blue california
Promise Health Plan

Policy Title: Independent Medical Review Process		POLICY #: 70.2.41 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 1/01	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 3/21**	

PURPOSE

To establish a process that meets the provisions of the Health and Safety Code sections 1374.30 to 1374.36, which provides an enrollee the opportunity to seek an Independent Medical Review (IMR) whenever the health services have been denied, modified, or delayed by Blue Shield of California Promise Health Plan (Blue Shield Promise) or by one of the contracted Participating Provider Groups (PPGs) if the decision was based in the whole or in part, on the finding that the proposed heath care services are not medically indicated.

POLICY

Blue Shield Promise Health Plan directly handles the clinical appeal's process for its membership. This procedure is not a PPG delegated function as stipulated in Blue Shield Promise contractual agreement with the PPG. As part of the appeals process the Blue Shield Promise will inform enrollees of their right to request an IMR through the Department of Managed Health Care (DMHC). An enrollee may designate an agent to act on his or her behalf. In the event that the Plan is notified by DMHC that an enrollee, or the enrollee's representative, or the rendering provider is requesting an IMR, the Plan will comply with the provisions of the Health and Safety Code Sections 1374.30 to 1374.36.

PROCEDURE

In cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by Blue Shield Promise, or by one of its contracting providers. An enrollee may apply to the department for an independent medical review when all of the following conditions are met:

1. A member may request an IMR, to the DMHC, to obtain an impartial review of Blue Shield Promise Health Plan's decision concerning:
    a. The medical necessity of a proposed treatment
    b. Experimental or investigational therapies for a life threatening or seriously debilitating disease or condition; and
    c. Denied claims for out-of-plan emergency or urgent medical services

2. The following conditions must be met for members to exercise their right to request an IMR for a disputed decision to delay, deny, or modify services based on medical necessity:
    a. The enrollee's provider has recommended a health care service as medically necessary, or
    b. The enrollee has received urgent care or emergency services that a provider determined was medically necessary, or
    c. The enrollee, in the absence of a provider recommendation or the receipt of urgent care or emergency services by a provider, has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review, the plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.

3. The enrollee shall not be required to participate in Blue Shield Promise grievance process for more than thirty (30) days, if disputed decision is upheld or the grievance remains unresolved after thirty (30) days. For expedited review, the enrollee shall not be required to participate for more than three (3) days.

4. In most cases the enrollee will be expected to go through the Plan's grievance system before applying to the DMHC for an IMR. The Department may waive the requirement that the enrollee participate in Blue Shield Promise grievance process if it is determined that extraordinary and compelling circumstances exist, which include, but are not limited to, serious pain, potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the enrollee. Blue Shield Promise allows the enrollee to request an expedited IMR if an imminent danger or serious threat to the health of the enrollee exists. Application for independent medical review shall be submitted on a one-page form entitled Independent Medical Review Application/Complaint Form, provided by the Department, containing a signed release from the enrollee, or a person authorized to act on behalf of the enrollee, authorizing release of medical and treatment information. If expedited review is requested for a decision eligible for IMR, the application shall include a certification from the enrollee's physician indicating that imminent or serious threat to enrollee's physician indicating that imminent or serious threat to enrollee's health exists, or that the proposed therapy would significantly be less effective if not promptly initiated.

5. In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the independent medical review shall determine whether the services were emergency or urgent services necessary to screen and stabilize the enrollee's condition.

6. The member request for an IMR will be processed by the DMHC within six (6) months of a decision to delay, deny or modify a service based on medical necessity. The application will include:
    a. Patient identification information including primary care physician and contact number
    b. Treatment information including diagnosis, treatments requested, provider of service, identified facility and a narrative of services requested
    c. Description or name of the denied medical service or treatment
    d. A separate signed statement of consent from the member to obtain any necessary medical records is not necessary

e. Copy of Blue Shield Promise Health Plan's denial letter

7. The member has the right to provide any information or documentation to support the application either directly or through their provider

8. There is no application either directly or through their provider

9. The DMHC will determine if the member's request qualifies for an IMR; and if the member's condition meets the expedited review criteria, if expedited review is requested.

10. The DMHC is responsible for contacting the IMR organization (IMRO) for screening and to initiate reviewer selection

11. The DMHC will notify Blue Shield Promise via facsimile or by telephone that the case has been referred for determination

12. When requested, Blue Shield Promise Health Plan shall send medical records and all other appropriate documentation to the IMRO within the required (24) hours for expedited reviews and three (3) days for standard reviews

13. The DMHC will also notify the member as well as any representative or physician involved in the application. In the notification letter, the DMHC will identify the IMRO who will be conducting the review and other information relating to the review process.

14. The IMRO determinations will be issued to the member, Blue Shield Promise Health Plan and the DMHC concurrently. The DMHC HMO help counsel will review the IMRO determination and forward a formal adoption letter to the member, Blue Shield Promise, and the member's physician. If the adoption letter requires Blue Shield Promise to reverse its initial determination (the denial is overturned), then Blue Shield Promise must implement the determination and notify the DMHC in writing of their compliance with the determination.

15. The enrollee (Medi-Cal only) can request an independent medical review if he/she has not filed a Fair Hearing Process with the Department of Health Services (DHS)

Submitting Required Documentation:
Blue Shield Promise and Delegated physicians' groups are responsible for submitting the required documentation and information with an IMR request as follows:

1. A copy of the enrollee's medical records in the possession of Blue Shield Promise or its contracting providers relevant to each of the following:
    a. Complete copy of all medical records and other information used by Blue Shield Promise in making decision regarding the disputed health care service
    b. The disputed health care services requested by the enrollee for the condition
    c. Blue Shield Promise response to any additional issues raised in the enrollee's application for independent medical review
    d. Copy of cover page of the evidence of coverage and complete pages with the referenced sections highlighted.

2. Blue Shield Promise shall promptly provide the enrollee with an annotated lit of all documents submitted to the independent medical review organization, together with information on how copies may be requested.

3. Blue Shield Promise shall provide additional information such as, any medical records or other relevant matters not available at the time of initial DMHC notification, or that result from enrollee's on-going medical care or treatment for the medical condition under review. Such shall be forwarded to DMHC as soon as possible, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases. In expedited review, Blue Shield Promise shall immediately notify the enrollee and the enrollee's health care provider by telephone or fax to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of Blue Shield Promise or its contracting providers.

4. IMR requests are submitted by mail, except that emergency IMR requests can be submitted by fax and then followed by a hard copy via mail.

When Member Qualifies for an IMR:

- The HMO Help Center will review IMR applications and send letter within seven (7) days telling that the requester qualified for an IMR. When all information is received, including relevant medical records, the IMR decision will be made within thirty (30) days or within three (3) to seven (7) days if the case is urgent. The member will be notified of the decision made by the doctors who have received the member's case. If the IMR is decided in the member's favor, LA care will give the service, or the treatment requested.

When Member Does Not Qualify for IMR:

- The member's issue will be reviewed through the Department's standard complaint process. The member will receive a written notice of decision within thirty (30) days.

Overturned Decision:

- When the disputed health care service is determined medically necessary, Blue Shield Promise shall promptly implement the decision. In the case of reimbursement for services already rendered, Blue Shield Promise shall reimburse the provider or enrollee, whichever applies, within five (5) working days. In the case of services not yet rendered, Blue Shield Promise shall authorize the services within five (5) working days of receipt of the written decision, or sooner if appropriate for the nature of the enrollee's medical condition and shall inform the enrollee and provider of the authorization.
- Blue Shield Promise health plan shall not engage in any conduct that has the effect of prolonging the independent review process.
- Blue Shield Promise shall reimburse the enrollee for any reasonable costs associated with those services that were covered benefit under the terms and conditions of the health care service contract.

REFERENCES

Health and Safety Code sections 1374.30 to 1374.36

ATTACHMENTS:

IMR Application/Complaint Form