



FACT SHEET

Independent Medical Review in California

July 2009

What is IMR?

Independent medical review (IMR) is an important protection for California's HMO enrollees. If an enrollee is denied medical services or treatment they deem to be medically necessary, they can request an IMR from the HMO Help Center, overseen by the Department of Managed Health Care (DMHC). The DMHC has the power to make the final decision about an enrollee's appeal related to a denied service. The decision is legally binding upon the plan and DMHC.

A **disputed health care service** is any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan due to a finding that the service is not **medically necessary**¹.

A **coverage decision** is based on whether a particular service is included or excluded as a covered benefit under the terms and conditions of the enrollee's contract¹.

What cases are eligible for IMR?

IMR is limited to **disputed health care services** that question **medical necessity**. These denials are eligible for review under IMR when the following conditions are met¹:

1. The enrollee's provider has recommended a health care service as medically necessary; or, he/she has received urgent care or emergency services that a provider determined was medically necessary; or, he/she has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks IMR.
2. The disputed health care services has been denied, delayed or modified based on a decision that the care is not medically necessary.
3. The enrollee filed a grievance with the plan and the disputed decision is upheld or the grievance remains unresolved after 30 days.

If an enrollee has a complaint about a **coverage decision**, they must go through the standard grievance process and are not eligible for IMR².

Who is eligible for IMR?

A plan enrollee must meet one of the following conditions to be eligible for IMR:

1. Had services or treatment denied, delayed, or modified by the plan based on a decision that the care is not medically necessary.
2. Had services or treatment denied for a life-threatening or seriously debilitating condition because it was determined to be "experimental or investigational³."
3. Had received emergency or urgent medical services or treatment, but the health plan denied reimbursement because the service was not medically necessary.

What is the process?

After a patient requests IMR, an independent IMR organization, which the DMHC contracts with, reviews a health plan's treatment denial to make a determination about medical necessity⁴. These organizations retain expert medical professionals to review a patient's medical information. Physician reviewers use medical records, their medical expertise, and scientific and medical evidence, to make a determination about whether the disputed service was medically necessary⁵. Reviewers are expected to limit their examination of the grievance to the medical necessity of the disputed health care services and "shall not include any consideration of coverage decisions or other contractual issues⁶."

The process for IMR of **experimental/ investigational services** is slightly different than other services. Issues addressed are more proscribed and require three reviewers³.

Who pays for IMR?

The IMR system is funded by the state's health plans – there is no charge to enrollees. The results of IMR findings are available online at the DMHC's website: <http://wp.dmhc.ca.gov/imr/>. The IMR process has upheld the decisions made by the health plans over 60 percent of the time⁷.

SOURCES: ¹ California Health and Safety Code § 1374.30(j) | ² California Health and Safety Code § 1368.30(b) | ³ California Health and Safety Code § 1370.4 | ⁴ California Health and Safety Code § 1374.32(a) | ⁵ California Health and Safety Code § 1374.33(b) | ⁶ California Health and Safety Code § 1374.31(c) | ⁷ CAHP analysis on 500 IMR reviews produced through online search review. 302 of 500 upheld the health plan's decision as of 19 March 2009.

Please contact Maral Farsi at mfarsi@calhealthplans.org or 916.558.1545 with any questions about this fact sheet.

California Association of Health Plans • 1415 L Street, Suite 850 • Sacramento, CA 95814 • 916.552.2910 • www.calhealthplans.org
The California Association of Health Plans (CAHP) is a statewide trade association representing 39 full-service health care plans. Through legislative advocacy, education, and collaboration with other member organizations, CAHP works to sustain a strong environment in which our member plans can provide access to products that offer choice and flexibility to the more than 21 million Californians they serve.