMBLY APRIL 27, 1999

AMENDED IN ASSEMBLY APRIL 15, 1999

AMENDED IN ASSEMBLY APRIL 12, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

**ASSEMBLY BILL**

**No. 55**

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**Introduced by Assembly Members Migden, ~~Strom-Martin,~~  
and Thomson and Senator Schiff  
(Principal coauthor: Senator Speier)  
(Principal coauthors: Assembly Member Strom-Martin and  
Senator Speier)  
(Coauthor: Assembly Member Wayne)**

December 7, 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, add Article 5.55 (commencing~~  
~~with Section 1374.30) to Chapter 2.2 of Division 2 of the Health~~  
and Safety Code, and to add Article 2.55 ~~(commencing with~~  
~~Section 10145.80) 3.5 (commencing with Section 10169)~~ 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~~  
*coverage: independent medical review.*

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 provides for the regulation of insurance, administered by the Commissioner of Insurance.

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.~~

~~Under existing law, a health care service plan's grievance system is required to include an expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient.~~

~~This bill would require when service is being denied to an enrollee who is an inpatient at a hospital that the service be handled as an expedited plan grievance.~~

This bill would also, ~~on and after January 1, 2001,~~ require every health care service plan ~~to provide an enrollee contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, to provide an enrollee, effective January 1, 2001,~~ with the opportunity to seek an independent medical review whenever health care services have been denied, ~~significantly modified, or delayed, terminated, or otherwise limited~~ by the plan or by one of its contracting



providers *if the decision was based on a finding that the proposed services are not medically necessary.* The bill would ~~require the Department of Corporations to~~ establish, *commencing January 1, 2000,* an independent medical review system whereby requests for reviews ~~are assigned to~~ *shall be conducted by* an independent medical review organization, as specified. 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.~~

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. Section 1368 of the Health and Safety~~
- 2 *SECTION 1. Article 5.55 (commencing with Section*
- 3 *1374.30) is added to Chapter 2.2 of Division 2 of the Health*
- 4 *and Safety Code, to read:*
- 5



1 Article 5.55. Appeals Seeking Independent Medical  
2 Reviews

3  
4 1374.30. (a) Commencing January 1, 2001, there is  
5 hereby established in the department the Independent  
6 Medical Review System.

7 (b) For the purposes of this chapter, “disputed health  
8 care service” means any health care service eligible for  
9 coverage and payment under a health care service plan  
10 contract that has been denied, modified, or delayed by a  
11 decision of the plan, or by one of its contracting providers,  
12 in whole or in part due to a finding that the service is not  
13 medically necessary. A decision regarding a disputed  
14 health care service relates to the practice of medicine and  
15 is not a coverage decision. A disputed health care service  
16 does not include services provided by a specialized health  
17 care service plan, except to the extent that the service (1)  
18 involves the practice of medicine, or (2) is provided  
19 pursuant to a contract with a health care service plan. If  
20 a plan, or one of its contracting providers, issues a decision  
21 denying, modifying, or delaying health care services,  
22 based in whole or in part on a finding that the proposed  
23 health care services are not a covered benefit under the  
24 contract that applies to the enrollee, the statement of  
25 decision shall clearly specify the provision in the contract  
26 that excludes that coverage.

27 (c) For the purposes of this chapter, “coverage  
28 decision” means the approval or denial of health care  
29 services by a plan, or by one of its contracting entities,  
30 substantially based on a finding that the provision of a  
31 particular service is included or excluded as a covered  
32 benefit under the terms and conditions of the health care  
33 service plan contract. A “coverage decision” does not  
34 encompass a plan or contracting provider decision  
35 regarding a disputed health care service.

36 (d) (1) All enrollee grievances involving a disputed  
37 health care service are eligible for review under the  
38 Independent Medical Review System if the requirements  
39 of this article are met. If the department finds that an  
40 enrollee grievance involving a disputed health care



1 service does not meet the requirements of this article for  
2 review under the Independent Medical Review System,  
3 the enrollee request for review shall be treated as a  
4 request for the department to review the grievance  
5 pursuant to subdivision (b) of Section 1368. All other  
6 enrollee grievances, including grievances involving  
7 coverage decisions, remain eligible for review by the  
8 department pursuant to subdivision (b) of Section 1368.

9 (2) In any case in which an enrollee or provider asserts  
10 that a decision to deny, modify, or delay health care  
11 services was based, in whole or in part, on consideration  
12 of medical necessity, the department shall have the final  
13 authority to determine whether the grievance is more  
14 properly resolved pursuant to an independent medical  
15 review as provided under this article or pursuant to  
16 subdivision (a) of Section 1368.

17 (3) The department shall be the final arbiter when  
18 there is a question as to whether an enrollee grievance is  
19 a disputed health care service or a coverage decision. The  
20 department shall establish a process to complete an initial  
21 screening of an enrollee grievance. If there appears to be  
22 any medical necessity issue, the grievance shall be  
23 resolved pursuant to an independent medical review as  
24 provided under this article or pursuant to subdivision (a)  
25 of Section 1368.

26 (e) Every health care service plan contract that is  
27 issued, amended, renewed, or delivered in this state on or  
28 after January 1, 2000, shall, effective January 1, 2001,  
29 provide an enrollee with the opportunity to seek an  
30 independent medical review whenever health care  
31 services have been denied, modified, or delayed by the  
32 plan, or by one of its contracting providers, if the decision  
33 was based in whole or in part on a finding that the  
34 proposed health care services are not medically  
35 necessary. For purposes of this article, an enrollee may  
36 designate an agent to act on his or her behalf, as described  
37 in paragraph (2) of subdivision (b) of Section 1368. The  
38 provider may join with or otherwise assist the enrollee in  
39 seeking an independent medical review, and may  
40 advocate on behalf of the enrollee.



1 (f) *Medi-Cal beneficiaries enrolled in a health care*  
2 *service plan shall not be excluded from participation.*  
3 *Medicare beneficiaries shall not be excluded unless*  
4 *expressly preempted by federal law. Reviews of cases for*  
5 *Medi-Cal enrollees shall be conducted in accordance with*  
6 *statutes and regulations for the Medi-Cal program.*

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

16 (h) *The independent medical review process*  
17 *authorized by this article is in addition to any other*  
18 *procedures or remedies that may be available.*

19 (i) *No later than January 1, 2001, every health care*  
20 *service plan shall prominently display in every plan*  
21 *member handbook or relevant informational brochure,*  
22 *in every plan contract, on enrollee evidence of coverage*  
23 *forms, on copies of plan procedures for resolving*  
24 *grievances, on letters of denials issued by either the plan*  
25 *or its contracting organization, on the grievance forms*  
26 *required under Section 1368, and on all written responses*  
27 *to grievances, information concerning the right of an*  
28 *enrollee to request an independent medical review in*  
29 *cases where the enrollee believes that health care*  
30 *services have been improperly denied, modified, or*  
31 *delayed by the plan, or by one of its contracting providers.*

32 (j) *An enrollee may apply to the department for an*  
33 *independent medical review when all of the following*  
34 *conditions are met:*

35 (1) (A) *The enrollee's provider has recommended a*  
36 *health care service as medically necessary.*

37 (B) *The enrollee has received urgent care or*  
38 *emergency services that a provider determined was*  
39 *medically necessary.*



1 (C) *The enrollee, in the absence of a provider*  
2 *recommendation under subparagraph (A) or the receipt*  
3 *of urgent care or emergency services by a provider under*  
4 *subparagraph (B), has been seen by an in-plan provider*  
5 *for the diagnosis or treatment of the medical condition for*  
6 *which the enrollee seeks independent review. The plan*  
7 *shall expedite access to an in-plan provider upon request*  
8 *of an enrollee. The in-plan provider need not recommend*  
9 *the disputed health care service as a condition for the*  
10 *enrollee to be eligible for an independent review.*

11 *For purposes of this article, the enrollee's provider may*  
12 *be an out-of-plan provider. However, the plan shall have*  
13 *no liability for payment of services provided by an*  
14 *out-of-plan provider.*

15 (2) *The disputed health care service has been denied,*  
16 *modified, or delayed by the plan, or by one of its*  
17 *contracting providers, based in whole or in part on a*  
18 *decision that the health care service is not medically*  
19 *necessary.*

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

29 (k) *An enrollee may apply to the department for an*  
30 *independent medical review of a decision to deny,*  
31 *modify, or delay health care services, based in whole or*  
32 *in part on a finding that the disputed health care services*  
33 *are not medically necessary, within six months of any of*  
34 *the qualifying periods or events under subdivision (j).*  
35 *The director may extend the application deadline beyond*  
36 *six months if the circumstances of a case warrant the*  
37 *extension.*

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

1 (m) As part of its notification to the enrollee regarding  
2 a disposition of the enrollee's grievance that denies,  
3 modifies, or delays health care services, the plan shall  
4 provide the enrollee with a one-page application form  
5 approved by the department, and an addressed envelope,  
6 which the enrollee may return to initiate an independent  
7 medical review. The plan shall include on the form any  
8 information required by the department to facilitate the  
9 completion of the independent medical review, such as  
10 the enrollee's diagnosis or condition, the nature of the  
11 disputed health care service sought by the enrollee, a  
12 means to identify the enrollee's case, and any other  
13 material information. The form shall also include the  
14 following:

15 (1) Notice that a decision not to participate in the  
16 independent medical review process may cause the  
17 enrollee to forfeit any statutory right to pursue legal  
18 action against the plan regarding the disputed health care  
19 service.

20 (2) A statement indicating the enrollee's consent to  
21 obtain any necessary medical records from the plan, any  
22 of its contracting providers, and any out-of-plan provider  
23 the enrollee may have consulted on the matter, to be  
24 signed by the enrollee.

25 (3) Notice of the enrollee's right to provide  
26 information or documentation, either directly or through  
27 the enrollee's provider, regarding any of the following:

28 (A) A provider recommendation indicating that the  
29 disputed health care service is medically necessary for the  
30 enrollee's medical condition.

31 (B) Medical information or justification that a  
32 disputed health care service, on an urgent care or  
33 emergency basis, was medically necessary for the  
34 enrollee's medical condition.

35 (C) Reasonable information supporting the enrollee's  
36 position that the disputed health care service is or was  
37 medically necessary for the enrollee's medical condition,  
38 including all information provided to the enrollee by the  
39 plan or any of its contracting providers, still in the  
40 possession of the enrollee, concerning a plan or provider



1 decision regarding disputed health care services, and a  
2 copy of any materials the enrollee submitted to the plan,  
3 still in the possession of the enrollee, in support of the  
4 grievance, as well as any additional material that the  
5 enrollee believes is relevant.

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

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

17 (i) The enrollee's medical condition.

18 (ii) The health care services being provided by the  
19 plan and its contracting providers for the condition.

20 (iii) The disputed health care services requested by  
21 the enrollee for the condition.

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

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



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

7 (3) *A copy of any other relevant documents or*  
8 *information used by the plan or its contracting providers*  
9 *in determining whether disputed health care services*  
10 *should have been provided, and any statements by the*  
11 *plan and its contracting providers explaining the reasons*  
12 *for the decision to deny, modify, or delay disputed health*  
13 *care services on the basis of medical necessity. The plan*  
14 *shall concurrently provide a copy of documents required*  
15 *by this paragraph, except for any information found by*  
16 *the director to be legally privileged information, to the*  
17 *enrollee and the enrollee's provider. The department*  
18 *and the independent review organization shall maintain*  
19 *the confidentiality of any information found by the*  
20 *director to be the proprietary information of the plan.*

21 1374.31. (a) *If there is an imminent and serious*  
22 *threat to the health of the enrollee, as specified in*  
23 *subdivision (c) of Section 1374.33, all necessary*  
24 *information and documents shall be delivered to an*  
25 *independent medical review organization within 24*  
26 *hours of approval of the request for review. In reviewing*  
27 *a request for review, the department may waive the*  
28 *requirement that the enrollee follow the plan's grievance*  
29 *process in extraordinary and compelling cases, where the*  
30 *director finds that the enrollee has acted reasonably.*

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 plan shall promptly*  
36 *issue a notification to the enrollee, after submitting all of*  
37 *the required material to the independent medical review*  
38 *organization, that includes an annotated list of*  
39 *documents submitted and offer the enrollee the*  
40 *opportunity to request copies of those documents from*



1 *the plan. The department shall promptly approve*  
2 *enrollee requests whenever the enrollee's plan has*  
3 *agreed that the case is eligible for an independent*  
4 *medical review. The department shall not refer coverage*  
5 *decisions for independent review. To the extent an*  
6 *enrollee request for independent review is not approved*  
7 *by the department, the enrollee request shall be treated*  
8 *as an immediate request for the department to review the*  
9 *grievance pursuant to subdivision (b) of Section 1368.*

10 *(c) An independent medical review organization,*  
11 *specified in Section 1374.32, shall conduct the review in*  
12 *accordance with Section 1374.33 and any regulations or*  
13 *orders of the director adopted pursuant thereto. The*  
14 *organization's review shall be limited to an examination*  
15 *of the medical necessity of the disputed health care*  
16 *services and shall not include any consideration of*  
17 *coverage decisions or other contractual issues.*

18 *1374.32. (a) By January 1, 2001, the department shall*  
19 *contract with one or more independent medical review*  
20 *organizations in the state to conduct reviews for purposes*  
21 *of this article. The independent medical review*  
22 *organizations shall be independent of any health care*  
23 *service plan doing business in this state. The director may*  
24 *establish additional requirements, including*  
25 *conflict-of-interest standards, consistent with the*  
26 *purposes of this article, that an organization shall be*  
27 *required to meet in order to qualify for participation in*  
28 *the Independent Medical Review System.*

29 *(b) The independent medical review organizations*  
30 *and the medical professionals retained to conduct*  
31 *reviews shall be deemed to be medical consultants for*  
32 *purposes of Section 43.98 of the Civil Code.*

33 *(c) The independent medical review organization,*  
34 *any experts it designates to conduct a review, or any*  
35 *officer, director, or employee of the independent medical*  
36 *review organization shall not have any material*  
37 *professional, familial, or financial affiliation, as*  
38 *determined by the director, with any of the following:*

39 *(1) The plan.*

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



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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

31 (H) A description of how the independent medical  
32 review organization ensures compliance with the  
33 conflict-of-interest provisions of this section.

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

37 (A) Ensures that the medical professionals retained  
38 are appropriately credentialed and privileged.



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

4 (C) Ensures that the method of selecting medical  
5 professionals for individual cases achieves a fair and  
6 impartial panel of medical professionals who are qualified  
7 to render recommendations regarding the clinical  
8 conditions and the medical necessity of treatments or  
9 therapies in question.

10 (D) Ensures the confidentiality of medical records  
11 and the review materials, consistent with the  
12 requirements of this section and applicable state and  
13 federal law.

14 (E) Ensures the independence of the medical  
15 professionals retained to perform the reviews through  
16 conflict-of-interest policies and prohibitions, and ensures  
17 adequate screening for conflicts-of-interest, pursuant to  
18 paragraph (5).

19 (4) Medical professionals selected by independent  
20 medical review organizations to review medical  
21 treatment decisions shall be physicians or other  
22 appropriate providers who meet the following minimum  
23 requirements:

24 (A) The medical professional shall be a clinician  
25 knowledgeable in the treatment of the enrollee's medical  
26 condition, knowledgeable about the proposed treatment,  
27 and familiar with guidelines and protocols in the area of  
28 treatment under review.

29 (B) The medical professional shall hold a  
30 nonrestricted license in the any state of the United States,  
31 and for physicians, a current certification by a recognized  
32 American medical specialty board in the area or areas  
33 appropriate to the condition or treatment under review.  
34 The independent medical review organization shall give  
35 preference to the use of a physician licensed in California  
36 as the reviewer, except when training and experience  
37 with the issue under review reasonably requires the use  
38 of an out-of-state reviewer.

39 (C) The medical professional shall have no history of  
40 disciplinary action or sanctions, including, but not limited



1 to, loss of staff privileges or participation restrictions,  
2 taken or pending by any hospital, government, or  
3 regulatory body.

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

8 (A) The plan or a provider group of the plan, except  
9 that an academic medical center under contract to the  
10 plan to provide services to enrollees may qualify as an  
11 independent medical review organization provided it  
12 will not provide the service and provided the center is not  
13 the developer or manufacturer of the proposed  
14 treatment.

15 (B) Any officer, director, or management employee of  
16 the plan.

17 (C) The physician, the physician's medical group, or  
18 the independent practice association (IPA) proposing  
19 the treatment.

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

22 (E) The development or manufacture of the  
23 treatment proposed for the enrollee whose condition is  
24 under review.

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

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

28 (A) "Material familial affiliation" means any  
29 relationship as a spouse, child, parent, sibling, spouse's  
30 parent, or child's spouse.

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



1 (C) “Material financial affiliation” means any financial  
2 interest of more than 5 percent of total annual revenue  
3 or total annual income of an independent medical review  
4 organization or individual to which this subdivision  
5 applies. “Material financial affiliation” does not include  
6 payment by the plan to the independent medical review  
7 organization for the services required by this section, nor  
8 does “material financial affiliation” include an expert’s  
9 participation as a contracting plan provider where the  
10 expert is affiliated with an academic medical center or a  
11 National Cancer Institute-designated clinical cancer  
12 research center.

13 (e) The department shall provide, upon the request of  
14 any interested person, a copy of all nonproprietary  
15 information, as determined by the director, filed with it  
16 by an independent medical review organization seeking  
17 to contract under this article. The department may  
18 charge a nominal fee to the interested person for  
19 photocopying the requested information.

20 1374.33. (a) Upon receipt of information and  
21 documents related to a case, the medical professional  
22 reviewer or reviewers selected to conduct the review by  
23 the independent medical review organization shall  
24 promptly review all pertinent medical records of the  
25 enrollee, provider reports, as well as any other  
26 information submitted to the organization as authorized  
27 by the department or requested from any of the parties  
28 to the dispute by the reviewers. If reviewers request  
29 information from any of the parties, a copy of the request  
30 and the response shall be provided to all of the parties.  
31 The reviewer or reviewers shall also review relevant  
32 information related to the criteria set forth in subdivision  
33 (b).

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

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

40 (2) Nationally recognized professional standards.



1 (3) *Expert opinion.*

2 (4) *Generally accepted standards of medical practice.*

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

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

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

37 (e) *The independent medical review organization*  
38 *shall provide the director, the plan, the enrollee, and the*  
39 *enrollee's provider with the analyses and determinations*  
40 *of the medical professionals reviewing the case, and a*



1 description of the qualifications of the medical  
2 professionals. The independent medical review  
3 organization shall keep the names of the reviewers  
4 confidential in all communications with entities or  
5 individuals outside the independent medical review  
6 organization, except in cases where the reviewer is called  
7 to testify and in response to court orders. If more than one  
8 medical professional reviewed the case and the result was  
9 differing determinations, the independent medical  
10 review organization shall provide each of the separate  
11 reviewer's analyses and determinations.

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

16 (g) After removing the names of the parties,  
17 including, but not limited to, the enrollee, all medical  
18 providers, the plan, and any of the insurer's employees or  
19 contractors, director decisions adopting a determination  
20 of an independent medical review organization shall be  
21 made available by the department to the public upon  
22 request, at the department's cost and after considering  
23 applicable laws governing disclosure of public records,  
24 confidentiality, and personal privacy.

25 1374.34. (a) Upon receiving the decision adopted by  
26 the director pursuant to Section 1374.33 that a disputed  
27 health care service is medically necessary, the plan shall  
28 immediately contact the enrollee and offer to promptly  
29 implement the decision.

30 (b) In any case where an enrollee secured urgent care,  
31 emergency services, or other extraordinary and  
32 compelling health care services outside of the plan  
33 provider network, which services are later found by the  
34 independent medical review organization to have been  
35 medically necessary, the director shall require the plan to  
36 promptly reimburse the enrollee for any reasonable costs  
37 associated with those services when the director finds  
38 that the enrollee's decision to secure the services outside  
39 of the plan provider network prior to completing the plan  
40 grievance process or seeking an independent medical



1 review was reasonable under the circumstances and the  
2 disputed health care services were a covered benefit  
3 under the terms and conditions of the health care service  
4 plan contract.

5 1374.35. (a) After considering the results of a  
6 competitive bidding process and any other relevant  
7 information on program costs, the director shall establish  
8 a reasonable, per-case reimbursement schedule to pay  
9 the costs of independent medical review organization  
10 reviews, which may vary depending on the type of  
11 medical condition under review and on other relevant  
12 factors.

13 (b) The costs of the independent medical review  
14 system for enrollees shall be borne by health care service  
15 plans pursuant to an assessment fee system established by  
16 the director. In determining the amount to be assessed,  
17 the director shall consider all appropriations available for  
18 the support of this chapter, and existing fees paid to the  
19 department. The director may adjust fees upward or  
20 downward, on a schedule set by the department, to  
21 address shortages or overpayments, and to reflect  
22 utilization of the independent review process.

23 SEC. 2. Article 3.5 (commencing with Section 10169)  
24 is added to Chapter 1 of Part 2 of Division 2 of the  
25 Insurance Code, to read:

26

27 Article 3.5. Appeals Seeking Independent Medical  
28 Review

29

30 10169. (a) Commencing January 1, 2001, there is  
31 hereby established in the department the Independent  
32 Medical Review System.

33 (b) For the purposes of this chapter, "disputed health  
34 care service" means any health care service eligible for  
35 coverage and payment under a disability insurance  
36 contract that has been denied, modified, or delayed by a  
37 decision of the insurer, or by one of its contracting  
38 providers, in whole or in part due to a finding that the  
39 service is not medically necessary. A decision regarding  
40 a disputed health care service relates to the practice of



1 *medicine and is not a coverage decision. A disputed*  
2 *health care service does not include services provided by*  
3 *a group policy of vision-only or dental-only coverage,*  
4 *except to the extent that (1) the service involves the*  
5 *practice of medicine, or (2) is provided pursuant to a*  
6 *contract with a disability insurer. If an insurer, or one of*  
7 *its contracting providers, issues a decision denying,*  
8 *modifying, or delaying health care services, based in*  
9 *whole or in part on a finding that the proposed health care*  
10 *services are not a covered benefit under the contract that*  
11 *applies to the insured, the statement of decision shall*  
12 *clearly specify the provision in the contract that excludes*  
13 *that coverage.*

14 *(c) For the purposes of this chapter, “coverage*  
15 *decision” means the approval or denial of health care*  
16 *services by an insurer, or by one of its contracting entities,*  
17 *substantially based on a finding that the provision of a*  
18 *particular service is included or excluded as a covered*  
19 *benefit under the terms and conditions of the disability*  
20 *insurance contract. A coverage decision does not*  
21 *encompass a plan or contracting provider decision*  
22 *regarding a disputed health care service.*

23 *(d) (1) All insured grievances involving a disputed*  
24 *health care service are eligible for review under the*  
25 *Independent Medical Review System if the requirements*  
26 *of this article are met. If the department finds that an*  
27 *insured grievance involving a disputed health care*  
28 *service does not meet the requirements of this article for*  
29 *review under the Independent Medical Review System,*  
30 *the insured request for review shall be treated as a*  
31 *request for the department to review the grievance. All*  
32 *other insured grievances, including grievances involving*  
33 *coverage decisions, remain eligible for review by the*  
34 *department.*

35 *(2) In any case in which an insured or provider asserts*  
36 *that a decision to deny, modify, or delay health care*  
37 *services was based, in whole or in part, on consideration*  
38 *of medical necessity, the department shall have the final*  
39 *authority to determine whether the grievance is more*



1 properly resolved pursuant to an independent medical  
2 review as provided under this article.

3 (3) The department shall be the final arbiter when  
4 there is a question as to whether an insured grievance is  
5 a disputed health care service or a coverage decision. The  
6 department shall establish a process to complete an initial  
7 screening of an insured grievance. If there appears to be  
8 any medical necessity issue, the grievance shall be  
9 resolved pursuant to an independent medical review as  
10 provided under this article.

11 (e) Every disability insurance contract that is issued,  
12 amended, renewed, or delivered in this state on or after  
13 January 1, 2000, shall, effective, January 1, 2001, provide  
14 an insured with the opportunity to seek an independent  
15 medical review whenever health care services have been  
16 denied, modified, or delayed by the insurer, or by one of  
17 its contracting providers, if the decision was based in  
18 whole or in part on a finding that the proposed health care  
19 services are not medically necessary. For purposes of this  
20 article, an insured may designate an agent to act on his or  
21 her behalf. The provider may join with or otherwise assist  
22 the insured in seeking an independent medical review,  
23 and may advocate on behalf of the insured.

24 (f) Medicare beneficiaries shall not be excluded unless  
25 expressly preempted by federal law.

26 (g) The department may seek to integrate the quality  
27 of care and consumer protection provisions, including  
28 remedies, of the Independent Medical Review System  
29 with related dispute resolution procedures of other  
30 health care agency programs, including the Medicare  
31 program, in a way that minimizes the potential for  
32 duplication, conflict, and added costs. Nothing in this  
33 subdivision shall be construed to limit any rights  
34 conferred upon insureds under this chapter.

35 (h) The independent medical review process  
36 authorized by this article is in addition to any other  
37 procedures or remedies that may be available.

38 (i) No later than January 1, 2001, every insurer shall  
39 prominently display in every insurer member handbook  
40 or relevant informational brochure, in every insurance

1 contract, on insured evidence of coverage forms, on  
2 copies of insurer procedures for resolving grievances, on  
3 letters of denials issued by either the insurer or its  
4 contracting organization, and on all written responses to  
5 grievances, information concerning the right of an  
6 insured to request an independent medical review in  
7 cases where the insured believes that health care services  
8 have been improperly denied, modified, or delayed by  
9 the plan, or by one of its contracting providers.

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

13 (1) (A) The insured's provider has recommended a  
14 health care service as medically necessary.

15 (B) The insured has received urgent care or  
16 emergency services that a provider determined was  
17 medically necessary.

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

28 For purposes of this article, the insured's provider may  
29 be an out-of-plan provider. However, the insurer shall  
30 have no liability for payment of services provided by an  
31 out-of-plan provider.

32 (2) The disputed health care service has been denied,  
33 modified, or delayed by the insurer, or by one of its  
34 contracting providers, based in whole or in part on a  
35 decision that the health care service is not medically  
36 necessary.

37 (3) The insured has filed a grievance with the insurer  
38 or its contracting provider, and the disputed decision is  
39 upheld or the grievance remains unresolved after 30 days.  
40 The insured shall not be required to participate in the



1 insurer's grievance process for more than 30 days. In the  
2 case of a grievance that requires expedited review, the  
3 insured shall not be required to participate in the  
4 insurer's grievance process for more than three days.

5 (k) An insured may apply to the department for an  
6 independent medical review of a decision to deny,  
7 modify, or delay health care services, based in whole or  
8 in part on a finding that the disputed health care services  
9 are not medically necessary, within six months of any of  
10 the qualifying periods or events under subdivision (j).  
11 The commissioner may extend the application deadline  
12 beyond six months if the circumstances of a case warrant  
13 the extension.

14 (l) The insured shall pay no application or processing  
15 fees of any kind.

16 (m) As part of its notification to the insured regarding  
17 a disposition of the insured's grievance that denies,  
18 modifies, or delays health care services, the insurer shall  
19 provide the insured with a one-page application form  
20 approved by the department, and an addressed envelope,  
21 which the insured may return to initiate an independent  
22 medical review. The insurer shall include on the form any  
23 information required by the department to facilitate the  
24 completion of the independent medical review, such as  
25 the insured's diagnosis or condition, the nature of the  
26 disputed health care service sought by the insured, a  
27 means to identify the insured's case, and any other  
28 material information. The form shall also include the  
29 following:

30 (1) Notice that a decision not to participate in the  
31 independent review process may cause the insured to  
32 forfeit any statutory right to pursue legal action against  
33 the insurer regarding the disputed health care service.

34 (2) A statement indicating the insured's consent to  
35 obtain any necessary medical records from the insurer,  
36 any of its contracting providers, and any out-of-plan  
37 provider the insured may have consulted on the matter,  
38 to be signed by the insured.



1 (3) Notice of the insured's right to provide  
2 information or documentation, either directly or through  
3 the insured's provider, regarding any of the following:

4 (A) A provider recommendation indicating that the  
5 disputed health care service is medically necessary for the  
6 insured's medical condition.

7 (B) Medical information or justification that a  
8 disputed health care service, on an urgent care or  
9 emergency basis, was medically necessary for the  
10 insured's medical condition.

11 (C) Reasonable information supporting the insured's  
12 position that the disputed health care service is or was  
13 medically necessary for the insured's medical condition,  
14 including all information provided to the insured by the  
15 insurer or any of its contracting providers, still in the  
16 possession of the insured, concerning an insurer or  
17 provider decision regarding disputed health care  
18 services, and a copy of any materials the insured  
19 submitted to the insurer, still in the possession of the  
20 insured, in support of the grievance, as well as any  
21 additional material that the insured believes is relevant.

22 (n) Upon notice from the department that the insured  
23 has applied for an independent medical review, the  
24 insurer or its contracting providers, shall provide to the  
25 independent medical review organization a copy of all of  
26 the following documents within three business days of the  
27 insurer's receipt of the department's notice of a request  
28 by an insured for an independent review:

29 (1) (A) A copy of all of the insured's medical records  
30 in the possession of the insurer or its contracting  
31 providers relevant to each of the following:

32 (i) The insured's medical condition.

33 (ii) The health care services being provided by the  
34 insurer and its contracting providers for the condition.

35 (iii) The disputed health care services requested by  
36 the insured for the condition.

37 (B) Any newly developed or discovered relevant  
38 medical records in the possession of the insurer or its  
39 contracting providers after the initial documents are  
40 provided to the independent medical review



1 organization shall be forwarded immediately to the  
2 independent medical review organization. The insurer  
3 shall concurrently provide a copy of medical records  
4 required by this subparagraph to the insured or the  
5 insured's provider, if authorized by the insured, unless  
6 the offer of medical records is declined or otherwise  
7 prohibited by law. The confidentiality of all medical  
8 record information shall be maintained pursuant to  
9 applicable state and federal laws.

10 (2) A copy of all information provided to the insured  
11 by the insurer and any of its contracting providers  
12 concerning insurer and provider decisions regarding the  
13 insured's condition and care, and a copy of any materials  
14 the insured or the insured's provider submitted to the  
15 insurer and to the insurer's contracting providers in  
16 support of the insured's request for disputed health care  
17 services. This documentation shall include the written  
18 response to the insured's grievance. The confidentiality  
19 of any insured medical information shall be maintained  
20 pursuant to applicable state and federal laws.

21 (3) A copy of any other relevant documents or  
22 information used by the insurer or its contracting  
23 providers in determining whether disputed health care  
24 services should have been provided, and any statements  
25 by the insurer and its contracting providers explaining  
26 the reasons for the decision to deny, modify, or delay  
27 disputed health care services on the basis of medical  
28 necessity. The insurer shall concurrently provide a copy  
29 of documents required by this paragraph, except for any  
30 information found by the commissioner to be legally  
31 privileged information, to the insured and the insured's  
32 provider. The department and the independent review  
33 organization shall maintain the confidentiality of any  
34 information found by the commissioner to be the  
35 proprietary information of the insurer.

36 10169.1. (a) If there is an imminent and serious  
37 threat to the health of the insured, as specified in  
38 subdivision (c) of Section 10169.3, all necessary  
39 information and documents shall be delivered to an  
40 independent medical review organization within 24



1 hours of approval of the request for review. In reviewing  
2 a request for review, the department may waive the  
3 requirement that the insured follow the insurer's  
4 grievance process in extraordinary and compelling cases,  
5 where the commissioner finds that the insured has acted  
6 reasonably.

7 (b) The department shall expeditiously review  
8 requests and immediately notify the insured in writing as  
9 to whether the request for an independent medical  
10 review has been approved, in whole or in part, and, if not  
11 approved, the reasons therefor. The insurer shall  
12 promptly issue a notification to the insured, after  
13 submitting all of the required material to the  
14 independent medical review organization, that includes  
15 an annotated list of documents submitted and offer the  
16 insured the opportunity to request copies of those  
17 documents from the insurer. The department shall  
18 promptly approve insured requests whenever the insurer  
19 has agreed that the case is eligible for an independent  
20 medical review. The department shall not refer coverage  
21 decisions for independent review. To the extent an  
22 insured request for independent review is not approved  
23 by the department, the insured request shall be treated  
24 as an immediate request for the department to review the  
25 grievance.

26 (c) An independent medical review organization,  
27 specified in Section 10169.2, shall conduct the review in  
28 accordance with Section 10169.3 and any regulations or  
29 orders of the commissioner adopted pursuant thereto.  
30 The organization's review shall be limited to an  
31 examination of the medical necessity of the disputed  
32 health care services and shall not include any  
33 consideration of coverage decisions or other contractual  
34 issues.

35 10169.2. (a) By January 1, 2001, the department shall  
36 contract with one or more independent medical review  
37 organizations in the state to conduct reviews for purposes  
38 of this article. The independent medical review  
39 organizations shall be independent of any insurer doing  
40 business in this state. The commissioner may establish



1 *additional requirements, including conflict-of-interest*  
2 *standards, consistent with the purposes of this article, that*  
3 *an organization shall be required to meet in order to*  
4 *qualify for participation in the Independent Medical*  
5 *Review System.*

6 *(b) The independent medical review organizations*  
7 *and the medical professionals retained to conduct*  
8 *reviews shall be deemed to be medical consultants for*  
9 *purposes of Section 43.98 of the Civil Code.*

10 *(c) The independent medical review organization,*  
11 *any experts it designates to conduct a review, or any*  
12 *officer, director, or employee of the independent medical*  
13 *review organization shall not have any material*  
14 *professional, familial, or financial affiliation, as*  
15 *determined by the commissioner, with any of the*  
16 *following:*

17 *(1) The insurer.*

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

19 *(3) A physician, the physician's medical group, or the*  
20 *independent practice association involved in the health*  
21 *care service in dispute.*

22 *(4) The facility or institution at which either the*  
23 *proposed health care service, or the alternative service,*  
24 *if any, recommended by the insurer, would be provided.*

25 *(5) The development or manufacture of the principal*  
26 *drug, device, procedure, or other therapy proposed by*  
27 *the insured whose treatment is under review, or the*  
28 *alternative therapy, if any, recommended by the insurer.*

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

30 *(d) In order to contract with the department for*  
31 *purposes of this article, an independent medical review*  
32 *organization shall meet all of the following requirements:*

33 *(1) The organization shall not be an affiliate or a*  
34 *subsidiary of, nor in any way be owned or controlled by,*  
35 *an insurer or a trade association of insurers. A board*  
36 *member, director, officer, or employee of the*  
37 *independent medical review organization shall not serve*  
38 *as a board member, director, or employee of an insurer.*  
39 *A board member, director, or officer of an insurer or a*  
40 *trade association of insurers shall not serve as a board*



1 member, director, officer, or employee of an  
2 independent medical review organization.

3 (2) The organization shall submit to the department  
4 the following information upon initial application to  
5 contract for purposes of this article and, except as  
6 otherwise provided, annually thereafter upon any change  
7 to any of the following information:

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

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

13 (C) The names of all corporations and organizations  
14 that the independent medical review organization  
15 controls or is affiliated with, and the nature and extent of  
16 any ownership or control, including the affiliated  
17 organization's type of business.

18 (D) The names and biographical sketches of all  
19 directors, officers, and executives of the independent  
20 medical review organization, as well as a statement  
21 regarding any past or present relationships the directors,  
22 officers, and executives may have with any health care  
23 service plan, disability insurer, managed care  
24 organization, provider group, or board or committee of  
25 a plan, managed care organization, or provider group.

26 (E) (i) The percentage of revenue the independent  
27 medical review organization receives from expert  
28 reviews, including, but not limited to, external medical  
29 reviews, quality assurance reviews, and utilization  
30 reviews.

31 (ii) The names of any insurer or provider group for  
32 which the independent medical review organization  
33 provides review services, including, but not limited to,  
34 utilization review, quality assurance review, and external  
35 medical review. Any change in this information shall be  
36 reported to the department within five business days of  
37 the change.

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



1 (G) A description of the system the independent  
2 medical review organization uses to identify and recruit  
3 medical professionals to review treatment and treatment  
4 recommendation decisions, the number of medical  
5 professionals credentialed, and the types of cases and  
6 areas of expertise that the medical professionals are  
7 credentialed to review.

8 (H) A description of how the independent medical  
9 review organization ensures compliance with the  
10 conflict-of-interest provisions of this section.

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

14 (A) Ensures that the medical professionals retained  
15 are appropriately credentialed and privileged.

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

19 (C) Ensures that the method of selecting medical  
20 professionals for individual cases achieves a fair and  
21 impartial panel of medical professionals who are qualified  
22 to render recommendations regarding the clinical  
23 conditions and the medical necessity of treatments or  
24 therapies in question.

25 (D) Ensures the confidentiality of medical records  
26 and the review materials, consistent with the  
27 requirements of this section and applicable state and  
28 federal law.

29 (E) Ensures the independence of the medical  
30 professionals retained to perform the reviews through  
31 conflict-of-interest policies and prohibitions, and ensures  
32 adequate screening for conflicts-of-interest, pursuant to  
33 paragraph (5).

34 (4) Medical professionals selected by independent  
35 medical review organizations to review medical  
36 treatment decisions shall be physicians or other  
37 appropriate providers who meet the following minimum  
38 requirements:

39 (A) The medical professional shall be a clinician  
40 knowledgeable in the treatment of the insured's medical



1 condition, knowledgeable about the proposed treatment,  
2 and familiar with guidelines and protocols in the area of  
3 treatment under review.

4 (B) The medical professional shall hold a  
5 nonrestricted license in the any state of the United States,  
6 and for physicians, a current certification by a recognized  
7 American medical specialty board in the area or areas  
8 appropriate to the condition or treatment under review.  
9 The independent medical review organization shall give  
10 preference to the use of a physician licensed in California  
11 as the reviewer, except when training and experience  
12 with the issue under review reasonably requires the use  
13 of an out-of-state reviewer.

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

19 (5) Neither the expert reviewer, nor the independent  
20 medical review organization, shall have any material  
21 professional, material familial, or material financial  
22 affiliation with any of the following:

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

30 (B) Any officer, director, or management employee of  
31 the insurer.

32 (C) The physician, the physician's medical group, or  
33 the independent practice association (IPA) proposing  
34 the treatment.

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

37 (E) The development or manufacture of the  
38 treatment proposed for the insured whose condition is  
39 under review.

40 (F) The insured or the insured's immediate family.



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

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

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

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

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

35 10169.3. (a) Upon receipt of information and  
36 documents related to a case, the medical professional  
37 reviewer or reviewers selected to conduct the review by  
38 the independent medical review organization shall  
39 promptly review all pertinent medical records of the  
40 insured, provider reports, as well as any other information



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

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

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

15 (B) Nationally recognized professional standards.

16 (C) Expert opinion.

17 (D) Generally accepted standards of medical practice.

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

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



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

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

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

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

1 10169.4. (a) Upon receiving the decision adopted by  
2 the commissioner pursuant to Section 10169.3 that a  
3 disputed health care service is medically necessary, the  
4 insurer shall immediately contact the insured and offer to  
5 promptly implement the decision.

6 (b) In any case where an insured secured urgent care,  
7 emergency services, or other extraordinary and  
8 compelling health care services outside of the insurer  
9 provider network, which services are later found by the  
10 independent medical review organization to have been  
11 medically necessary, the commissioner shall require the  
12 insurer to promptly reimburse the insured for any  
13 reasonable costs associated with those services when the  
14 commissioner finds that the insured's decision to secure  
15 the services outside of the insurer provider network prior  
16 to completing the insurer grievance process or seeking an  
17 independent medical review was reasonable under the  
18 circumstances and the disputed health care services were  
19 a covered benefit under the terms and conditions of the  
20 disability insurance contract.

21 10169.5. (a) After considering the results of a  
22 competitive bidding process and any other relevant  
23 information on program costs, the commissioner shall  
24 establish a reasonable, per-case reimbursement schedule  
25 to pay the costs of independent medical review  
26 organization reviews, which may vary depending on the  
27 type of medical condition under review and on other  
28 relevant factors.

29 (b) The costs of the independent medical review  
30 system for insureds shall be borne by insurers pursuant to  
31 an assessment fee system established by the  
32 commissioner. In determining the amount to be assessed,  
33 the commissioner shall consider all appropriations  
34 available for the support of this article, and existing fees  
35 paid to the department. The commissioner may adjust  
36 fees upward or downward, on a schedule set by the  
37 department, to address shortages or overpayments, and  
38 to reflect utilization of the independent review process.

39 SEC. 3. No reimbursement is required by this act  
40 pursuant to Section 6 of Article XIII B of the California



1 *Constitution because the only costs that may be incurred*  
2 *by a local agency or school district will be incurred*  
3 *because this act creates a new crime or infraction,*  
4 *eliminates a crime or infraction, or changes the penalty*  
5 *for a crime or infraction, within the meaning of Section*  
6 *17556 of the Government Code, or changes the definition*  
7 *of a crime within the meaning of Section 6 of Article*  
8 *XIII B of 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, August 24, 1999 (JR 11)**

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