KERN HEALTH SYSTEMS

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)