CALIFORNIA INDEPENDENT MEDICAL REVIEW (IMR) PROGRAM

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What Is an Independent Medical Review?

An Independent Medical Review (IMR) is a process in which expert independent medical professionals are selected to review specific medical decisions made by the insurance company. The California Department of Insurance (CDI) administers an Independent Medical Review program that enables you, the insured, to request an impartial appraisal of medical decisions within certain guidelines as specified by the law.

Sections 10169 through 10169.5 of the California Insurance Code (CIC), which became effective January 1, 2001, explain the IMR process in detail. In addition, Section 10145.3 explains the IMR process as it relates to experimental or investigational therapies. An IMR can be requested only if the insurance company's decision involves:

- The medical necessity of a treatment,
- An experimental or investigational therapy for certain medical conditions, or
- A claims denial for emergency or urgent medical services.

It is important to note that the IMR process cannot be used for an insurance company decision that is based on a coverage issue. Only decisions regarding a disputed health care service, as it relates to the practice of medicine, that do **not** involve a coverage issue are qualified for the IMR program.

Unlike review procedures available through the internal appeals/grievance process of health insurance companies and health plans, the IMR request is received, reviewed, and processed by the CDI. When your request qualifies for the IMR program it is sent to the Independent Medical Review organization designated by the CDI. You are required to exhaust the internal appeals/grievance process of your particular insurance company before applying for an IMR with the CDI.

Who Can Request an Independent Medical Review?

Any person who is insured by a health insurance company has the opportunity to seek an IMR whenever health care services have been denied, modified, or delayed by the health insurer if the decision was based in whole or in part on a finding that the health care service was not medically necessary or deemed to be experimental or investigational. As the insured, you can designate a person to act as your authorized IMR assistant to help you with this process. Also, a health care professional (such as your doctor) is allowed to join with you and assist you with the IMR request. To designate a person to act on your behalf, you must complete and sign the Authorization for Release of Medical Records and Designation of IMR Agent found on the last page of the Application for IMR form.

When Can an Independent Medical Review Be Requested?

It is necessary in most situations to go through the appeals/grievance process with your health insurance company before applying for an IMR with the CDI. If the insurance company upholds its decision or has not provided a ruling within 30 days of filing the appeal/grievance, then you can file an IMR request. Your request for an IMR must be made within 6 months of the insurance company upholding its decision within the appeals/grievance process. If special circumstances are present, the law allows the Insurance Commissioner to consider extending the filing deadline beyond 6 months.

What Issues Are Eligible for an Independent Medical Review?

All insurance company decisions involving a disputed health care service are eligible for an IMR as long as they qualify under the following three categories:

- Health claims that have been denied, modified, or delayed by the insurance company because a regularly covered service or treatment was not considered medically necessary;
- Health claims that have been denied for urgent or emergency services; or
- Health claims that have been denied for investigational or experimental therapies.

You can request an IMR when services or treatments have been performed or when they have been proposed only (a preauthorization denial).

What Issues Are Not Eligible for an Independent Medical Review?

All other insurance company decisions that are not included in the above three categories are not eligible for an

IMR. These decisions may include, but are not limited to, the following:

- Health claims that have been denied by the insurance company because the service or treatment is not covered under the insurance contract. Denials due to coverage issues or other related underwriting policy issues do not qualify for the IMR program.
- Legal interpretations of policy language, provisions, and terms do not qualify for the IMR program.
- Bad faith allegations and other demands for extra payments under the health insurance contract do not qualify for the IMR program.

How Does the Independent Medical Review Program Work?

The First Step - Notification You or any person you have designated may request an IMR if you disagree with a health insurer's decision regarding a disputed health care service that has been determined not to be medically necessary or has been denied as experimental or investigational. Your insurance company is required to send you an IMR application with its denial letter. If you do not receive an application from your insurance company, you can request one from the CDI by calling 1-800-927-HELP or by completing an Application for IMR form.

The Second Step - The Agreement. Since making a request for an IMR is voluntary, you must give written consent indicating that you wish to participate in the IMR program. The application form includes a consent statement which when signed gives your permission to obtain any necessary medical records in order to proceed with the IMR.

The Third Step - Eligibility. When your completed application with any additional information is received, the CDI will determine if your request qualifies for the IMR program. If your request does qualify, you will be notified. If your request does not qualify for the IMR program, then your claims review request will be referred to the complaint/mediation program within the CDI.

The Fourth Step - The Review Process. When your request qualifies as an IMR, the case is then sent to the IMR organization designated by the CDI. The CDI notifies the health insurance company involved and requires them to provide the IMR organization with copies of all documents necessary to conduct the IMR. In most cases, your insurance company must provide all relevant documents including medical records to the IMR organization within three business days. The IMR organization is required to complete its review in writing within 30 days.

The Fifth Step - The Determination. Once the IMR organization has made its determination, the written determination will be provided to you, to your insurance company, and to the Insurance Commissioner. The determination must contain your medical condition, the important documents reviewed, and the findings that are relevant to your request.

The Sixth Step - Implementation. Upon receiving the IMR determination, the Insurance Commissioner adopts the recommendation from the IMR organization immediately. A written decision will be issued by the CDI to you and to your insurance company explaining that the recommendation is binding on the insurance company.

What Are the Criteria Used in an Independent Medical Review Determination?

When the IMR organization has completed its review of your particular case, they will have determined whether the disputed health care service is medically necessary. This determination is based upon your specific medical needs and any of the following factors:

- Peer-reviewed scientific and medical evidence regarding the effectiveness of the contested health care service
- Nationally recognized professional standards
- Expert opinion
- Generally accepted standards of medical practice
- Treatments that are likely to be effective for your medical condition rather than other treatments that are not.

Is There a Way to Process an Independent Medical Review More Quickly in Extraordinary Circumstances?

The IMR process allows for exceptions to be made when there is a serious or imminent threat to your health. CIC Section 10169.3(c) states that if the "insured's provider [your doctor/medical professional] or the department (CDI) certifies in writing that an imminent and serious threat to the health of the insured [you] may exist,

including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the insured," the IMR organization must make its determination within three days of receiving the proper case information. Moreover, your insurance company must deliver the necessary information and documents to the IMR organization within 24 hours of approval from the CDI of your IMR request.

When the CDI reviews your request for an IMR, the Department may waive the requirement that you first go through your insurance company's appeals/grievance process when an extraordinary or compelling case exists. The Insurance Commissioner may make exceptions based on the criteria listed in CIC Section 10169.3(c) above and based on the Insurance Commissioner finding that you have acted reasonably in the dispute with your insurance company.

Will an Independent Medical Review be Costly?

You will not be required to pay any kind of application or processing fee for an IMR. The cost of the IMR is paid completely by your insurance company after it has been decided that your request qualifies for an IMR by the CDI.

Does Independent Medical Review Participation Prevent Future Legal Action?

Submitting, being approved for, or participating in an IMR does not prevent you from seeking other legal resolution to your dispute. However, if you decide not to participate in an IMR, you may waive any right you have to pursue legal action against your insurance company in the future regarding the contested health care service. You may wish to seek the advice of an attorney in this matter.

Are Medical Records Kept Confidential in the Independent Medical Review Process?

All medical records are confidential throughout the IMR process. The confidentiality of medical records and review materials is subject to all applicable state and federal laws.

How Do I Request an Independent Medical Review from the California Department of Insurance?

To request an IMR it is necessary for you to send in the IMR application that your insurance company is required to enclose with its denial letter. If you have questions or concerns regarding the application, the IMR process, or you have not received an application from your insurance company, then you may reach the CDI by phone, mail, or e-mail.

Health Insurance Terms and Phrases

Assignment of Benefits - Your signed authorization to your doctor or hospital (medical provider) to collect monies for your medical treatment from your health insurance company.

Business Day - Every day that insurance companies are open for business which excludes Saturday, Sunday, and state and federal holidays.

Calendar Day - Every day of the calendar month which includes Saturday, Sunday, and state and federal holidays. However, if any action tied to a time frame in an insurance policy or CDI regulation or code falls on a Saturday, Sunday, or state or federal holiday; then the action is postponed to the next calendar day that does not fall on a Saturday, Sunday, or state or federal holiday.

Certificate of Coverage - A document issued to a member of a group health insurance plan showing evidence of participation in the insurance.

Claim - A notification to your insurance company that payment is due under the policy provisions.

Co-payment - The portion of charges you pay to your provider for covered health care services in addition to any deductible.

Coverage - The scope of protection provided by an insurance contract which includes any of the listed benefits in an insurance policy.

Denial - An insurance company decision to withhold a claim payment or pre-authorization. A denial may be made because the medical service is not covered, not medically necessary, or experimental or investigational.

Deductible - A fixed amount which is deducted from eligible expenses before benefits from the insurance

company are payable.

ERISA - The Employee Retirement Income Security Act (1974). Administered by the U.S. Department of Labor, ERISA regulates employer sponsored pension and insurance plans (self-insured plans) for employees.

Exclusions and/or Limitations - Conditions or circumstances spelled out in an insurance policy which limit or exclude coverage benefits. It is important to read all exclusion, limitation, and reduction clauses in your health insurance policy or certificate of coverage to determine which expenses are not covered.

Experimental and/or Investigational Medical Services - A drug, device, procedure, treatment plan, or other therapy which is currently not within the accepted standards of medical care.

In Writing - The language in an insurance contract, code, or regulation which requires a request or action to be authorized by written correspondence and/or signature. Written correspondence includes letters, notes, and facsimile (fax) transmissions.

Medically Necessary - A drug, device, procedure, treatment plan, or other therapy that is covered under your health insurance policy and that your doctor, hospital, or provider has determined essential for your medical well-being, specific illness, or underlying condition.

Policy - The written contract between an individual or group policyholder and an insurance company. The policy outlines the duties, obligations, and responsibilities of both the policyholder and the insurance company. A policy may include any application, endorsement, certificate, or any other document that can describe, limit, or exclude coverage benefits under the policy.

Preexisting Condition - Any illness or health condition for which you have received medical advice or treatment during the six months prior to obtaining health insurance. Group healthcare policies cover preexisting conditions after you have been insured for 6 months, and individual policies cover preexisting conditions after you have been insured for 1 year. CIC Section 10198.7.

Prior Qualifying Coverage or Credible Coverage - The health insurance you had in place before your current or new policy became effective must be credited towards any preexisting condition exclusion in either a group or individual policy.

Usual, Reasonable, and Customary - The amount that your insurance company determines is the normal payment range for a specific medical procedure performed within a given geographic area. If the charges you submit to your health insurance company are higher than what is considered normal for the covered health care services, then your health insurance company may not allow the full amount charged to you, and you may be responsible for the balance.