KERN HEALTH SYSTEMS **POLICY AND PROCEDURES**					
SUBJECT: Independent Medical Review			POLICY #: 14.51-P		
DEPARTMENT: Compliance Department					
Effective Date: 09/1998	Review/Revised Date: 12/1/2022	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_______________________________________ Date ____________________
Emily Duran
Chief Executive Officer

_______________________________________ Date ____________________
Chief Medical Officer

_______________________________________ Date ____________________
Chief Operating Officer

_______________________________________ Date ____________________
Director of Member Services

_______________________________________ Date ____________________
Director of Compliance and Regulatory Affairs

POLICY:

Kern Health Systems (KHS) Medi-Cal members may request an Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) if the Plan denies, changes, or delays a service or treatment because the Plan determined that it was not medically necessary, will not cover an experimental or investigative treatment for a serious mental condition, or will not pay for emergency or urgent medical services that the member has already received. If the DMHC determines that an IMR request does not meet the requirements for review under the IMR System,

the request for review is processed under the DMHC Grievance Review System. See *KHS Policy and Procedure #14.52 – DMHC Grievance Review System* for additional information.

IMRs related to services carved out of KHS' scope of coverage will be redirected to the appropriate entity.

KHS will not engage in any conduct that has the effect of prolonging the independent review process.[1]

The IMR process will conform to the requirements outlined in the following statutory, regulatory, and contractual sources:

- California Health and Safety Code[2] §1370.4; 1374.30; 1374.31; and 1374.34
- California Code of Regulations Title 28 §1300.70.4 and 1300.74.30

DEFINITIONS:

Coverage decision[3]	The approval or denial of health care services by a plan substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract.
Disputed health care service[4]	Any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or its contracted providers, in whole or in part due to a finding that the service is not medically necessary.
Life-threatening[5]	The likelihood of death is high unless the course of the disease is interrupted, or there is a potentially fatal outcome, where the end point of clinical intervention is survival.

Medical scientific evidence[6]	Documentation, including the following sources: (i) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff (ii) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR). (iii) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act. (iv) Standard reference compendia including the American Hospital Formulary Service Drug Information or the American Dental Association Accepted Dental Therapeutics. Also included are compendia recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen. (e.g., Elsevier Gold Standard’s Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium or the Thomson Micromedex DrugDex. (v) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institute of Health for the purpose of evaluating the medical value of health services. (vi) Peer reviewed abstracts accepted for presentation at major medical association meetings.
Seriously debilitating[7]	Diseases or conditions causing major irreversible morbidity.

PROCEDURES:

1.0 QUALIFICATIONS FOR INDEPENDENT MEDICAL REVIEW

The IMR process is not available to Medi-Cal members for review of services denied as not a covered benefit. Additionally, Medi-Cal cases that have completed the State Fair Hearing process are not eligible for IMR

1.1 Experimental and Investigational Therapies

Members qualify for external independent review for experimental and investigational therapies if they meet all of the following criteria[8]:

A. The member has a life-threatening or seriously debilitating condition.
B. The member's physician certifies that the member has such a condition, as defined in paragraph A above, for which standard therapies have not been effective in improving the condition of the member, or for which standard therapies would not be medically appropriate for the member, or for which there is no more beneficial standard therapy covered by KHS than the therapy proposed.
C. Either (a) the member's physician, who is under contract with or employed by KHS, has recommended a drug, device or procedure or other therapy that the physician certifies in writing is likely to be more beneficial to the member than any available standard therapies, or (b) the member, or the member's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's condition, has requested a therapy that, based on at least two (2) documents from the medical and scientific evidence is likely to be more beneficial for the member than any available standard therapy. A physician certification shall include a statement of the evidence relied upon in certifying his or her recommendation.
D. The member has been denied coverage by KHS for a drug, device, procedure, or other therapy recommended or requested.
E. The specific drug, device, procedure, or other therapy recommended would be a covered service, except for KHS' utilization review process determination that the therapy is experimental or investigational.

1.2 Services Denied, Delayed, or Modified Based on Medical Necessity

A member may apply to the Department of Managed Health Care (DMHC) for IMR when all of the following conditions are met[9]:

A. The member's provider (including a non-contracted provider) has recommended a service as medically necessary, or the member has received urgent/emergency service that a provider determined was medically necessary, or the member has been seen by a contracted provider for the diagnosis or treatment of the medical condition for which the member seeks independent review.
B. The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, based in whole or in

part on a decision that the health care service is not medically necessary.

C. The member has completed the KHS grievance process or participated in the grievance process and the grievance remains unresolved after thirty (30) days in the case of a routine grievance or the grievance in an expedited case remains unresolved after three (3) days. This requirement may be waived by DMHC upon determination that extraordinary and compelling circumstances exist.[10]

1.2.1 Review of Emergency and Urgent Services[11]

In cases involving a claim for emergency/urgent services determined to be medically necessary by a non-contracted provider, the IMR will determine whether the services were emergency or urgent services necessary to screen and stabilize the member's condition.

For the purposes of Section 1.2 of this policy, "urgent services" are all services, except emergency services, where the member has obtained the services without prior authorization from KHS.

2.0 MEMBER NOTIFICATION OF RIGHT TO IMR

The following documents include information concerning the right of a member to request IMR[12]:

A. Member Handbooks (EOCs)

B. KHS grievance procedures including *#5.01-I: Member Grievance Process* and *#5.01-P: Member Grievance Process*

C. Notice that a service has been denied, modified, or delayed in whole or in part due to a finding that the service is not medically necessary. See *KHS Policy and Procedure #3.22-P: Referral and Authorization Process* for details.

D. Notice that a service has been denied due to a finding that is an experimental or investigational therapy.[13] See *KHS Policy and Procedure #3.22-P: Referral and Authorization Process* for details.

E. Grievance forms and responses. *See KHS Policy and Procedure #5.01-I: Member Grievance Process* and *KHS Policy and Procedure #5.01-P: Member Grievance Process* for details.

Grievance resolution letters that uphold a decision to deny, modify, or delay health care services, include the DMHC IMR application form and an envelope addressed to DMHC.[14] See *KHS Policy and Procedure #5.01-I: Member Grievance Process* for details.

3.0 MEMBER REQUEST FOR IMR

Provided that a Medi-Cal member meets the requirements listed in Section 1.0, the member may apply directly to the DMHC for an IMR "by calling the Department's toll free telephone number (**1-866-466-2210**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired." "The department's internet website www.dmhc.ca.gov has the

complaint forms and instructions." Application forms are sent to members during the grievance process. (See Attachment A). Application forms are also available to members by calling the Member Services Department at 1-800-391-2000.

IMR for non-experimental/non-investigational services must be requested within six (6) months of any of the qualifying periods or events listed in Section 1.2 of this procedure. The DMHC director may extend the application deadline beyond six (6) months if the circumstances of a case warrant an extension[15].

3.1 Member Agents and Advocates[16]

If the member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the member, as appropriate, may submit the IMR request as the agent of the member. The provider may join with or otherwise assist the member in seeking IMR and may advocate on behalf of the member. Following the submission of the IMR request, the member or member's agent may authorize the provider to assist, including advocating on behalf of the member.

4.0 KHS SUBMISSION OF INFORMATION TO THE IMR ORGANIZATION

On receiving notice from the DMHC that a KHS Plan member has applied for IMR meeting the requirements for DMHC intervention, KHS provides to the DMHC designated IMR organization a copy of the following documents within three (3) business days for routine cases or within 24 hours for cases that involve an imminent and serious threat to the health of the member[17]:

A. The medical records in the possession of the Plan or its contracting providers relevant to:
   (i) The member's condition
   (ii) The health care services being provided by KHS for the condition
   (iii) The disputed health care services requested by the enrollee

B. A copy of any relevant documents used by KHS in determining whether the proposed service should be covered, and any statement by KHS or its providers explaining the reasons for the decision to deny, delay, or modify the disputed service.

C. Any information submitted by the member or the member's physician to KHS in support of the member's request for coverage of the proposed service.

D. Copies of all information provided to the member, including grievance documents, concerning KHS decisions regarding the member's condition and care

E. A copy of the cover page of the *Member Handbook* and complete pages with the referenced sections highlighted or underlined sections, if the *Member Handbook* was referenced in the grievance resolution

F. KHS' response to any additional issues raised in the member's application for IMR

If the member has filed a grievance over the same issue, the Compliance Department

will notify the Grievance Review Team and request the grievance file from the Grievance Coordinator.

A letter listing all the documents submitted to the IMR organization is sent to the member along with copies of documents listed in item (B) above and information on how to request copies of the other listed documents. Copies of these documents will also be provided to the member's provider if authorized.[18]

[19]Any medical records provided to KHS after the initial documents are provided to the IMR organization shall be forwarded by KHS to the IMR organization as soon as possible upon receipt by KHS, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases. Copies of such records are forwarded to the member.

Additional medical records or other information requested by the IMR organization are sent within five (5) business days in routine cases, or one calendar day in expedited cases. In expedited reviews, KHS immediately notifies the member and the member's provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of KHS.[20]

All disclosures must comply with state and federal laws regarding Protected Health Information See *KHS Policy and Procedure #14.04-P, Protected Health Information* for details.

5.0 DECISION

The DMHC will immediately adopt the determination of the IMR organization and promptly issue a written decision to the parties that shall be binding on KHS.

If the majority of experts on the panel recommend providing the proposed service, KHS must provide the service. If the recommendations of the experts on the panel are evenly divided as to whether the service should be provided, then the panel's decision shall be deemed to be in favor of coverage. If less than a majority of the experts on the panel recommend providing the service, KHS is not required to provide the service.

[21]Upon receipt of the decision, KHS immediately contacts the member and offers to promptly implement the decision. If the services have already been rendered, KHS reimburses the provider or member, whichever applies, within five (5) business days. If the services have not yet been rendered, KHS authorizes the services within five (5) business days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition. Services are authorized and notice of the authorization is provided as outlined in *KHS Policy and Procedure #3.22-P: Referral and Authorization Process*.

Coverage for the services required under this policy shall be provided subject to the terms and conditions generally applicable to other benefits under the KHS contract.

6.0 NON-CONTRACTING PROVIDER

Nothing in this policy shall be construed to require KHS to pay for the services, with the exception of urgent/emergency services, of a nonparticipating physician provided pursuant to this policy that is not otherwise covered pursuant to KHS contract.

7.0 REPORTING

The Compliance Department will use the DMHC Complaint Log to track IMR & Complaint information on behalf of the Plan (see Attachment B).

ATTACHMENTS:

- Attachment A – *Independent Medical Review Application*
- Attachment B –*DMHC Complaint Log*

REFERENCE:

Revision 2022-12: Minor edits were included per Director of Compliance and Regulatory Affairs recommendation. **Revision 2022-03:** Policy revised to include updates to Attachments A, B, the DMHC contact information and hyperlink access to the IMR Application Forms. **Revision 2021-04:** Policy revised to comply with MCL RX, DHCS APL 20-020. Approved by the DMHC on 2/4/22 and approved by the DHCS on 11/23/21 **Revision 2020-12:** DMHC All Plan Letter 18-013 provided Plans with revised Independent Medical Review Application/Complaint Forms. Revised forms included with policy. **Revision 2015-12:** Medi-Cal cases that have completed the State Fair Hearing process are not eligible for IMR.
Independent Medical Review (IMR) form revised by the DMHC must be used by KHS in 2016. **Revision 2013-10:** Policy reviewed by Director of Compliance.

[1] HSC 1374.34(b)
[2] HSC 1374.32; 1374.33; 1374.35; and 1374.36 are not included because the sections outline requirements for IMR organizations and the DMHC.
[3] HSC 1374.30(c)
[4] HSC 1374.30(b)
[5] HSC 1370.4(a)(1)(B)
[6] HSC 1370.4(d)
[7] HSC 1370.4(a)(1)(C)
[8] HSC 1370.4
[9] HSC 1374.30(j)
[10] Title 28 §1300.74.30(b)
[11] Title 28 §1300.74.30(c)
[12] HSC 1374.30(i)
[13] HSC 1370.4(c)(1)
[14] HSC 1374.30(m)
[15] HSC 1374.30(k)
[16] HSC 1374.30(e); 1368(b)(2) as referenced.
[17] HSC 1374.30(n); Title 28 §1300.74.30(j)
[18] HSC 1374.31(b) requires an annotated list and only notice that the member can request copies. HSC 1374.30(n)(3) states "the plan will concurrently provide" the documents that are the subject of the paragraph. Title 28 §1300.74.30 also requires only notice to the member regarding how to obtain copies.
[19] HSC 1374.30 (n)(1)(B); Title 28 §1300.74.30(k)(1)
[20] Title 28 §1300.74.30(k)(2)
[21] HSC 1374.34(a)

DEPARTMENT OF Managed Health Care

INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

IMPORTANT INFORMATION

You can submit your IMR Application/Complaint Form online at: www.HealthHelp.ca.gov

- **FREE:** The IMR/Complaint process is free.
- **FAST:** IMRs are usually decided within 45 days, or within 7 days if the health issue is urgent.
- **SUCCESSFUL:** Approximately **68** percent of patients receive the requested service through IMR**.**
- **FINAL:** Health plans must follow the IMR decision and promptly provide the service.

PATIENT INFORMATION

First Name ____________ Middle Initial __ Last Name ____________

Patient's Date of Birth (mm/dd/yyyy) ____________

Gender: ☐ Male ☐ Female ☐ Something Else ____________

Name of Parent or Guardian if Filing for Minor Child ____________

Street Address ____________

City ____________ State ______ Zip ____________

Phone # ____________ Email Address____________

Would you like communication/correspondence sent to this email? ☐ Yes ☐ No

Health Plan Name ____________ Patient's Membership # ____________

Medical Group Name (if enrolled in a medical group) ____________

Employer ____________

Do you want someone to help you with your complaint? ☐ Yes ☐ No

If yes, please complete the attached 'Authorized Assistant Form.'

Do you have Medi-Cal? ☐ Yes ☐ No

If yes, have you filed a Request for a State Fair Hearing? ☐ Yes ☐ No

Do you have Medicare or Medicare Advantage? ☐ Yes ☐ No

Have you filed a complaint or grievance with your health plan? ☐ Yes ☐ No

Do you want payment for a health care service that you already received? ☐ Yes ☐ No

If yes, list the date(s) of service, and the provider's name:

____

YOUR HEALTH PROBLEM

(Use a separate sheet and attach other documents, if needed.)

Do you want your health plan to pay for future services? ☐ Yes ☐ No

What is your medical condition or doctor's diagnosis (Please be specific) ________________________________

What medical treatment(s)/service(s) and/or medication(s) are you asking for? (Please be specific)

____

Did your health plan deny, delay or modify your treatment? ☐ Yes ☐ No

If yes, please check the reason given: (Check one)

☐ Not Medically Necessary ☐ Experimental or Investigational ☐ Not an Emergency/Urgent
☐ Not an Emergency/Urgent ☐ Other (Please explain below)

____

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition.

____

Have you seen any out-of-network providers for your condition? ☐ Yes ☐ No

If yes, please include the medical records with this form.

Briefly describe the problem you are having with your plan. For example, explain if the problem is a denied treatment, an unpaid bill, trouble getting an appointment or medication, or if your coverage has been cancelled by the health plan.

MEDICAL RELEASE

I request the Department of Managed Health Care (Department) to make a decision about my problem with my health plan. I request the Department to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or the Department's Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Department to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the Department to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Patient or Parent Name (Print) ________________________________

Patient or Parent Signature ________________________________ Date ______________

Please see the instruction sheet for mailing or faxing information.

STATISTICAL INFORMATION ONLY

You are asked to voluntarily provide the following information. Giving this information will help the Department identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the Department to obtain this information for research and statistical purposes. Giving this information is optional and will not affect the IMR or complaint decision in any way.

Primary Language Spoken:________________________________

Would you like us to communicate/correspond with you in your primary language? ☐ Yes

Race/Ethnicity:________________________________

DEPARTMENT OF Managed Health Care

AUTHORIZED ASSISTANT FORM

- If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (Department). I allow the Department and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Name (Print)____

Patient Signature______________________________ Date____________

PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print)____________________________________

Address____

City________________________________ State____ Zip__________

Relationship to Patient____

Primary Phone #____________________Secondary Phone #__________________

Email Address____

☐ My power of attorney for health care decisions or other legal document is attached.

IMR Application/Complaint Form Instruction Sheet

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

Before You File:

In most cases, you must complete your plan's complaint or grievance process before you file a complaint or IMR request to the Department. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental/investigational, you do not have to take part in your plan's complaint or grievance process before you file an IMR application.

You must apply for an IMR within six months after your health plan sends you a written response to your appeal. The Department may accept your application after six months if it is determined that circumstances prevented timely submission. Please be aware that if you decide not to file a complaint with the DEPARTMENT for an issue that would qualify for an IMR, you may be giving up your rights to pursue legal action against your plan regarding the service or treatment you are requesting.

How to File:

1. File online at www.HealthHelp.ca.gov. [This is the fastest way.]
   OR
   Fill out and sign the IMR Application/Complaint Form.
2. If you want someone to help you with your IMR or complaint, complete the 'Authorized Assistant Form.'
3. If you have medical records from ***out of network*** *providers*, please include them with your IMR Application/Complaint Form. Your plan will provide medical records from network providers.
4. You may include other documents that support your request. However, there is no need to provide any documents or correspondence between you and your plan relating to this complaint. The Department will obtain this information directly from your plan as part of the investigation.
5. If you are not submitting online, please mail or fax your form and any supporting documents to:

   Department of Managed Health Care Help Center
   980 9th Street, Suite 500
   Sacramento, CA 95814-2725
   FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter within seven days telling you if you qualify for an IMR. If it is determined that your complaint qualifies for an IMR, your case is assigned to a state contractor who will perform the review. The state contractor is also known as the Independent Medical Review Organization (IMRO). All of the information in the Help Center's possession related to your complaint, including your medical records, will be sent to the IMRO. The IMRO will make a decision usually within 30 days or within seven days if your case is urgent. You will be notified in writing of the decision.

If it is determined that your complaint should be reviewed through the Consumer Complaint process, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

IMR Application/Complaint Form Instruction Sheet

The Information Practices Act of 1977 (California Civil Code Section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the Department the authority to regulate health plans and investigate the complaints of health plan members.
- The Department's Help Center uses your personal information to investigate your problem with your plan and to provide an IMR if you qualify for one.
- You provide the Department this information voluntarily. You do not have to provide this information. However, if you do not, the Department may not be able to investigate your complaint or provide an IMR.
- The Department may share your personal information, as needed, with the plan and providers who conduct the IMR.
- The Department may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the Department Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.

DEPARTMENT OF Managed Health Care

Formulario de queja/solicitud de revisión médica independiente (IMR)

INFORMACIÓN IMPORTANTE

Puede presentar su formulario de queja/solicitud de IMR en línea en: www.HealthHelp.ca.gov

- **GRATIS:** El proceso de solicitud de IMR y de presentación de quejas de parte de los consumidores es gratis.
- **RÁPIDO:** Las IMR generalmente se deciden dentro de 45 días o dentro de 7 días si el asunto de salud es urgente.
- **EXITOSO:** Aproximadamente el **68 por ciento** de los pacientes reciben el servicio solicitado a través de una IMR.
- **DEFINITIVO:** Los planes de salud deben acatar la decisión de la IMR y proveer el servicio con prontitud.

INFORMACIÓN DEL PACIENTE

Nombre______________________ Inicial del segundo nombre____ Apellido______________________

Fecha de nacimiento del paciente (mm/dd/aaaa)____

Género: ☐ Masculino ☐ Femenino ☐ Algo Más____

Nombre del padre o tutor si el solicitante es menor de edad___________________________________

Dirección____

Ciudad____ Estado______ Código postal____________

Teléfono ________________________________ Correo electrónico____________________________

¿Desea que le envíen mensajes/correspondencia a este correo electrónico? ☐ Sí ☐ No

Nombre del plan de salud__________________ Núm. de membresía del paciente_________________

Nombre del grupo médico (si está en uno)____

Empleador____

¿Desea que alguien lo ayude con su queja? ☐ Sí ☐ No

De ser así, llene el ‘Formulario de asistente autorizado’ adjunto.

¿Desea recibir un pago por un servicio de atención médica que ya recibió? ☐ Sí ☐ No

De ser así, anote la(s) fecha(s) de servicio y el nombre del proveedor:

____

SU PROBLEMA DE SALUD **(**Use una hoja aparte y adjunte otros documentos de ser necesario)

¿Desea que su plan de salud pague servicios futuros? ☐ Sí ☐ No

¿Cuál es su condición médica o el diagnóstico del doctor? (sea específico)______________________

¿Qué tratamiento(s)/servicio(s) o medicamento(s) está pidiendo? (sea específico)

____

¿Su plan de salud le negó, retrasó o modificó su tratamiento?

Si fue así, marque la razón que le dieron: (marque una opción):

- ☐ No es medicamente necesario
- ☐ No es una emergencia/no es urgente
- ☐ Es experimental o de investigación
- ☐ No es un beneficio cubierto
- ☐ Otro (explicar a continuación)

Anote el nombre y el teléfono de su doctor de atención primaria y de otros proveedores que lo hayan visto, tratado o informado de su condición.

¿Ha visto a proveedores que no están dentro de su red en relación con esta condición? ☐ Sí ☐ No

De ser así, incluya los registros médicos con este formulario.

Describa brevemente el problema que tiene con su plan de salud. Por ejemplo, explique si es el problema es acerca de un tratamiento denegado, una factura no pagada, problemas para obtener una cita o medicamento, o si el plan de salud canceló su cobertura.

Divulgación de información médica

Solicito al Departamento de Atención Administrada de la Salud (Departamento) que tome una decisión acerca del problema que tengo con mi plan de salud. Solicito al Departamento que revise mi formulario de queja/solicitud de revisión médica independiente para que determine si mi queja reúne los requisitos para una IMR o para el proceso de queja del consumidor del Departamento. Autorizo a mis proveedores, pasados y presentes, y a mi plan a divulgar mi información y registros médicos para que revisen este asunto. Estos registros podrían incluir informes médicos, de salud mental, abuso de sustancias, VIH, diagnóstico por imágenes y otros registros relacionados con mi caso. Estos registros podrían también incluir registros no médicos y cualquier información relacionada con mi caso. Autorizo al Departamento a que revise estos registros e información y a que los envíe a mi plan. Mi autorización caducará en un año a partir de la fecha que se indica a continuación, a excepción de lo que permita la ley. Por ejemplo, la ley permite al Departamento continuar usando mi información internamente. Puedo revocar mi autorización más pronto si así lo deseo. Toda la información que proporcioné en esta hoja es verdadera.

Nombre del paciente o padre (en letra de molde) ______________________________

Firma del paciente o padre______________________________ **Fecha**______________

Consulte la hoja de instrucciones para obtener la información para el envío por correo o fax.

PARA INFORMACIÓN ESTADÍSTICA

Se le pide que proporcione la siguiente información de manera voluntaria. Proporcionar esta información ayudará al Departamento a identificar cualquier patrón de los problemas. El artículo 1374.30 del Código de Salud y Seguridad (Health and Safety Code) autoriza al Departamento a que obtenga esta información para fines de investigación y estadística. Proporcionar esta información es opcional y no afectará de ninguna manera la decisión sobre la IMR o la queja.

Idioma principal que habla:______________________________

¿Desea que nos comuniquemos con usted/le enviemos mensajes en su idioma principal? Sí ☐

Raza/origen étnico:______________________________

State of California
Health and Human Services Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM – SPANISH
DMHC 20-160 New: 04/06 Rev: 01/20

DEPARTMENT OF Managed Health Care

FORMULARIO DE ASISTENTE AUTORIZADO

- Si desea dar permiso a otra persona para que lo asista con su queja o revisión médica independiente (Independent Medical Review, IMR), llene las partes A y B a continuación
- Si es un padre o tutor legal que presenta este formulario de queja/IMR en nombre de un menor de 18 años, no necesita llenar este formulario.
- Si presenta esta queja o solicitud de IMR en nombre de un paciente que no puede llenar este formulario debido a que es incompetente o tiene una discapacidad, y si usted tiene autoridad legal para actuar en nombre de este paciente, llene la parte B solamente. Además, adjunte una copia de la carta poder para tomar decisiones de atención de salud u otros documentos que digan que usted puede tomar decisiones en nombre del paciente.

PARTE A: COMPLETADA POR EL PACIENTE

Autorizo a la persona mencionada en la parte B a continuación para que me asista con la queja o solicitud de IMR que presenté ante el Departamento de Atención Administrada de la Salud (Departamento). Autorizo al personal del Departamento y la IMR a que compartan la información sobre mi(s) condición(es) y atención médicas con la persona mencionada a continuación. Esta información podría incluir tratamientos de salud mental, tratamientos y pruebas de VIH, tratamientos de alcoholismo o drogadicción u otra información de atención de salud.

Entiendo que sólo se compartirá la información relacionada con mi queja o IMR.

Mi autorización para esta asistencia es voluntaria y tengo derecho a anularla. Si deseo anularla, tengo que hacerlo por escrito.

Nombre del paciente (en letra de molde) ________________________

Firma del paciente ____ Fecha _________________

PARTE B: COMPLETADA POR LA PERSONA QUE ASISTE AL PACIENTE

Nombre de la persona que asiste al paciente (en letra de molde) ___________________________

Dirección ____

Ciudad _______________________________________ Estado ______ Código postal ______________

Relación con el paciente ____

Teléfono principal____

Teléfono secundario____

Correo electrónico____

☐ Mi carta poder para tomar decisiones de atención de salud u otro documento legal está incluida.

FORMULARIO DE QUEJA/SOLICITUD DE REVISIÓN MÉDICA INDEPENDIENTE

Si tiene preguntas, llame al Departamento al 1-888-466-2219 o TDD al 1-877-688-9891. La llamada es gratuita.

Antes de presentar el formulario:

En la mayoría de los casos, debe agotar el proceso de quejas o reclamaciones de su plan de salud antes de presentar una queja o solicitud de IMR ante el Departamento. Su plan de salud debe proporcionarle una decisión en un plazo de 30 días o de 3 días en caso de que su problema represente una amenaza seria e inmediata para su salud.

Si su plan de salud le negó el tratamiento debido a que era experimental/de investigación, usted no debe participar en el proceso de quejas o reclamaciones de su plan de salud antes de presentar una solicitud de IMR.

Debe solicitar una IMR dentro de un plazo de seis meses a partir de que su plan de salud le envíe una respuesta por escrito referente a su apelación. Usted todavía puede presentar su solicitud después de seis meses si hubo circunstancias especiales que evitaron que la presentara de forma oportuna. Tenga en cuenta que, si decide no presentar una queja ante el Departamento por un asunto que reúne los requisitos para una IMR, podría renunciar a su derecho a emprender acciones legales contra su plan en relación con el servicio o tratamiento que está solicitando.

Cómo presentar el formulario:

1) Preséntelo en línea en www.HealthHelp.ca.gov. **Esta es la manera más rápida.**
   o
   Llene y firme el formulario de queja/solicitud de IMR. Use el sobre que viene con el formulario.

2) Si desea que alguien lo ayude con su queja o IMR, llene el 'Formulario de asistente autorizado'. Tanto usted como su asistente autorizado deben firmar el formulario.
3) Si tiene registros médicos de proveedores ***fuera de la red***, inclúyalos con su formulario de queja/solicitud de IMR. Su plan proveerá los registros médicos de los proveedores dentro de la red.
4) Puede incluir otros documentos que apoyen su solicitud. Sin embargo, no es necesario proveer ningún documento o carta entre usted y su plan en relación con su queja. El Departamento obtendrá esta información directamente de su plan como parte de la investigación.
5) Si no hace su presentación en línea, envíe su formulario y todos los documentos de apoyo por correo postal o fax a:
   Department of Managed Health Care Help Center
   980 9th Street Suite 500
   Sacramento CA 95814-2725
   FAX: 916-255-5241

¿Qué sucederá a continuación?

El Departamento determinará si su caso reúne los requisitos para una IMR o una queja. Un caso reúne los requisitos para una IMR si los servicios de atención médica se retrasaron, modificaron o denegaron con base en una necesidad médica o por ser experimentales/de investigación.

Los casos que no reúnen los requisitos para una IMR se procesan a través del proceso de queja del consumidor. Estos casos implican asuntos como la negación de un servicio de atención médica por no ser un beneficio cubierto, las disputas por el pago de una reclamación, la cancelación de la cobertura, la calidad de la atención y el deducible/los gastos de bolsillo. El Departamento le enviará una carta dentro de un plazo de siete días informándole si reúne los requisitos para una IMR. Si el Departamento decide que su queja reúne los requisitos para una IMR, su caso se asignará a un contratista estatal que llevará a cabo la revisión. Al contratista estatal también se le conoce como una organización de revisión médica independiente. Toda la información que el Centro de Ayuda ha relacionado con su queja, incluyendo sus registros médicos, se enviará a la organización de revisión. La organización de revisión tomará una decisión, generalmente dentro de un plazo de 45 días o dentro de siete días si su caso es urgente. El Departamento le enviará una carta con la decisión.

Si el Departamento decide que su queja debe revisarse mediante el proceso de Queja del Consumidor, se tomará una decisión acerca de su asunto dentro de un plazo de 30 días. El Departamento le enviará una carta con la decisión.

La Ley de Prácticas Informativas (Information Practices Act) de 1977 (artículo 1798.17 del Código Civil de California) requiere que se haga la siguiente notificación.

- La Ley Knox-Keene de California otorga al Departamento la autoridad para que regule los planes de salud e investigue las quejas de los miembros de los planes de salud.
- El Centro de Ayuda del Departamento usa su información personal para investigar el problema que tiene con su plan de salud y para concederle una IMR si reúne los requisitos para una.
- Usted proporciona esta información al Departamento de manera voluntaria. Usted no tiene que proporcionar esta información. Sin embargo, si no lo hace, el Departamento podría ser incapaz de investigar su queja o concederle una IMR.
- El Departamento podría compartir su información personal, según sea necesario, con el plan, los proveedores y la organización de revisión que lleva a cabo la IMR.
- El Departamento podría también compartir su información con otras agencias gubernamentales como lo exija o permita la ley.
- Usted tiene derecho a ver su información personal. Para hacerlo, comuníquese con el Coordinador de Solicitudes de Registros del Departamento, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, o llame a 916-322-6727.

DMHC Complaint Log

Order	Assigned to	Entity	Date Rec'd	Priority	Type	Case #	Last Name	First Name	Issue/ Complaint	Service	Category	KHS Response	Due Date	Response date	Timely?	Notes/Comments	DMHC Response Date	DMHC Response
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