

## Policy & Procedure

### Independent Medical Review for Members

#### Policy:

The Physicians Integrated Medical Group (PIMG) provides information regarding the Department of Managed Health Care's (DMHC) independent medical review (IMR) process to members whenever PIMG:

1. Denies, modifies or delays authorizations of drugs, devices, procedures or other therapies, because they are not considered medically necessary. The member is informed that the IMR process is available after the Plan's grievance and appeal process is exhausted or 30 calendar days after a grievance is filed, whichever is sooner. If the grievance process is expedited, the Plan notifies the DMHC, and the member may apply for IMR immediately.
2. Denies, modifies or delays authorizations of drugs, devices, procedures or other therapies, because they are considered experimental or investigational.
3. Denies claims for out-of-plan emergency or urgent services.

#### Procedure:

1. The Health Plan's denial letter and PIMG's denial letters inform the member about IMR. *If a member is denied experimental or investigational therapy (Health Plan responsibility)*, the following documents are included with the denial letter:
  - an IMR application
  - an Authorization for Release of Medical Records Form
  - a Physician Certification of Experimental/Investigational Denials form
  - an envelope addressed to the DMHC is enclosed in the denial letter
2. Standard written correspondence used to acknowledge and respond to member grievances and appeals provides the member with information about IMR. The final resolution letter includes:
  - an IMR application
  - an Authorization for Release of Medical Records form
  - an envelope addressed to the DMHC
3. IMR forms are also provided to members who qualified for expedited review, and when the Plan fails to resolve a grievance within 30 calendar days.
4. The Health Plan educates its members about the IMR process. SFHP educates its members about the IMR process in the Medi-Cal Member Rules and Benefits Booklet and in commercial evidences of coverage that are distributed upon enrollment and at least annually.
5. The Health Plans educates its providers about the IMR in the Provider Operation Manuals.

6. The Health Plan Medical Director is responsible for implementing the IMR procedure. If a member applies for IMR through a practitioner or PIMG, the practitioner or PIMG contacts the Health Plan Medical Director immediately.
7. When the DMHC notifies the Plan that a request for IMR has been submitted, the Health Plan Medical Director completes the Request for Health Plan Information. The Plan returns the requested information to the DMHC within two calendar days for a standard request, or within 24 hours for an expedited request.
8. When the DMHC notifies the Plan that a case qualifies for IMR, the Health Plan Medical Director submits relevant medical records to the DMHC. The Plan submits the records within three business days for a standard request, or within 24 hours for an expedited request. The submission includes:
  - medical records relevant to the patient's condition for which the proposed therapy has been recommended and any other pertinent documentation that is in the Plan's possession
  - copies of any relevant document(s) used by the Plan to reach the conclusion that the proposed therapy should not be covered
  - statement by the Plan explaining its rationale for the denial
  - any member or provider statement in support of the request for coverage that is received by the Plan
9. If any additional information is obtained, the Health Plan forwards it to the DMHC immediately.
10. The Health Plan informs the member of all information provided to the DMHC, and provides copies upon request.
11. When the DMHC notifies the Health Plan of its IMR determination, the Health Plan Medical Director informs PIMG, the member and the practitioner of the decision in writing within one business day. If the review was expedited the Health Plan immediately contacts the member and practitioner by phone or fax, and sends written notification within one business day.
12. The Health Plan Medical Director works with PIMG to arrange and authorize the service within five business days after the IMR decision is received, or sooner if medically indicated. If the service has already been rendered, any outstanding claims are reimbursed within five business days.
13. The Health Plan notifies the DMHC that the IMR determination has been implemented.
14. The request for independent medical review can be filed with the Department of Managed Health Care (DMHC) after the member has filed a grievance or appeal and the decision was upheld by the Health Plan or remains unresolved after 30 days.
15. IMR review must be requested within six (6) months of the above condition(s) directly to the DMHC (800-400-0815).

**References:**

1. Health and Safety Code Article 5.55
2. Independent Medical Review, DMHC Update, 11/30/2000 <http://www.dmhc.ca.gov/imr/> provides consumer information and forms.
3. AB 55 (Migden)

**Independent Medical Review Timelines**

<b>Action</b>	<b>Expedited</b>	<b>Standard</b>
DMHC notifies physician and Health Plan if application is eligible	Within 48 hours after receipt of application	Within seven days after receipt of application
Health Plan returns the Health Plan Information Form to the DMHC	Within 24 hours of the DMHC notification	Within two days of DMHC notification
Health Plan submits medical records to IMR	Within 24 hours of the DMHC notification	Within three days of DMHC notification
Health Plan provides additional information to IMR	Within one day of receipt	Within one day of receipt
IMR makes determination	Within three days of receipt of records, may take up to seven days for experimental/investigational care	Within 21 days of receipt of records
DMHC issues written decision	Within one day of receipt of IMR determination	Within three days of receipt of IMR determination
Health Plan notifies PIMG, member and practitioner	Immediately upon receipt of IMR determination	Within 24 hours of receipt of IMR determination
Health Plan or PIMG authorizes or pays for approved treatment	Within 24 hrs of receipt of IMR determination	Within five days of receipt of IMR determination