

AMENDED IN SENATE MARCH 29, 2012

SENATE BILL

No. 1410

Introduced by Senator Hernandez

February 24, 2012

An act to amend Sections *1374.30*, *1374.32*, and *1374.33* of the Health and Safety Code, and to amend Sections *10169*, *10169.2*, and *10169.3* of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1410, as amended, Hernandez. Independent medical review.

Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires the department and the commissioner to establish an independent medical review system under which a patient may seek an independent medical review whenever health care services have been denied, modified, or delayed by a health care service plan or health insurer and the patient has previously filed a grievance that remains unresolved after 30 days. Existing law requires medical professionals selected by an independent medical review organization to review medical treatment decisions to meet certain minimum requirements, including that the medical professional be a clinician knowledgeable in the treatment of the patient's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

This bill would instead require the medical professional to be a clinician expert in the treatment of the enrollee's medical condition and knowledgeable about the proposed treatment through recent or current actual clinical experience treating patients with the same or similar

condition. *This bill would require the application form provided to an enrollee or insured seeking independent review to include a section designed to collect information on the enrollee's or insured's ethnicity, race, and primary language spoken, which would be provided at the option of the enrollee or insured and used only for statistical purposes.*

Existing law requires the Director of Managed Health Care and the Insurance Commissioner to adopt the determination of an independent medical review organization as a director or commissioner decision. Existing law requires the decisions to be made available, on request, to the public at cost. Existing law requires certain information to be removed from the decision, including the name of the health plan.

This bill would require the decisions to be made available at no charge on the Internet Web site of the Department of Managed Health Care or Department of Insurance, as applicable. The bill would delete the requirement to remove the name of the health plan.

This bill would also require the 2 departments to consult with each other regarding the establishment of a common searchable database for these decisions, and would specify the information that is to be made available in that regard.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. *Section 1374.30 of the Health and Safety Code*
2 *is amended to read:*

3 1374.30. (a) Commencing January 1, 2001, there is hereby
4 established in the department the Independent Medical Review
5 System.

6 (b) For the purposes of this chapter, "disputed health care
7 service" means any health care service eligible for coverage and
8 payment under a health care service plan contract that has been
9 denied, modified, or delayed by a decision of the plan, or by one
10 of its contracting providers, in whole or in part due to a finding
11 that the service is not medically necessary. A decision regarding
12 a disputed health care service relates to the practice of medicine
13 and is not a coverage decision. A disputed health care service does
14 not include services provided by a specialized health care service
15 plan, except to the extent that the service (1) involves the practice
16 of medicine, or (2) is provided pursuant to a contract with a health

1 care service plan that covers hospital, medical, or surgical benefits.
2 If a plan, or one of its contracting providers, issues a decision
3 denying, modifying, or delaying health care services, based in
4 whole or in part on a finding that the proposed health care services
5 are not a covered benefit under the contract that applies to the
6 enrollee, the statement of decision shall clearly specify the
7 provision in the contract that excludes that coverage.

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

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

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

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

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

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

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

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

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

33 (i) No later than January 1, 2001, every health care service plan
34 shall prominently display in every plan member handbook or
35 relevant informational brochure, in every plan contract, on enrollee
36 evidence of coverage forms, on copies of plan procedures for
37 resolving grievances, on letters of denials issued by either the plan
38 or its contracting organization, on the grievance forms required
39 under Section 1368, and on all written responses to grievances,
40 information concerning the right of an enrollee to request an

1 independent medical review in cases where the enrollee believes
2 that health care services have been improperly denied, modified,
3 or delayed by the plan, or by one of its contracting providers.

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

6 (1) (A) The enrollee's provider has recommended a health care
7 service as medically necessary, or

8 (B) The enrollee has received urgent care or emergency services
9 that a provider determined was medically necessary, or

10 (C) The enrollee, in the absence of a provider recommendation
11 under subparagraph (A) or the receipt of urgent care or emergency
12 services by a provider under subparagraph (B), has been seen by
13 an in-plan provider for the diagnosis or treatment of the medical
14 condition for which the enrollee seeks independent review. The
15 plan shall expedite access to an in-plan provider upon request of
16 an enrollee. The in-plan provider need not recommend the disputed
17 health care service as a condition for the enrollee to be eligible for
18 an independent review.

19 For purposes of this article, the enrollee's provider may be an
20 out-of-plan provider. However, the plan shall have no liability for
21 payment of services provided by an out-of-plan provider, except
22 as provided pursuant to subdivision (c) of Section 1374.34.

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

27 (3) The enrollee has filed a grievance with the plan or its
28 contracting provider pursuant to Section 1368, and the disputed
29 decision is upheld or the grievance remains unresolved after 30
30 days. The enrollee shall not be required to participate in the plan's
31 grievance process for more than 30 days. In the case of a grievance
32 that requires expedited review pursuant to Section 1368.01, the
33 enrollee shall not be required to participate in the plan's grievance
34 process for more than three days.

35 (k) An enrollee may apply to the department for an independent
36 medical review of a decision to deny, modify, or delay health care
37 services, based in whole or in part on a finding that the disputed
38 health care services are not medically necessary, within six months
39 of any of the qualifying periods or events under subdivision (j).

1 The director may extend the application deadline beyond six
2 months if the circumstances of a case warrant the extension.

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

5 (m) As part of its notification to the enrollee regarding a
6 disposition of the enrollee’s grievance that denies, modifies, or
7 delays health care services, the plan shall provide the enrollee with
8 a one-page application form approved by the department, and an
9 addressed envelope, which the enrollee may return to initiate an
10 independent medical review. The plan shall include on the form
11 any information required by the department to facilitate the
12 completion of the independent medical review, such as the
13 enrollee’s diagnosis or condition, the nature of the disputed health
14 care service sought by the enrollee, a means to identify the
15 enrollee’s case, and any other material information. The form shall
16 also include the following:

17 (1) Notice that a decision not to participate in the independent
18 medical review process may cause the enrollee to forfeit any
19 statutory right to pursue legal action against the plan regarding the
20 disputed health care service.

21 (2) A statement indicating the enrollee’s consent to obtain any
22 necessary medical records from the plan, any of its contracting
23 providers, and any out-of-plan provider the enrollee may have
24 consulted on the matter, to be signed by the enrollee.

25 (3) Notice of the enrollee’s right to provide information or
26 documentation, either directly or through the enrollee’s provider,
27 regarding any of the following:

28 (A) A provider recommendation indicating that the disputed
29 health care service is medically necessary for the enrollee’s medical
30 condition.

31 (B) Medical information or justification that a disputed health
32 care service, on an urgent care or emergency basis, was medically
33 necessary for the enrollee’s medical condition.

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

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

3 *(4) A section designed to collect information on the enrollee's*
4 *ethnicity, race, and primary language spoken that includes both*
5 *of the following:*

6 *(A) A statement of intent indicating that the information is used*
7 *for statistics only, in order to ensure that all enrollees get the best*
8 *care possible.*

9 *(B) A statement indicating that providing this information is*
10 *optional and will not affect the independent medical review process*
11 *in any way.*

12 (n) Upon notice from the department that the health care service
13 plan's enrollee has applied for an independent medical review, the
14 plan or its contracting providers shall provide to the independent
15 medical review organization designated by the department a copy
16 of all of the following documents within three business days of
17 the plan's receipt of the department's notice of a request by an
18 enrollee for an independent review:

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

22 (i) The enrollee's medical condition.

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

25 (iii) The disputed health care services requested by the enrollee
26 for the condition.

27 (B) Any newly developed or discovered relevant medical records
28 in the possession of the plan or its contracting providers after the
29 initial documents are provided to the independent medical review
30 organization shall be forwarded immediately to the independent
31 medical review organization. The plan shall concurrently provide
32 a copy of medical records required by this subparagraph to the
33 enrollee or the enrollee's provider, if authorized by the enrollee,
34 unless the offer of medical records is declined or otherwise
35 prohibited by law. The confidentiality of all medical record
36 information shall be maintained pursuant to applicable state and
37 federal laws.

38 (2) A copy of all information provided to the enrollee by the
39 plan and any of its contracting providers concerning plan and
40 provider decisions regarding the enrollee's condition and care, and

1 a copy of any materials the enrollee or the enrollee's provider
2 submitted to the plan and to the plan's contracting providers in
3 support of the enrollee's request for disputed health care services.
4 This documentation shall include the written response to the
5 enrollee's grievance, required by paragraph (4) of subdivision (a)
6 of Section 1368. The confidentiality of any enrollee medical
7 information shall be maintained pursuant to applicable state and
8 federal laws.

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

21 ~~SECTION 4.~~

22 *SEC. 2.* Section 1374.32 of the Health and Safety Code is
23 amended to read:

24 1374.32. (a) The department shall contract with one or more
25 independent medical review organizations in the state to conduct
26 reviews for purposes of this article. The independent medical
27 review organizations shall be independent of any health care service
28 plan doing business in this state. The director may establish
29 additional requirements, including conflict-of-interest standards,
30 consistent with the purposes of this article, that an organization
31 shall be required to meet in order to qualify for participation in the
32 Independent Medical Review System and to assist the department
33 in carrying out its responsibilities.

34 (b) The independent medical review organizations and the
35 medical professionals retained to conduct reviews shall be deemed
36 to be medical consultants for purposes of Section 43.98 of the Civil
37 Code.

38 (c) The independent medical review organization, any experts
39 it designates to conduct a review, or any officer, director, or
40 employee of the independent medical review organization shall

1 not have any material professional, familial, or financial affiliation,
2 as determined by the director, with any of the following:

- 3 (1) The plan.
- 4 (2) Any officer, director, or employee of the plan.
- 5 (3) A physician, the physician's medical group, or the
6 independent practice association involved in the health care service
7 in dispute.
- 8 (4) The facility or institution at which either the proposed health
9 care service, or the alternative service, if any, recommended by
10 the plan, would be provided.
- 11 (5) The development or manufacture of the principal drug,
12 device, procedure, or other therapy proposed by the enrollee whose
13 treatment is under review, or the alternative therapy, if any,
14 recommended by the plan.

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

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

19 (1) The organization shall not be an affiliate or a subsidiary of,
20 nor in any way be owned or controlled by, a health plan or a trade
21 association of health plans. A board member, director, officer, or
22 employee of the independent medical review organization shall
23 not serve as a board member, director, or employee of a health
24 care service plan. A board member, director, or officer of a health
25 plan or a trade association of health plans shall not serve as a board
26 member, director, officer, or employee of an independent medical
27 review organization.

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

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

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

36 (C) The names of all corporations and organizations that the
37 independent medical review organization controls or is affiliated
38 with, and the nature and extent of any ownership or control,
39 including the affiliated organization's type of business.

1 (D) The names and biographical sketches of all directors,
2 officers, and executives of the independent medical review
3 organization, as well as a statement regarding any past or present
4 relationships the directors, officers, and executives may have with
5 any health care service plan, disability insurer, managed care
6 organization, provider group, or board or committee of a plan,
7 managed care organization, or provider group.

8 (E) (i) The percentage of revenue the independent medical
9 review organization receives from expert reviews, including, but
10 not limited to, external medical reviews, quality assurance reviews,
11 and utilization reviews.

12 (ii) The names of any health care service plan or provider group
13 for which the independent medical review organization provides
14 review services, including, but not limited to, utilization review,
15 quality assurance review, and external medical review. Any change
16 in this information shall be reported to the department within five
17 business days of the change.

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

21 (G) A description of the system the independent medical review
22 organization uses to identify and recruit medical professionals to
23 review treatment and treatment recommendation decisions, the
24 number of medical professionals credentialed, and the types of
25 cases and areas of expertise that the medical professionals are
26 credentialed to review.

27 (H) A description of how the independent medical review
28 organization ensures compliance with the conflict-of-interest
29 provisions of this section.

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

32 (A) Ensures that the medical professionals retained are
33 appropriately credentialed and privileged.

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

37 (C) Ensures that the method of selecting medical professionals
38 for individual cases achieves a fair and impartial panel of medical
39 professionals who are qualified to render recommendations

1 regarding the clinical conditions and the medical necessity of
2 treatments or therapies in question.

3 (D) Ensures the confidentiality of medical records and the
4 review materials, consistent with the requirements of this section
5 and applicable state and federal law.

6 (E) Ensures the independence of the medical professionals
7 retained to perform the reviews through conflict-of-interest policies
8 and prohibitions, and ensures adequate screening for conflicts of
9 interest, pursuant to paragraph (5).

10 (4) Medical professionals selected by independent medical
11 review organizations to review medical treatment decisions shall
12 be physicians or other appropriate providers who meet the
13 following minimum requirements:

14 (A) The medical professional shall be a clinician expert in the
15 treatment of the enrollee's medical condition and knowledgeable
16 about the proposed treatment through recent or current actual
17 clinical experience treating patients with the same or a similar
18 medical condition as the enrollee.

19 (B) Notwithstanding any other provision of law, the medical
20 professional shall hold a nonrestricted license in any state of the
21 United States, and for physicians, a current certification by a
22 recognized American medical specialty board in the area or areas
23 appropriate to the condition or treatment under review. The
24 independent medical review organization shall give preference to
25 the use of a physician licensed in California as the reviewer, except
26 when training and experience with the issue under review
27 reasonably requires the use of an out-of-state reviewer.

28 (C) The medical professional shall have no history of
29 disciplinary action or sanctions, including, but not limited to, loss
30 of staff privileges or participation restrictions, taken or pending
31 by any hospital, government, or regulatory body.

32 (5) Neither the expert reviewer, nor the independent medical
33 review organization, shall have any material professional, material
34 familial, or material financial affiliation with any of the following:

35 (A) The plan or a provider group of the plan, except that an
36 academic medical center under contract to the plan to provide
37 services to enrollees may qualify as an independent medical review
38 organization provided it will not provide the service and provided
39 the center is not the developer or manufacturer of the proposed
40 treatment.

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

2 (C) The physician, the physician’s medical group, or the
3 independent practice association (IPA) proposing the treatment.

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

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

7 (F) The enrollee or the enrollee’s immediate family.

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

10 (A) “Material familial affiliation” means any relationship as a
11 spouse, child, parent, sibling, spouse’s parent, or child’s spouse.

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

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

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

37 ~~SEC. 2.~~

38 *SEC. 3.* Section 1374.33 of the Health and Safety Code is
39 amended to read:

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

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

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

18 (2) Nationally recognized professional standards.

19 (3) Expert opinion.

20 (4) Generally accepted standards of medical practice.

21 (5) Treatments that are likely to provide a benefit to a patient
22 for conditions for which other treatments are not clinically
23 efficacious.

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

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

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

24 (f) The director shall immediately adopt the determination of
25 the independent medical review organization, and shall promptly
26 issue a written decision to the parties that shall be binding on the
27 plan.

28 (g) After removing the name of the enrollee, the names of all
29 medical providers, the names of the health care service plan's
30 employees or contractors, and the name of any other party, other
31 than the plan, director decisions adopting a determination of an
32 independent medical review organization shall be made available
33 by the department to the public on the department's Internet Web
34 site, after considering applicable laws governing disclosure of
35 public records, confidentiality, and personal privacy. Pursuant to
36 this requirement, the department shall consult with and coordinate
37 with the Department of Insurance in the planning and
38 implementation of a common, searchable database that contains
39 information about each director and Insurance Commissioner
40 decision pursuant to subdivision (h).

- 1 (h) (1) Information regarding each director and commissioner
2 decision provided by the database referenced in subdivision (g)
3 shall include all of the following:
- 4 (A) Enrollee or insured demographic profile information,
5 including age; ~~and gender, and ethnicity.~~
 - 6 (B) *The enrollee or insured diagnosis and disputed health care*
7 *service.*
 - 8 (C) *The name of the health care service plan or health insurer.*
 - 9 ~~(B)~~
 - 10 (D) The department that contracted the independent medical
11 review organization that made the determination.
 - 12 (E) *Whether the independent medical review was for medically*
13 *necessary services pursuant to this article or for experimental or*
14 *investigational therapies pursuant to Section 1370.4.*
 - 15 (F) *Whether the independent medical review was standard or*
16 *expedited.*
 - 17 ~~(E)~~
 - 18 (G) ~~Length of time to complete the independent medical review~~
19 *from the receipt by the independent review organization of the*
20 *application for review and supporting documentation to the*
21 *rendering of a determination by the independent review*
22 *organization in writing.*
 - 23 (H) *Length of time from receipt by the department of the*
24 *independent medical review application to the issuance of the*
25 *director's or commissioner's determination in writing to the parties*
26 *that is binding on the health care service plan or health insurer.*
 - 27 ~~(D)~~
 - 28 (I) Credentials and qualifications of the reviewer *or reviewers.*
 - 29 ~~(E)~~
 - 30 (J) The nature of the statutory criteria set forth in subdivision
31 (b) that the reviewer *or reviewers* used to make the case decision.
 - 32 (K) *The final result of the determination.*
 - 33 (L) *The year the determination was made.*
 - 34 ~~(F)~~
 - 35 (M) A detailed case summary that includes the specific
36 standards, criteria, and medical and scientific evidence, if any, that
37 led to the case decision.
- 38 (2) The database referenced in subdivision (g) shall ~~also include~~
39 ~~both~~ *be accompanied by all of the following:*

1 (A) The annual rate of independent medical review among the
2 total *enrolled and* insured population.

3 (B) *The annual rate of independent medical review cases by*
4 *health care service plan or health insurer.*

5 ~~(B)~~

6 (C) The number, type, and resolution of independent medical
7 review cases by *health care service plan or health insurer.*

8 (D) *The number, type, and resolution of independent medical*
9 *review cases by ethnicity, race, and primary language spoken.*

10 SEC. 4. *Section 10169 of the Insurance Code is amended to*
11 *read:*

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

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

33 (c) For the purposes of this chapter, “coverage decision” means
34 the approval or denial of health care services by a disability insurer,
35 or by one of its contracting entities, substantially based on a finding
36 that the provision of a particular service is included or excluded
37 as a covered benefit under the terms and conditions of the disability
38 insurance contract. A coverage decision does not encompass a
39 disability insurer or contracting provider decision regarding a
40 disputed health care service.

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

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

17 (3) The department shall be the final arbiter when there is a
18 question as to whether an insured grievance is a disputed health
19 care service or a coverage decision. The department shall establish
20 a process to complete an initial screening of an insured grievance.
21 If there appears to be any medical necessity issue, the grievance
22 shall be resolved pursuant to an independent medical review as
23 provided under this article.

24 (e) Every disability insurance contract that is issued, amended,
25 renewed, or delivered in this state on or after January 1, 2000,
26 shall, effective, January 1, 2001, provide an insured with the
27 opportunity to seek an independent medical review whenever
28 health care services have been denied, modified, or delayed by the
29 insurer, or by one of its contracting providers, if the decision was
30 based in whole or in part on a finding that the proposed health care
31 services are not medically necessary. For purposes of this article,
32 an insured may designate an agent to act on his or her behalf. The
33 provider may join with or otherwise assist the insured in seeking
34 an independent medical review, and may advocate on behalf of
35 the insured.

36 (f) Medicare beneficiaries enrolled in Medicare + Choice
37 products shall not be excluded unless expressly preempted by
38 federal law.

39 (g) The department may seek to integrate the quality of care
40 and consumer protection provisions, including remedies, of the

1 Independent Medical Review System with related dispute
2 resolution procedures of other health care agency programs,
3 including the Medicare program, in a way that minimizes the
4 potential for duplication, conflict, and added costs. Nothing in this
5 subdivision shall be construed to limit any rights conferred upon
6 insureds under this chapter.

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

10 (i) No later than January 1, 2001, every disability insurer shall
11 prominently display in every insurer member handbook or relevant
12 informational brochure, in every insurance contract, on insured
13 evidence of coverage forms, on copies of insurer procedures for
14 resolving grievances, on letters of denials issued by either the
15 insurer or its contracting organization, and on all written responses
16 to grievances, information concerning the right of an insured to
17 request an independent medical review in cases where the insured
18 believes that health care services have been improperly denied,
19 modified, or delayed by the insurer, or by one of its contracting
20 providers.

21 (j) An insured may apply to the department for an independent
22 medical review when all of the following conditions are met:

23 (1) (A) The insured's provider has recommended a health care
24 service as medically necessary, or

25 (B) The insured has received urgent care or emergency services
26 that a provider determined was medically necessary, or

27 (C) The insured, in the absence of a provider recommendation
28 under subparagraph (A) or the receipt of urgent care or emergency
29 services by a provider under subparagraph (B), has been seen by
30 a contracting provider for the diagnosis or treatment of the medical
31 condition for which the insured seeks independent review. The
32 insurer shall expedite access to a contracting provider upon request
33 of an insured. The contracting provider need not recommend the
34 disputed health care service as a condition for the insured to be
35 eligible for an independent review.

36 For purposes of this article, the insured's provider may be a
37 noncontracting provider. However, the insurer shall have no
38 liability for payment of services provided by a noncontracting
39 provider, except as provided pursuant to Section 10169.3.

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

5 (3) The insured has filed a grievance with the insurer or its
6 contracting provider, and the disputed decision is upheld or the
7 grievance remains unresolved after 30 days. The insured shall not
8 be required to participate in the insurer's grievance process for
9 more than 30 days. In the case of a grievance that requires
10 expedited review, the insured shall not be required to participate
11 in the insurer's grievance process for more than three days.

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

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

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

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

37 (2) A statement indicating the insured's consent to obtain any
38 necessary medical records from the insurer, any of its contracting
39 providers, and any noncontracting provider the insured may have
40 consulted on the matter, to be signed by the insured.

1 (3) Notice of the insured’s right to provide information or
2 documentation, either directly or through the insured’s provider,
3 regarding any of the following:

4 (A) A provider recommendation indicating that the disputed
5 health care service is medically necessary for the insured’s medical
6 condition.

7 (B) Medical information or justification that a disputed health
8 care service, on an urgent care or emergency basis, was medically
9 necessary for the insured’s medical condition.

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

20 (4) *A section designed to collect information on the insured’s*
21 *ethnicity, race, and primary language spoken that includes both*
22 *of the following:*

23 (A) *A statement of intent indicating that the information is used*
24 *for statistics only, in order to ensure that all insureds get the best*
25 *care possible.*

26 (B) *A statement indicating that providing this information is*
27 *optional and will not affect the independent medical review process*
28 *in any way.*

29 (n) Upon notice from the department that the insured has applied
30 for an independent medical review, the insurer or its contracting
31 providers, shall provide to the independent medical review
32 organization designated by the department a copy of all of the
33 following documents within three business days of the insurer’s
34 receipt of the department’s notice of a request by an insured for
35 an independent review:

36 (1) (A) A copy of all of the insured’s medical records in the
37 possession of the insurer or its contracting providers relevant to
38 each of the following:

39 (i) The insured’s medical condition.

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

3 (iii) The disputed health care services requested by the insured
4 for the condition.

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

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

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

38 ~~SEC. 3.~~

39 *SEC. 5.* Section 10169.2 of the Insurance Code is amended to
40 read:

1 10169.2. (a) The department shall contract with one or more
2 independent medical review organizations in the state to conduct
3 reviews for purposes of this article. The independent medical
4 review organizations shall be independent of any disability insurer
5 doing business in this state. The commissioner may establish
6 additional requirements, including conflict-of-interest standards,
7 consistent with the purposes of this article, that an organization
8 shall be required to meet in order to qualify for participation in the
9 Independent Medical Review System and to assist the department
10 in carrying out its responsibilities.

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

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

20 (1) The insurer.

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

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

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

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

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

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

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

1 insurer. A board member, director, or officer of a disability insurer
2 or a trade association of insurers shall not serve as a board member,
3 director, officer, or employee of an independent medical review
4 organization.

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

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

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

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

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

24 (E) (i) The percentage of revenue the independent medical
25 review organization receives from expert reviews, including, but
26 not limited to, external medical reviews, quality assurance reviews,
27 and utilization reviews.

28 (ii) The names of any insurer or provider group for which the
29 independent medical review organization provides review services,
30 including, but not limited to, utilization review, quality assurance
31 review, and external medical review. Any change in this
32 information shall be reported to the department within five business
33 days of the change.

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

37 (G) A description of the system the independent medical review
38 organization uses to identify and recruit medical professionals to
39 review treatment and treatment recommendation decisions, the
40 number of medical professionals credentialed, and the types of

1 cases and areas of expertise that the medical professionals are
2 credentialed to review.

3 (H) A description of how the independent medical review
4 organization ensures compliance with the conflict-of-interest
5 provisions of this section.

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

8 (A) Ensures that the medical professionals retained are
9 appropriately credentialed and privileged.

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

13 (C) Ensures that the method of selecting medical professionals
14 for individual cases achieves a fair and impartial panel of medical
15 professionals who are qualified to render recommendations
16 regarding the clinical conditions and the medical necessity of
17 treatments or therapies in question.

18 (D) Ensures the confidentiality of medical records and the
19 review materials, consistent with the requirements of this section
20 and applicable state and federal law.

21 (E) Ensures the independence of the medical professionals
22 retained to perform the reviews through conflict-of-interest policies
23 and prohibitions, and ensures adequate screening for conflicts of
24 interest, pursuant to paragraph (5).

25 (4) Medical professionals selected by independent medical
26 review organizations to review medical treatment decisions shall
27 be physicians or other appropriate providers who meet the
28 following minimum requirements:

29 (A) The medical professional shall be a clinician expert in the
30 treatment of the insured's medical condition and knowledgeable
31 about the proposed treatment through recent or current actual
32 clinical experience treating patients with the same or a similar
33 medical condition as the insured.

34 (B) Notwithstanding any other provision of law, the medical
35 professional shall hold a nonrestricted license in ~~the~~ any state of
36 the United States, and for physicians, a current certification by a
37 recognized American medical specialty board in the area or areas
38 appropriate to the condition or treatment under review. The
39 independent medical review organization shall give preference to
40 the use of a physician licensed in California as the reviewer, except

1 when training and experience with the issue under review
2 reasonably requires the use of an out-of-state reviewer.

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

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

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

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

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

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

21 (E) The development or manufacture of the treatment proposed
22 for the insured whose condition is under review.

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

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

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

28 (B) "Material professional affiliation" means any
29 physician-patient relationship, any partnership or employment
30 relationship, a shareholder or similar ownership interest in a
31 professional corporation, or any independent contractor
32 arrangement that constitutes a material financial affiliation with
33 any expert or any officer or director of the independent medical
34 review organization. "Material professional affiliation" does not
35 include affiliations that are limited to staff privileges at a health
36 facility.

37 (C) "Material financial affiliation" means any financial interest
38 of more than 5 percent of total annual revenue or total annual
39 income of an independent medical review organization or
40 individual to which this subdivision applies. "Material financial

1 affiliation” does not include payment by the insurer to the
2 independent medical review organization for the services required
3 by this section, nor does “material financial affiliation” include an
4 expert’s participation as a contracting provider where the expert
5 is affiliated with an academic medical center or a National Cancer
6 Institute-designated clinical cancer research center.

7 (e) The department shall provide, upon the request of any
8 interested person, a copy of all nonproprietary information, as
9 determined by the commissioner, filed with it by an independent
10 medical review organization seeking to contract under this article.
11 The department may charge a nominal fee to the interested person
12 for photocopying the requested information.

13 (f) The commissioner may contract with the Department of
14 Managed Health Care to administer the independent medical review
15 process established by this article.

16 ~~SEC. 4.~~

17 *SEC. 6.* Section 10169.3 of the Insurance Code is amended to
18 read:

19 10169.3. (a) Upon receipt of information and documents
20 related to a case, the medical professional reviewer or reviewers
21 selected to conduct the review by the independent medical review
22 organization shall promptly review all pertinent medical records
23 of the insured, provider reports, as well as any other information
24 submitted to the organization as authorized by the department or
25 requested from any of the parties to the dispute by the reviewers.
26 If reviewers request information from any of the parties, a copy
27 of the request and the response shall be provided to all of the
28 parties. The reviewer or reviewers shall also review relevant
29 information related to the criteria set forth in subdivision (b).

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

34 ~~(A)~~

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

37 ~~(B)~~

38 (2) Nationally recognized professional standards.

39 ~~(C)~~

40 (3) Expert opinion.

1 ~~(D)~~

2 (4) Generally accepted standards of medical practice.

3 ~~(E)~~

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

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

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

33 (e) The independent medical review organization shall provide
34 the director, the insurer, the insured, and the insured's provider
35 with the analyses and determinations of the medical professionals
36 reviewing the case, and a description of the qualifications of the
37 medical professionals. The independent medical review
38 organization shall keep the names of the reviewers confidential in
39 all communications with entities or individuals outside the
40 independent medical review organization, except in cases where

1 the reviewer is called to testify and in response to court orders. If
 2 more than one medical professional reviewed the case and the
 3 result was differing determinations, the independent medical review
 4 organization shall provide each of the separate reviewer’s analyses
 5 and determinations.

6 (f) The commissioner shall immediately adopt the determination
 7 of the independent medical review organization, and shall promptly
 8 issue a written decision to the parties that shall be binding on the
 9 insurer.

10 (g) After removing the name of the insured, the names of all
 11 medical providers, the names of the insurer’s employees or
 12 contractors, and the name of any other party, other than the ~~health~~
 13 ~~plan insurer~~, commissioner decisions adopting a determination of
 14 an independent medical review organization shall be made
 15 available by the department on the department’s Internet Web site,
 16 after considering applicable laws governing disclosure of public
 17 records, confidentiality, and personal privacy. Pursuant to this
 18 requirement, the department shall consult with and coordinate with
 19 the Department of Managed Health Care in the planning and
 20 implementation of a common, searchable database that contains
 21 information about each commissioner and Director of Managed
 22 Health Care decision pursuant to subdivision (h).

23 (h) (1) Information regarding each commissioner and director
 24 decision provided by the database referenced in subdivision (g)
 25 shall include all of the following:

26 (A) Insured or enrollee demographic profile information,
 27 including age; *and* gender; ~~and ethnicity.~~

28 (B) *The enrollee or insured diagnosis and disputed health care*
 29 *service.*

30 (C) *The name of the health care service plan or health insurer.*

31 ~~(B)~~

32 (D) *The department that contracted the independent medical*
 33 *review organization that made the determination.*

34 (E) *Whether the independent medical review was for medically*
 35 *necessary services pursuant to this article or for experimental or*
 36 *investigational therapies pursuant to Section 10145.3.*

37 (F) *Whether the independent medical review was standard or*
 38 *expedited.*

39 ~~(E)~~

- 1 (G) Length of time to complete the independent medical review
2 from the receipt by the independent review organization of the
3 application for review and supporting documentation to the
4 rendering of a determination by the independent review
5 organization in writing.
- 6 (H) Length of time from receipt by the department of the
7 independent medical review application to the issuance of the
8 director's or commissioner's determination in writing to the parties
9 that is binding on the health care service plan or health insurer.
- 10 ~~(I)~~
- 11 (I) Credentials and qualifications of the reviewer or reviewers.
12 ~~(E)~~
- 13 (J) The nature of the statutory criteria set forth in subdivision
14 (b) that the reviewer or reviewers used to make the case decision.
- 15 (K) The final result of the determination.
- 16 (L) The year the determination was made.
- 17 ~~(F)~~
- 18 (M) A detailed case summary that includes the specific
19 standards, criteria, and medical and scientific evidence, if any, that
20 led to the case decision.
- 21 (2) The database referenced in subdivision (g) shall also include
22 both be accompanied by all of the following:
- 23 (A) The annual rate of independent medical review among the
24 total enrolled and insured population.
- 25 (B) The annual rate of independent medical review cases by
26 health care service plan or health insurer.
- 27 ~~(B)~~
- 28 (C) The number, type, and resolution of independent medical
29 review cases by health care service plan or health insurer.
- 30 (D) The number, type, and resolution of independent medical
31 review cases by ethnicity, race, and primary language spoken.

O