

AMENDED IN SENATE SEPTEMBER 9, 1999
AMENDED IN SENATE SEPTEMBER 8, 1999
AMENDED IN SENATE AUGUST 24, 1999
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

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

December 7, 1998

An act to 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 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 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 every health care service plan 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, modified, or delayed 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 establish, commencing January 1, 2000, an independent medical review system whereby requests for reviews 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. The bill would enact other related provisions.

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

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. Article 5.55 (commencing with Section
2 1374.30) is added to Chapter 2.2 of Division 2 of the Health
3 and Safety Code, to read:

4

5 Article 5.55. Appeals Seeking Independent Medical
6 Reviews

7

8 1374.30. (a) Commencing January 1, 2001, there is
9 hereby established in the department the Independent
10 Medical Review System.

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



1 contract that applies to the enrollee, the statement of
2 decision shall clearly specify the provision in the contract
3 that excludes that coverage.

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

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

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

34 (3) The department shall be the final arbiter when
35 there is a question as to whether an enrollee grievance is
36 a disputed health care service or a coverage decision. The
37 department shall establish a process to complete an initial
38 screening of an enrollee grievance. If there appears to be
39 any medical necessity issue, the grievance shall be
40 resolved pursuant to an independent medical review as



1 provided under this article or pursuant to subdivision (a)
2 of Section 1368.

3 (e) Every health care service plan contract that is
4 issued, amended, renewed, or delivered in this state on or
5 after January 1, 2000, shall, effective January 1, 2001,
6 provide an enrollee with the opportunity to seek an
7 independent medical review whenever health care
8 services have been denied, modified, or delayed by the
9 plan, or by one of its contracting providers, if the decision
10 was based in whole or in part on a finding that the
11 proposed health care services are not medically
12 necessary. For purposes of this article, an enrollee may
13 designate an agent to act on his or her behalf, as described
14 in paragraph (2) of subdivision (b) of Section 1368. The
15 provider may join with or otherwise assist the enrollee in
16 seeking an independent medical review, and may
17 advocate on behalf of the enrollee.

18 (f) Medi-Cal beneficiaries enrolled in a health care
19 service plan shall not be excluded from participation.
20 Medicare beneficiaries *enrolled in a health care service*
21 *plan* shall not be excluded unless expressly preempted by
22 federal law. Reviews of cases for Medi-Cal enrollees shall
23 be conducted in accordance with statutes and regulations
24 for the Medi-Cal program.

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

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

37 (i) No later than January 1, 2001, every health care
38 service plan shall prominently display in every plan
39 member handbook or relevant informational brochure,
40 in every plan contract, on enrollee evidence of coverage



1 forms, on copies of plan procedures for resolving
2 grievances, on letters of denials issued by either the plan
3 or its contracting organization, on the grievance forms
4 required under Section 1368, and on all written responses
5 to grievances, information concerning the right of an
6 enrollee to request an independent medical review in
7 cases where the enrollee believes that health care
8 services have been improperly denied, modified, or
9 delayed by the plan, or by one of its contracting providers.

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

13 (1) (A) The enrollee's provider has recommended a
14 health care service as medically necessary; *or*

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

18 (C) The enrollee, 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 enrollee seeks independent review. The plan
24 shall expedite access to an in-plan provider upon request
25 of an enrollee. The in-plan provider need not recommend
26 the disputed health care service as a condition for the
27 enrollee to be eligible for an independent review.

28 For purposes of this article, the enrollee's provider may
29 be an out-of-plan provider. However, the plan shall have
30 no liability for payment of services provided by an
31 out-of-plan provider, *except as provided pursuant to*
32 *subdivision (b) of Section 1374.34.*

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

38 (3) The enrollee has filed a grievance with the plan or
39 its contracting provider pursuant to Section 1368, and the
40 disputed decision is upheld or the grievance remains



1 unresolved after 30 days. The enrollee shall not be
2 required to participate in the plan's grievance process for
3 more than 30 days. In the case of a grievance that requires
4 expedited review pursuant to Section 1368.01, the
5 enrollee shall not be required to participate in the plan's
6 grievance process for more than three days.

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

16 (l) The enrollee shall pay no application or processing
17 fees of any kind.

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

32 (1) Notice that a decision not to participate in the
33 independent medical review process may cause the
34 enrollee to forfeit any statutory right to pursue legal
35 action against the plan regarding the disputed health care
36 service.

37 (2) A statement indicating the enrollee's consent to
38 obtain any necessary medical records from the plan, any
39 of its contracting providers, and any out-of-plan provider



1 the enrollee may have consulted on the matter, to be
2 signed by the enrollee.

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

6 (A) A provider recommendation indicating that the
7 disputed health care service is medically necessary for the
8 enrollee's medical condition.

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

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

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

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

36 (i) The enrollee's medical condition.

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

39 (iii) The disputed health care services requested by
40 the enrollee for the condition.



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

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

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



1 1374.31. (a) If there is an imminent and serious
2 threat to the health of the enrollee, as specified in
3 subdivision (c) of Section 1374.33, all necessary
4 information and documents shall be delivered to an
5 independent medical review organization within 24
6 hours of approval of the request for review. In reviewing
7 a request for review, the department may waive the
8 requirement that the enrollee follow the plan's grievance
9 process in extraordinary and compelling cases, where the
10 director finds that the enrollee has acted reasonably.

11 (b) The department shall expeditiously review
12 requests and immediately notify the enrollee in writing
13 as to whether the request for an independent medical
14 review has been approved, in whole or in part, and, if not
15 approved, the reasons therefor. The plan shall promptly
16 issue a notification to the enrollee, after submitting all of
17 the required material to the independent medical review
18 organization, that includes an annotated list of
19 documents submitted and offer the enrollee the
20 opportunity to request copies of those documents from
21 the plan. The department shall promptly approve
22 enrollee requests whenever the enrollee's plan has
23 agreed that the case is eligible for an independent
24 medical review. The department shall not refer coverage
25 decisions for independent review. To the extent an
26 enrollee request for independent review is not approved
27 by the department, the enrollee request shall be treated
28 as an immediate request for the department to review the
29 grievance pursuant to subdivision (b) of Section 1368.

30 (c) An independent medical review organization,
31 specified in Section 1374.32, shall conduct the review in
32 accordance with Section 1374.33 and any regulations or
33 orders of the director adopted pursuant thereto. The
34 organization's review shall be limited to an examination
35 of the medical necessity of the disputed health care
36 services and shall not include any consideration of
37 coverage decisions or other contractual issues.

38 1374.32. (a) By January 1, 2001, the department shall
39 contract with one or more independent medical review
40 organizations in the state to conduct reviews for purposes



1 of this article. The independent medical review
2 organizations shall be independent of any health care
3 service plan doing business in this state. The director may
4 establish additional requirements, including
5 conflict-of-interest standards, consistent with the
6 purposes of this article, that an organization shall be
7 required to meet in order to qualify for participation in
8 the Independent Medical Review System *and to assist the*
9 *department in carrying out its responsibilities.*

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

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

20 (1) The plan.

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

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

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

28 (5) The development or manufacture of the principal
29 drug, device, procedure, or other therapy proposed by
30 the enrollee whose treatment is under review, or the
31 alternative therapy, if any, recommended by the plan.

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

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

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



1 as a board member, director, or employee of a health care
2 service plan. A board member, director, or officer of a
3 health plan or a trade association of health plans shall not
4 serve as a board member, director, officer, or employee
5 of an independent medical review organization.

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

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

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

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

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

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

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



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

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

11 (H) A description of how the independent medical
12 review organization ensures compliance with the
13 conflict-of-interest provisions of this section.

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

17 (A) Ensures that the medical professionals retained
18 are appropriately credentialed and privileged.

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

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

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

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

37 (4) Medical professionals selected by independent
38 medical review organizations to review medical
39 treatment decisions shall be physicians or other



1 appropriate providers who meet the following minimum
2 requirements:

3 (A) The medical professional shall be a clinician
4 knowledgeable in the treatment of the enrollee's medical
5 condition, knowledgeable about the proposed treatment,
6 and familiar with guidelines and protocols in the area of
7 treatment under review.

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

19 (C) The medical professional shall have no history of
20 disciplinary action or sanctions, including, but not limited
21 to, loss of staff privileges or participation restrictions,
22 taken or pending by any hospital, government, or
23 regulatory body.

24 (5) Neither the expert reviewer, nor the independent
25 medical review organization, shall have any material
26 professional, material familial, or material financial
27 affiliation with any of the following:

28 (A) The plan or a provider group of the plan, except
29 that an academic medical center under contract to the
30 plan to provide services to enrollees may qualify as an
31 independent medical review organization provided it
32 will not provide the service and provided the center is not
33 the developer or manufacturer of the proposed
34 treatment.

35 (B) Any officer, director, or management employee of
36 the plan.

37 (C) The physician, the physician's medical group, or
38 the independent practice association (IPA) proposing
39 the treatment.



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

3 (E) The development or manufacture of the
4 treatment proposed for the enrollee whose condition is
5 under review.

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

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

9 (A) "Material familial affiliation" means any
10 relationship as a spouse, child, parent, sibling, spouse's
11 parent, or child's spouse.

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

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

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



1 1374.33. (a) Upon receipt of information and
2 documents related to a case, the medical professional
3 reviewer or reviewers selected to conduct the review by
4 the independent medical review organization shall
5 promptly review all pertinent medical records of the
6 enrollee, provider reports, as well as any other
7 information submitted to the organization as authorized
8 by the department or requested from any of the parties
9 to the dispute by the reviewers. If reviewers request
10 information from any of the parties, a copy of the request
11 and the response shall be provided to all of the parties.
12 The reviewer or reviewers shall also review relevant
13 information related to the criteria set forth in subdivision
14 (b).

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

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

21 (2) Nationally recognized professional standards.

22 (3) Expert opinion.

23 (4) Generally accepted standards of medical practice.

24 (5) Treatments that are likely to provide a benefit to
25 a patient for conditions for which other treatments are
26 not clinically efficacious.

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



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

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

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

33 (f) The director shall immediately adopt the
34 determination of the independent medical review
35 organization, and shall promptly issue a written decision
36 to the parties that shall be binding on the plan.

37 (g) After removing the names of the parties,
38 including, but not limited to, the enrollee, all medical
39 providers, the plan, and any of the insurer's employees or
40 contractors, director decisions adopting a determination



1 of an independent medical review organization shall be
2 made available by the department to the public upon
3 request, at the department's cost and after considering
4 applicable laws governing disclosure of public records,
5 confidentiality, and personal privacy.

6 ~~1374.34. (a) Upon receiving the decision adopted by~~
7 ~~the director pursuant to Section 1374.33 that a disputed~~
8 ~~health care service is medically necessary, the plan shall~~
9 ~~immediately contact the enrollee and offer to promptly~~
10 ~~implement the decision.~~

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

26 1374.35. (a) After considering the results of a
27 competitive bidding process and any other relevant
28 information on program costs, the director shall establish
29 a reasonable, per-case reimbursement schedule to pay
30 the costs of independent medical review organization
31 reviews, which may vary depending on the type of
32 medical condition under review and on other relevant
33 factors.

34 (b) The costs of the independent medical review
35 system for enrollees shall be borne by health care service
36 plans pursuant to an assessment fee system established by
37 the director. In determining the amount to be assessed,
38 the director shall consider all appropriations available for
39 the support of this chapter, and existing fees paid to the
40 department. The director may adjust fees upward or



1 downward, on a schedule set by the department, to
2 address shortages or overpayments, and to reflect
3 utilization of the independent review process.

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

7

8 Article 3.5. Appeals Seeking Independent Medical
9 Review

10

11 10169. (a) Commencing January 1, 2001, there is
12 hereby established in the department the Independent
13 Medical Review System.

14 (b) For the purposes of this chapter, “disputed health
15 care service” means any health care service eligible for
16 coverage and payment under a disability insurance
17 contract that has been denied, modified, or delayed by a
18 decision of the insurer, or by one of its contracting
19 providers, in whole or in part due to a finding that the
20 service is not medically necessary. A decision regarding
21 a disputed health care service relates to the practice of
22 medicine and is not a coverage decision. A disputed
23 health care service does not include services provided by
24 a group policy of vision-only or dental-only coverage,
25 except to the extent that (1) the service involves the
26 practice of medicine, or (2) is provided pursuant to a
27 contract with a disability insurer. If an insurer, or one of
28 its contracting providers, issues a decision denying,
29 modifying, or delaying health care services, based in
30 whole or in part on a finding that the proposed health care
31 services are not a covered benefit under the contract that
32 applies to the insured, the statement of decision shall
33 clearly specify the provision in the contract that excludes
34 that coverage.

35 (c) For the purposes of this chapter, “coverage
36 decision” means the approval or denial of health care
37 services by an insurer, or by one of its contracting entities,
38 substantially based on a finding that the provision of a
39 particular service is included or excluded as a covered
40 benefit under the terms and conditions of the disability



1 insurance contract. A coverage decision does not
2 encompass a plan or contracting provider decision
3 regarding a disputed health care service.

4 (d) (1) All insured grievances involving a disputed
5 health care service are eligible for review under the
6 Independent Medical Review System if the requirements
7 of this article are met. If the department finds that an
8 insured grievance involving a disputed health care
9 service does not meet the requirements of this article for
10 review under the Independent Medical Review System,
11 the insured request for review shall be treated as a
12 request for the department to review the grievance. All
13 other insured grievances, including grievances involving
14 coverage decisions, remain eligible for review by the
15 department.

16 (2) In any case in which an insured or provider asserts
17 that a decision to deny, modify, or delay health care
18 services was based, in whole or in part, on consideration
19 of medical necessity, the department shall have the final
20 authority to determine whether the grievance is more
21 properly resolved pursuant to an independent medical
22 review as provided under this article.

23 (3) The department shall be the final arbiter when
24 there is a question as to whether an insured grievance is
25 a disputed health care service or a coverage decision. The
26 department shall establish a process to complete an initial
27 screening of an insured grievance. If there appears to be
28 any medical necessity issue, the grievance shall be
29 resolved pursuant to an independent medical review as
30 provided under this article.

31 (e) Every disability insurance contract that is issued,
32 amended, renewed, or delivered in this state on or after
33 January 1, 2000, shall, effective, January 1, 2001, provide
34 an insured with the opportunity to seek an independent
35 medical review whenever health care services have been
36 denied, modified, or delayed by the insurer, or by one of
37 its contracting providers, if the decision was based in
38 whole or in part on a finding that the proposed health care
39 services are not medically necessary. For purposes of this
40 article, an insured may designate an agent to act on his or



1 her behalf. The provider may join with or otherwise assist
2 the insured in seeking an independent medical review,
3 and may advocate on behalf of the insured.

4 (f) Medicare beneficiaries *enrolled in Medicare +*
5 *Choice products* shall not be excluded unless expressly
6 preempted by federal law.

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
12 program, in a way that minimizes the potential for
13 duplication, conflict, and added costs. Nothing in this
14 subdivision shall be construed to limit any rights
15 conferred upon insureds 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 insurer shall
20 prominently display in every insurer member handbook
21 or relevant informational brochure, in every insurance
22 contract, on insured evidence of coverage forms, on
23 copies of insurer procedures for resolving grievances, on
24 letters of denials issued by either the insurer or its
25 contracting organization, and on all written responses to
26 grievances, information concerning the right of an
27 insured to request an independent medical review in
28 cases where the insured believes that health care services
29 have been improperly denied, modified, or delayed by
30 the plan, or by one of its contracting providers.

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

34 (1) (A) The insured's provider has recommended a
35 health care service as medically necessary; *or*

36 (B) The insured has received urgent care or
37 emergency services that a provider determined was
38 medically necessary; *or*

39 (C) The insured, in the absence of a provider
40 recommendation under subparagraph (A) or the receipt



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

9 For purposes of this article, the insured's provider may
10 be an out-of-plan provider. However, the insurer shall
11 have no liability for payment of services provided by an
12 out-of-plan provider, *except as provided pursuant to*
13 *subdivision (b) of Section 10169.4.*

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

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

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

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

38 (m) As part of its notification to the insured regarding
39 a disposition of the insured's grievance that denies,
40 modifies, or delays health care services, the insurer shall



1 provide the insured with a one-page application form
2 approved by the department, and an addressed envelope,
3 which the insured may return to initiate an independent
4 medical review. The insurer shall include on the form any
5 information required by the department to facilitate the
6 completion of the independent medical review, such as
7 the insured's diagnosis or condition, the nature of the
8 disputed health care service sought by the insured, a
9 means to identify the insured's case, and any other
10 material information. The form shall also include the
11 following:

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

16 (2) A statement indicating the insured's consent to
17 obtain any necessary medical records from the insurer,
18 any of its contracting providers, and any out-of-plan
19 provider the insured may have consulted on the matter,
20 to be signed by the insured.

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

24 (A) A provider recommendation indicating that the
25 disputed health care service is medically necessary for the
26 insured's medical condition.

27 (B) Medical information or justification that a
28 disputed health care service, on an urgent care or
29 emergency basis, was medically necessary for the
30 insured's medical condition.

31 (C) Reasonable information supporting the insured's
32 position that the disputed health care service is or was
33 medically necessary for the insured's medical condition,
34 including all information provided to the insured by the
35 insurer or any of its contracting providers, still in the
36 possession of the insured, concerning an insurer or
37 provider decision regarding disputed health care
38 services, and a copy of any materials the insured
39 submitted to the insurer, still in the possession of the



1 insured, in support of the grievance, as well as any
2 additional material that the insured believes is relevant.

3 (n) Upon notice from the department that the insured
4 has applied for an independent medical review, the
5 insurer or its contracting providers, shall provide to the
6 independent medical review organization *designated by*
7 *the department* a copy of all of the following documents
8 within three business days of the insurer's receipt of the
9 department's notice of a request by an insured for an
10 independent review:

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

14 (i) The insured's medical condition.

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

17 (iii) The disputed health care services requested by
18 the insured for the condition.

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

32 (2) A copy of all information provided to the insured
33 by the insurer and any of its contracting providers
34 concerning insurer and provider decisions regarding the
35 insured's condition and care, and a copy of any materials
36 the insured or the insured's provider submitted to the
37 insurer and to the insurer's contracting providers in
38 support of the insured's request for disputed health care
39 services. This documentation shall include the written
40 response to the insured's grievance. The confidentiality



1 of any insured medical information shall be maintained
2 pursuant to applicable state and federal laws.

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

18 10169.1. (a) If there is an imminent and serious
19 threat to the health of the insured, as specified in
20 subdivision (c) of Section 10169.3, all necessary
21 information and documents shall be delivered to an
22 independent medical review organization within 24
23 hours of approval of the request for review. In reviewing
24 a request for review, the department may waive the
25 requirement that the insured follow the insurer's
26 grievance process in extraordinary and compelling cases,
27 where the commissioner finds that the insured has acted
28 reasonably.

29 (b) The department shall expeditiously review
30 requests and immediately notify the insured in writing as
31 to whether the request for an independent medical
32 review has been approved, in whole or in part, and, if not
33 approved, the reasons therefor. The insurer shall
34 promptly issue a notification to the insured, after
35 submitting all of the required material to the
36 independent medical review organization, that includes
37 an annotated list of documents submitted and offer the
38 insured the opportunity to request copies of those
39 documents from the insurer. The department shall
40 promptly approve insured requests whenever the insurer



1 has agreed that the case is eligible for an independent
2 medical review. The department shall not refer coverage
3 decisions for independent review. To the extent an
4 insured request for independent review is not approved
5 by the department, the insured request shall be treated
6 as an immediate request for the department to review the
7 grievance.

8 (c) An independent medical review organization,
9 specified in Section 10169.2, shall conduct the review in
10 accordance with Section 10169.3 and any regulations or
11 orders of the commissioner adopted pursuant thereto.
12 The organization's review shall be limited to an
13 examination of the medical necessity of the disputed
14 health care services and shall not include any
15 consideration of coverage decisions or other contractual
16 issues.

17 10169.2. (a) By January 1, 2001, the department shall
18 contract with one or more independent medical review
19 organizations in the state to conduct reviews for purposes
20 of this article. The independent medical review
21 organizations shall be independent of any insurer doing
22 business in this state. The commissioner may establish
23 additional requirements, including conflict-of-interest
24 standards, consistent with the purposes of this article, that
25 an organization shall be required to meet in order to
26 qualify for participation in the Independent Medical
27 Review System *and to assist the department in carrying*
28 *out its responsibilities.*

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 commissioner, with any of the
39 following:

40 (1) The insurer.



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

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

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

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

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

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

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

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

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

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

36 (C) The names of all corporations and organizations
37 that the independent medical review organization
38 controls or is affiliated with, and the nature and extent of
39 any ownership or control, including the affiliated
40 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 insurer or provider group for
15 which the independent medical review organization
16 provides review services, including, but not limited to,
17 utilization review, quality assurance review, and external
18 medical review. Any change in this information shall be
19 reported to the department within five business days of
20 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 insured'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~~ *Notwithstanding any other provision of law,*
30 *the* medical professional shall hold a nonrestricted license
31 in the any state of the United States, and for physicians,
32 a current certification by a recognized American medical
33 specialty board in the area or areas appropriate to the
34 condition or treatment under review. The independent
35 medical review organization shall give preference to the
36 use of a physician licensed in California as the reviewer,
37 except when training and experience with the issue
38 under review reasonably requires the use of an
39 out-of-state reviewer.



1 (C) The medical professional shall have no history of
2 disciplinary action or sanctions, including, but not limited
3 to, loss of staff privileges or participation restrictions,
4 taken or pending by any hospital, government, or
5 regulatory body.

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

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

17 (B) Any officer, director, or management employee of
18 the insurer.

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

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

24 (E) The development or manufacture of the
25 treatment proposed for the insured whose condition is
26 under review.

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

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

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

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



1 include affiliations that are limited to staff privileges at a
2 health facility.

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

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

22 10169.3. (a) Upon receipt of information and
23 documents related to a case, the medical professional
24 reviewer or reviewers selected to conduct the review by
25 the independent medical review organization shall
26 promptly review all pertinent medical records of the
27 insured, provider reports, as well as any other information
28 submitted to the organization as authorized by the
29 department or requested from any of the parties to the
30 dispute by the reviewers. If reviewers request
31 information from any of the parties, a copy of the request
32 and the response shall be provided to all of the parties.
33 The reviewer or reviewers shall also review relevant
34 information related to the criteria set forth in subdivision
35 (b).

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



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

3 (B) Nationally recognized professional standards.

4 (C) Expert opinion.

5 (D) Generally accepted standards of medical practice.

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

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

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



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

16 (f) The commissioner shall immediately adopt the
17 determination of the independent medical review
18 organization, and shall promptly issue a written decision
19 to the parties that shall be binding on the insurer.

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

29 ~~10169.4. (a) Upon receiving the decision adopted by~~
30 ~~the commissioner pursuant to Section 10169.3 that a~~
31 ~~disputed health care service is medically necessary, the~~
32 ~~insurer shall immediately contact the insured and offer to~~
33 ~~promptly implement the decision.~~

34 ~~(b) In any case where an insured secured urgent care,~~
35 ~~emergency services, or other extraordinary and~~
36 ~~compelling health care services outside of the insurer~~
37 ~~provider network, which services are later found by the~~
38 ~~independent medical review organization to have been~~
39 ~~medically necessary, the commissioner shall require the~~
40 ~~insurer to promptly reimburse the insured for any~~



1 ~~reasonable costs associated with those services when the~~
 2 ~~commissioner finds that the insured's decision to secure~~
 3 ~~the services outside of the insurer provider network prior~~
 4 ~~to completing the insurer grievance process or seeking an~~
 5 ~~independent medical review was reasonable under the~~
 6 ~~circumstances and the disputed health care services were~~
 7 ~~a covered benefit under the terms and conditions of the~~
 8 ~~disability insurance contract.~~

9 10169.5. (a) After considering the results of a
 10 competitive bidding process and any other relevant
 11 information on program costs, the commissioner shall
 12 establish a reasonable, per-case reimbursement schedule
 13 to pay the costs of independent medical review
 14 organization reviews, which may vary depending on the
 15 type of medical condition under review and on other
 16 relevant factors.

17 (b) The costs of the independent medical review
 18 system for insureds shall be borne by insurers pursuant to
 19 an assessment fee system established by the
 20 commissioner. In determining the amount to be assessed,
 21 the commissioner shall consider all appropriations
 22 available for the support of this article, and existing fees
 23 paid to the department. The commissioner may adjust
 24 fees upward or downward, on a schedule set by the
 25 department, to address shortages or overpayments, and
 26 to reflect utilization of the independent review process.

27 SEC. 3. No reimbursement is required by this act
 28 pursuant to Section 6 of Article XIII B of the California
 29 Constitution because the only costs that may be incurred
 30 by a local agency or school district will be incurred
 31 because this act creates a new crime or infraction,
 32 eliminates a crime or infraction, or changes the penalty
 33 for a crime or infraction, within the meaning of Section
 34 17556 of the Government Code, or changes the definition
 35 of a crime within the meaning of Section 6 of Article
 36 XIII B of the California Constitution.

