

AMENDED IN ASSEMBLY AUGUST 20, 2012

AMENDED IN SENATE MAY 25, 2012

AMENDED IN SENATE APRIL 26, 2012

AMENDED IN SENATE MARCH 29, 2012

SENATE BILL

No. 1410

Introduced by Senator Hernandez

February 24, 2012

An act to amend, repeal, and add Sections 1374.30, 1374.32, and 1374.33 of the Health and Safety Code, and to amend, repeal, and add 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. *Existing law requires a plan or insurer to provide a one-page application form to an enrollee or insured to be used to initiate a review pursuant to these provisions.*

This bill would make certain changes to requirements applicable to an independent medical review organization, effective on ~~the later of January 1, 2013, or the termination date of a specified contract between the department or commissioner and an independent medical review organization to provide independent medical review services July 1, 2015.~~ The bill would 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~~ *The* bill would require the application form provided to an enrollee or insured seeking independent review *to be one or 2 pages and* 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 in a searchable database on the Internet Web site of the Department of Managed Health Care or *the* Department of Insurance, as applicable, *and would require the databases to include other specified information.* ~~The bill would delete the requirement to remove the name of the health plan.~~

These requirements would also become effective on ~~the later of January 1, 2013, or the termination date of a specified contract between the department or commissioner and an independent medical review organization to provide independent medical review services July 1, 2015.~~

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
17 care service plan that covers hospital, medical, or surgical benefits.
18 If a plan, or one of its contracting providers, issues a decision
19 denying, modifying, or delaying health care services, based in
20 whole or in part on a finding that the proposed health care services
21 are not a covered benefit under the contract that applies to the
22 enrollee, the statement of decision shall clearly specify the
23 provision in the contract that excludes that coverage.

24 (c) For the purposes of this chapter, “coverage decision” means
25 the approval or denial of health care services by a plan, or by one
26 of its contracting entities, substantially based on a finding that the
27 provision of a particular service is included or excluded as a
28 covered benefit under the terms and conditions of the health care
29 service plan contract. A “coverage decision” does not encompass
30 a plan or contracting provider decision regarding a disputed health
31 care service.

32 (d) (1) All enrollee grievances involving a disputed health care
33 service are eligible for review under the Independent Medical
34 Review System if the requirements of this article are met. If the
35 department finds that an enrollee grievance involving a disputed
36 health care service does not meet the requirements of this article
37 for review under the Independent Medical Review System, the
38 enrollee request for review shall be treated as a request for the

1 department to review the grievance pursuant to subdivision (b) of
2 Section 1368. All other enrollee grievances, including grievances
3 involving coverage decisions, remain eligible for review by the
4 department pursuant to subdivision (b) of Section 1368.

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

12 (3) The department shall be the final arbiter when there is a
13 question as to whether an enrollee grievance is a disputed health
14 care service or a coverage decision. The department shall establish
15 a process to complete an initial screening of an enrollee grievance.
16 If there appears to be any medical necessity issue, the grievance
17 shall be resolved pursuant to an independent medical review as
18 provided under this article or pursuant to subdivision (b) of Section
19 1368.

20 (e) Every health care service plan contract that is issued,
21 amended, renewed, or delivered in this state on or after January
22 1, 2000, shall, effective January 1, 2001, provide an enrollee with
23 the opportunity to seek an independent medical review whenever
24 health care services have been denied, modified, or delayed by the
25 plan, or by one of its contracting providers, if the decision was
26 based in whole or in part on a finding that the proposed health care
27 services are not medically necessary. For purposes of this article,
28 an enrollee may designate an agent to act on his or her behalf, as
29 described in paragraph (2) of subdivision (b) of Section 1368. The
30 provider may join with or otherwise assist the enrollee in seeking
31 an independent medical review, and may advocate on behalf of
32 the enrollee.

33 (f) Medi-Cal beneficiaries enrolled in a health care service plan
34 shall not be excluded from participation. Medicare beneficiaries
35 enrolled in a health care service plan shall not be excluded unless
36 expressly preempted by federal law. Reviews of cases for Medi-Cal
37 enrollees shall be conducted in accordance with statutes and
38 regulations for the Medi-Cal program.

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 and Medi-Cal programs, in a way that
4 minimizes the potential for duplication, conflict, and added costs.
5 Nothing in this subdivision shall be construed to limit any rights
6 conferred upon enrollees 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 health care service plan
11 shall prominently display in every plan member handbook or
12 relevant informational brochure, in every plan contract, on enrollee
13 evidence of coverage forms, on copies of plan procedures for
14 resolving grievances, on letters of denials issued by either the plan
15 or its contracting organization, on the grievance forms required
16 under Section 1368, and on all written responses to grievances,
17 information concerning the right of an enrollee to request an
18 independent medical review in cases where the enrollee believes
19 that health care services have been improperly denied, modified,
20 or delayed by the plan, or by one of its contracting providers.

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

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

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

27 (C) The enrollee, 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 an in-plan provider for the diagnosis or treatment of the medical
31 condition for which the enrollee seeks independent review. The
32 plan shall expedite access to an in-plan provider upon request of
33 an enrollee. The in-plan provider need not recommend the disputed
34 health care service as a condition for the enrollee to be eligible for
35 an independent review.

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

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

5 (3) The enrollee has filed a grievance with the plan or its
6 contracting provider pursuant to Section 1368, and the disputed
7 decision is upheld or the grievance remains unresolved after 30
8 days. The enrollee shall not be required to participate in the plan's
9 grievance process for more than 30 days. In the case of a grievance
10 that requires expedited review pursuant to Section 1368.01, the
11 enrollee shall not be required to participate in the plan's grievance
12 process for more than three days.

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

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

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

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

38 (2) A statement indicating the enrollee's consent to obtain any
39 necessary medical records from the plan, any of its contracting

1 providers, and any out-of-plan provider the enrollee may have
2 consulted on the matter, to be signed by the enrollee.

3 (3) Notice of the enrollee's right to provide information or
4 documentation, either directly or through the enrollee's provider,
5 regarding any of the following:

6 (A) A provider recommendation indicating that the disputed
7 health care service is medically necessary for the enrollee's medical
8 condition.

9 (B) Medical information or justification that a disputed health
10 care service, on an urgent care or emergency basis, was medically
11 necessary for the enrollee's medical condition.

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

21 (n) Upon notice from the department that the health care service
22 plan's enrollee has applied for an independent medical review, the
23 plan or its contracting providers shall provide to the independent
24 medical review organization designated by the department a copy
25 of all of the following documents within three business days of
26 the plan's receipt of the department's notice of a request by an
27 enrollee for an independent review:

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

31 (i) The enrollee's medical condition.

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

34 (iii) The disputed health care services requested by the enrollee
35 for the condition.

36 (B) Any newly developed or discovered relevant medical records
37 in the possession of the plan or its contracting providers after the
38 initial documents are provided to the independent medical review
39 organization shall be forwarded immediately to the independent
40 medical review organization. The plan shall concurrently provide

1 a copy of medical records required by this subparagraph to the
2 enrollee or the enrollee's provider, if authorized by the enrollee,
3 unless the offer of medical records is declined or otherwise
4 prohibited by law. The confidentiality of all medical record
5 information shall be maintained pursuant to applicable state and
6 federal laws.

7 (2) A copy of all information provided to the enrollee by the
8 plan and any of its contracting providers concerning plan and
9 provider decisions regarding the enrollee's condition and care, and
10 a copy of any materials the enrollee or the enrollee's provider
11 submitted to the plan and to the plan's contracting providers in
12 support of the enrollee's request for disputed health care services.
13 This documentation shall include the written response to the
14 enrollee's grievance, required by paragraph (4) of subdivision (a)
15 of Section 1368. The confidentiality of any enrollee medical
16 information shall be maintained pursuant to applicable state and
17 federal laws.

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

30 ~~(o) This section shall become inoperative on the later of (1)~~
31 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
32 ~~on January 1, 2013, between the department and an independent~~
33 ~~medical review organization to provide independent medical review~~
34 ~~services, and this section shall be repealed on January 1 of the year~~
35 ~~after it becomes inoperative. This section shall become inoperative~~
36 ~~on July 1, 2015, and, as of January 1, 2016, is repealed, unless a~~
37 ~~later enacted statute, that becomes operative on or before January~~
38 ~~1, 2016, deletes or extends the dates on which it becomes~~
39 ~~inoperative and is repealed.~~

1 SEC. 2. Section 1374.30 is added to the Health and Safety
2 Code, 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
17 care service plan that covers hospital, medical, or surgical benefits.
18 If a plan, or one of its contracting providers, issues a decision
19 denying, modifying, or delaying health care services, based in
20 whole or in part on a finding that the proposed health care services
21 are not a covered benefit under the contract that applies to the
22 enrollee, the statement of decision shall clearly specify the
23 provision in the contract that excludes that coverage.

24 (c) For the purposes of this chapter, “coverage decision” means
25 the approval or denial of health care services by a plan, or by one
26 of its contracting entities, substantially based on a finding that the
27 provision of a particular service is included or excluded as a
28 covered benefit under the terms and conditions of the health care
29 service plan contract. A “coverage decision” does not encompass
30 a plan or contracting provider decision regarding a disputed health
31 care service.

32 (d) (1) All enrollee grievances involving a disputed health care
33 service are eligible for review under the Independent Medical
34 Review System if the requirements of this article are met. If the
35 department finds that an enrollee grievance involving a disputed
36 health care service does not meet the requirements of this article
37 for review under the Independent Medical Review System, the
38 enrollee request for review shall be treated as a request for the
39 department to review the grievance pursuant to subdivision (b) of
40 Section 1368. All other enrollee grievances, including grievances

1 involving coverage decisions, remain eligible for review by the
2 department pursuant to subdivision (b) of Section 1368.

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

10 (3) The department shall be the final arbiter when there is a
11 question as to whether an enrollee grievance is a disputed health
12 care service or a coverage decision. The department shall establish
13 a process to complete an initial screening of an enrollee grievance.
14 If there appears to be any medical necessity issue, the grievance
15 shall be resolved pursuant to an independent medical review as
16 provided under this article or pursuant to subdivision (b) of Section
17 1368.

18 (e) Every health care service plan contract that is issued,
19 amended, renewed, or delivered in this state on or after January
20 1, 2000, shall provide an enrollee with the opportunity to seek an
21 independent medical review whenever health care services have
22 been denied, modified, or delayed by the plan, or by one of its
23 contracting providers, if the decision was based in whole or in part
24 on a finding that the proposed health care services are not medically
25 necessary. For purposes of this article, an enrollee may designate
26 an agent to act on his or her behalf, as described in paragraph (2)
27 of subdivision (b) of Section 1368. The provider may join with or
28 otherwise assist the enrollee in seeking an independent medical
29 review, and may advocate on behalf of the enrollee.

30 (f) Medi-Cal beneficiaries enrolled in a health care service plan
31 shall not be excluded from participation. Medicare beneficiaries
32 enrolled in a health care service plan shall not be excluded unless
33 expressly preempted by federal law. Reviews of cases for Medi-Cal
34 enrollees shall be conducted in accordance with statutes and
35 regulations for the Medi-Cal program.

36 (g) The department may seek to integrate the quality of care
37 and consumer protection provisions, including remedies, of the
38 Independent Medical Review System with related dispute
39 resolution procedures of other health care agency programs,
40 including the Medicare and Medi-Cal programs, in a way that

1 minimizes the potential for duplication, conflict, and added costs.
2 Nothing in this subdivision shall be construed to limit any rights
3 conferred upon enrollees under this chapter.

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

7 (i) Every health care service plan shall prominently display in
8 every plan member handbook or relevant informational brochure,
9 in every plan contract, on enrollee evidence of coverage forms, on
10 copies of plan procedures for resolving grievances, on letters of
11 denials issued by either the plan or its contracting organization,
12 on the grievance forms required under Section 1368, and on all
13 written responses to grievances, information concerning the right
14 of an enrollee to request an independent medical review in cases
15 where the enrollee believes that health care services have been
16 improperly denied, modified, or delayed by the plan, or by one of
17 its contracting providers.

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

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

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

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

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

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

1 (3) The enrollee has filed a grievance with the plan or its
2 contracting provider pursuant to Section 1368, and the disputed
3 decision is upheld or the grievance remains unresolved after 30
4 days. The enrollee shall not be required to participate in the plan's
5 grievance process for more than 30 days. In the case of a grievance
6 that requires expedited review pursuant to Section 1368.01, the
7 enrollee shall not be required to participate in the plan's grievance
8 process for more than three days.

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

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

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

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

34 (2) A statement indicating the enrollee's consent to obtain any
35 necessary medical records from the plan, any of its contracting
36 providers, and any out-of-plan provider the enrollee may have
37 consulted on the matter, to be signed by the enrollee.

38 (3) Notice of the enrollee's right to provide information or
39 documentation, either directly or through the enrollee's provider,
40 regarding any of the following:

1 (A) A provider recommendation indicating that the disputed
2 health care service is medically necessary for the enrollee’s medical
3 condition.

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

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

16 (4) A section designed to collect information on the enrollee’s
17 ethnicity, race, and primary language spoken that includes both of
18 the following:

19 (A) A statement of intent indicating that the information is used
20 for statistics only, in order to ensure that all enrollees get the best
21 care possible.

22 (B) A statement indicating that providing this information is
23 optional and will not affect the independent medical review process
24 in any way.

25 (n) Upon notice from the department that the health care service
26 plan’s enrollee has applied for an independent medical review, the
27 plan or its contracting providers shall provide to the independent
28 medical review organization designated by the department a copy
29 of all of the following documents within three business days of
30 the plan’s receipt of the department’s notice of a request by an
31 enrollee for an independent review:

32 (1) (A) A copy of all of the enrollee’s medical records in the
33 possession of the plan or its contracting providers relevant to each
34 of the following:

35 (i) The enrollee’s medical condition.

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

38 (iii) The disputed health care services requested by the enrollee
39 for the condition.

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

12 (2) A copy of all information provided to the enrollee by the
13 plan and any of its contracting providers concerning plan and
14 provider decisions regarding the enrollee's condition and care, and
15 a copy of any materials the enrollee or the enrollee's provider
16 submitted to the plan and to the plan's contracting providers in
17 support of the enrollee's request for disputed health care services.
18 This documentation shall include the written response to the
19 enrollee's grievance, required by paragraph (4) of subdivision (a)
20 of Section 1368. The confidentiality of any enrollee medical
21 information shall be maintained pursuant to applicable state and
22 federal laws.

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

35 (o) This section shall become operative on ~~the later of (1)~~
36 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
37 ~~on January 1, 2013, between the department and an independent~~
38 ~~medical review organization to provide independent medical review~~
39 ~~services July 1, 2015.~~

1 SEC. 3. Section 1374.32 of the Health and Safety Code is
2 amended to read:

3 1374.32. (a) By January 1, 2001, the department shall contract
4 with one or more independent medical review organizations in the
5 state to conduct reviews for purposes of this article. The
6 independent medical review organizations shall be independent
7 of any health care service plan doing business in this state. The
8 director may establish additional requirements, including
9 conflict-of-interest standards, consistent with the purposes of this
10 article, that an organization shall be required to meet in order to
11 qualify for participation in the Independent Medical Review System
12 and to assist the department in carrying out its responsibilities.

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

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

22 (1) The plan.

23 (2) Any officer, director, or employee of the plan.

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

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

30 (5) The development or manufacture of the principal drug,
31 device, procedure, or other therapy proposed by the enrollee whose
32 treatment is under review, or the alternative therapy, if any,
33 recommended by the plan.

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

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

38 (1) The organization shall not be an affiliate or a subsidiary of,
39 nor in any way be owned or controlled by, a health plan or a trade
40 association of health plans. A board member, director, officer, or

1 employee of the independent medical review organization shall
2 not serve as a board member, director, or employee of a health
3 care service plan. A board member, director, or officer of a health
4 plan or a trade association of health plans shall not serve as a board
5 member, director, officer, or employee of an independent medical
6 review organization.

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

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

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

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

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

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

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

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

39 (G) A description of the system the independent medical review
40 organization uses to identify and recruit medical professionals to

1 review treatment and treatment recommendation decisions, the
2 number of medical professionals credentialed, and the types of
3 cases and areas of expertise that the medical professionals are
4 credentialed to review.

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

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

10 (A) Ensures that the medical professionals retained are
11 appropriately credentialed and privileged.

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

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

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

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

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

31 (A) The medical professional shall be a clinician knowledgeable
32 in the treatment of the enrollee's medical condition, knowledgeable
33 about the proposed treatment, and familiar with guidelines and
34 protocols in the area of treatment under review.

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

1 the use of a physician licensed in California as the reviewer, except
2 when training and experience with the issue under review
3 reasonably requires the use of an out-of-state reviewer.

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

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

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

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

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 enrollee whose condition is under review.

23 (F) The enrollee or the enrollee'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 plan to the independent
2 medical review organization for the services required by this
3 section, nor does “material financial affiliation” include an expert’s
4 participation as a contracting plan provider where the expert is
5 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 director, filed with it by an independent medical
10 review organization seeking to contract under this article. The
11 department may charge a nominal fee to the interested person for
12 photocopying the requested information.

13 (f) This section shall become inoperative on ~~the later of (1)~~
14 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
15 ~~on January 1, 2013, between the department and an independent~~
16 ~~medical review organization to provide independent medical review~~
17 ~~services July 1, 2015, and this section shall be repealed on January~~
18 ~~1 of the year after it becomes inoperative.~~

19 SEC. 4. Section 1374.32 is added to the Health and Safety
20 Code, to read:

21 1374.32. (a) The department shall contract with one or more
22 independent medical review organizations in the state to conduct
23 reviews for purposes of this article. The independent medical
24 review organizations shall be independent of any health care service
25 plan doing business in this state. The director may establish
26 additional requirements, including conflict-of-interest standards,
27 consistent with the purposes of this article, that an organization
28 shall be required to meet in order to qualify for participation in the
29 Independent Medical Review System and to assist the department
30 in carrying out its responsibilities.

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

35 (c) The independent medical review organization, any experts
36 it designates to conduct a review, or any officer, director, or
37 employee of the independent medical review organization shall
38 not have any material professional, familial, or financial affiliation,
39 as determined by the director, with any of the following:

40 (1) The plan.

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

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

5 (4) The facility or institution at which either the proposed health
6 care service, or the alternative service, if any, recommended by
7 the plan, would be provided.

8 (5) The development or manufacture of the principal drug,
9 device, procedure, or other therapy proposed by the enrollee whose
10 treatment is under review, or the alternative therapy, if any,
11 recommended by the plan.

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

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

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

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

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

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

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

37 (D) The names and biographical sketches of all directors,
38 officers, and executives of the independent medical review
39 organization, as well as a statement regarding any past or present
40 relationships the directors, officers, and executives may have with

1 any health care service plan, disability insurer, managed care
2 organization, provider group, or board or committee of a plan,
3 managed care organization, or provider group.

4 (E) (i) The percentage of revenue the independent medical
5 review organization receives from expert reviews, including, but
6 not limited to, external medical reviews, quality assurance reviews,
7 and utilization reviews.

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

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

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

23 (H) A description of how the independent medical review
24 organization ensures compliance with the conflict-of-interest
25 provisions of this section.

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

28 (A) Ensures that the medical professionals retained are
29 appropriately credentialed and privileged.

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

33 (C) Ensures that the method of selecting medical professionals
34 for individual cases achieves a fair and impartial panel of medical
35 professionals who are qualified to render recommendations
36 regarding the clinical conditions and the medical necessity of
37 treatments or therapies in question.

38 (D) Ensures the confidentiality of medical records and the
39 review materials, consistent with the requirements of this section
40 and applicable state and federal law.

- 1 (E) Ensures the independence of the medical professionals
- 2 retained to perform the reviews through conflict-of-interest policies
- 3 and prohibitions, and ensures adequate screening for conflicts of
- 4 interest, pursuant to paragraph (5).
- 5 (4) Medical professionals selected by independent medical
- 6 review organizations to review medical treatment decisions shall
- 7 be physicians or other appropriate providers who meet the
- 8 following minimum requirements:
- 9 (A) The medical professional shall be a clinician expert in the
- 10 treatment of the enrollee’s medical condition and knowledgeable
- 11 about the proposed treatment through recent or current actual
- 12 clinical experience treating patients with the same or a similar
- 13 medical condition as the enrollee.
- 14 (B) Notwithstanding any other provision of law, the medical
- 15 professional shall hold a nonrestricted license in any state of the
- 16 United States, and for physicians, a current certification by a
- 17 recognized American medical specialty board in the area or areas
- 18 appropriate to the condition or treatment under review. The
- 19 independent medical review organization shall give preference to
- 20 the use of a physician licensed in California as the reviewer, except
- 21 when training and experience with the issue under review
- 22 reasonably requires the use of an out-of-state reviewer.
- 23 (C) The medical professional shall have no history of
- 24 disciplinary action or sanctions, including, but not limited to, loss
- 25 of staff privileges or participation restrictions, taken or pending
- 26 by any hospital, government, or regulatory body.
- 27 (5) Neither the expert reviewer, nor the independent medical
- 28 review organization, shall have any material professional, material
- 29 familial, or material financial affiliation with any of the following:
- 30 (A) The plan or a provider group of the plan, except that an
- 31 academic medical center under contract to the plan to provide
- 32 services to enrollees may qualify as an independent medical review
- 33 organization provided it will not provide the service and provided
- 34 the center is not the developer or manufacturer of the proposed
- 35 treatment.
- 36 (B) Any officer, director, or management employee of the plan.
- 37 (C) The physician, the physician’s medical group, or the
- 38 independent practice association (IPA) proposing the treatment.
- 39 (D) The institution at which the treatment would be provided.

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

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

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

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

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

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

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

33 (f) This section shall become operative ~~on the later of (1)~~
34 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
35 ~~on January 1, 2013, between the department and an independent~~
36 ~~medical review organization to provide independent medical review~~
37 ~~services July 1, 2015.~~

38 SEC. 5. 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 names of the parties, including, but not
29 limited to, the enrollee, all medical providers, the plan, and any of
30 the insurer's plan's employees or contractors, director decisions
31 adopting a determination of an independent medical review
32 organization shall be made available by the department to the
33 public upon request, at the department's cost and after considering
34 applicable laws governing disclosure of public records,
35 confidentiality, and personal privacy.

36 ~~(h) This section shall become inoperative on the later of (1)~~
37 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
38 ~~on January 1, 2013, between the department and an independent~~
39 ~~medical review organization to provide independent medical review~~
40 ~~services, and this section shall be repealed on January 1 of the year~~

1 ~~after it becomes inoperative.~~ *This section shall become inoperative*
2 *on July 1, 2015, and, as of January 1, 2016, is repealed, unless a*
3 *later enacted statute, that becomes operative on or before January*
4 *1, 2016, deletes or extends the dates on which it becomes*
5 *inoperative and is repealed.*

6 SEC. 6. Section 1374.33 is added to the Health and Safety
7 Code, to read:

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

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

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

25 (2) Nationally recognized professional standards.

26 (3) Expert opinion.

27 (4) Generally accepted standards of medical practice.

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

31 (c) The organization shall complete its review and make its
32 determination in writing, and in layperson's terms to the maximum
33 extent practicable, within 30 days of the receipt of the application
34 for review and supporting documentation, or within less time as
35 prescribed by the director. If the disputed health care service has
36 not been provided and the enrollee's provider or the department
37 certifies in writing that an imminent and serious threat to the health
38 of the enrollee may exist, including, but not limited to, serious
39 pain, the potential loss of life, limb, or major bodily function, or
40 the immediate and serious deterioration of the health of the

1 enrollee, the analyses and determinations of the reviewers shall
2 be expedited and rendered within three days of the receipt of the
3 information. Subject to the approval of the department, the
4 deadlines for analyses and determinations involving both regular
5 and expedited reviews may be extended by the director for up to
6 three days in extraordinary circumstances or for good cause.

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

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

30 (f) The director shall immediately adopt the determination of
31 the independent medical review organization, and shall promptly
32 issue a written decision to the parties that shall be binding on the
33 plan.

34 (g) After removing the name of the enrollee, the names of all
35 medical providers, the names of the health care service plan's
36 employees or contractors, and the name of any other party, other
37 than the plan, names of the parties, including, but not limited to,
38 the enrollee, all medical providers, the plan, and any of the plan's
39 employees or contractors, director decisions adopting a
40 determination of an independent medical review organization shall

1 be made available by the department to the public in a searchable
2 database on the department’s Internet Web site, after considering
3 applicable laws governing disclosure of public records,
4 confidentiality, and personal privacy.

5 (h) (1) Information regarding each director decision provided
6 by the database referenced in subdivision (g) shall include all of
7 the following:

8 (A) Enrollee demographic profile information, including age
9 and gender.

10 (B) The enrollee diagnosis and disputed health care service.

11 ~~(C) The name of the health care service plan.~~

12 ~~(D)~~

13 (C) Whether the independent medical review was for medically
14 necessary services pursuant to this article or for experimental or
15 investigational therapies pursuant to Section 1370.4.

16 ~~(E)~~

17 (D) Whether the independent medical review was standard or
18 expedited.

19 ~~(F)~~

20 (E) Length of time from the receipt by the independent medical
21 review organization of the application for review and supporting
22 documentation to the rendering of a determination by the
23 independent medical review organization in writing.

24 ~~(G)~~

25 (F) Length of time from receipt by the department of the
26 independent medical review application to the issuance of the
27 director’s determination in writing to the parties that is binding on
28 the health care service plan.

29 ~~(H)~~

30 (G) Credentials and qualifications of the reviewer or reviewers.

31 ~~(I)~~

32 (H) The nature of the statutory criteria set forth in subdivision
33 (b) that the reviewer or reviewers used to make the case decision.

34 ~~(J)~~

35 (I) The final result of the determination.

36 ~~(K)~~

37 (J) The year the determination was made.

38 ~~(L)~~

1 (K) A detailed case summary that includes the specific standards,
2 criteria, and medical and scientific evidence, if any, that led to the
3 case decision.

4 (2) The database referenced in subdivision (g) shall be
5 accompanied by all of the following:

6 (A) The annual rate of independent medical review among the
7 total enrolled population.

8 (B) The annual rate of independent medical review cases by
9 health care service plan.

10 (C) The number, type, and resolution of independent medical
11 review cases by health care service plan.

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

14 (i) This section shall become operative on ~~the later of (1) January~~
15 ~~1, 2013, or (2) the termination date of a contract in effect on~~
16 ~~January 1, 2013, between the department and an independent~~
17 ~~medical review organization to provide independent medical review~~
18 ~~services July 1, 2015.~~

19 SEC. 7. Section 10169 of the Insurance Code is amended to
20 read:

21 10169. (a) Commencing January 1, 2001, there is hereby
22 established in the department the Independent Medical Review
23 System.

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

1 that applies to the insured, the statement of decision shall clearly
2 specify the provision in the contract that excludes that coverage.

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

11 (d) (1) All insured grievances involving a disputed health care
12 service are eligible for review under the Independent Medical
13 Review System if the requirements of this article are met. If the
14 department finds that an insured grievance involving a disputed
15 health care service does not meet the requirements of this article
16 for review under the Independent Medical Review System, the
17 insured request for review shall be treated as a request for the
18 department to review the grievance. All other insured grievances,
19 including grievances involving coverage decisions, remain eligible
20 for review by the department.

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

27 (3) The department shall be the final arbiter when there is a
28 question as to whether an insured grievance is a disputed health
29 care service or a coverage decision. The department shall establish
30 a process to complete an initial screening of an insured grievance.
31 If there appears to be any medical necessity issue, the grievance
32 shall be resolved pursuant to an independent medical review as
33 provided under this article.

34 (e) Every disability insurance contract that is issued, amended,
35 renewed, or delivered in this state on or after January 1, 2000,
36 shall, effective, January 1, 2001, provide an insured with the
37 opportunity to seek an independent medical review whenever
38 health care services have been denied, modified, or delayed by the
39 insurer, or by one of its contracting providers, if the decision was
40 based in whole or in part on a finding that the proposed health care

1 services are not medically necessary. For purposes of this article,
2 an insured may designate an agent to act on his or her behalf. The
3 provider may join with or otherwise assist the insured in seeking
4 an independent medical review, and may advocate on behalf of
5 the insured.

6 (f) Medicare beneficiaries enrolled in Medicare + Choice
7 products shall not be excluded unless expressly preempted by
8 federal law.

9 (g) The department may seek to integrate the quality of care
10 and consumer protection provisions, including remedies, of the
11 Independent Medical Review System with related dispute
12 resolution procedures of other health care agency programs,
13 including the Medicare program, in a way that minimizes the
14 potential for duplication, conflict, and added costs. Nothing in this
15 subdivision shall be construed to limit any rights conferred upon
16 insureds under this chapter.

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

20 (i) No later than January 1, 2001, every disability insurer shall
21 prominently display in every insurer member handbook or relevant
22 informational brochure, in every insurance contract, on insured
23 evidence of coverage forms, on copies of insurer procedures for
24 resolving grievances, on letters of denials issued by either the
25 insurer or its contracting organization, and on all written responses
26 to grievances, information concerning the right of an insured to
27 request an independent medical review in cases where the insured
28 believes that health care services have been improperly denied,
29 modified, or delayed by the insurer, or by one of its contracting
30 providers.

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

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

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

37 (C) The insured, in the absence of a provider recommendation
38 under subparagraph (A) or the receipt of urgent care or emergency
39 services by a provider under subparagraph (B), has been seen by
40 a contracting provider for the diagnosis or treatment of the medical

1 condition for which the insured seeks independent review. The
2 insurer shall expedite access to a contracting provider upon request
3 of an insured. The contracting provider need not recommend the
4 disputed health care service as a condition for the insured to be
5 eligible for an independent review.

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

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

14 (3) The insured has filed a grievance with the insurer or its
15 contracting provider, and the disputed decision is upheld or the
16 grievance remains unresolved after 30 days. The insured shall not
17 be required to participate in the insurer's grievance process for
18 more than 30 days. In the case of a grievance that requires
19 expedited review, the insured shall not be required to participate
20 in the insurer's grievance process for more than three days.

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

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

30 (m) As part of its notification to the insured regarding a
31 disposition of the insured's grievance that denies, modifies, or
32 delays health care services, the insurer shall provide the insured
33 with a one-page application form approved by the department, and
34 an addressed envelope, which the insured may return to initiate an
35 independent medical review. The insurer shall include on the form
36 any information required by the department to facilitate the
37 completion of the independent medical review, such as the
38 insured's diagnosis or condition, the nature of the disputed health
39 care service sought by the insured, a means to identify the insured's

1 case, and any other material information. The form shall also
2 include the following:

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

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

11 (3) Notice of the insured's right to provide information or
12 documentation, either directly or through the insured's provider,
13 regarding any of the following:

14 (A) A provider recommendation indicating that the disputed
15 health care service is medically necessary for the insured's medical
16 condition.

17 (B) Medical information or justification that a disputed health
18 care service, on an urgent care or emergency basis, was medically
19 necessary for the insured's medical condition.

20 (C) Reasonable information supporting the insured's position
21 that the disputed health care service is or was medically necessary
22 for the insured's medical condition, including all information
23 provided to the insured by the insurer or any of its contracting
24 providers, still in the possession of the insured, concerning an
25 insurer or provider decision regarding disputed health care services,
26 and a copy of any materials the insured submitted to the insurer,
27 still in the possession of the insured, in support of the grievance,
28 as well as any additional material that the insured believes is
29 relevant.

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

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

40 (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 medical review
36 organization shall maintain the confidentiality of any information
37 found by the commissioner to be the proprietary information of
38 the insurer.

39 ~~(o) This section shall become inoperative on the later of (1)~~
40 ~~January 1, 2013, or (2) the termination date of a contract in effect~~

1 on January 1, 2013, between the department and an independent
2 medical review organization to provide independent medical review
3 services, and this section shall be repealed on January 1 of the year
4 after it becomes inoperative. *This section shall become inoperative*
5 *on July 1, 2015, and, as of January 1, 2016, is repealed, unless a*
6 *later enacted statute, that becomes operative on or before January*
7 *1, 2016, deletes or extends the dates on which it becomes*
8 *inoperative and is repealed.*

9 SEC. 8. Section 10169 is added to the Insurance Code, to read:

10 10169. (a) Commencing January 1, 2001, there is hereby
11 established in the department the Independent Medical Review
12 System.

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

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

39 (d) (1) All insured grievances involving a disputed health care
40 service are eligible for review under the Independent Medical

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

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

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

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

33 (f) Medicare beneficiaries enrolled in Medicare + Choice
34 products shall not be excluded unless expressly preempted by
35 federal law.

36 (g) The department may seek to integrate the quality of care
37 and consumer protection provisions, including remedies, of the
38 Independent Medical Review System with related dispute
39 resolution procedures of other health care agency programs,
40 including the Medicare program, in a way that minimizes the

1 potential for duplication, conflict, and added costs. Nothing in this
2 subdivision shall be construed to limit any rights conferred upon
3 insureds under this chapter.

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

7 (i) Every disability insurer shall prominently display in every
8 insurer member handbook or relevant informational brochure, in
9 every insurance contract, on insured evidence of coverage forms,
10 on copies of insurer procedures for resolving grievances, on letters
11 of denials issued by either the insurer or its contracting
12 organization, and on all written responses to grievances,
13 information concerning the right of an insured to request an
14 independent medical review in cases where the insured believes
15 that health care services have been improperly denied, modified,
16 or delayed by the insurer, or by one of its contracting providers.

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

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

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

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

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

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

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

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

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

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

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

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

37 (3) Notice of the insured's right to provide information or
38 documentation, either directly or through the insured's provider,
39 regarding any of the following:

1 (A) A provider recommendation indicating that the disputed
2 health care service is medically necessary for the insured's medical
3 condition.

4 (B) Medical information or justification that a disputed health
5 care service, on an urgent care or emergency basis, was medically
6 necessary for the insured's medical condition.

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

17 (4) A section designed to collect information on the insured's
18 ethnicity, race, and primary language spoken that includes both of
19 the following:

20 (A) A statement of intent indicating that the information is used
21 for statistics only, in order to ensure that all insureds get the best
22 care possible.

23 (B) A statement indicating that providing this information is
24 optional and will not affect the independent medical review process
25 in any way.

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

33 (1) (A) A copy of all of the insured's medical records in the
34 possession of the insurer or its contracting providers relevant to
35 each of the following:

36 (i) The insured's medical condition.

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

39 (iii) The disputed health care services requested by the insured
40 for the condition.

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

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

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

35 (o) This section shall become operative on ~~the later of (1)~~
36 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
37 ~~on January 1, 2013, between the department and an independent~~
38 ~~medical review organization to provide independent medical review~~
39 ~~services July 1, 2015.~~

1 SEC. 9. Section 10169.2 of the Insurance Code is amended to
2 read:

3 10169.2. (a) By January 1, 2001, the department shall contract
4 with one or more independent medical review organizations in the
5 state to conduct reviews for purposes of this article. The
6 independent medical review organizations shall be independent
7 of any disability insurer doing business in this state. The
8 commissioner may establish additional requirements, including
9 conflict-of-interest standards, consistent with the purposes of this
10 article, that an organization shall be required to meet in order to
11 qualify for participation in the Independent Medical Review System
12 and to assist the department in carrying out its responsibilities.

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

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

22 (1) The insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39 (G) A description of the system the independent medical review
40 organization uses to identify and recruit medical professionals to

1 review treatment and treatment recommendation decisions, the
2 number of medical professionals credentialed, and the types of
3 cases and areas of expertise that the medical professionals are
4 credentialed to review.

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

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

10 (A) Ensures that the medical professionals retained are
11 appropriately credentialed and privileged.

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

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

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

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

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

31 (A) The medical professional shall be a clinician knowledgeable
32 in the treatment of the insured's medical condition, knowledgeable
33 about the proposed treatment, and familiar with guidelines and
34 protocols in the area of treatment under review.

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

1 the use of a physician licensed in California as the reviewer, except
2 when training and experience with the issue under review
3 reasonably requires the use of an out-of-state reviewer.

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

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

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

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

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

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

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

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

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

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

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

38 (C) "Material financial affiliation" means any financial interest
39 of more than 5 percent of total annual revenue or total annual
40 income of an independent medical review organization or

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

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

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

17 ~~(g) This section shall become inoperative on the later of (1)~~
18 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
19 ~~on January 1, 2013, between the department and an independent~~
20 ~~medical review organization to provide independent medical review~~
21 ~~services, and this section shall be repealed on January 1 of the year~~
22 ~~after it becomes inoperative. This section shall become inoperative~~
23 ~~on July 1, 2015, and, as of January 1, 2016, is repealed, unless a~~
24 ~~later enacted statute, that becomes operative on or before January~~
25 ~~1, 2016, deletes or extends the dates on which it becomes~~
26 ~~inoperative and is repealed.~~

27 SEC. 10. Section 10169.2 is added to the Insurance Code, to
28 read:

29 10169.2. (a) The department shall contract with one or more
30 independent medical review organizations in the state to conduct
31 reviews for purposes of this article. The independent medical
32 review organizations shall be independent of any disability insurer
33 doing business in this state. The commissioner may establish
34 additional requirements, including conflict-of-interest standards,
35 consistent with the purposes of this article, that an organization
36 shall be required to meet in order to qualify for participation in the
37 Independent Medical Review System and to assist the department
38 in carrying out its responsibilities.

39 (b) The independent medical review organizations and the
40 medical professionals retained to conduct reviews shall be deemed

1 to be medical consultants for purposes of Section 43.98 of the Civil
2 Code.

3 (c) The independent medical review organization, any experts
4 it designates to conduct a review, or any officer, director, or
5 employee of the independent medical review organization shall
6 not have any material professional, familial, or financial affiliation,
7 as determined by the commissioner, with any of the following:

8 (1) The insurer.

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

10 (3) A physician, the physician's medical group, or the
11 independent practice association involved in the health care service
12 in dispute.

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

16 (5) The development or manufacture of the principal drug,
17 device, procedure, or other therapy proposed by the insured whose
18 treatment is under review, or the alternative therapy, if any,
19 recommended by the insurer.

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

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

24 (1) The organization shall not be an affiliate or a subsidiary of,
25 nor in any way be owned or controlled by, a disability insurer or
26 a trade association of insurers. A board member, director, officer,
27 or employee of the independent medical review organization shall
28 not serve as a board member, director, or employee of a disability
29 insurer. A board member, director, or officer of a disability insurer
30 or a trade association of insurers shall not serve as a board member,
31 director, officer, or employee of an independent medical review
32 organization.

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

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

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

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

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

12 (E) (i) The percentage of revenue the independent medical
13 review organization receives from expert reviews, including, but
14 not limited to, external medical reviews, quality assurance reviews,
15 and utilization reviews.

16 (ii) The names of any insurer or provider group for which the
17 independent medical review organization provides review services,
18 including, but not limited to, utilization review, quality assurance
19 review, and external medical review. Any change in this
20 information shall be reported to the department within five business
21 days of the change.

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

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

31 (H) A description of how the independent medical review
32 organization ensures compliance with the conflict-of-interest
33 provisions of this section.

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

36 (A) Ensures that the medical professionals retained are
37 appropriately credentialed and privileged.

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

1 (C) Ensures that the method of selecting medical professionals
2 for individual cases achieves a fair and impartial panel of medical
3 professionals who are qualified to render recommendations
4 regarding the clinical conditions and the medical necessity of
5 treatments or therapies in question.

6 (D) Ensures the confidentiality of medical records and the
7 review materials, consistent with the requirements of this section
8 and applicable state and federal law.

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

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

17 (A) The medical professional shall be a clinician expert in the
18 treatment of the insured’s medical condition and knowledgeable
19 about the proposed treatment through recent or current actual
20 clinical experience treating patients with the same or a similar
21 medical condition as the insured.

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

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

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

38 (A) The disability insurer or a provider group of the insurer,
39 except that an academic medical center under contract to the insurer
40 to provide services to insureds may qualify as an independent

1 medical review organization provided it will not provide the service
2 and provided the center is not the developer or manufacturer of
3 the proposed treatment.

4 (B) Any officer, director, or management employee of the
5 insurer.

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

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

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

11 (F) The insured or the insured’s immediate family.

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

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

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

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

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

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

4 (g) This section shall become operative ~~on the later of (1)~~
5 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
6 ~~on January 1, 2013, between the department and an independent~~
7 ~~medical review organization to provide independent medical review~~
8 ~~services July 1, 2015.~~

9 SEC. 11. Section 10169.3 of the Insurance Code is amended
10 to read:

11 10169.3. (a) Upon receipt of information and documents
12 related to a case, the medical professional reviewer or reviewers
13 selected to conduct the review by the independent medical review
14 organization shall promptly review all pertinent medical records
15 of the insured, provider reports, as well as any other information
16 submitted to the organization as authorized by the department or
17 requested from any of the parties to the dispute by the reviewers.
18 If reviewers request information from any of the parties, a copy
19 of the request and the response shall be provided to all of the
20 parties. The reviewer or reviewers shall also review relevant
21 information related to the criteria set forth in subdivision (b).

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

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

28 (2) Nationally recognized professional standards.

29 (3) Expert opinion.

30 (4) Generally accepted standards of medical practice.

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

34 (c) The organization shall complete its review and make its
35 determination in writing, and in layperson's terms to the maximum
36 extent practicable, within 30 days of the receipt of the application
37 for review and supporting documentation, or within less time as
38 prescribed by the commissioner. If the disputed health care service
39 has not been provided and the insured's provider or the department
40 certifies in writing that an imminent and serious threat to the health

1 of the insured may exist, including, but not limited to, serious pain,
2 the potential loss of life, limb, or major bodily function, or the
3 immediate and serious deterioration of the health of the insured,
4 the analyses and determinations of the reviewers shall be expedited
5 and rendered within three days of the receipt of the information.
6 Subject to the approval of the department, the deadlines for
7 analyses and determinations involving both regular and expedited
8 reviews may be extended by the commissioner for up to three days
9 in extraordinary circumstances or for good cause.

10 (d) The medical professionals' analyses and determinations
11 shall state whether the disputed health care service is medically
12 necessary. Each analysis shall cite the insured's medical condition,
13 the relevant documents in the record, and the relevant findings
14 associated with the provisions of subdivision (b) to support the
15 determination. If more than one medical professional reviews the
16 case, the recommendation of the majority shall prevail. If the
17 medical professionals reviewing the case are evenly split as to
18 whether the disputed health care service should be provided, the
19 decision shall be in favor of providing the service.

20 (e) The independent medical review organization shall provide
21 the director, the insurer, the insured, and the insured's provider
22 with the analyses and determinations of the medical professionals
23 reviewing the case, and a description of the qualifications of the
24 medical professionals. The independent medical review
25 organization shall keep the names of the reviewers confidential in
26 all communications with entities or individuals outside the
27 independent medical review organization, except in cases where
28 the reviewer is called to testify and in response to court orders. If
29 more than one medical professional reviewed the case and the
30 result was differing determinations, the independent medical review
31 organization shall provide each of the separate reviewer's analyses
32 and determinations.

33 (f) The commissioner shall immediately adopt the determination
34 of the independent medical review organization, and shall promptly
35 issue a written decision to the parties that shall be binding on the
36 insurer.

37 (g) After removing the names of the parties, including, but not
38 limited to, the insured, all medical providers, the insurer, and any
39 of the insurer's employees or contractors, commissioner decisions
40 adopting a determination of an independent medical review

1 organization shall be made available by the department to the
2 public upon request, at the department's cost and after considering
3 applicable laws governing disclosure of public records,
4 confidentiality, and personal privacy.

5 ~~(h) This section shall become inoperative on the later of (1)~~
6 ~~January 1, 2013, or (2) the termination date of a contract in effect~~
7 ~~on January 1, 2013, between the department and an independent~~
8 ~~medical review organization to provide independent medical review~~
9 ~~services, and this section shall be repealed on January 1 of the year~~
10 ~~after it becomes inoperative. This section shall become inoperative~~
11 ~~on July 1, 2015, and, as of January 1, 2016, is repealed, unless a~~
12 ~~later enacted statute, that becomes operative on or before January~~
13 ~~1, 2016, deletes or extends the dates on which it becomes~~
14 ~~inoperative and is repealed.~~

15 SEC. 12. Section 10169.3 is added to the Insurance Code, to
16 read:

17 10169.3. (a) Upon receipt of information and documents
18 related to a case, the medical professional reviewer or reviewers
19 selected to conduct the review by the independent medical review
20 organization shall promptly review all pertinent medical records
21 of the insured, provider reports, as well as any other information
22 submitted to the organization as authorized by the department or
23 requested from any of the parties to the dispute by the reviewers.
24 If reviewers request information from any of the parties, a copy
25 of the request and the response shall be provided to all of the
26 parties. The reviewer or reviewers shall also review relevant
27 information related to the criteria set forth in subdivision (b).

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

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

34 (2) Nationally recognized professional standards.

35 (3) Expert opinion.

36 (4) Generally accepted standards of medical practice.

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

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

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

27 (e) The independent medical review organization shall provide
28 the director, the insurer, the insured, and the insured's provider
29 with the analyses and determinations of the medical professionals
30 reviewing the case, and a description of the qualifications of the
31 medical professionals. The independent medical review
32 organization shall keep the names of the reviewers confidential in
33 all communications with entities or individuals outside the
34 independent medical review organization, except in cases where
35 the reviewer is called to testify and in response to court orders. If
36 more than one medical professional reviewed the case and the
37 result was differing determinations, the independent medical review
38 organization shall provide each of the separate reviewer's analyses
39 and determinations.

1 (f) The commissioner shall immediately adopt the determination
2 of the independent medical review organization, and shall promptly
3 issue a written decision to the parties that shall be binding on the
4 insurer.

5 (g) After removing the name of the insured, the names of all
6 ~~medical providers, the names of the insurer's employees or~~
7 ~~contractors, and the name of any other party, other than the insurer,~~
8 *names of the parties, including, but not limited to, the insured, all*
9 *medical providers, the insurer, and any of the insurer's employees*
10 *or contractors,* commissioner decisions adopting a determination
11 of an independent medical review organization shall be made
12 available by the department in a searchable database on the
13 department's Internet Web site, after considering applicable laws
14 governing disclosure of public records, confidentiality, and
15 personal privacy.

16 (h) (1) Information regarding each commissioner decision
17 provided by the database referenced in subdivision (g) shall include
18 all of the following:

19 (A) Insured demographic profile information, including age and
20 gender.

21 (B) The insured diagnosis and disputed health care service.

22 ~~(C) The name of the health insurer.~~

23 ~~(D)~~

24 (C) Whether the independent medical review was for medically
25 necessary services pursuant to this article or for experimental or
26 investigational therapies pursuant to Section 10145.3.

27 ~~(E)~~

28 (D) Whether the independent medical review was standard or
29 expedited.

30 ~~(F)~~

31 (E) Length of time from the receipt by the independent medical
32 review organization of the application for review and supporting
33 documentation to the rendering of a determination by the
34 independent medical review organization in writing.

35 ~~(G)~~

36 (F) Length of time from receipt by the department of the
37 independent medical review application to the issuance of the
38 commissioner's determination in writing to the parties that is
39 binding on the health insurer.

40 ~~(H)~~

- 1 (G) Credentials and qualifications of the reviewer or reviewers.
- 2 ~~(H)~~
- 3 (H) The nature of the statutory criteria set forth in subdivision
- 4 (b) that the reviewer or reviewers used to make the case decision.
- 5 ~~(I)~~
- 6 (I) The final result of the determination.
- 7 ~~(K)~~
- 8 (J) The year the determination was made.
- 9 ~~(L)~~
- 10 (K) A detailed case summary that includes the specific standards,
- 11 criteria, and medical and scientific evidence, if any, that led to the
- 12 case decision.
- 13 (2) The database referenced in subdivision (g) shall be
- 14 accompanied by all of the following:
- 15 (A) The annual rate of independent medical review among the
- 16 total insured population.
- 17 (B) The annual rate of independent medical review cases by
- 18 health insurer.
- 19 (C) The number, type, and resolution of independent medical
- 20 review cases by health insurer.
- 21 (D) The number, type, and resolution of independent medical
- 22 review cases by ethnicity, race, and primary language spoken.
- 23 (i) This section shall become operative on ~~the later of (1) January~~
- 24 ~~1, 2013, or (2) the termination date of a contract in effect on~~
- 25 ~~January 1, 2013, between the department and an independent~~
- 26 ~~medical review organization to provide independent medical review~~
- 27 ~~services July 1, 2015.~~

O