

CSB

HEALTH

UNIT

PROCEDURES

MANUAL

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CSB HEALTH UNIT PROCEDURES MANUAL

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SECTION 1:

HEALTH INSURANCE

CASE REVIEW

PROCEDURES

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

CLAIMS SERVICES BUREAU HEALTH UNIT

INDIVIDUAL CASE REVIEW

SECTION I. HEALTH INSURANCE CASE REVIEW PROCEDURES

I. OVERVIEW

Compliance officers are responsible for the timely processing of consumer complaints regarding health insurance claims. They must provide a timely response to the insured and acknowledge the receipt of the complaint within 10 days of the Department's receipt of the complaint. The compliance officer works independently, or in consultation with other staff, to determine if claims handling practices indicated in requests for assistance are in compliance with California law and consistent with the provisions of the subject health insurance policy. Compliance officers are expected to conduct prompt and thorough reviews of requests for assistance (RFA) submitted by consumers and health care providers. The goal is to facilitate a fair and accurate claims review process by the insurer, resulting in the resolution of the dispute or to obtain a comprehensive explanation of the insurer's final disposition of the claim. The work process goal is to obtain complete documentation of a case file in 30 days or less and to complete all review determinations and close the case within 30 days of receiving the complete documentation.

II. TYPES OF CASES TO BE HANDLED IN THE HEALTH INSURANCE COMPLAINT UNIT

1. Independent Medical Review Program (IMR)
 - ◆ Refer to Section 2, the Independent Medical Review Procedures Manual
 - ◆ Refer to CIC Sections 10169 – 10169.5
2. Provider Health Care Program (HCP)
 - ◆ Refer to Section III, the Provider Health Care Procedures Manual
 - ◆ Refer to CIC Sections 10123.137, 10133.6, 10133.66, 10133.661
3. General health insurance complaints
4. Dental insurance complaints
5. Vision-care insurance complaints

6. LTC

7. A + F A-3

III. INITIAL WORKLOAD ASSIGNMENT

1. Clerical support staff will index the new RFA and create a case file after determining the complaint is not a duplicate of a previous file. If it is determined that the complaint is a duplicate, it will be routed to the compliance officer assigned to the original complaint. Clerical support staff will enter the consumer's name and address on the case detail page. If the RFA was submitted by the health care provider (HCP), then the clerical support staff will enter the health care provider name and address on the case detail page. In this second scenario, the name of the patient will be entered on a separate line to assist with the tracking and identification of duplicate complaints. It is the Officer's responsibility to identify any duplicate cases not previously recognized by clerical support and to review and correct for accuracy the HCP and/or patient/consumer information on the case detail page.

2. Distribution of Work

A Supervising Compliance Officer, or designated Senior Insurance Compliance Officer will assign cases to the individual compliance officers assigned to the Health Insurance Team.

IV. CRITICAL CASE WORK INSTRUCTIONS

In general, cases in this category are those in which the consumer or his/her dependents has been diagnosed with a serious, life-threatening condition. The services in question will generally be diagnostic, exploratory, or life-saving measures. The services will not yet have been performed, and the consumer is waiting for company approval, authorization or certification in order to continue with or obtain the necessary medical procedure or medication.

Examples of life-threatening diagnoses would be (but not limited to) cancer, heart disease, heart attack or stroke.

Examples of the procedures being requested would be inpatient hospitalization, surgical procedures (inpatient or outpatient), ambulance services, prescription drugs, laboratory testing, radiology testing, or services obtained in a hospital emergency room.

1. The compliance officer will review the complaint to determine whether or not the case belongs in the Independent Medical Review Unit. If it does not, proceed to step 3.
2. If a complaint is received from a provider indicating that the diagnosis and requested treatment is critical, the case should be reclassified as a critical IMR case requiring an expedited review. At this point, the case will need to be handled according to IMR procedures.
3. The compliance officer will place a call to the consumer to acknowledge that we have received his/her complaint and to reassure the consumer that his/her case is being expedited. If the compliance officer has determined that additional information is needed from the consumer, arrangements to obtain such information should be discussed with the consumer during the acknowledgement call.

4. In an effort to provide immediate assistance to the consumer, once jurisdiction is established, the compliance officer will place a call to the insurance company. The purpose of this call is to notify the insurer that a complaint has been received, determine the reason for the delay or denial of services, and to determine whether or not the problem can be resolved on the same day via telephonic communications. While performing critical case activities, the compliance officer will also proceed according to the standard instructions for the written case work. All letters to the insurer will be transmitted via facsimile or email with a copy of the correspondence also sent via regular mail. Proceed to the Standard Case Work Instructions for procedural instructions. However, a very tight diary must be kept until the case is resolved or there is nothing further the CDI can do to assist the consumer.

5. Insurer contacts for critical cases

Critical cases will generally be reclassified as critical IMR cases.

Therefore, compliance officers should use the IMR contact list when calling the insurers. These cases will be handled according to Expedited IMR procedures (see Independent Medical Review Program Section 2A).

6. Upon identifying a case as being critical, the compliance officer should notify the supervisor in charge of the Health Unit immediately for tracking purposes. At that time, the supervisor will provide the assigned compliance officer with any special instructions regarding the handling of the case. Critical cases received from the Commissioner's Office, Ombudsman's Office, Division Headquarters, and Legislative Referrals should be handled in compliance with the special VIP procedures also.

V. STANDARD CASE WORK INSTRUCTIONS

1. The assigned compliance officer will review the complaint and will enter PCA code "24" into the case detail screen. The officer should also enter the appropriate special handling codes applicable to the case. All cases must have both codes recorded, and it is the responsibility of the individual compliance officer to ensure that the file is coded properly and completely.
2. If the RFA submitted by the does not contain sufficient information for the compliance officer to initiate an investigation, the initial acknowledgement letter should specifically request the specific information needed (such as the correct name of the insurer or the ID number of the insured/member/subscriber, dates of service, claim number(s), reason for denial, delay or reduction of benefits), and advise the consumer that it is due within 20 days. If the information is not provided within 20 days, the officer will close the file until the information is received, whereupon it may be reopened. Determination of proper jurisdiction is crucial and cannot be overlooked or stressed enough.
3. If any of the claims or disputed services in the request concern medical services that have been denied, modified or delayed based upon the insurer's reasonable and customary determination, CPT codes, or PPO contract language, the case will be handled according to HCP procedures.

4. If any of the claims or disputed services concern medical services that have been denied, modified or delayed based upon the insurer's determination that the services were not medically necessary or considered to be experimental or investigational, the case will be handled according to IMR procedures.
5. If the complaint file contains a request for assistance from both a provider and a consumer regarding the same services and the same date of service, these issues must be addressed in separate letters to both the provider and the consumer. However, if the insurer is found to be in violation of any applicable statutes or regulations, only one violation letter should be sent to the insurer. This may vary if the consumer complaint has been closed before we received the provider complaint. For the purposes of the Consumer Complaint Study, our Department will not cite the insurer multiple times for the same violations of the law on the same date of service. Such practices would be duplicative and deemed "double dipping". Any questions regarding the citation of violations should be discussed with the supervisor of the Health Unit.

VI. REQUEST FOR INSURANCE COVERAGE INFORMATION

JURISDICTION

If the compliance Officer determines the complaint to be non-jurisdictional, he/she will enter the findings in the notes field, and follow case closing procedures. Only the copy of the RFA without the supporting documentation will be copied and filed in the case folder. The RFA and all of the supporting documents will be forwarded to the entity having proper regulatory authority over the insurance contract with the appropriate referral. (Refer back to the Claims Services Bureau Procedures Manual for the standard instructions in referring a case to another agency.)

If the case is within the Department's jurisdiction, follow the instructions provided in item V of this section.

VII. CASE OPENING PROCEDURES AND REQUESTING SUPPORTING DOCUMENTS FROM THE HEALTH INSURER

1. Send a letter to the health insurer requesting a full and complete response to the complainant and if additional documentation is needed from the health insurer, send a letter requesting the specific information or documents needed to complete the regulatory review of the case. Pend the case for 26-calendar days. When it is necessary to expedite the handling of the case, refer to the Health Insurer Contact List and call for the status of the requested information or documents
2. If the health insurer does not respond to the request for information during the 26-calendar day period, send a follow up letter requesting the information again, advising them of the requirements of Fair Claims Settlement Regulation §2695.5(a). Pend the file for 26-calendar days.
3. When the health insurer submits the requested additional information, proceed with the case review process to its conclusion.

VIII. CASE REVIEW AND CLOSURE PROCESS

1. If the health insurer self corrects incorrect processing of claim(s), record the settlement recovery details into the case detail closing screen. Send the appropriate closing letter to the complainant/provider advising that the insurer indicates the problem has been resolved and, if not, to contact our department.
2. If the health insurer provides substantive support for its final processing of the claim(s), a closing letter will be sent to the complainant/provider stating the review process has concluded, provide the Department's findings and advise of CSB's inability to provide further assistance. The letter will also provide any other options available to the complainant to pursue the matter further.
3. All information received will be reviewed to determine compliance with California insurance statutes and regulations [including any interest or self-imposed increase due per CIC§10123.147(e)] and with all provisions of the Insurance Policy, Certificate of Insurance (COI), or Evidence of Coverage (EOC). In cases where a violation has been detected, the insurance company is to be sent a written notification of that fact.
4. Follow normal case closing procedures used for all other non-health care provider complaints.

IX. USUAL & CUSTOMARY/REASONABLE & CUSTOMARY

Insurance companies have the right to utilize the process of "usual and customary". This process is generally known as the method of determining a statistical profile of providers' charges. The insurer or a separate entity hired by the insurer collects provider charge data from more than 150 major contributors including commercial insurance companies and third party administrators. Data is collected from all 50 states, the District of Columbia, Puerto Rico and the Virgin Islands. Since physicians' fees, along with laboratory, radiology and anesthesiology fees reflect differing costs of doing business in various parts of the country, the insurer recognizes these regional differences and uses the first three (3) digits of the United States Postal Service zip code to divide the charges into population areas based on cost-similar and geographically adjacent areas. Research indicates there are 281 zip code areas for surgery and anesthesia services and 334 areas for medicine, radiology, pathology and laboratory services.

Fee information for the most recent twelve(12) month period is used as a basis for the profile, which is the basic tool for Usual and Prevailing determinations. The profile is updated semi-annually. Among other pertinent data, the profile reflects for each procedure within each of the population areas, the dollar value of the charge representing the 80th percentile. This charge is the one which is at least as great as 80% of all charges recorded in that area for a given procedure.

To date, we know of no laws prohibiting an insurer from utilizing this practice.

The term **Down Coding** is the reassignment of a different CPT code for the purposes of paying a reduced amount.

BRIEF HISTORY OF R & C:

Ingenix is one of a few different companies that perform this service for health insurance companies. Historically, the only source for this information was the Health Insurance Association of America (HIAA) which maintained this data for the entire country. HIAA has changed their business focus to represent health insurance companies throughout the country and they no longer offer the R & C services. After this change, other companies emerged to conduct the same or similar services.

CSB PROCEDURES WHEN THE R & C AMOUNT IS DISPUTED:

We need to thoroughly review the provider complaints that target "down coding" as the issue.

We need to require the insurers prove to us why a reduction in benefits has occurred. This means that we not only require a thorough explanation, but we must also require insurers provide us with the name of the company/entity that either conducted the reasonable and customary review or provided the insurance company with the data that would assist the insurance company in arriving at the reasonable and customary figure. The insurance companies must also provide us with the criteria used along with copies of any worksheets, reference materials and/or manuals that enable them to arrive at a reasonable and customary figure and the company must advise us and provide proof of the percentile under which the R & C figure is being paid.

In those cases where the insurer has an extremely large manual as a reference, ask the insurer to provide a copy of the page with the CPT code, description of the procedure and the unit value, underlined or highlighted. In addition, the insurer will need to copy the cover page of the manual that shows who/what entity produced the manual and collected the data. We also need to know how often the data is updated and how that takes place.

Request the following from insurers:

1. the criteria used and a thorough explanation for the reduction in benefits to include their figures and computations;
2. the complete name of the company/entity that conducted the reasonable and customary review or provided the insurer with the data that would assist the insurer in arriving at the reasonable and customary figure;
3. a copy of any/all worksheets, reference materials and/or manuals that enable the insurer to arrive at a reasonable and customary figure;
4. advise and provide proof of the percentile under which the R & C amount will be paid under that particular policy;
5. advise the Department how often and through what means the data is updated.

X. DOCUMENTATION

All correspondence and documents must be maintained in the active complaint file. All phone calls will be recorded in the activity screen. All e-mails should be printed, and attached to the file folder.

XI. ENFORCEMENT REFERRAL PROCESS

Any further regulatory enforcement actions submitted to Legal (such as Legal Service Referrals and Direct Enforcement Actions), and referrals to FCB and/or FRUB will be made only upon the recommendation of the supervisor of the Health Unit. Final approval of such referrals shall be the responsibility of CSB's Bureau Chief.

XI. TRAINING AND CROSS TRAINING BETWEEN THE IMR PROGRAM AND THE HEALTH CARE PROVIDER PROGRAM.

All compliance officers that have volunteered to work on the Health Insurance Team are encouraged to learn and participate in both programs. Participation and knowledge of both programs will soon be mandatory.

SECTION 2:

INDEPENDENT

MEDICAL REVIEW

PROGRAM

SECTION 2A:

OVERVIEW

SECTION 2A

INDEPENDENT MEDICAL REVIEW PROGRAM

INTRODUCTION

On January 1, 2001, the Department of Insurance began administering an Independent Medical Review (IMR) program. This program allows insureds to request that the Department obtain an impartial review of the insurance company's decisions concerning:

- the medical necessity of a proposed treatment;
- experimental or investigational therapies for certain medical conditions; and
- denied claims for emergency or urgent medical services.

Under sections 10169 through 10169.5 of the California Insurance Code, an insured may seek an IMR (Independent Medical Review) when dissatisfied by an insurer's decision regarding a disputed health care service relating to the practice of medicine and does not involve a coverage decision. Unlike current California Insurance Code Section 10145.3 and existing external reviews in insurance plan's appeals/grievance procedures, requests for IMR are received and processed by the Department. Insureds are required to have exhausted the insurance company's appeals/grievance system before applying. This requirement may be waived by the Department for Critical, Expedited, IMR cases per CIC 10169.1(a).

In order to ensure that the IMR program continually functions effectively, clear guidelines, prompt communications and comprehensive responses between the insurance companies, the Department of Insurance and the Department's IMR contractor are necessary.

IMR PROCESS AND ORGANIZATION

CLAIMS SERVICES BUREAU. The IMR program is managed within the Department's Claims Service Bureau in Los Angeles by a team comprised of Claims Officers, the Department's IMR Committee and Department Counsel.

- ◆ Claims Officers are responsible for receiving and processing incoming applications and determining whether cases are IMR eligible and which eligible cases should be expedited, develop any case-specific questions necessary for a review and provide other analysis of the needs of a particular review, if necessary.
- ◆ IMR Committee and Counsel are responsible for resolving whether the services in dispute pertain to a contractual or legally-required benefit, as well as assessing the insurer's compliance with statutory requirements regarding appeals/grievance and IMR processes, the Department's initial review and adopting the determinations made by the IMR contractor.
- ◆ Issues relating to Department policy, quality assurance and overall IMR system effectiveness are reviewed by the Department's IMR Committee as well as the Department's Management and Supervisory Staff.

Internal Medical Review Organization (IMRO) The Department of Managed Health Care (DMHC) has completed the competitive bidding process and has contracted with an Independent Medical Review Organization (IMRO), effective January 1, 2001. The Department of Insurance contracts with the DMHC by way of an Interagency Agreement. It is from this Interagency Agreement that the Department of Insurance manages the funding of this program.

STANDARD IMR APPLICATIONS AND FORMS

Copies of the forms necessary for the IMR system are attached in Appendix A.:

- ◆ **IMR Application Form** (or other Department-approved application) must be provided to the insured by the insurance company when advising that a determination has been made which could be subject to an IMR [CIC 10169(i)]. For example, this form (and an envelope addressed to the Claims Services Bureau, IMR Unit) must be included when an insurer issues its resolution to an appeal/grievance that finds an otherwise covered service is not medically necessary. A request for extension is also included.

Physician Certification Form is required if the IMR application concerns services denied by the insurance company as experimental or investigational. A physician certification is required to establish that the insured's medical condition is life-threatening or seriously debilitating and that a physician has recommended a drug, device or service as more beneficial than available standard therapies. Non-Contracted Providers or Insureds requesting Independent Medical Review on their own are required to present two documents to the Department of Insurance from specialized medical and scientific literature sources to support the above certification that the requested therapy is likely to be more beneficial to the Enrollee than any available standard therapy.
[CIC 10145.3(a)(3)]

- ◆ **Authorization for Release of Medical Records and Declaration of Relationship Form** allows a representative to act on behalf of the insured when an insured requests or requires assistance during the IMR process. The form also allows the representative to authorize release of the insured's medical records.
- ◆ **Request for Insurance Coverage Information (RICI)** will be used by the Department's IMR Unit to request additional information from the insurance companies, and when necessary to determine the jurisdiction of the policy and eligibility of an IMR application. It will also provide the insurer notice that the insured has sought an IMR following the insurance company's decision.

Critical Timelines

Following is a quick-reference chart on the critical timelines for IMR processing:

Case type	Expedited (Medical Necessity)	Expedited (Experimental)	Standard
Department notifies insured, insured's physician and the insurance company if application is eligible	Within 48 hours of application receipt	Within 48 hours of application receipt	Within 10 days of application receipt
Insurance company provides medical records/information to the Review Organization	Within 24 hours of DOI notification (ie. Fax Email, overnight mail)	Within 24 hours of DOI notification (ie. Fax Email, overnight mail)	Within 3 business days of DOI notification
Insurance company provides new records (not available at the time of the original submission) to the Review Organization	Within 24 hours of receipt (ie. Fax Email, overnight mail)	Within 24 hours of receipt (ie. Fax Email, overnight mail)	Within 3 business days of receipt
Review Organization renders determination	Within 3 days of receipt of records	Within 3 days of receipt of records	Within 30 days of receipt of records
Department adopts Review Organization determination and issues written decision	Within 1 day of receipt of Review Organization determination	Within 1 day of receipt of Review Organization determination	Within 10 days of receipt of Review Organization determination

Frequently Asked Questions

During the development of the operational processes for Independent Medical Review, the Department resolved a number of issues that may be of interest to insurers as they prepare to interact with the IMR system.

1. Are disputes that deal with benefits or terms of coverage eligible for IMR?

The issues that are to be submitted to the independent medical reviewers must pertain to a disputed health care service. If the dispute involves only a question of whether a particular service is included or excluded as a covered benefit under the policy, the Department's Claims Services Bureau will resolve the dispute without referring the case to IMR. The insurer's categorization of the dispute is not determinative. The Department may determine that the dispute inherently involved a policy provision related to the practice of medicine and the medical necessity of a requested health care service.

The insurer, insured and (ultimately) the Department must be able to understand and clearly articulate both the nature of the dispute and the basis for the insurer's actions. If it is unclear whether the issues involve findings relating to medical necessity or a coverage dispute, the Department will obtain information from the insurer, providers or the insured as it deems necessary to determine whether the case should be referred to IMR [CIC10169.(d)(2) and (3)].

2. Are disputes concerning prescription benefits, such as brand versus generic medications and formulary versus non-formulary eligible for IMR?

Insurer's denials, delays or modifications to health care services based on medical necessity are eligible for IMR. Depending upon the policy provisions, the insurer's resolution of a drug-related appeal/grievance may be based on a finding of medical necessity and could be eligible for IMR.

3. Before applying for an IMR due to the denial of experimental or investigational treatment, does an insured have to participate and complete the insurance company's appeal/grievance process?

The statute (CIC Code Section 10145.3) allows an insured to apply for an IMR after the insurance company has denied an experimental or investigational therapy for a life-threatening or seriously debilitating disease or condition. There is no requirement that the insured file an appeal or grievance with the insurance company before contacting the Department. (Except for expedited cases, insureds are expected to file and participate in the insurer's appeal/grievance process for at least 30 days before submitting an application for an IMR based on medical necessity).

4. What will the independent medical reviewer determine if the case involves a dispute over the insurer's refusal to reimburse the insured for out of network emergency and urgent medical services?

An IMR application involving a dispute over whether the insurer should reimburse the insured for emergency or urgent services will require the Department to assess whether the dispute involves the reasonableness of the insured's actions to seek such care or the scope and extent of the services sought out and provided. If the former, the issue for the Department primarily depends on whether the insured acted as a reasonable and prudent person and can be resolved within the Department's Claims Services Bureau complaint-resolution process. If the Department is unable to make that determination or if the case concerns whether the services were medically necessary to provide immediate care and stabilize the patient's condition, the case will be forwarded for IMR.

5. When does the right to IMR begin?

Appeals/grievances resolved or still pending with the insurance company on or after January 1, 2001 will be subject to the new IMR process. The Department expects that experimental and investigation treatment reviews that have been referred to the plan's IMRO before January 1st will be completed under the terms of the current law.

6. Will the Department accept IMR applications directly from the insurance company?

The insurance company may submit an IMR application on behalf of an insured, but the insured must consent to the IMR. (The consent can occur either prior to or after receipt of the application by the Department.)

7. What will happen if the Department receives an incomplete IMR application?

The Department will attempt to contact the insured, the insured's representative or the insurer to obtain the necessary information. If the Department is unable to obtain information necessary to determine whether the case is eligible for IMR within a reasonable time, the case will be closed.

8. What happens if the application does not qualify and will not be referred to the IMRO?

If the IMR application does not qualify and the insured is not eligible to utilize the IMR, the insured and provider will be notified that the application for IMR is denied. The case will then be assessed to determine whether the Department should consider the application as a complaint to the Department under Section 2695.7(3).

9. How does the Department qualify an IMR case as "expedited"?

If the insured, their representative or the treating physician requests an expedited review, the case will be referred to the Department's IMR Committee to determine if the insured's condition meets the expedited review criteria.

10. What is the process for forwarding a case to the IMRO?

Immediately after an IMR application is approved, the Department will contact an IMRO for a conflict of interest screening and to initiate reviewer selection. If the IMRO is unavailable for a particular case, the Department will have at least one other IMRO under contract. When accepted for review by an IMRO, the Department will notify the insurance company via facsimile and by telephone that the case has been referred for a determination. The insurance company must send medical records and all other appropriate documentation to the IMRO within the required timeframes (24 hours for expedited reviews and 3 days for standard reviews).

11. How will the insured be notified their case will be reviewed by an IMRO?

The Department will notify the insured, as well as any representative or physician involved in the application. In the notification letter, the Department will identify the IMRO who will be conducting the review and other information relating to the review process.

12. What happens once the IMRO sends its determination?

The IMRO determinations will be issued to the insured, the insurance company and the Department concurrently. The Department's IMR Unit will receive and review the IMRO determination and will forward a formal adoption letter to the insured, the insurance company, and the insured's physician. If the adoption letter requires the insurer to reverse its initial determination (the denial is overturned), the insurer must implement the binding determination and notify the Department (in writing) of their compliance with the determination.

WHAT CAN INSURANCE COMPANIES DO TO MAKE THE IMR PROGRAM A SUCCESS?

- Assure that treatment authorization denials and responses to appeals/grievances clearly identify the service, procedure, treatment, therapy, medication, or device that is being denied, the number and/or type of treatments, the reason(s) for the denial, and the criteria on which the decision was based. Specific and clear language should be used to identify whether the insurer's action is based upon contractual policy language or the result of a medical finding that the requested care was found not medically necessary.
- Be sure that the Department has accurate and updated contact information for the insurance company's staff responsible for handling appeals/grievances and IMR requests during business and non-business hours.
- Ensure that the member handbook, policy/certificate, evidence of coverage documents, appeals/grievance letters, and any other appropriate documents have information regarding the right of an insured to request an IMR. The IMR application and relevant information should be provided to insured when appropriate.

- When requested by the Claims Services Bureau, complete and return the Request for Insurance Coverage Information to allow for an appropriate determination of whether or not an application qualifies for IMR.
- For policies that delegate any or part of their utilization review or appeal/grievance processes, ensure that the information flow will not impede compliance to critical time frames. All requests for information will go directly to the Insurance Company, not to the delegated entity. Insurance Companies should work to ensure that their PPOs and IPAs are knowledgeable of the new IMR regulations and that points of contact are available within the groups to ensure swift response times.

DOI CONTACT INFORMATION

The Department has a team dedicated to the processing of Independent Medical Reviews. We periodically provide additional information relative to this program, including a list of DOI staff to contact with additional questions.

SECTION 2B:

INDIVIDUAL

CASE REVIEW

INDEPENDENT MEDICAL REVIEW UNIT

CASE REVIEW PROCESS PROCEDURES

SECTION 2B

INDIVIDUAL CASE REVIEW

I. OVERVIEW

Compliance officers are responsible for the timely processing of requests for Independent Medical Reviews. They must provide a timely response to the insured and acknowledge the receipt of the complaint within 10 days of the Department's receipt of the complaint. The compliance officer works independently or in consultation with other staff to determine if claims handling practices indicated in requests for Independent Medical Reviews (IMR) are in compliance with California law and consistent with the provisions of the Health Insurance Policy. The goal is to assist consumers with timely, correct processing of IMR requests to create a fair and accurate review process resulting in resolution of the problem or a better explanation of the insurer's final disposition of claims. The work process goal is to complete documentation of a case file in 30 days or less and to complete all review determinations and close the case within 30 days of complete documentation. The exception is with those cases that are an emergency. Please refer to the chart on page 7 for the specific timelines.

II. INITIAL WORKLOAD ASSIGNMENT

SUPERVISORS

1. No IMR case shall be assigned to an officer who is not physically present that day.
2. If IMR mail is assigned to an absent officer, or an officer who needs to leave work early, that mail shall be pulled immediately and reassigned to another IMR officer.

OFFICERS

1. Clerical support staff will index the new IMR's and create a case file after determining the complaint is not a duplicate of a previous file. If it is determined that the complaint is a duplicate, it will be routed to the compliance officer assigned to the original complaint. Clerical support staff will enter the consumer health care provider name and address on the case detail page. If the IMR request was submitted by the provider, the clerical support staff will enter the health care provider name and address on the case detail page. In this second scenario, the name of the patient will be entered on a separate line to assist with the tracking and identification of duplicates.

2. Supervising Compliance Officers, or designated Senior Insurance Compliance Officers, will assign cases to the individual compliance officers participating the Independent Medical Review Unit.
3. The compliance officer will review the complaint and enter PCA code "23" into the case detail screen. The officer should also enter all special handling codes applicable to the case. All cases must have both codes recorded, and it is the responsibility of the individual compliance officer to ensure that the file is coded properly and completely.
4. If the consumer or provider fails to document that the dispute was previously submitted to the insurer's appeal or grievance process, the IMR request shall be treated as a request to review the grievance [CIC 10169.(d)(1)] which means the request will receive a standard review.
5. The Department of Insurance shall remain the final arbiter when there is a question as to whether an insured grievance is a disputed health care service or a coverage decision. (CIC 10169.(d)(3)).
6. If the consumer or provider fails to include all of the documents requested in the Department's initial acknowledgement letter to the consumer (such as the correct name of the insurer or the ID number of the insured/member/subscriber, dates of service, claim number(s), reason for denial, delay or reduction of benefits), the appropriate letter will be sent to obtain the necessary additional information, which is due within 20 days. If the information is not provided within 20 days, the officer will close the file until the information is received, whereupon it may be reopened. Determination of proper jurisdiction is crucial and cannot be overlooked or stressed enough.
7. If any of the claims or disputed services in the IMR request concern medical services that have been denied, modified or delayed based upon the insurer's reason and customary determination, CPT codes, or PPO contract language, the case will be referred to the Provider HealthCare Unit for processing and coded appropriately on the case detail screen.
8. If the complaint file contains a request for assistance from both a provider and a consumer regarding the same services and the same date of service, these issues must be addressed in separate letters to both the provider and the consumer. The regulatory duties will need to be addressed simultaneously to the company with one violation letter being sent out if necessary. This may vary if the consumer complaint has been closed before we received the provider complaint. For the purposes of the Consumer Complaint Study, our Department will not take multiple violations for the same violations of the law on the same date of service. Such practices would be duplicative and deemed "double dipping". Any questions regarding the citation of violations should be discussed with the supervisor of the Health Unit.

III. REQUEST FOR INSURANCE COVERAGE INFORMATION (RICI)

If there is a question of jurisdiction, send a RICI form to the health insurer to verify that the insured was eligible for coverage on the date of service and that CDI has jurisdiction over the health insurance product. The RICI will be sent via facsimile, and the insurer will be asked to respond within three working days. It may be necessary to request actual excerpts or pages from the Evidence of Coverage or the Certificate of Insurance that prominently display the proper jurisdiction of the health insurance contract.

IV. DETERMINATION OF DEPARTMENT JURISDICTION

1. Review the information on the Independent Medical Review request for assistance form, all the requested documentation and the RICI to determine if the Department has jurisdiction. Review the insurer field on the Case Query Screen and verify the insurer name using the supporting documents received. Change the insurer name if necessary. When it is necessary to expedite the processing of the complaint, refer to the Health Insurer Contact List and clarify/confirm jurisdiction via telephone or fax
2. If the compliance Officer determines the complaint to be non-jurisdictional, he/she will enter the findings in the notes field and follow case closing procedures. Only the copy of the IMR request or complaint without the supporting documentation will be copied and filed in the case folder. The IMR request and all of the supporting documents will be forwarded to the entity having proper regulatory authority over the insurance contract or health plan with the appropriate referral letter. The document entitled "Information and Instructions Regarding the Independent Medical Review Request for Assistance" should be included as an attachment when appropriate.

If within the Department's jurisdiction, continue to item V of this section.

V. OPENING CASE REVIEW PROCESS

1. If the request for an IMR form and all requested supporting documents are received, send the opening acknowledgement IMR letter to the insured and/or provider and/or the designated representative/or attorney. Confirm that the insured/patient name is entered on the Case Query screen, and when available, enter all the dates of service on the case detail screen to help identify future duplicate complaint submissions.
2. Send the opening IMR letter to the IMRO (Maximus/CHDR) and to the insurer, and suspend the case for 26 days.

VI. ADDITIONAL DOCUMENTS FROM THE INSURED OR PROVIDER

Additional supporting documentation can be considered at any time during the IMR process. Upon receipt of such information, forward it to the IMRO (Maximus/CHDR) with a cover letter of explanation (use fax or Email as appropriate). Send a copy of this letter to the insured. Diary the case for 20 calendar days.

VII. REQUESTING SUPPORTING DOCUMENTS FROM THE HEALTH INSURER

1. If additional documentation is needed from the health insurer, send a letter requesting the specific information or documents needed to complete the regulatory review of the case. Pend the case for 26-calendar days. When it is necessary to expedite the processing of the complaint refer to the Health Insurer Contact List and call for status on the requested information or documents
2. If the health insurer does not respond to the request for information during the 26 calendar day period, send a follow up letter requesting the information again and advising them of the requirements of Fair Claims Settlement Regulation §2695.5(a). Pend the file for 26-calendar days.
3. When the health insurer submits the requested additional information, proceed with the case review process to its conclusion.

VIII. CASE REVIEW AND CLOSURE PROCESS

1. If the health insurer self-corrects incorrect processing of claim(s), record the settlement recovery details into the case detail closing screen. Send the appropriate IMR closing letter to the provider/consumer advising that the insurer indicates the problem has been resolved and, if not, to contact our department.
2. Upon CSB's receipt of the IMRO (Maximus/CHDR) determination, a closing letter in compliance with CIC 10169.3(f) shall be sent to all parties concerned.
3. All information contained in our case file will be reviewed to determine compliance with California Insurance statutes and regulations, along with all provisions of the Insurance Policy, Certificate of Coverage, or Evidence of Coverage. Violations will be cited in writing.
4. Follow normal case closing procedures used for all other non-IMR complaints being certain the proper coding is entered. See subsection below for specific coding instructions.

IMR closings: Disposition Section and the Consumer Complaint Study

If there is an additional payment, then the Dispo Code has to be 1295. It cannot be a positive outcome for the complainant or it will show up on the CCS as a mark against the company. The company will write to us, telling us they didn't do anything wrong.

If no violation is cited with the "additional payment" code, then the other Dispo Code must be 1295.

In addition, we conducted a review of the coding for the IMR Program for 1/10/ to 4/30/08.

Disposition Codes used:

~~1220 coverage extended~~
1295 company position upheld
1310 other
1285 question of fact
1230 claim settled
1300 no jurisdiction
1207 advised complaint
1303 recovery
~~1217 entered into arbitration/mediation~~
1210 additional payment
1253 information furnished/expanded
1240 refer to proper agency

~~1220~~ is not necessary or appropriate if there has been an additional payment. Coverage was in place on the date of loss, but the company denied the claim. "Coverage extended" has a different meaning.

~~1217~~ should never be used unless the consumer chose instead to utilize the company's arbitration process. Not all health insurers offer an arbitration process. Also, this code was meant for Property/Casualty claims and not Life/Disability claims.

Activity Screen Codes used:

~~47~~--Letters to the IMRO are being coded 47 on the activity screen. This code should never be used for any Life/Disability activities. When corresponding with the IMRO, a code will have to be used, because there is no special code for the IMRO.

PCA Codes:

On ~~self-funded~~ cases, please use the PCA code 26 with a 02 for suspense/open close.

When we receive an IMR request from a PPO (PAR) provider, who have had medical services denied as not medically necessary, but the insured is not financially responsible for the bill, if the insured is requesting the IMR, then we should follow through and send the case to the IMRO following the usual procedures.

Any objections from the insurance company should be brought to the IMR Supervisor for review.

IX. RE-REVIEW REQUESTS

Appeals of the IMRO decision are not allowed. However, a request for a re-review with additional or new information not previously seen or considered by the Department or the IMRO will be accepted for review.

The reasoning for this can be found under CIC Section 10169.(n)(1)(B), which states,

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

The key is contained within the first sentence. It is important that any new and relevant medical information pertaining to an IMR request be forwarded to the IMRO for review. New and relevant information could dramatically affect the outcome of a case.

This interpretation was developed by the Department's Legal Counsel, Marsha Seeley, and the Claims Services Bureau in 2000 during the initial start up phase of the IMR Program.

X. DOCUMENTATION

All correspondence and documents must be maintained in the active complaint file. All phone calls must be recorded in the activity screen. All e-mails should be printed, and attached to file folder. When the officer determines that the documents are no longer necessary, the file may be purged and non-essential documents and correspondence may be shredded.

XI. ENFORCEMENT REFERRAL PROCESS

Any further regulatory enforcement actions submitted to Legal (such as Legal Service Referrals and Direct Enforcement Actions), and referrals to FCB and/or FRUB will be made only upon the recommendation of the supervisor of the Health Unit. Final approval of such referrals shall be the responsibility of CSB's Bureau Chief.

SECTION 3:

PROVIDER

HEALTHCARE

PROCEDURES

SECTION 3

HEALTHCARE PROVIDER COMPLAINT UNIT

INDIVIDUAL CASE REVIEW

I. OVERVIEW

Compliance officers are responsible for the timely processing of Health Care Provider Complaints. They must provide a timely response to the provider, acknowledging the complaint within 10 days its receipt by the CDI. The compliance officer works independently, or in consultation with other staff, to determine if claims handling practices indicated in a provider complaint are in compliance with California law and consistent with the provisions of the health insurance policy/certificate. The goal is to assist providers with timely, correct processing of claims to create a fair and accurate external review process, resulting in resolution of the problem or a better explanation of the insurer's final disposition of claims. The work process goal is to obtain all documentation pertaining to a case file in 45 days, or less. All necessary reviews, determinations and the closure of the case should be should be completed within 45 days of the receipt of all pertinent documentation.

II. INITIAL WORKLOAD ASSIGNMENT

1. Clerical support staff will index the new provider complaints and create a case file after determining the complaint is not a duplicate of a previous file. If it is determined that the complaint is a duplicate, it will be routed to the compliance officer assigned to the original complaint. Clerical support staff will enter the health care provider name and address on the case detail page. The name of the patient will be entered on a separate line to assist with the tracking and identification of duplicates.
2. Supervising Compliance Officer(s), or designated Senior Insurance Compliance Officers will assign cases to the individual compliance officers assigned to the Health Care Provider Complaint Unit.
3. The compliance officer will review the complaint and enter PCA code "25" into the case detail screen. This entry should automatically cause the special handling code "14W" to be entered into the special handling code field. All cases must have both codes recorded, and it is the responsibility of the individual compliance officer to ensure that the file is coded properly and completely.
4. If the complaint indicates all dates of service in dispute were provided prior to 1/1/06, the file will be closed, and the complaint will be returned to the provider, in its entirety, with the appropriate Health Care Provider (HCP) letter advising that the complaint is not eligible for review. The officer will copy only the Provider Request for Assistance (PRFA) or complaint for the file and not the supporting documentation. The file will be closed and routed to the closed file room.
5. If the provider complaint fails to document that the dispute was previously submitted to the insurer's internal Dispute Resolution Process (DRP) for a minimum of 60 days without response, or fails to submit a copy of the insurer's Dispute Resolution Process determination

letter, the file will be closed and the complaint will be returned to the complainant according to the procedures above in #4.

6. If the complaint does not relate to a claims issue (i.e. pre-certification or contractual), the complaint will be returned to the provider as per #4 above with the appropriate HCP letter.
7. Bulk filings (i.e. the provider simply copies their bills to our Department or submits multiple internet RFAs over the name of the consumer without including an actual HPRFA or a narrative request for assistance) will be coded "06" in the Status field of the Case Query Screen, and no further action will be taken, except to enter PCA code 25 and special handling code 14W. A letter should be sent to the provider in order to educate them about the proper filing of a provider complaint. The letter should include the following enclosures: a copy of the HPRFA, the Instructions for the HPRFA and the Health Care Provider Guide to the Complaint Process.
8. If the provider fails to include all of the documents requested in the HPRFA, and additional information is needed to determine jurisdiction (such as the correct name of the insurer or the ID number of the insured/member/subscriber, dates of service, claim number(s), reason for denial, copy of dispute resolution determination letter etc.), the appropriate HCP letter will be sent to obtain the necessary additional information, which is due within 20 days. If the information is not provided within 20 days the officer will close the file until the information is received, whereupon it may be reopened. Determination of proper jurisdiction is crucial and cannot be overlooked or stressed enough.
9. If any of the claims or disputed services in the HPRFA concern medical services that have been denied, modified or delayed based upon the insurer's determination that the services were not medically necessary or considered to be experimental or investigational, the case will be referred to the IMR Unit for processing and coded appropriately on the Case Detail screen.
10. If the complaint file contains requests for assistance from both a provider and a consumer regarding the same services and the same date of service, these issues must be addressed in separate letters to both the provider and the consumer. The regulatory duties will need to be addressed simultaneously to the company with one violation letter being sent out if necessary. This may vary if the consumer complaint has been closed before we received the provider complaint. For the purposes of the Consumer Complaint Study, our Department will not take multiple violations for the same violations of the law on the same date of service. Such practices would be duplicative and deemed "double dipping".

III. REQUEST FOR HEALTH PLAN INFORMATION (RHCI)

If there is still a question of jurisdiction, send an RHCI form to the health plan to verify that the enrollee was eligible for coverage on the date of service and CDI has jurisdiction over the health care product. The RHCI is to be sent via facsimile, and the insurer will be asked to respond in five working days. It may be necessary to request actual excerpts or pages from the Evidence of Coverage or the Certificate of Insurance that prominently display the proper jurisdiction of the health plan.

IV. DETERMINATION OF DEPARTMENT JURISDICTION

1. Review the information on the Health Provider Request for Assistance form, all the requested documentation and the RHCI to determine if the Department has jurisdiction. Review the insurer field on the Case Query Screen and verify the insurer name using the supporting documents received. Change the insurer name if necessary. If it is necessary to expedite the handling of the case, refer to the Health Insurer Contact List and clarify/confirm jurisdiction via telephone or fax.
2. If the compliance Officer determines the complaint to be non-jurisdictional, he/she will enter the findings in the notes field, and follow case closing procedures. Only the copy of the HPRFA or complaint, without the supporting documentation, will be copied and filed in the case folder. The HPRFA and all of the supporting documents will be returned to the provider with the appropriate HCP letter and may include, when appropriate, the document entitled "Information and Instructions Regarding Health Care Provider Request for Assistance" as an attachment. Complaints will not be forwarded to other agencies.
3. If within the Department's jurisdiction, continue to item V of this section.

V. VERIFY PROVIDER SUBMITTED DOCUMENTATION REQUESTED

1. If the provider sent in all the requested documents, proceed to item VI below to commence the review process.
2. If the provider did not send all the requested documents, review the case to determine if the additional documents are needed. If the documents are not needed for your review, proceed to item VI below.
3. If the outstanding documents are not received within the 20-calendar day period, document this fact in the case Activity Screen, and follow the case closing process. If the outstanding documents are subsequently received, proceed to step item VI below.

VI. OPENING CASE REVIEW PROCESS

1. If the Health Care Provider Complaint Form and all requested supporting documents are received, send the opening acknowledgement HCP letter to the Provider. Confirm that the insured/patient name is entered on the Case Query screen, and when available, enter all the dates of service on the Case Detail screen to help identify future duplicate complaint submissions.
2. Send the opening inquiry HCP letter to the insurer and suspend the case for 26 days.

3. If, at any time during the process, the provider submits documents that are related to a case other than the one being reviewed, the assigned compliance officer is to determine whether such documents are associated with another active case in the system. If not, return them to the provider with a HPRFA and the appropriate macro letter.

VII. REQUESTING ADDITIONAL DOCUMENTS FROM THE PROVIDER

1. Additional supporting documents can be requested from the provider at any time during the review process. If such supporting documentation is necessary, send a letter requesting the specific information or documents needed to resolve the case. Pend the case for 20-calendar days while awaiting the receipt of such documentation.
2. If the additional supporting documents are not received within the 20-calendar day period, document this fact in the in the Case Activity screen, and send a follow-up letter to the provider explaining that without the requested information, the case will be closed.
3. If the additional supporting documents are received, proceed with the analysis.

VIII. REQUESTING SUPPORTING DOCUMENTS FROM THE HEALTH INSURER

1. If additional documentation is needed from the health insurer, send a letter requesting the specific information or documents needed to complete the regulatory review of the case. Pend the case for 26 calendar days. If it is necessary to expedite the handling of the case, refer to the Health Insurer Contact List and call for status on the requested information or documents.
2. If the health insurer does not respond to the request for information during the 26 calendar day period, send a follow up letter requesting the information again, advising it of the requirements of Fair Claims Settlement Regulation §2695.5(a). Pend the file for 26 calendar days.
3. When the health insurer submits the requested additional information, proceed with the case review process to its conclusion.

IX. CASE REVIEW AND CLOSURE PROCESS

1. If the health insurer self-corrects the incorrect processing of claim(s), record the settlement recovery details into the Case Detail Closing screen. Send the appropriate HCP closing letter to the provider/complainant advising that the insurer has reported to CSB the problem has been resolved. The provider should be directed to contact CSB if the problem has not actually been resolved.
2. If the health insurer provides substantive support for its final processing of the claim(s), a HCP closing letter will be sent to the provider stating the review process has concluded and provide the Department's findings and inability to provide further assistance. The letter will also provide any other options available to the complainant to pursue the matter further.

3. All information received from the provider and the insurer will be reviewed to determine compliance with California Insurance statutes and regulations [including any interest or self imposed increase due per CIC§10123.147(e)], as well as all provisions of the Insurance Policy, Certificate of Insurance, or Evidence of Coverage. Violations will be cited in writing.
4. Follow normal case closing procedures used for all other non-health care provider complaints.

X. DOCUMENTATION

All correspondence and documents must be maintained in the active complaint file. All phone calls will be documented in the Activity screen. All e-mails should be printed and attached to file folder.

XI. ENFORCEMENT REFERRAL PROCESS

Any further regulatory enforcement actions submitted to Legal (such as Legal Service Referrals and Direct Enforcement Actions), and referrals to FCB and/or FRUB will be made only upon the recommendation of the supervisor of the Health Unit. Final approval of such referrals shall be the responsibility of CSB's Bureau Chief.

APPENDICES

APPENDIX A

DEPARTMENT OF INSURANCE

CLAIMS SERVICES BUREAU

100 SOUTH SPRING STREET, SOUTH TOWER

LOS ANGELES, CA 90013

www.insurance.ca.gov

CSB-005 P

Revised: 12/21/06



APPLICATION FOR INDEPENDENT MEDICAL REVIEW

Name

Work Phone: ()

Address

Home Phone: ()

City Zip

Please be aware that a copy of this Application for Independent Medical Review will be provided to the insurance company. Also, please be advised that:

- A decision not to participate in the independent review process may cause the forfeiture of any statutory right to pursue legal action against the insurer regarding the disputed health care service.
- Your consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any out-of-plan provider the insured may have consulted on the matter, is necessary to be signed by you.
- You have the right to provide information or documentation, either directly or through your provider, regarding any of the following:
- The provider's recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.
- Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.
- Reasonable information supporting your position that the disputed health care service is or was medically necessary for the medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

1. Complete name of insurance company and policy/certificate number:
2. Claim number and date(s) of medical service(s):
3. Have you contacted the company to request an Independent Medical Review? Yes No (Provide copies of all correspondence)
4. If there is an imminent and serious threat to the health of the insured or claimant, please check and indicate the diagnosis.
5. Briefly describe the disputed medical service or expense that you want referred to the Independent Medical Review Organization and list the physicians who have treated you for this condition. Use additional paper as needed.

I hereby request Independent Medical Review of my dispute with the insurer. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the insurer, the California Department of Insurance and any Independent Medical Review Organization. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously release pursuant to this authorization. I attest that the information provided is accurate and truthful.

Signature

Date

**INFORMATION AND INSTRUCTIONS REGARDING
YOUR APPLICATION FOR INDEPENDENT MEDICAL REVIEW**

Before you request an Independent Medical Review with the Department of Insurance, you are required to first file an appeal/grievance with the insurance company in an effort to resolve the issue(s). If you do not receive a satisfactory response after 30 days, then complete the application form, attach copies of any important papers that relate to your complaint and mail to the address shown on the application form. You may also attach additional sheets as necessary to explain and/or describe the situation and disagreement with your insurance company. We consider this information necessary to our review and within the powers and duties expressed in the California Insurance Code, Section 12921.3 and Section 10169. Please review our privacy statement regarding information we obtain from you.

Please be aware that a copy of your Application for Independent Medical Review will be provided to the insurance company and the Independent Medical Review Organization.

You have the right to provide information or documentation you believe will support your position in this review.

You may inspect the information you submit at any time as long as the department's case is maintained. All original documents will be returned to you upon completion of our handling.

**APPLICATION FOR INDEPENDENT MEDICAL REVIEW MAY BE SUBMITTED TO THE
DEPARTMENT OF INSURANCE FOR THE FOLLOWING TYPES OF PROBLEMS:**

Denial of a claim due to the company's opinion that the treatment or service is not medically necessary or that it is experimental and excluded by a policy provision.

- 1 An offer of an amount less than that indicated in the policy due to the company's opinion of medical necessity.
- 2 Delay in settlement of a claim due to the disputed issue of medical necessity.

4. Denial of a claim for urgent or emergency services.

Under the Independent Medical Review process, one or more physicians will determine these issues and their decision will be binding on the insurance company.

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
DOI / IMR

(To Be Completed By Treating Physician)

I hereby certify that I am the treating physician for _____ (insured's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is Experimental and/or Investigational. I understand that in order for the Insured to obtain the right to an Independent Medical Review of this denial, as treating physician I must certify that the Insured's medical condition meets certain requirements.

In my medical opinion as the Insured's treating physician, I hereby certify to the following:
(Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the member to qualify for an Independent Medical Review).

- 1) The Insured has a terminal medical condition, or a life threatening condition, or a seriously debilitating condition.
- 2) The Insured has a condition that qualifies under one or more of the following:
[please indicate which description(s) apply]:
- Standard therapies have not been effective in improving the Insured's condition;
 - Standard therapies would not be medically appropriate for the Insured; or
 - There is no more beneficial standard therapy covered by the policy.
- 3) The treatment I have recommended and which has been denied in my medical opinion, based on current clinical literature and medical evidence, is likely to be more beneficial to the Insured than any available standard therapies.
- 4) The treatment I have recommended would be significantly less effective if not promptly initiated.
Explain: _____

Contracted Providers: 1) Please state the evidence relied upon in this determination. Please provide a description below or attach to this request form, and fax to the Department.

2) Please provide a description of the experimental or investigational drug, device, procedure, or other therapy recommended by the patient or myself. (Attach additional sheets as necessary.)

Non-Contracted Providers or Insureds requesting Independent Medical Review on their own:

You are required to present two documents to the Department of Insurance from specialized medical and scientific literature sources to support the above certification that the requested therapy is likely to be more beneficial to the Enrollee than any available standard therapy. Please refer to the reverse side that lists the medical and scientific literature sources, which qualify as supporting documentation for Independent Medical Review requests, and fax or overnight.

Documentation may be forwarded by facsimile or overnighted with this form to:
Department of Insurance, IMR Unit, 300 South Spring Street, Los Angeles, CA 90013.
If you have any questions, the Department can be reached at (800) 927-4357, fax (213) 897-5891,
or the Department's web site at www.insurance.ca.gov.

Physician's/Insured's Signature

Date

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

**MEDICAL and SCIENTIFIC EVIDENCE WHICH QUALIFIES
FOR INDEPENDENT MEDICAL REVIEW REQUESTS
as DEFINED UNDER HEALTH and SAFETY CODE SECTION 1370.4(d)**

1. 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 a part of the editorial staff;
2. 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);
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
5. Findings, studies and 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 Institutes of Health for the purpose of evaluating the medical value of health services; or
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
AND DECLARATION OF RELATIONSHIP

If the patient is incompetent or incapacitated, or requests representation, the parent, guardian, conservator, relative, physician, attorney or other designee of the insured, as appropriate, may submit the Application for Independent Medical Review, and act on the behalf of the insured.

Except as expressly limited above and herein, the undersigned hereby consents to the release of any and all medical records and information, of any type, or pertaining to _____ (Name of Insured).

The scope of this authorization includes medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information.

This authorizes release by and among all medical providers, the Patient's insurance company, the California Department of Insurance, and any Independent Medical Review Organization or reviewers authorized by the Department of Insurance to review appeals/grievances regarding health care services. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of an appeal/grievance or complaint regarding health care services.

This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization.

This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously released pursuant to this authorization.

_____ Printed Name	_____ Signature
_____ Print Relationship to Patient	_____ Date
_____ Insured's Signature	_____ Date

Return the completed form to Department of Insurance, IMR Unit, 300 S. Spring Street, 11th Floor, Los Angeles, CA 90013. If you have any questions, the Department can be reached at (800) 927-4357, Outside of California (213) 897-8921, fax # (213) 897-5891.

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

INDEPENDENT MEDICAL REVIEW
REQUEST FOR EXTENSION OF SIX-MONTH DEADLINE

1. **Enrollee Information**
(To be considered for an IMR, complete an IMR Application and this form.)

Name: _____ Telephone: _____
Day Evening Fax
Address: _____
Street City State Zip Email

2. **Reason Enrollee Did Not Submit a Request for an Independent Medical Review Within Six Months From the Date of the Health Plan's Written Response that the Disputed Medical Service or Treatment is Not Medically Necessary or Experimental/Investigational:**

3. **List Health Plan's Denial Letter Date, and Other Pertinent Dates:**

Signature: _____ Date: _____

Complete an IMR application and return with this form to Department of Insurance, Claims Service Bureau IMR Unit, 300 South Spring Street, 11th Floor, Los Angeles, CA 90013. If you have any questions, the Department can be reached at (213) 346-6570, fax (213) 897-5891, or the Department's web site at www.insurance.ca.gov.

(Department of Insurance Use Only)

Reviewed By: _____ Date: _____

Reviewer's Signature: _____

Request Decision: Accept / Reject (Circle one)

Comments: _____

EXPEDITED REQUEST
*If checked, return to DOI
within 24 hours

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

INDEPENDENT MEDICAL REVIEW PROGRAM
REQUEST FOR INSURANCE COVERAGE INFORMATION (RICI)

The Department of Insurance (DOI) has received a request from an insured for an Independent Medical Review (IMR) related to the following health care service dispute:

Insurance Company Name: _____
Disputed medical service or treatment: _____
Insured's Name: _____ Address: _____
SSN: _____ DOB: _____
Patient's Name: _____ Policy No.: _____
Policyholder's Name: _____ Claim No.: _____

In order to process the IMR application, DOI is requesting additional benefit information. Please provide, circle or check the answers that apply for the following:

- Confirmation that health coverage was in force on the date of service. Yes / No Termination date: ___/___/___
- A copy of the insurer's letter and appeal /grievance response specific to the dispute noted above. (Please attach a copy. If applicable, please attach relevant underlined segments of the insurance policy)

The insurer's reason for denial was based on which of the following determinations: (Check the box)

Benefit Coverage		Medical Necessity	
Experimental/Investigation Treatment		ER or Urgent Care Claim Denial	
Medication Denial		Denial of Mental Health Services	

- Please provide the ICD-9, CPT-4 or other codes appropriate for the insured's condition and requested services.
ICD - 9 code(s): _____ CPT - 4 or other service code: _____
- Are the medical services requested or rendered HMO, PPO, POS or Indemnity? _____
- Has the treatment been rendered to the insured? Yes / No
- Please indicate the date the insured's appeal/grievance was received by the insurer. ___/___/___
- Please indicate the date the appeal/grievance was resolved. ___/___/___
- Was the appeal/grievance resolved? Yes / No If Yes, Briefly Explain: _____

List names and specialties of physicians or clinical staff involved in the review of this case.

Name and specialty of the treating physician: _____

- Is the insured covered by Medicare? Yes / No If Yes, is there other coverage? No / Yes
If Yes, Briefly Explain: _____

DATE RICI FAXED TO INSURER: ___/___/___
DATE OF INSURER'S RESPONSE ___/___/___

Important Response Times: Insurer's response for Expedited Requests is 24 hours from date of fax. Insurer's response time for Standard IMR Requests is 3 calendar days from date of fax.

Please fax this form and attachments to DOI: Fax # (213) 897-5891 ATTN: IMR UNIT

If you have any questions, please contact _____

APPENDIX B

List of Paragraphs X

Find

Code	Description	Paragraph
MR-1	Advise of 1 MR program	We are in receipt of your recent co
MR-2	Request app., auth., declaration	When someone other than the actu
csb1MR-3	Advise appeal process.	If you have not already done so, yo
csb1MR-5	Closing Paragraph	Upon our receipt of this information
csb1MR-6	Standard review only	We have reviewed your application
csb1MR-7	Approved for IMR	We have reviewed your application
csb1MR10	Final Adoption Letter	The Department of Insurance has r
csb601	MEVA - Opening letter	Thank you for recent inquiry. □□Y□
csb609	Opening - Variable	We have received your request for
csb60T	Governors Referral/Legislative - (To Complainant)	Thank you for your letter of @@@
csb60j	Acknowledgment To Complainant - (Initiate Investigation)	We have received your request for
csb60t	Governors Referral/Legislative - (To Complainant)	Thank you for your letter of (date) t
csb60y	Acknowledgment to Complainant - (Non-Admitted Carrier)	We have received your request for
csb610	Opening - Contact	This will confirm our telephone con
csb6100	Administrator Non-Personae	We have not been able to obtain a

Find

OK

Cancel

csb IMR-1

We are in receipt of your recent correspondence.

It appears the basis of this complaint is that health care services have been denied, modified or delayed due to the finding of your insurance company that the services were not medically necessary.

Recently passed California legislation provides that enrollees of health plans can request an independent medical review of health care services which have been determined to be medically unnecessary. This review is conducted by independent licensed medical health care professionals.

Addr Info

Signature

PARAGRAPHS

LINE C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord



csb IMR-2

When someone other than the actual insured is requesting an independent medical review, an application as well as an authorization is required. Please complete and return both enclosed Application for Independent Medical Review as well as the Authorization for Release of Medical Records and Declaration of Relationship,

Addr Info

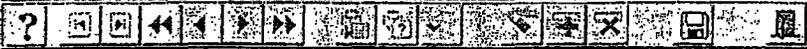
Signature

PARAGRAPHS

View C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord



IMR-3

If you have not already done so, you must file a grievance with your insurance company to resolve the issue. If you did not or do not receive a satisfactory response after 30 days and wish to have the claim matter independently reviewed, complete and return the enclosed Application for Independent Medical Review.

Addr Info

Signature

PARAGRAPHS

LINE 1 C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord



IMR-5

Upon our receipt of this information, we will determine if this matter qualifies for an independent medical review (IMR) and you will be advised accordingly.

Addr Info

Signature

PARAGRAPHS

IMR-5 C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord



IMR-6

We have reviewed your application for an independent medical review. Only claims which have been denied, modified or delayed by the insurer on the basis that an otherwise covered service or treatment was not medically necessary are eligible for the review. Unfortunately, your claim dispute does not meet these criteria. We will however, perform a regulatory review of your claim.

Add Info

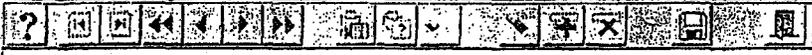
Signature

PARAGRAPHS

10/14/01 C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord



c. IMR-7

We have reviewed your application for an Independent Medical Review. The necessary information is now being provided to the Independent Medical Review Organization. We will advise you of the results of this review within the next 30 days. If you have any questions, please contact the undersigned.

Addr Info

Signature

PARAGRAPHS

IMR-7 C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord

IMR-10

The Department of Insurance has received the final determination of the Independent Medical Review Organization.

Per CIC Section 10169.3 (f) the Department of Insurance adopts the decision of the Independent Medical Review Organization.

The decision of the Independent Medical Review Organization is final and not subject to further appeals.

Addr Info

Signature

PARAGRAPHS

10169.3 C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord

List of Paragraphs

Find

Code	Description	Paragraph
1MR-4	Request completed - RICI Form	We have received an independent
1MR-8	Supply Medical Records to I MRO	The above referenced insured has
1MR-9	Opening Paragraph	We are submitting the above refere
csb60a	Opening Paragraph - Request for Assistance	We have received the request for
csb60h	Special - (Third Party Claim)	We have received a request for as
csb60w	Opening Paragraph - (Catastrophic Illness) (Letter to Cc	This is a follow up to our telephone
csb621	PS 3A Follow-Up To Insurer - Our Letter	Our records indicate we have not r
csb6212	Re-Open - New File Number (Company)	Please note the new file number as
csb6214	Letter To Confirm Telephone Conversation	This letter will document our teleph
csb6215	Jams-Letter To Company	The above-referenced claimant has
csb6216	Certification Reply	We have received your recent corr
csb6217	SALES TAX-SALVAGE	Dear _____; On 1993, the Le
csb622	PS 3A Follow-Up To Insurer - Your Letter	Our records indicate we have not r
csb623	Opening To Insurer	We have received your recent lette
csb62c	Request For File	We have received your recent corr

Find

OK

Cancel



IMR-4

We have received an Independent Medical Review Application for the above referenced insured. Please see the attached copy.

We require that the enclosed Request for Insurance Coverage Information (RICI) form be completed and returned to this Department via FAX within 3 calendar days from your receipt.

If it is determined that this matter qualifies for an Independent Medical Review, your company will be contacted again and required to provide the insured's medical records to the Independent Medical Review Organization within 3 business days.

Add Info

Signature

PARAGRAPHS

C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord

IMR-8

The above referenced insured has applied for an Independent Medical Review and the application has been accepted. Pursuant to California Insurance Code Section 10169, the complete medical records for the insured must be sent to the Independent Medical Review Organization within 3 business days. Please forward them to:

Please advise us once the records have been sent.

Addr info

Signature

PARAGRAPHS

1 C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord



IMR-9

We are submitting the above referenced case for Independent Medical Review. Attached please find the necessary information for processing. Please advise us when the case has been accepted for review. If you have any questions, please contact the undersigned.

Add Info.

Signature

PARAGRAPHS

1/1/98 C

Consumer	Subject
Open	Open
Middle	Middle
Close	Close

To MSWord

IMR Letter #1

We have received your application for an Independent Medical Review. We contacted the insurance company and were advised you have not completed the internal appeal/grievance procedures with them. They further advised that they have now initiated the appeal process with the receipt of your application for an IMR from us.

Before we may commence the IMR process, you must file a grievance with your insurance company to resolve the issue. If you did not or do not receive a satisfactory response after 30 days and wish to have the matter independently reviewed, you will need to contact us and provide copies of any additional denial notice(s) or correspondence from the insurer.

If we do not hear from you in 45 days we will assume that the matter has been resolved or that you are no longer interested in pursuing it.

Sincerely,

ROBERT MASTERS
ASSOCIATE INSURANCE COMPLIANCE OFFICER
Phone: 213-346-6543
Fax: 213-897-5891
Email: mastersr@insurance.ca.gov

Please refer to our file number when corresponding with us.

IMR³ Letter #2

We are in receipt of your recent correspondence.

It appears the basis of this complaint is that health care services have been denied, modified or delayed due to the finding of your insurance company that the services were not medically necessary.

Recently passed California legislation provides that enrollees of health plans can request an independent medical review of health care services which have been determined to be not medically necessary. This review is conducted by independent licensed medical health care professionals.

Please complete and return the enclosed application for an Independent Medical Review as soon as possible. Please advise if your health insurer provided an application with the letters denying the medical services. Please provide the dates for the entire period of treatment and bills for which you are requesting assistance.

If we do not hear from you within thirty (30) days we will assume you are no longer interested in requesting our assistance and will close our file.

Sincerely,

ROBERT MASTERS
ASSOCIATE INSURANCE COMPLIANCE OFFICER
Phone: 213-346-6543
Fax: 213-897-5891
Email: mastersr@insurance.ca.gov

Please refer to our file number when corresponding with us.

IMR #3

We are in receipt of recent application for Independent Medical review dated 4/12/04. It appears that you intended to send this to the insurer to initiate an appeal/grievance. We are the Department of insurance and we do not process claims or administer appeals, we regulate the insurance industry in California.

We are returning the correspondence to you in order for you to follow up with the appropriate party. We will keep a copy in our files should you wish to contact us for assistance at a later date.

Recently passed California legislation provides that enrollees of health plans can request an independent medical review of health care services which have been determined to be medically unnecessary. This review is conducted by independent licensed medical health care professionals.

You have not provided enough specific information as to what services are in dispute, the date of the services, the provider of the services, and what the reason for denial was. In order for us to initiate an investigation of the problem please we would need the following items:

- * A copy of your entire insurance policy or certificate of Insurance or copy of your I.D. Card.
- * Any correspondence such as a denial or EOB, which you have received concerning this matter.

If you have not already done so, you must file a grievance with your insurance company to resolve the issue. If you did not or do not receive a satisfactory response after 30 days and wish to have the claim matter independently reviewed, contact us to initiate the process.

Sincerely,

ROBERT MASTERS
ASSOCIATE INSURANCE COMPLIANCE OFFICER
Phone: 213-346-6543
Fax: 213-897-5891
Email: mastersr@insurance.ca.gov

Please refer to our file number when corresponding with us.

IMR #4

We have received and reviewed your Independent Medical Review Application. We have determined that there is not an issue of medical necessity. The health care services in question were denied as excluded under the terms and conditions of the insurance contract.

We will follow up on your request under our duties to seek a non-judicial resolution and to conduct a regulatory review of claims handling.

So that you may anticipate what will happen with your file, we will briefly explain the steps in the complaint mediation process.

We are taking the following steps:

-- We have written to the insurance company, furnishing it with a copy of your request if you have given permission to do so. This is because you are best able to explain your problem.

-- If you have not given permission, your concerns have been paraphrased and summarized for the insurance company's response.

-- The insurance company will re-evaluate its handling of your claim and will respond to both you and the Department. Insurance laws provide the insurance company with twenty-one days to respond to the Department's letter, although this period may extend a few days longer, taking into account mailing times.

-- If a mistake has been made by the insurance company, it will correct what is wrong because it is the insurer's responsibility to correct its mistakes.

-- If the insurance company takes a position unfavorable to you, we will determine if it has adequate legal or contractual support for its position.

-- We will also determine if the insurer has complied with applicable California insurance laws, but the regulatory process of ensuring that compliance is separate from our trying to resolve your insurance problem.

-- If your issue is not resolved by our intervention, we will tell you of any alternative avenues you can take to reach a favorable result. Some problems require that certain questions of fact or law must first be resolved. These can include questions of market values, methods of repair, and legal liability. Because our courts can hear witnesses and weigh testimony, only they have the power to decide these kinds of issues.

Please allow me to provide you with some information regarding our Department.

Our Department is governed by the State of California Insurance Code. We have two primary duties.

The first duty, direct consumer assistance, is geared toward the needs of a specific consumer and concludes when we have reached the limit of our authority to seek a non-judicial resolution to the consumer's complaint. We cannot force a particular liability decision on an insurer and we cannot order a specific payment on a particular claim.

When questions of fact arise, only a judge or jury can resolve the matter. Also, the court is the only institution authorized to order an insurer to make a specific claim payment.

Our second duty is the regulatory review of the insurer's claim handling. This is separate from our consumer assistance activities and is designed to

protect the public at large, rather than a specific consumer. The results of the review of a company's claim handling of a specific claim are confidential unless at such time we take regulatory action, which results in some sort of public action or notice.

You are welcome to seek legal advice from an attorney to pursue this matter with the company at any time if you feel that they can resolve this matter for you more expeditiously and in a cost-effective manner.

We realize how important this matter is to you and will attempt to complete our inquiries quickly. Due to the complexity of some claim issues, however, we may need to correspond several times with the insurer and conduct research into disputed points. This may result in the file being open sixty days or longer, but please be assured that your concerns are important to us too, and we will advise you of our findings when we conclude our investigation.

Thank you for contacting us with your concerns.

Sincerely,

ROBERT MASTERS
ASSOCIATE INSURANCE COMPLIANCE OFFICER
Phone: 213-346-6543
Fax: 213-897-5891
Email: mastersr@insurance.ca.gov

Please refer to our file number when corresponding with us.

IMR³ Letter #5 (the works)

We are in receipt of your recent correspondence.

It appears the basis of this complaint may be that health care services have been denied, modified or delayed due to the finding of your insurance company that the services were not medically necessary.

Recently passed California legislation provides that enrollees of health plans can request an independent medical review of health care services which have been determined to be medically unnecessary. This review is conducted by independent licensed medical health care professionals.

If not already done, a grievance must be filed with the insurance company to resolve the issue. If a satisfactory response was not received after 30 days the claim issue may be independently reviewed, complete and return the enclosed Application for Independent Medical Review.

In order for us to initiate an investigation of the problem please send us the following items:

- A copy of the entire insurance policy or certificate of insurance or copy of your ID Card.
(or)
- The full name of the insurance company involved, together with any information you have to identify the complete policy and/or claim number.
- Any correspondence you have received concerning this matter.

When someone other than the actual insured is requesting an independent medical review, an application as well as an authorization is required. Please complete and return both enclosed Application for Independent Medical Review as well as the Authorization for Release of Medical Records and Declaration of Relationship.

Before we submit your request for an independent medical review it is essential to have your physician complete and sign the attached PHYSICIAN CERTIFICATION EXPERIMENTAL/INVESTIGATIONAL DENIALS form and return it to us as soon as possible. This certification will be forwarded to the Independent Medical Review Organization to be considered along with your medical records. If you wish to provide other supporting information for consideration please include it when returning this form.

If we do not hear from you in 30 days we will assume that the matter has been resolved or that you are no longer interested in pursuing it.

Sincerely,

Please refer to our file number when corresponding with us.

IMR Letter #6

We are in receipt of your recent correspondence.

It appears the basis of this complaint is that health care services have been denied, modified or delayed due to the finding of your insurance company that the services were not medically necessary.

California legislation provides that enrollees of health plans can request an independent medical review of health care services which have been determined to be medically unnecessary. This review is conducted by independent licensed medical health care professionals.

Before we submit your request for an independent medical review it is essential to have your physician complete and sign the attached physician certification form and return it to us as soon as possible. This certification will be forwarded to the Independent Medical Review Organization to be considered along with your medical records. If you wish to provide other supporting information for consideration please include it when returning this form.

If we do not hear from you in 30 days we will assume that the matter has been resolved or that you are no longer interested in pursuing it.

Sincerely,

ROBERT MASTERS
ASSOCIATE INSURANCE COMPLIANCE OFFICER
Phone: 213-346-6543
Fax: 213-897-5891
Email: mastersr@insurance.ca.gov

Please refer to our file number when corresponding with us.

IMR Letter #7

When someone other than the actual insured is requesting an independent medical review, an application as well as an authorization is required. Please complete and return both enclosed Application for Independent Medical Review as well as the Authorization for Release of Medical Records and Declaration of Relationship.

IMR Letter #8

Dear HEALTH PROVIDER.:

are in receipt of your recent application for an Independent Medical Review.

Recently passed California legislation provides that enrollees of health plans can request an independent medical review of health care services which have been determined to be medically unnecessary. This review is conducted by independent licensed medical health care professionals.

The medical bills you have provided do not indicate that the services were denied due to the insurer's determination that they were not medically necessary. Therefore, this matter would not qualify for an IMR.

Please be further advised of the following.

The position of the Department of Insurance is to handle complaints over the signature of the insured. The exception is group medical coverage if an assignment of benefits is taken and then only if the complaint relates to recognition of the assignment by the insurer.

Should your patient desire to request our assistance regarding delay and/or improper consideration of claim, he/she should not hesitate to contact us directly. To expedite the matter, please have your patient reference this file number. If your patient contacted us we would require at a minimum the following information.

- * A copy of the entire insurance policy or certificate of insurance or copy of ID card.
- * Any correspondence received concerning this matter.

Thank you for taking the time to advise this Department of the problems you are experiencing. Although this office is unable to assist you at this time, the information you provided will be maintained on file in the event of any regulatory activity with respect to the conduct of our licensee.

Sincerely,

Please refer to our file number when corresponding with us.

IMR Letter #10 (recovery letter to insurer)

The Department of Insurance has received the final determination of the Independent Medical Review Organization, copy attached.

Per CIC Section 10169.3 (f) the Department of Insurance adopts the decision of the Independent Medical Review Organization.

The decision of the Independent Medical Review Organization is final and not subject to further appeals.

Please provide the amounts and dates paid in compliance with the Independent Medical Review determination and/or a copy of the EOB.

If the IMR determination pertained to the authorization of services previously denied please provide documentation of compliance with the IMR determination. After the medical services have been provided please provide a detailed accounting of amounts and dates of payments or a copy of the EOB(s).

This information will assist us in closing our file.

Sincerely,

Please refer to our file number when corresponding with us.

IMR Letter #11

MAXIMUS/CHDR
ATTN: TOM NAUGHTON
3130 KILGORE ROAD, STE 100
RANCHO CORDOVA, CA 95670

Dear Mr. Naughton:

We are submitting the above referenced case for an Independent Medical Review. Enclosed please find the application for this individual. The medical records are being sent to you directly by the insurance company. Please advise when the case has been accepted for review. If you have any questions, please contact the undersigned.

Thank you for your attention to this matter.

Sincerely,

Please refer to the DEPARTMENT OF INSURANCE FILE NUMBER when corresponding

IMR Letter #12

Dear Mr. Naughton:

We submitted the above referenced case for an Independent Medical Review on ----- Enclosed please find additional information from the applicant. Please include these records in the file for the Independent Medical Review. If you have any questions, please contact the undersigned.

Thank you for your attention to this matter.

Sincerely,

Please refer to the DEPARTMENT OF INSURANCE FILE NUMBER when corresponding

IMR³ Letter #13

Dear Mr. Naughton:

We submitted the above referenced case for an Independent Medical Review on 10/7/04. Enclosed please find additional information from the applicant. Please include these records in the file for the Independent Medical Review. If you have any questions, please contact the undersigned.

Thank you for your attention to this matter.

Sincerely,

Robert Masters
Associate Insurance Compliance Officer
Claims Services Bureau
TEL(213) 346-6543
FAX(213) 897-5891
mastersr@insurance.ca.gov

Please refer to the DEPARTMENT OF INSURANCE FILE NUMBER when corresponding

IMR Letter # 14

Any additional information you wish to provide that supports the medical necessity of the health care services in question should be submitted together with the physician certification.

We realize how important it is to process your IMR expeditiously. However, it is important to note that you only get one chance at trying to reverse the denial of the medical services in question, so we should make sure we do it right in order to increase the chance of being successful. Any supporting literature from sources such as those mentioned in the attachment as well as from internet sources like WEB M.D. may be helpful in convincing the independent doctor(s) to overturn the denial of medical services.

OR

Please include any additional information or records that you feel would helpful to submit to the Independent Medical Review Organization and which you have not already provided.

IMK Letter #15

(For Hospital and Clinics etc.)

It appears that your problem is not with the insurer but with the medical service provider. We have no jurisdiction over medical service providers. Your inquiry does not relate to a matter within the jurisdiction of this Department. Unfortunately we are not able to assist with this matter.

We are returning the original documents you submitted. You may be able to obtain assistance by contacting:

Department of Health Services
5555 Ferguson Dr.
Covina Ca 90022
(323) 869-8500

(Southern California)

or

Department of Health Services
350 90th St.
Daly City, Ca 94105
(650) 301-9971

(For Physicians) It appears that your problem is not with the insurer but with the medical service provider. We have no jurisdiction over medical service providers. Your inquiry does not relate to a matter within the jurisdiction of this Department. Unfortunately we are not able to assist with this matter.

Medical Board of California
1426 Howe Ave.
Sacramento, Ca. 95825

(800) 633-2322

APPENDIX C

(

List of Paragraphs



Find

User Code	Description	Paragraph	DIV
15	Federal Employees Health Benefits Program	□We have received your recent inquiry concerning the heal	CCO
	Rescission Closing Letter	We have completed our review of the available information t	CCO
csuJR-1	+Attorney Rep.	We have completed our analysis of all information secured f	CCO
csbJR2	Self-Funded Employee Benefit Plan	We have recently been advised that your health plan is self-	CCO
csbUACV	ACV \$ amount undetermined	The amount of claim that has been determined and is not in c	CCO
csbVIP-1	Ombudsman's Opening to VIP	Proposed Opening Letter □□□Dear (Name of legislator) :□	CCO
csbesq3	Attorney- Complaint	Proposed Attorney Complaint Macro - To be used when the	CCO
csbhcp2	Provider DRP Info Request	We have received your complaint and request for assistanc	CCO
csbhcp4a	RFA Request to Consumer - Non Provider Issue	(to consumer)□□Recently, (insert name of provider) advise	CCO
csbhcp4b	Suspense Close to Provider - Non Provider Issue	We have received your request for assistance involving the	CCO
csbhcp5a	Provider Request for Additional Info	We have received your request for assistance.□□After rev	CCO
csbhcp5b	Provider Request for Additional Info (short)	(to provider)□□The California Department of Insurance is cu	CCO
csbhcp6	Provider Opening Letter	We are in receipt of your Health Care Provider Request for /	CCO
csbrehab	Legion - Villanova	This letter is to advise you that on April 25, 2003 California Ir	CCO

Find

OK

Cancel

cp2 - Provider DRP Request for Info

We have received your complaint and request for assistance.

Recently passed California legislation provides that health care providers may submit complaints to California Department of Insurance (CDI) beginning July 1, 2006. The Department will accept all complaints for services rendered after January 1, 2006. Also, before filing a complaint with the CDI, the provider must submit a written appeal to the insurer's internal Dispute Resolution Mechanism process.

After reviewing the information you submitted, additional documentation is required in order for us to determine our ability to assist you with your problem. Please submit the following items:

- * A copy of the insurer's Dispute Resolution Mechanism process determination letter ; or
- * Documentation that you have submitted the dispute to the insurer and it has been 60 calendar days or more without receiving a determination.

If we do not hear from you within the next 20 calendar days we will

10/15/06



cp4a - RFA request to consmer Non Provider issue

Recently, (insert name of provider) advised this Department that (insert name of insurer) may have improperly denied certain benefits and/or services under your health insurance policy. We would appreciate your assistance in the performance of our regulatory duties by providing us with additional information concerning the denied services of (insert dates of service and/or denied service info).

In order to initiate an investigation of the improper claims handling allegations against the insurer, please complete the enclosed "Request for Assistance" form in full. In addition, please submit copies of any correspondence you have received from the insurer concerning the problem in question, along with a copy of your insurance policy or certificate if available.

We would appreciate a response from you within the next twenty(20) calendar days. If we do not hear from you within this period, we will assume you are not interested in pursuing the matter with this Department at this time, and we will close our file.

If you have any questions regarding this matter, please contact the undersigned.

Address

Signature

The image shows a vertical strip of forms. At the top is a 'Request for Assistance' form with a 'C' in a box. Below it are two 'Complaint' forms, each with a 'Date' field. The forms are partially obscured by a dark, textured overlay.

Phone

c p4b - Suspense Close to Provider |

We have received your request for assistance involving the above insurance company.

In order to participate in the health care provider complaint process, the issue(s) must relate to claim matters involving the denial, delay or interruption of covered services and necessary administrative procedures that are available to the insured claimant.

If the reported concerns relate to coverage issues, such as treatment or service exclusions, benefit limitations, eligibility or termination of coverage, then the matter may only be addressed at the request of the insured claimant.

Unfortunately, your reported concerns do not meet the above participation criteria, and we are unable to initiate an inquiry to the insurer on your behalf. However, we are contacting your patient in order to obtain the necessary information that will enable us to evaluate and investigate your allegations.

We appreciate the time that you have taken in order to advise us of your concerns. Should we require further information from you, we will contact you.

App Info

Print

Complaint Subject

Open	Open
Misc	Misc
Close	Close

Close



cp5a - Provider Request for Additional Info

We have received your request for assistance.

After reviewing the information you submitted, additional documentation is required in order for us to determine our ability to assist you. Please submit the following items:

(Officer choose one or more, or add own text)

* If you wish to file a complaint against the insurance company complete the attached Health Care Provider Request for Assistance form and return it to us.

* A copy of your patient's medical card (front and back).

* The patient's name, the full name of the insurance company involved, together with any information you have to identify the complete policy and/or claim number.

* Copies of any correspondence you or your patient has received concerning this matter, including all related EOBs.

* A copy of the patient's original signed Assignment of Benefits.

cp5b - Provider request for additional info short

(to provider)

The California Department of Insurance is currently reviewing the above referenced provider complaint. In order to proceed with its review of the submitted complaint, the Department requests the following additional information:

- 1.
- 2.

Please respond within 20 calendar days and include a copy of this letter with your response. Mail your response to the Department at the following address:

Department of Insurance
Claims Service Bureau
Health Care Provider Complaint Unit
300 South Spring Street, 11th Floor
Los Angeles, CA 90013

If we do not hear from you within the next twenty (20) days, we will assume you that you are not interested in pursuing the matter at this

Complaint	Subject
OPEN	OPEN



06 - Provider opening letter

We are in receipt of your Health Care Provider Request for Assistance and have initiated our investigation. So that you may anticipate what will happen with your file, the following is a brief explanation of the complaint review process:

We have furnished the insurance company with a copy of your request.

The insurance company will re-evaluate its handling of the claim and will respond to both you and the Department. Insurance laws provide the insurer with twenty-one days to respond to the Department's letter, although this period may extend a few days longer, taking into account mailing times.

We will make every effort to complete our investigation process quickly. However, due to the complexity of claim issues, we may need to communicate several times with the insurer and conduct research into disputed points. This may result in your file being open sixty days or longer, but please be assured that your concerns are important to us. We will advise you of our findings when we conclude our investigation.

Thank you for contacting us with your concerns. If you have any questions, please contact the undersigned.

Appendix

Signature

SEARCH

Complaint Subject

Open Open

Middle Middle

Close Close

MSWORD

List of Paragraphs



Find

csb%

User Code	Description	Paragraph	DIV
csb60u	Re-Open - New File Number (Complainant)	Please note the new file number assigned to this case and r	CCC
5	Variable - closing	Upon our receiving this information, we will determine our al	CCC
csb616	Closing in 30 days	If we do not hear from you in 30 days we will assume that t	CCC
csb61q	Closing - Returning Documents	We are returning the original documents you submitted.□□	CCC
csb6217	VIP Closing paragraph	Since @@@ has expressed an interest in your inquiry, a cc	CCC
csbVIP-2	Ombudsmen's Closing to VIP	Proposed Closing Letter □□Dear (Name of Legislator) : □□A	CCC
csbhcp1	Provider C-C Ineligible	Thank you for contacting the California Department of Insura	CCC
csbhcp3	Provider S/O/C - Referrals	We are in receipt of your provider complaint form and assoc	CCC
csbhcp7	Provider Closing Favorable	We have completed our investigation into the insurance com	CCC
csbhcp8	Provider Closing Unfavorable	We have completed our investigation into the insurance com	CCC
csbmedia	Residential Mediation Referral to CCB-closing letter	□Please be advised that a further review of your complaint	CCC
csb1899L	Office of Personnel Management	OFFICE OF PERSONNEL MANAGEMENT □	ACC



Activities for a Case...

cp1 - Provider Open-Close Ineligible

Thank you for contacting the California Department of Insurance. We are in receipt of your request for assistance.

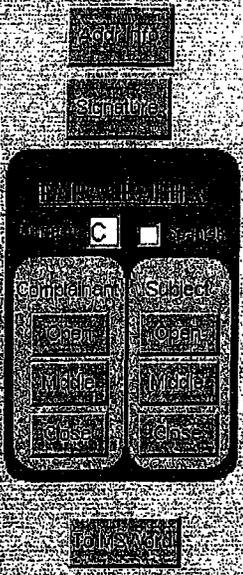
To be eligible for a Departmental review, the complaint must involve a disputed claim with a date of service on or after January 1, 2006.

(Select one or more of the following)

Our review of the documents indicates the claim date(s) of service is/are prior to January 1, 2006.

The issues in your complaint do not relate to the processing of a claim.

Therefore, this complaint is not eligible for review by this Department. We are returning any original documents you may have submitted.



c p3 Provider S/O/C -Referrals

We are in receipt of your provider complaint form and associated documents you may have submitted. This Department's regulatory responsibility lies solely with health insurance policies written in this state by our licensees.

Based on the information provided, it appears your patient's health coverage is provided through _____ (select one)

- A Self Funded Plan
- An HMO Plan
- A Health Plan issued from another state
- A Workers Compensation Policy
- A Medicare Plan
- Other: Explain

Therefore, this coverage is not within our jurisdiction and not eligible for review.

Self-funded Employee Benefit Plans and Union Health and Welfare Trust Funds are regulated by the United States Department of Labor. They

Signature

Signature

COMPLAINANT

SEARCH

Complainant	Subject
Case	Case
View	View
Close	Close

Print



Case #7 Provider Closing Favorable

We have completed our investigation into the insurance company's handling of the disputed claim(s).

Recent information provided by the above-captioned insurer states that the claim issues you originally brought to our attention have been resolved. If they are not, please contact us at your earliest convenience.

Thank you for getting in touch with us. It is through contacts such as yours that the California Department of Insurance (CDI) is alerted to potential problems that occur in the insurance industry. Certainly the Department would find its task of regulating the insurance industry much more difficult without the help of interested parties like you.

If you have any questions on other insurance-related matters, a good source of information is the CDI's internet website at www.insurance.ca.gov or you may call our toll-free telephone number at 1-800-927-HELP.

COMMENTS
SIGNATURE
PRINTED BY C
PRINTED DATE
COMPLETED
COMPLETED DATE
COMPLETED BY
COMPLETED DATE
CLOSE
CLOSE
CLOSE

Calacp8 - Provider Closing Unfavorable

We have completed our investigation into the insurance company's handling of the disputed claim issues you recently brought to our attention.

At our request, the insurance company has reviewed its handling of the claim. The insurer believes it has properly considered this matter under the terms of the insurance contract and has cited the reasons supporting its position. These reasons are outlined in its letter of (insert date), a copy of which was sent to you.

After reviewing the information provided, we conclude that we are unable to assist you further with this matter. The issues involved with your complaint indicate that there is a difference of opinion between you and the insurance company that this Department, as outlined in California Insurance Code Section 12921.4(a), does not have the authority to decide.

The Department's action on your file is not meant to reflect on the ultimate merits of any potential legal case nor is it intended to discourage you from taking further action that you deem appropriate. The Department's review is based on the information and documents

Calacp8

Signature

COMPLAINANT

DATE:

Complainant	Subject
DOB	DOB
VOL	VOL
DOB	DOB

DATE:

List of Paragraphs



Find

C%

User Code	Description	Paragraph	DIV
csb623	Opening To Insurer	We have received your recent letter.	CSO
csb624	Request For File	We have received your recent correspondence concerning	CSO
csb621	Company's Position To Complainant (New)	Thank you for your recent letter concerning the captioned m	CSO
csb62u	Closing To Company	We have completed our review of the above subject matter	CSO
csb62v	Insured's Response To Company	We received your recent correspondence with copy to the	CSO
csb62y	Senior Letter	This letter is to inform you that an insurance officer of this D	CSO
csb62z	Senior Letter - 1st Follow-Up	Kindly refer to my letter of recent date which I have not as y	CSO
csb790nj	Violation Letter -- Complaint Not Justified	On (date complaint received by D.O.I), a complaint was file	CSO
csb790x	Violation Letter -- Complaint Justified	On (date complaint received by D.O.I), a complaint was file	CSO
csb899A	1899 - Opening to Insurer(unrepresented consumer)	Mr/Ms. has contacted this office in connection with his/her t	CSO
csbJust	Justification Letter	Re: Department Compliance with California Insurance Code	CSO
csbPR	MEDICAL PAYMENT COVERAGE	This is a follow up to your _____ response to the	CSO
csbacy	ACV \$ amount determined by company	It is clear from our review of the documents provided that \$	CSO
csbhcp8	Opening To Company	We have received the request for assistance reference	CSO





csbhcp9 - Provider Opening to Insurer

We have received the request for assistance referenced above, see enclosed.

The complainant contends that claims have been incorrectly processed.

We request that you reevaluate this problem and in no later than twenty-one (21) days inform the complainant in writing of the results.

Please send us a copy of your letter to the complainant and a copy of all claims information related to the services in question. All relevant information that is being stored electronically should be duplicated to hard copy prior to submission. In addition please include a spreadsheet that displays all bills for the period ----- through ----- with the dates received, dates processed, dates and amounts paid. Please provide copies of the actual bills and the EOB's along with any correspondence and records of telephone contacts. With this material, please forward a copy of the subject policy as issued to the insured.

Assign

Assign

SEARCH

NEW C

Complainant	Subject
Open	Open
Close	Close
Open	Open
Close	Close

Assign

APPENDIX D

INSURER CONTACTS FOR THE IMR UNIT

Deborah A. Rudolph, Quality Manager
National External Review Unit
AETNA LIFE INSURANCE COMPANY
11675 GREAT OAKS WAY
ALPHARETTA, GA 30022
(770) 346-1450 (tel)
(770) 346-1087 (fax)
887-848-5855 (toll free main line)
RudolphD@aetna.com

Anthem Blue Cross Life and Health Insurance Company
IMR contacts:

Debbie Burgio/Doris Cook, Kathy McCartt, Barbara Plexin
Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard St.

Woodland Hills, CA 91367

TEL#: (818) 234-2243 Doris Cook

TEL#: (818) 234-2937 Debbie Burgio

FAX#: (818) 234-8930

HOTLINE# TO DETERMINE JURISDICTION or Subscriber INFORMATION FOR ALL

Anthem Blue Cross Life and Health Insurance Company: (818)234-3471

Miriam Mondragon, Hotline Contact/Jurisdiction

Tel#: (818) 234-3471 fax#: (818) 785-2825

Additional Hotline Contacts: Kathy McCartt, Barbara Plexin

Emma Flores, Manager Corporate Quality Review

Anthem Blue Cross Life and Health Insurance Company Behavioral

Melissa Wynn

9655 Granite Ridge Drive, 6th Floor

San Diego, CA 92123

TEL#: (858) 571-8235

FAX#: (858) 571-6092

Ron McGinnis, Director Grievance & Appeals

Tel#: (818) 234-3125

Blue Shield of Calif. Life & Health Appeal/Grievance Unit

6300 Canoga Avenue, 12th Floor Woodland Hills, CA 91367

For jurisdiction or status of non IMR complaints:

Orquidea Rivers, Sr. Operations Analyst (040308)

Preferred contact by Email to: Orquidea.Rivers@blueshieldca.com

With copy to Manager Jonathan Folmsbee: jonathan.folmsbee@blueshieldca.com

Tel#: (415) 229-5720 Fax#: (415)229-5744

Blue Shield of California Life & Health Insurance Company

P.O. Box 7168

50 Beale Street, 21st Floor

San Francisco, CA 94105

Natalia Lander, IMR (020608)

Tel# (916) 350-6178

Fax# (916) 350-7405

4203 Towne Center Bl.

El Dorado Hills, CA 95762

(916)350-7405 fax

Alternate IMR Unit contact: Stephanie Davenport, IMR Unit

Tel#: (916) 350-8538 Fax#: (916) 350-7405

Cal Farm (Nationwide Health Plan)

Fax# (916) 920-7619

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Rose Jung, Lead Consultant (Primary contact)
Connecticut General Life Insurance Company
Customer Advocacy, 521
P.O. Box 4319
Scranton, PA 18505--631
Phone: (818) 500-6998
Fax: (860) 731-2984

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Executive Escalation Unit, CUSTOMER ADVOCACY-C-301
P.O. BOX 990002
HARTFORD, CT 06199-0002
Fax#: (860) 731-2984
Tel#: (623) 516-7022

Lea Tonkin (Scranton Pennsylvania) (570) 496-5381 fax: (860) 731-2984 (1st Backup)

Sherrie Wolfe, Customer Advocate Consultant (5/17/06) (2nd Backup)

Executive Office of the President

Cigna HealthCare

3900 E. Mexico Ave., #100

Denver, CO 80210 sherriewolfec@cigna.com

Also: Erika Albury Tel# (410) 437-6231 (Internal STD Appeals only) (3rd Backup)

Note: Lisa Marie Golden for CIGNA Behavioral Health

Tel# (818) 551-2711 Fax# (818) 551-2711

450 North Brand Blvd., Suite 500

Glendale, CA 91203 (623) 516-7022

FORTIS INSURANCE COMPANY

Steven Johnson/Claudia Dietrich

MARKET CONDUCT ANALYST

FORTIS INSURANCE COMPANY

ASSURANT HEALTH (as of 12/1/04)

P.O. BOX 3050

MILWAUKEE, WI 53201

Tel#: (414) 299-8102

Tel#: (800) 454-5105 ext 6239 (toll free) Fax#: (299-7555)

GREAT-WEST LIFE & ANNUITY CO.

Attn: Maria E. Rivera (3/21/07)

655 North Central Ave, 20th Floor

Glendale, CA 91203

Fax#: (866) 817-9340 Tel#: (818) 539-9006

Karen Brown Tel: (800) 537-2033 ext 71683 or (303) 737-1683

General Contact person: Maricel Del Rosario (818) 539-9041

(800) 325-5079 general customer service for jurisdiction information

Note: Great-West Healthcare the administrator for Great-West Life and Annuity Insurance Co. was acquired by CIGNA in 2008; see CIGNA for contacts.

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Al J. LaFaive (11/10/05) IMR contact

Manager Group Quality

The Guardian Life Insurance Company

2300 E. Capitol Dr.

Appleton, WI 54911-8730

Miriam Lopez, Manager (9/1/05)

GUARDIAN COMPLIANCE,

7 HANOVER SQUARE Area 19-A

NEW YORK, NEW YORK 10004

Tel#: (212) 598-8704 Fax#: (212) 919-3339

(THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA continued)

Magdalia Rosado, Assistant

Tel#: (212) 598-8862 Fax#: (212) 919-3339

CC: Janet Eckstein (claims office)

Tel#: (920) 749-6193 Fax#: (920) 749-6229

Secondary contacts: Greg Rankin, Karen Reagan, Managed Benefits Unit:

Tel#: (920) 749-5325 Fax#: (920) 749-5332

Melissa Fritz, Medical Claims Supervisor (11/21/05)

Tel# (800) 872-4542 Fax#: (920) 749-5655

HEALTH NET LIFE INSURANCE COMPANY

PAUL SEDGWICK

DIRECTOR, REGULATORY COMPLIANCE

HEALTH NET LIFE INSURANCE COMPANY

11971 FOUNDATION PLACE

RANCHO CORDOVA, CA 95670

Tel#: (916) 935-6623

Fax#: (916) 935-4533

(Health Net requests we fax copies of our IMR correspondence to Mr. Sedgwick

and also to: Legal Affairs; Marci Armin/Eden Rich/Carol Kolosseus

/Barbara Millman @ Fax#(818) 676-8958 Tel# (818) 676-6333

21281 Burbank Blvd.

Woodland Hills, CA 91367-6607 Or P.O. Box 9103 Van Nuys, CA, 91409-9103

Marci Armin Tel#: (818) 676-6857

HUMANA INSURANCE COMPANY

ATTN: Jesse Cisneroz

1100 Employers Blvd.

Green Bay, WI 54344

Tel#: (900) 558-4444 ext 7951

Fax#: (920) 337-7661

Kaiser Insurance Company (510) 271-5917

Ingrid Mealer, National Operations Manager

Kaiser Permanente Insurance Company

300 Lakeside Drive, 26th Floor

Oakland, CA 94612

(510) 271-6391

E-mail: ingrid.mealer@kp.org

George Kitzmiller, Director of Operations

Tel#: (510) 271-2614

Fax#: (510) 271-4816

E-mail: george.kitzmiller@kp.org

UNITED OF OMAHA LIFE INSURANCE COMPANY

KRISTY KIVINIEMI RB,BS

GRIEVANCE AND APPEALS SECTION

UNITED OF OMAHA LIFE INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA

OMAHA, NE 68175

Tel#: (402) 351-8065

Fax#: (402) 351-1682

4/28/05

Another Mutual of Omaha contact to add to the contact list:

JANE MANCZUK, RN

APPEALS COORDINATOR

MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA

OMAHA, NE 68175

FAX (402) 351-1682

TEL (800) 228-0286, EXT 8061 (direct line)

TEL (402) 342-7600 (company line)

Jane.Manczuk@mutualofomaha.com

Nationwide Life Insurance Company
Nationwide Health Plans
Linda Pender, IMR Unit (012408)
Tel#: (800)237-7767 ext 4757
Fax#: (813)289-7937
Nationwide Life Insurance Company
Nationwide Health Plans
5525 Park Center
MS CO-01-25
Dublin, OH 43017

Nippon Life Insurance Company
Cindy Peterson, External Grievance Unit
Nippon Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0302
Tel#: (515) 247-6785
Fax#: (515) 246-4906
Additional contact:
Sherry Ferry
Tel# (800) 897-7948
Fax#: (515) 246-4906
Tel#: (515) 247-5435

Pacific Life & Annuity
Gail Burnikel, Supervisor (11/6/06)
Pacific Life & Annuity
C/O Midwest Securities
2700 Midwest Drive
Onaska, Wisconsin 54650-8764
Tel#: (800) 584-0117
(This TPA will handle the few remaining runoff claims that exist for
Pacific Life & Annuity which was merged into United HealthCare on 4/27/05 and
then ceased writing policies on 1/1/06)

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
~~Melissa Bailey, Appeals Research Analyst~~
~~714-226-8506~~
(866) 744-4543 Appeals and Grievance by committee (8/14/08)
5757 Plaza Drive, Mailstop CY44-157
Cypress, CA 90630
Phone: (714) 226-8506
Fax: (800) 558-4755
DRP fax# (866) 505-2284
Alternate Tel#: (800) 744-4543
Email: melissa.bailey@phs.com
Secondary contacts:
PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
Linda Clark
Tel#: (800) 624-7272
Fax#: (888) 615-6584
PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
P.O. BOX 6098
CYPRESS, CA 90630
Tel#: (714) 226-3014
Fax#: (714) 226-3462
PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
Kristy Tondre, Supervisor Appeals, IMR's (2/21/07)
Tel#: (210) 474-5190
Fax#: (888) 615-6584
Robin Warren (12/15/06) IMR's

(PACIFICARE LIFE AND HEALTH INSURANCE COMPANY continued)

Fax#: (888) 615-6584 (061307)
Tel#: (800) 624-7272 ext 45065
Pacificare Appeals Department
P.O. Box 4000046
Mailstop TX 0860100
San Antonio, TX 78229
Street address: 6200 Northwest Parkway
San Antonio, Texas 78249
Tel#: (800) 624-7272 ext 46065 Fax#: (888) 615-6584
PACIFICARE BEHAVIORAL HEALTH
Fran Bridge, Director of Compliance (091807)
425 Market St., 18th Floor
San Francisco, CA 94105
Tel# (415) 547-5354
Fax# (415) 547-5608

Principal Life Insurance Company
Cindy Peterson, External Grievance Unit
Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0302
Tel#: (515) 247-6785
Fax#: (515) 246-4906

Trustmark Life Insurance Company
Mr. Timothy Moore (11/23/05)
General Counsel
Trustmark Life Insurance Company
400 Field Dr.
Lake Forest, IL 60045
Tel#: (847) 615-3872
Fax#: (847) 283-4300
IMR's processed by additional contact
Missy Argiro (11/17/05)
Trustmark Life Insurance Company
Regional Benefits Office
P.O. Box 9055
Boardman, Ohio 44513-9055
Tel#: (330) 758-2212
Fax: (330) 965-7599
Add'l contact for all compliance/IMR's: Frank Lettera, ATTY
(847)283-4018 Fax (847) 615-3872

UNICARE Life and Health Insurance Company (1/9/08)

UniCare
Attn: Abigail Guevara
233 Wacker Drive
Chicago, Ill 60606
TEL#: (800) 705-7988 Doris Cook
FAX#: (312) 234-7502
FAX#: (877) 494-3083
E-Mail to: UNICARE.DOI@WELLPOINT.COM

UniCare Life and Health Insurance Company, NAIC 80314
UniCare Health Insurance Company of the Midwest, NAIC 70700
UniCare Health Plans of the Midwest Inc., NAIC 95505
UniCare Health Plans of Texas, Inc., NAIC 95420
UniCare Health Insurance Company of Texas, NAIC 10076

United Healthcare Insurance Company
Consumer and Regulatory Affairs
United Healthcare Insurance Company
MN015-2824

4316 Rice Lake Road
Duluth, MN 55811

Fax: (414) 918-3480 (2/15/08)

Tel# (218) 279-6534

Tami Rustad Central Escalation Unit (CEU) (3/5/08)

1st Alternate (designated responder and intervener)

Tel#: (218) 624-0691

DOI APPEALS - WESTERN & CENTRAL REGION

Sarah Lamphier (Non-IMR Complaints 3/30/06)

Consumer & Regulatory Affairs Department

UNITED HEALTHCARE INSURANCE COMPANY

MN015-2824

4316 RICE LAKE ROAD

DULUTH, MN 55811

Tel#: (218) 279-6764

Tel#: (866) 314-8152 ext 2182796764

Fax#: (218) 279-6912

Secondary contacts:

Judy D'Ambrosio, VP

Tel #: (714) 226-3799

5995 Plaza

MS CA112-0267

Cypress, CA 90630

Valerie Ridge Tel #: (714) 226-3345

Kathy Brownlee Tel#: (218) 279-6496

Cheryl Carlson, regulatory Analyst (10/5/06)

Tel#: (218) 529-8476

Fax#: (218) 279-6912

Yvette Little (7/28/06)

United Healthcare Insurance Company

MNO15-2824

4316 Rice Lake Road

Duluth, MN 55811

Tel# (218) 529-8542

Fax#: (218) 279-6912

Petra Anderson

Tel#: (218) 279-6569

Fax#: (218) 279-6912

Duluth Appeals Unit (fully insured): (800) 525-6377

Appeals Unit Tel#: (800) 396-0378 ext 5443

United Behavioral Health (UBH)

Appeal Department Tel#: (866) 566-8166

Fran Bridge, Director of Compliance

United Behavioral Health (also PBH)

425 Market Street, 27th Floor

San Francisco, CA 94105

Tel#: (800) 333-8724 ext 5354

Fax# (415) 547-5608 (provided by Fran Bridge on 1/4/08)

Fax# (262) 313-9892

Center for Health Dispute Resolution at Maximus (MAXIMUS/CHDR)

MAXIMUS/CHDR

attn: Tom Naughton

~~3130 KILGORE ROAD, STE 100~~

~~RANCHO CORDOVA, CA 95670~~

New Address Effective 8/26/08

11000 Olson Drive, Suite 200

Rancho Cordova, CA 95670

Tel#: (916) 364-8146

Fax#: (916) 364-8134

Julia Wood, Administrative Assistant

Tel (916) 669-3627

Fax (916) 364-8134

JuliaWood@maximus.com

Katherine Beshaw, Administrative Assistant

Tel: (916) 996-3632

Frances McNeil

francesmcneil@maximus.com

Tel#: (916) 336-3628

California Department of Managed Health Care (DMHC)

Lyn Gage RN

Health Program Manager I

HMO Help Center

IMR Unit

(916) 229-0315

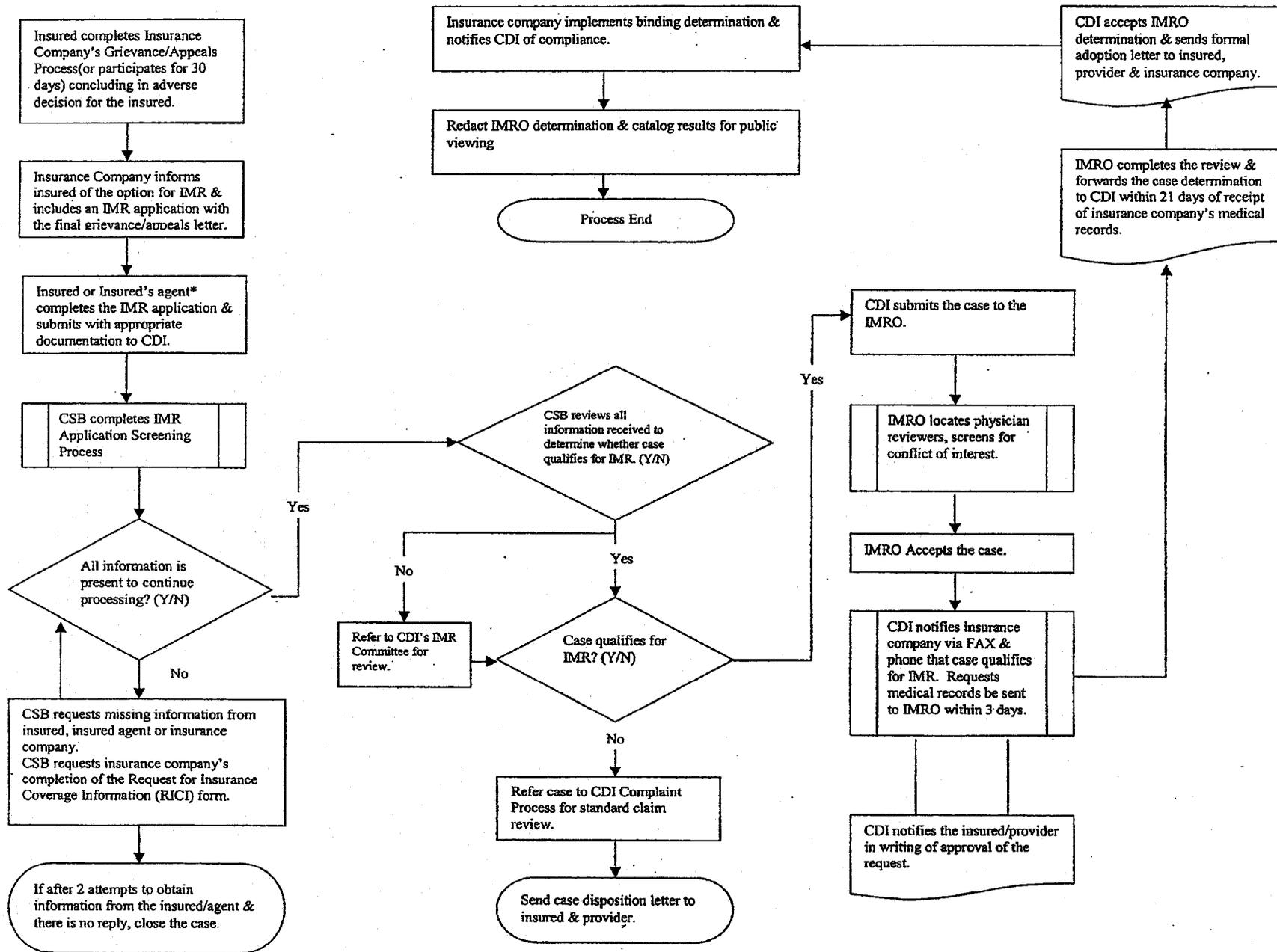
FAX (916) 229-4797

(The above contact information was current as of 8/26/08. Periodic updates to reflect changes and additions in contact info is required and should be shared with other IMR Unit Members)

APPENDIX E

CSB – Standard Process for Medical Necessity IMR
IMR Flow

As of: December 2000



APPENDIX F

PCA Codes

PCA Codes	Description
20	CSB-All Auto Complaints
21	CSB-Northern California Fires - 2007
22	CSB-Disaster-Southern California Fires
23	CSB-Claim Services Bureau Medical Review
24	CSB-Non 103 complaints w/companies -- non bill
25	CSB-Health Provider Complaints (Non bill)
26	CSB-Other (referrals, susp o/c, comp against "other")
27	CSB-Earthquake Mediation
81	CSB-Firestorm 2007 (Case specific)

APPENDIX G

CSB HEALTH UNIT
SPECIAL HANDLING CODES

<i>SH Code</i>	<i>Description</i>	<i>Comments/Notes</i>
02A	No Special Handling with this Complaint	
03X	Legislative Referrals	
04X	Permanent File	
07X	Fraud	
09X	AIDS Case	
10X	Senior Citizen	
11X	Unfair Discrimination	
14Q	Unknown (Health Insurance)	
14R	PPO (Health Insurance)	
14S	Non – PPO (Health Insurance)	
14T	Mental Health Parity Issue	
14U	Timely Access (CIC10133.5(e) – Healthcare)	
14V	Uninsured Discount Health Plans	
14W	Health Provider Inquiries & Complaints	
14W1	Provider Contract Complaint – CIC 10133.65	
14X	Catastrophic Illness	
14Y	Preauthorization Issues (Health Policies)	
14Z	Certification Issues (Disability Policies)	
28	CSB – Claim File Review	
37X	CSB – Telephone Medical Advice Service (CIC 10279)	
39	IMR	
	IMR Subcategories	
39A	CSB – IMR (Request Only)	
39B	CSB – IMR sent to IMRO	
39C	CSB – IMR decision favorable	
39D	CSB - IMR decision unfavorable	
45	Prescription Drug Card (Health & Safety Code 1363.03)	
58	Medicare – Part D	
59	Medicare Advantage Plans	

**California Department of Insurance
2007 Consumer Complaint Study (CY 2007)**

NAIC DISPOSITION CODES - ATTACHMENT B*		
Category 1 - Positive Outcome Codes		
NAIC Disposition Code	Description	
1	1205	Policy Issued/Restored
2	1210	Additional Payment
3	1215	Refund
4	1217	Entered Into Arbitration/Mediation
5	1220	Coverage Extended
6	1225	Claim Reopened
7	1230	Claim Settled
8	1245	Advertising Withdrawn
9	1250	Underwriting Practice Resolved
10	1253	Information Furnished/Expanded
11	1255	Delay Resolved
12	1257	Fine
13	1260	Cancel Notice Withdrawn
14	1265	Nonrenewal Notice Rescinded
15	1270	Prem Problem Resolved
16	1275	Apparent Unlicensed Activity
17	1280	Referred For Disciplinary Action
18	1287	Rating Problem Resolved
19	1297	Endorsement Processed

Category 2 - Without Merit Codes		
NAIC Disposition Code	Description	
1	1235	No Action Requested
2	1295	Company Position Upheld

Category 3 - Other Outcome Codes		
NAIC Disposition Code	Description	
1	1240	Referral to proper agency
2	1285	Question of fact
3	1290	Contract provision - Legal issue
4	13 00	No jurisdiction
5	1305	Insufficient info
6	1310	Other

* Attachment B is for informational use only. The Tables display the NAIC disposition codes used to develop the 2007 Consumer Complaint Study Notification. See your Notification for more details.

ACTIVITY CODES

Code	Description
00	Case Detail Activities
01	New Call – Sending RFA
02	Call for an existing Complaint
03	Mail for a new Complaint
04	Mail for an Existing Complaint
05	SELF-ASSIGNED CASE
06	Special General Correspondence
07	VIP Referral
08	New Call – No RFA – Call Back
09	Reopened Case
10	Letter – Complainant
11	Letter – Complaint Against
14	Justified Letter Sent
15	Violation Letter Sent
17	External Referral (outside CSD)
18	Internal Transfer (CSD)
20	Follow – up
21	Supervisor Reply to Co. Appeal
22	Send an RFA – Spanish
23	Send an RFA – Residential Property and ED Mediation
24	Send an RFA – Application for Independent Medical Review
25	Print a label – Queue it up
26	Send an RFA – Health Care Provider
33	Referral – supv assignment del
34	New mail – supv assignment del
35	Analysis and Conclusion of Case
36	CCU ACTIVITY
37	CCU INTAKE
38	Legislative opening Bureau Chief Letter
39	Legislative closing Bureau Chief Letter
40	Resolution
41	Contact Us handling
47	Letter to Mediator
50	Evaluation Returned Mail
52	Special Complainant - Instructions and notes
60	CCS – Receipt of Co. Inquiry
61	CCS-CSD Response
62	File Out Card
63	Returned File Back to CSD
99	CSD Management Referral

APPENDIX H

(

INSURANCE CODE

SECTION 10169-10169.5

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

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

(c) For the purposes of this chapter, "coverage decision" means the approval or denial of health care services by a disability insurer, or by one of its contracting entities, 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 disability insurance contract. A coverage decision does not encompass a disability insurer or contracting provider decision regarding a disputed health care service.

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

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

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

(e) Every disability insurance contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall, effective, January 1, 2001, provide an insured with the opportunity to seek an independent medical review whenever health

care services have been denied, modified, or delayed by the insurer, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. For purposes of this article, an insured may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the insured in seeking an independent medical review, and may advocate on behalf of the insured.

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

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

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

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

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

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

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

(C) The insured, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by a contracting provider for the diagnosis or treatment of the medical condition for which the insured seeks independent review. The insurer shall expedite access to a contracting provider upon request of an insured.

The contracting provider need not recommend the disputed health care service as a condition for the insured to be eligible for an independent review.

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

(2) The disputed health care service has been denied, modified, or delayed by the insurer, 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.

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

(k) An insured may apply to the department for an independent

medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six months of any of the qualifying periods or events under subdivision (j). The commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(1) The insured shall pay no application or processing fees of any kind.

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

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

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

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

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

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

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

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

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

(i) The insured's medical condition.

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

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

(B) Any newly developed or discovered relevant medical records in the possession of the insurer or its contracting providers after the

initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The insurer shall concurrently provide a copy of medical records required by this subparagraph to the insured or the insured's provider, if authorized by the insured, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

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

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

10169.1. (a) If there is an imminent and serious threat to the health of the insured, as specified in subdivision (c) of Section 10169.3, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the department may waive the requirement that the insured follow the insurer's grievance process in extraordinary and compelling cases, where the commissioner finds that the insured has acted reasonably.

(b) The department shall expeditiously review requests and immediately notify the insured in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. The insurer shall promptly issue a notification to the insured, after submitting all of the required material to the independent medical review organization, that includes an annotated list of documents submitted and offer the insured the opportunity to request copies of those documents from the insurer. The department shall promptly approve insured requests whenever the insurer has agreed that the case is eligible for an independent medical review. The department shall not refer coverage decisions for independent review. To the extent an insured request for independent review is not approved by the department, the insured request shall be treated as an immediate request for the department to review the grievance.

(c) An independent medical review organization, specified in Section 10169.2, shall conduct the review in accordance with Section 10169.3 and any regulations or orders of the commissioner adopted pursuant thereto. The organization's review shall be limited to an examination of the medical necessity of the disputed health care services and shall not include any consideration of coverage

decisions or other contractual issues.

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

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

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

- (1) The insurer.
- (2) Any officer, director, or employee of the insurer.
- (3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

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

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

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

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

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

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

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

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

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

(D) The names and biographical sketches of all directors, officers, and executives of the independent medical review organization, as well as a statement regarding any past or present

relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care organization, provider group, or board or committee of an insurer, a plan, a managed care organization, or a provider group.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) The medical professional shall have no history of disciplinary

action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

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

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

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

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

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

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

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

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

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

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

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

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

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

10169.3. (a) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the insured, provider reports, as well as any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the

response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b).

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

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

(B) Nationally recognized professional standards.

(C) Expert opinion.

(D) Generally accepted standards of medical practice.

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

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

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

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

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

(g) After removing the names of the parties, including, but not limited to, the insured, all medical providers, the insurer, and any of the insurer's employees or contractors, commissioner decisions adopting a determination of an independent medical review organization shall be made available by the department to the public

upon request, at the department's cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.

10169.5. (a) After considering the results of a competitive bidding process and any other relevant information on program costs, the commissioner shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(b) The costs of the independent medical review system for insureds shall be borne by disability insurers pursuant to an assessment fee system established by the commissioner. In determining the amount to be assessed, the commissioner shall consider all appropriations available for the support of this article, and existing fees paid to the department. The commissioner may adjust fees upward or downward, on a schedule set by the department, to address shortages or overpayments, and to reflect utilization of the independent review process.

(c) The commissioner may contract with the Department of Managed Health Care to administer the requirements of this article.

Experimental/Investigational

10145.3. (a) Every disability insurer that covers hospital, medical, or surgical benefits shall provide an external, independent review process to examine the insurer's coverage decisions regarding experimental or investigational therapies for individual insureds who meet all of the following criteria:

(1) (A) The insured has a life-threatening or seriously debilitating condition.

(B) For purposes of this section, "life-threatening" means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(C) For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

(2) The insured's physician certifies that the insured has a condition, as defined in paragraph (1), for which standard therapies have not been effective in improving the condition of the insured, for which standard therapies would not be medically appropriate for the insured, or for which there is no more beneficial standard therapy covered by the insurer than the therapy proposed pursuant to paragraph (3).

(3) Either (A) the insured's contracting physician has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the insured than any available standard therapies, or (B) the insured, or the insured's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d), is likely to be more beneficial for the insured than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require the insurer to pay for the services of a noncontracting physician, provided pursuant to this subdivision, that are not otherwise covered pursuant to the contract.

(4) The insured has been denied coverage by the insurer for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3), unless coverage for the specific therapy has been excluded by the insurer's contract.

(5) The specific drug, device, procedure, or other therapy recommended pursuant to paragraph (3) would be a covered service except for the insurer's determination that the therapy is experimental or under investigation.

(b) The insurer's decision to deny, delay, or modify experimental or investigational therapies shall be subject to the independent medical review process established under Article 3.5 (commencing with Section 10169) of Chapter 1 of Part 2 of Division 2, except that in lieu of the information specified in subdivision (b) of Section 10169.3, an independent medical reviewer shall base his or her determination on relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence defined in subdivision (d).

(c) The independent medical review process shall also meet the following criteria:

(1) The insurer shall notify eligible insureds in writing of the opportunity to request the external independent review within five business days of the decision to deny coverage.

(2) If the insured's physician determines that the proposed

therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three days for a delay in providing the documents required. The timeframes specified in this paragraph shall be in addition to any otherwise applicable timeframes contained in subdivision (c) of Section 10169.3.

(3) Each expert's analysis and recommendation shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for the insured than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be covered by the insurer, citing the insured's specific medical condition, the relevant documents, and the relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence as defined in subdivision (d), to support the expert's recommendation.

(4) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the contract.

(d) For the purposes of subdivision (b), "medical and scientific evidence" means the following sources:

(1) 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.

(2) Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS data base Health Services Technology Assessment Research (HSTAR).

(3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

(4) The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.

(5) 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 Institutes of Health for the purpose of evaluating the medical value of health services.

(6) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

(e) The independent review process established by this section shall be required on and after January 1, 2001.

10145.4. (a) For an insured diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer, every policy of disability insurance that provides hospital, medical, or surgical coverage in this state shall provide coverage for all routine patient care costs related to the clinical trial if the insured's treating physician, who is providing covered health care services to the insured under the insured's health benefit plan contract, recommends participation in the clinical trial after

determining that participation in the clinical trial has a meaningful potential to benefit the insured. For purposes of this section, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

(b) (1) "Routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:

(A) Health care services typically provided absent a clinical trial.

(B) Health care services required solely for the provision of the investigational drug, item, device, or service.

(C) Health care services required for the clinically appropriate monitoring of the investigational item or service.

(D) Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.

(E) Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

(2) For purposes of this section, "routine patient care costs" does not include the costs associated with the provision of any of the following:

(A) Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.

(B) Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that an insured may require as a result of the treatment being provided for purposes of the clinical trial.

(C) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

(D) Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under the insured's health plan.

(E) Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

(c) The treatment shall be provided in a clinical trial that either (1) involves a drug that is exempt under federal regulations from a new drug application or (2) that is approved by one of the following:

(A) One of the National Institutes of Health.

(B) The federal Food and Drug Administration, in the form of an investigational new drug application.

(C) The United States Department of Defense.

(D) The United States Veterans' Administration.

(d) In the case of health care services provided by a contracting provider, the payment rate shall be at the agreed-upon rate. In the case of a noncontracting provider, the payment shall be at the negotiated rate the insurer would otherwise pay to a contracting provider for the same services, less applicable copayments and deductibles. Nothing in this section shall be construed to prohibit a disability insurer from restricting coverage for clinical trials to hospitals and physicians in California unless the protocol for the clinical trial is not provided for at a California hospital or by a California physician.

(e) The provision of services when required by this section shall not, in itself, give rise to liability on the part of the insurer.

(f) This section shall not apply to vision-only, dental-only,

accident-only, specified disease, hospital indemnity, Medicare supplement, CHAMPUS supplement, long-term care, or disability income insurance, except that for specified disease and hospital indemnity insurance, coverage for benefits under this section shall apply, but only to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy. Nothing in this section shall be construed as imposing a new benefit mandate on specified disease or hospital indemnity insurance.

(g) Nothing in this section shall be construed to prohibit, limit, or modify an insured's rights to the independent review process available under Section 10145.3 or to the Independent Medical Review System available under Article 3.5 (commencing with Section 10169).

(h) Nothing in this section shall be construed to otherwise limit or modify any existing requirements under the provisions of this chapter or to prevent application of deductible or copayment provisions contained in the policy.

(i) Copayments and deductibles applied to services delivered in a clinical trial shall be the same as those applied to the same services if not delivered in a clinical trial.

10144.5. (a) Every policy of disability insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after July 1, 2000, shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions, as specified in subdivision (c).

(b) These benefits shall include the following:

- (1) Outpatient services.
- (2) Inpatient hospital services.
- (3) Partial hospital services.
- (4) Prescription drugs, if the policy or contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section that shall be applied equally to all benefits under the disability insurance policy shall include, but not be limited to, the following:

- (1) Maximum lifetime benefits.
- (2) Copayments and coinsurance.
- (3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:

- (1) Schizophrenia.
- (2) Schizoaffective disorder.
- (3) Bipolar disorder (manic-depressive illness).
- (4) Major depressive disorders.
- (5) Panic disorder.
- (6) Obsessive-compulsive disorder.
- (7) Pervasive developmental disorder or autism.
- (8) Anorexia nervosa.
- (9) Bulimia nervosa.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

(f) (1) For the purpose of compliance with this section, a disability insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A disability insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, disability insurers are not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a disability insurer may utilize case management, managed care, or utilization review.

(4) Any action that a disability insurer takes to implement this

section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(g) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

FAIR CLAIMS REGULATIONS
Effective 08/30/06

08/22/2008

VIOLATION TYPE "08" CODING SUMMARY			
Preamble			
VIOLATION SECTION	VIOLATION CODE (CSP)	VIOLATION DESCRIPTION	
1	2695.1f	140	Policy provisions shall be consistent with or more favorable to the insured than these regulations.
2	2695.1g	241	Commissioner access to records; power to examine; information reliability; confidentiality
File and Record Documentation			
VIOLATION SECTION	VIOLATION CODE (CSP)	VIOLATION DESCRIPTION	
3	2695.3a	1	File must contain all documents.
4	2695.3b1	2	Must maintain retrievable claim data.
5	2695.3b2	3	Must record date documents received.
6	2695.3b3	4	Must maintain files for current and last 4 years.
7	2695.3c	242	Plan submission regarding documentation due to inability to comply in unusual circumstances
Representation of Policy Provisions			
VIOLATION SECTION	VIOLATION CODE (CSP)	VIOLATION DESCRIPTION	
8	2695.4a	5	Must disclose all benefits, time limits & possible applicable provisions to 1st party claimants.
9	2695.4b	243	Cannot misrepresent or conceal provision of surety bond.
10	2695.4c	7	Cannot deny claim for failing to exhibit property-exceptions apply-see Regulations.
11	2695.4d	72	Cannot impose a time limit on filing 1st party claim unless time limit is stated in policy.
12	2695.4e1	9	Cannot require a release beyond claim unless legal effect explained in writing-see Regulations.
13	2695.4f	73	Cannot issue a partial payment with Release unless policy limits paid or compromise reached.
14	2695.4g	74	Cannot request duplicate proof of claim when coverage exists on more than 1 policy.
Duties upon Receipt of Communications			
VIOLATION SECTION	VIOLATION CODE (CSP)	VIOLATION DESCRIPTION	
15	2695.5a	15	Must respond to the California Department of Insurance within 21 calendar days.
16	2695.5b	16	Must provide complete response to claimant inquiries within 15 calendar days.
17	2695.5c	11	Authorization designating representative for claimant must be in writing.
18	2695.5d	107	Licensee or claims agent must immediately forward notice of claim to insurer.
19	2695.5e1	12	Must acknowledge notice of claim within 15 calendar days unless payment is made.
20	2695.5e2	17	Must supply forms, instructions & assistance within 15 calendar days of claim notification.
21	2695.5e3	18	Must begin investigation within 15 calendar days of notification of claim.
22	2695.5f	14	Cannot require a written notice of claim unless provided for in policy.
Training and Certification			
VIOLATION SECTION	VIOLATION CODE (CSP)	VIOLATION DESCRIPTION	
23	2695.6a	19	Must adopt and communicate claim standards to employees in writing.
24	2695.6b	75	Licensees shall provide thorough and adequate training to claim handlers except attorneys.
25	2695.6b1	20	Individual licensees must certify annually as to understanding of regulations.
26	2695.6b2A	21	Claims manual must contain copy of Regulations.
27	2695.6b2B	22	Must provide written instruction to claims adjusters.

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VIOLATION TYPE "08" CODING SUMMARY			
Standards for Prompt, Fair and Equitable Settlements			
VIOLATION SECTION	VIOLATION CODE (CS)	VIOLATION DESCRIPTION	
28	2695.6b3	108	Must provide training for insurance adjusters.
29	2695.6b4	24	Certification of training on Regulations must be maintained at principal place of business.
30	2695.6b5	76	Certification must be completed on or before September 1 of each year.
31	2695.7a	25	Cannot discriminate in claims settlement practices.
32	2695.7b	109	Must accept/deny or provide written delay notice within 40 calendar days of proof of claim.
33	2695.7b1	244	Must deny all claims in writing. Must cite statute, applicable law or policy provision on 1st party claims.
34	2695.7b3	111	Must notify claimant that claim denial can be reviewed by the California Dept. of Insurance.
35	2695.7c1	29	Must notify in writing every 30 calendar days if more time is required to investigate claim.
36	2695.7d	112	Insurer shall conduct a thorough, fair and objective investigation. Cannot seek unnecessary information from claimant.
37	2695.7e	245	Delay or deny settlement of 1st party claim based on responsibility for payment assumed by others
38	2695.7f	32	Written notice before 60 days of expiration of statute of limitations on bodily injury claims.
39	2695.7g	246	Cannot attempt settlement with unreasonably low offers. See subsections 1-7.
40	2695.7h	114	Must pay within 30 calendar days of accepting claim-exceptions apply- see Regulations.
41	2695.7i	77	Claimant rights not impaired if form/release unsigned unless notification is regarding statute of limitations or policy provision.
42	2695.7j	36	Cannot require polygraph test unless authorized by policy & state law.
43	2695.7k1	115	Must make diligent attempt to verify fraud within 80 calendar days from suspicion of fraud.
44	2695.7k2	116	Must make diligent attempt to verify fraud beyond 80 calendar days as ordered by the Commissioner.
45	2695.7l	39	Cannot deny claims bases on oral statement unless documented in file.
46	2695.7m	40	Cannot offset medical overpayment after paying provider-see Regulation for exceptions.
47	2695.7n	117	Cannot conduct unreasonable Independent Medical Exam to determine liability on medical claim.
48	2695.7o	118	Cannot require claimant to withdraw, rescind, or refrain from submitting claims complaint to the California Dept. of Insurance.
49	2695.7p	119	Must notify in writing the 1st party claimant when pursuing subrogation of the claim - see Regulations.
50	2695.7q	120	Subrogation demand must include 1st party deductible and cannot deduct legal or other expenses from recovery.
VIOLATION TYPE "08" CODING SUMMARY			
Additional Standards Applicable to Life and Disability Insurance			
VIOLATION SECTION	VIOLATION CODE (CS)	VIOLATION DESCRIPTION	
81	2695.11a	135	Cannot offset overpayments on health claims unless clearly erroneous-see Regulations.
82	2695.11b	70	Must provide an EOB on medical claims.
83	2695.11d	136	Life and Disability insurer shall affirm or deny within 30 calendar days from original notification - see CIC Section 10123.13.

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84	2695.11e	137	Preauthorization of non-emergency medical services must be given in writing immediately but in no event more than 5 calendar days.
85	2695.11f	138	No preauthorization shall be required by insurer for emergency medical services.

Compliance Date			
VIOLATION SECTION	VIOLATION CODE(S)	VIOLATION DESCRIPTION	
86	2695.14a	261	Compliance with amended regulations shall be within 90 calendar days after filing with Secretary of State
87	2695.14b	262	Prior to compliance date licensees shall adopt and communicate standards, provide training and instructions to claims agents
88	2695.14c	263	Regulations shall apply to any claims handling that takes place on or after compliance date in subsection a.

Unfair Practices -- California Insurance Code Sections

99	790.034	99	Regulations; settlement of claims; insurer's duties
100	790.03h1	78	Misrepresenting facts or policy provisions.
101	790.03h2	79	Failing to acknowledge and act promptly upon communications.
102	790.03h3	80	Failing to adopt and implement standards for the prompt investigation and processing of claims.
103	790.03h4	81	Failing to affirm or deny coverage within a reasonable time after proof of loss requirements have been completed.
104	790.03h5	82	Not attempting to effectuate prompt, fair, and equitable settlements of claims in which liability has become clear.

VIOLATION TYPE "00" CODING SUMMARY

Unfair Practices (continued) -- California Insurance Code Sections

VIOLATION SECTION	VIOLATION CODE(S)	VIOLATION DESCRIPTION	
105	790.03h6	83	Compelling insured to institute litigation to recover amounts due by offering less than the amounts recovered in actions brought by insureds, when the claims were for amounts similar to the amounts recovered.
106	790.03h7	84	Attempting to settle a claim by an insured for less than the amount which a reasonable man believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.
107	790.03h8	85	Attempting to settle claims on the basis of an application which was altered without notice, or knowledge or consent of, the insured, his or her representative, agent or broker.
108	790.03h10	87	Making known to insureds or claimants a practice of appealing from arbitration awards for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.
109	790.03h11	88	Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, containing the same information..
110	790.03h12	89	Failing to settle claims promptly, under one portion of a policy in order to influence settlements under other portions of the policy.
111	790.03h13	90	Failing to provide an explanation of the basis relied on in the policy, in relation to the facts or law, for the denial of claim or for the offer of a compromise settlement.
112	790.03h14	91	Directly advising a claimant not to obtain the services of an attorney.
113	790.03h15	92	Misleading a claimant as to the applicable statute of limitations.

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114	790.03h16	93	Delaying the payment of medical benefits for services provided for AIDS or AIDS-related complex for more than 60 days after the insurer has received a claim, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. (This 60-day period does not include any time during which the insurer is awaiting a response for medical information from a health care provider.)
Other Pertinent Information -- California Insurance Code Sections			
115	880	94	Must do business in own name.
116	1736.5	158	Producers must respond in writing to CDI inquiries within 21 days.
Fraud California Insurance Code Sections			
117	1871.2	98	Fraud clause
120	1872.4A	101	Insurer's belief of a fraudulent claim to be reported to Fraud Bureau within 60 days.
124	1879.2	143	Notice of penalty for fraudulent claims to appear on claim forms.
VIOLATION TYPE "00" CODING SUMMARY			
Life and Health California Insurance Code Sections-Continued			
	VIOLATION SECTION	VIOLATION CODE (CS)	VIOLATION DESCRIPTION
131	2083	147	Issuance of CA fire policy varying from std form is a misdemeanor
132	10111.2	105	Disability Income claims paid in 30 calendar days of receiving requirements or interest due.
133	10123.12	161	Health Insurer disclosure: Required language in conspicuous place to prospective insureds or enrollees
134	10123.13	95	Must pay, deny or give notice of delay on health claims within 30 working days. 10% interest on late payments. Code section used prior to July 01, 2006.
135	10123.13a	162	Claims must be paid, reimbursed, contested, or denied in 30 days to insured and provider. If contested written notice must contain DOI contact language. Code section used after July 01, 2006.
136	10123.13b	163	
137	10123.13c	164	For uncontested claims not paid within 30 days interest is due at 10% per year.
138	10123.13d	165	Contested claims become payable in 30 days or interest at 10% per year is due, after receipt of all required information.
139	10123.88	160	The obligation to comply with this section is not waived if insurer contracts with an entity to pay claims.
140	10123.135a	166	California health policy must cover "reconstructive surgery" as defined
141	10123.135b	167	A disability insurer or contracted entity reviewing requests for services that include Medical Necessity must comply with this section.
142	10123.135c	168	Medical Necessity Reviews require written policies and procedures that are made available to the public
143	10123.135d	169	Insurer must employ qualified Medical Director for Medical Necessity Review Process
144	10123.135e	170	Provider approval requests must be communicated to provider
145	10123.135f1	171	Unlicensed health care professional cannot deny request for services because of Medical Necessity.
146	10123.135f2A	172	Review process for specified care must be disclosed to Commissioner, providers, or if public requests.
147	10123.135f2B	173	Utilization review used by insurer or contracted entity must have developed compliant criteria or guidelines
148	10123.135f2C	174	Utilization review used by insurer or contracted entity must have consistent compliant criteria or guidelines
149	10123.135f2D	175	Utilization review used by insurer or contracted entity must have compliant criteria or guidelines evaluated and updated annually
150	10123.135f2E	176	Criteria or guidelines used to contest or deny services for Utilization Review must be disclosed to provider and insured
151	10123.135f3	177	Utilization review used by insurer or contracted entity must be available to the public upon request
			Required disclosure must include mandated language. See code section.

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152	10123.135g	178	Insurer may only request necessary information to approve, contest or deny service authorization requests
153	10123.135h1	179	In approval or contestation of Medical Necessity insurer must be made in 5 days; or 30 days for retrospective
154	10123.135h2	180	In approval or contestation of Medical Necessity insurer must be made within 72 hours if imminent and serious health condition
155	10123.135h3	181	In approval or contestation of Medical Necessity insurer decision must be communicated within: 2 days to insured, 24 hours to provider
156	10123.135h4	182	Decisions to approve, deny, delay or modify services must be in writing and communicated as prescribed
157	10123.135h5	183	If insurer cannot make decision within time frame due to incomplete information, insurer must send written notification
158	10123.135h6	184	Commissioner may assess administrative penalties for failure to comply with timeframes in section with notice and hearing
159	10123.135i	185	Phone access for providers to request authorization is required
160	10123.135j	186	Disability insurer shall not be defined as health care provider for this section

VIOLATION TYPE "00" CODING SUMMARY

Life and Health California Insurance Code Sections-Continued

VIOLATION SECTION	VIOLATION CODE (CS)	VIOLATION DESCRIPTION
161	10123.137a	187 Insurer is required to have dispute resolution mechanism for providers by 7/1/2006
162	10123.137b	188 Non contracting providers must have access to dispute resolution mechanism
163	10123.137c	189 Provider disputes must be in writing and determination must be made within 45 days
164	10123.137d	190 Beginning with 7/01/2007 insurer must provide annual report to the Department regarding its dispute resolution mechanism
165	10123.137e	191 Subsidiaries and affiliates licensed as health care service plans will continue to use the same dispute resolution process
166	10123.145	192 Group or individual disability insurance policies; overpayment; reimbursement; contested cases; interest
167	10123.147a	193 Emergency services claim must be paid, contested or denied within 30 working days by written notice with required language
168	10123.147b	194 Emergency services claim is unpaid, uncontested or not denied within timeframe must contain penalty when paid
169	10123.147c	195 Paper claim is complete upon submission of ER report and UB92 or HCFA1500 and other requested information within 30 days
170	10123.147d	196 This section does not apply to fraudulent or misrepresented claims or where provider denies access to information
171	10123.147e	197 Contested emergency service claim requesting additional information must be paid within 30 days of receipt it or penalty applies
172	10123.147f	198 Emergency service claim from one provider cannot be delayed due to lack of hospital or another provider claim without specific reason updated monthly
173	10123.147g	199 Insurer cannot require provider to waive rights pursuant to this section
174	10123.147h	200 This section applies to emergency services on or after September 1, 1999
175	10123.147i	201 This section does not affect rights or obligations under 10123.13
176	10123.147j	202 Section does not affect written agreement for provider to submit bills within specified time period
177	10133a	203 Disability insurer must pay group medical benefits to provider or to person who paid for services upon written insured consent
178	10133b	204 Section does not authorize insurer to furnish or directly provide, direct, or control the selection of the health care provider
179	10133c	205 Insurer may limit payments upon agreement with policy holder to alternate contracted provider rates
180	10133d	206 When alternate rates of payment are applicable to group policy holders, the contract must include quality review
181	10133e	207 Effective July 1, 1983 amendments made to this section must be applicable to both institutional and professional providers
182	10133.1	208 Roster providers for alternate rates

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176	10133.2	209	Negotiated rate contracts with providers of services; basis & calculation of maximum patient copayment
183	10133.3	210	Negotiated rate contracts under self-insured government plans; basis & calculation of maximum patient copayment
184	10133.5	211	Contracts with providers for alternative rates; regulations; guidelines; reports;
185	10133.55	212	Disability insurers; written policy filing; policy contents; nonparticipating providers contracts; out of network coverage;
186	10133.56	213	Completion of coverage; covered conditions;
187	10133.65b1	214	Alternate rates contract cannot contain provision requiring provider to accept patients beyond contracted number or if endangering patients
188	10133.65b2	215	Alternate rates contract cannot contain provision requiring utilization management program unless disclosed per timeframe
189	10133.65b3	216	Alternate rates contract cannot contain provision that waives or conflicts with the Insurance Code
190	10133.65b4	217	Alternate rates contract cannot contain provision requiring to permit access to patient information in violation of confidentiality laws
VIOLATION TYPE "00" CODING SUMMARY			
Life and Health California Insurance Code Sections-Continued			
VIOLATION SECTION	VIOLATION CODE (CIC)	VIOLATION DESCRIPTION	
191	10133.65c	218	Material change to alternate rate contract may be made after a 45 working days notice to provider
192	10133.65d	219	Any contract provision that violates subdivision b or c must be void, unlawful and unenforceable
193	10133.65f	220	Section may not be construed as setting the rate of payment in contracts between insurer and provider
194	10133.66a	221	Contracted providers deadline for submission of claim no less than 90 days; 180 days noncontracted;
195	10133.66b	222	Insurer cannot request overpayment of claim unless written request for reimbursement is sent with 1 yr; not for fraud;
196	10133.66c	223	Insurer must identify and acknowledge receipt of claim within 15 days
197	10133.66d1	224	Insurer must disclose to contracting providers the amount of payment for each service under contract
198	10133.66d2A	225	Insurer must be consistent with Current Procedural Terminology provisions
199	10133.66d2B	226	Insurer must clearly and accurately state what is covered by any global payment provision
200	10133.66d2Ci	227	Insurer must state policies regarding consolidation of multiple services or charges, and coding changes
201	10133.66d2Cii	228	Insurer must state policies regarding reimbursement for multiple procedures
202	10133.66d2Ciii	229	Insurer must state policies regarding reimbursement for assistant surgeons
203	10133.66d2Civ	230	Insurer must state policies regarding reimbursement for administration of immunization and injectable medications
204	10133.66d2Cv	231	Insurer must state policies regarding recognition of CPT modifiers
205	10133.67	232	Payment to health care provider; agreement by Commissioner;
206	10169	271	The insurer shall allow for an independent medical review for insured grievances involving disputed healthcare services
207	10169.1	148	Provide the IMRO all records within 24 hours of DOI notice when imminent health threat
208	10169e	149	Must offer Independent Medical Review on medical claims denied for no medical necessity
209	10169f	272	Must prominently display information concerning the right of the insured to request an independent medical review
210	10169m	273	If a disposition of the grievance denies/modifies/delays health care, statutory info & forms shall be provided to the insured
211	10169n1A	151	Provide the IMRO a complete copy of the claim file in 3 business days of DOI notice.
212	10169n1B	150	Provide Independent Medical Review Organization w/any new med records immediately

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213	10172.5a	96	Interest due on death benefits, from date of death, if not paid within 30 days from date of death.
214	10172.5b	96	Cannot delay payment longer than reasonably necessary.
215	10172.5c	96	Must advise beneficiary of the rate of interest.
216	10175.5	233	Disability insurance contracts with licensed health care practitioners; prohibition on certain incentive plans;
217	10176	234	Medical reimbursement provisions of disability policies; selection of certificate holder or licensee; mental health services coverage
218	10176.7	235	Disability insurance written or issued for delivery outside of state; selection of specified health care providers;
219	10178.3	236	Sale, lease or transfer of list of contracted health care providers and their reimbursement rates; disclosure and requirements
220	10178.4	237	Contracts between health care providers and contracting agents; definitions;
221	10179	238	Podiatric benefits coverag; negotiation of contracts with or affiliation with podiatrists for provision of service

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VIOLATION TYPE "00" CODING SUMMARY		
Liability- California Insurance Code Sections		
VIOLATION SECTION	VIOLATION CODE(S)	VIOLATION DESCRIPTION
222 10180	239	Disability insurers contracting for services at alternative rate of payment; consideration of proposals by providers
223 10350.7	159	Disability policy language must include 15 months claim filing time limit after date of loss
226 11583	156	Insurer failed to notify the recipient of advance liability payment of statute of limitations

APPENDIX I

DEPARTMENT OF INSURANCE

CLAIMS SERVICES BUREAU
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013

www.insurance.ca.gov

CCB-025 P

Eff.: 06/23/06



HEALTH CARE PROVIDER REQUEST FOR ASSISTANCE (HPRFA)

Patient's Name

Provider Contact Name (Last, First)

Provider/Facility Name

Phone Number

Provider's Address

City Zip

Providers may submit complaints for services rendered on or after January 1, 2006. Before you file for a case review with the Department of Insurance, you must first exhaust the Dispute Resolution (DR) process with the insurance company. You must allow the insurer up to 60 calendar days to complete their review or send you a written determination, whichever period is shorter. If you submit a complaint to the Department without going through the dispute resolution process first, the Department will not be able to conduct a case review.

To ensure proper review of the case, a copy of the completed Health Care Provider Request for Assistance form and other documentation submitted by you will be provided to the insurance company, agent or the broker.

1. Complete name of insurance company involved:

2. Type of Insurance: Individual Health Group Health

3. Do you have an existing contract with the insurance company? Yes (Provide copy) No

4. Primary policyholder's name if different than the patient:

Claim Number: Policy/Certificate/ID Number:

Group Name: Group Number:

Date(s) of Medical Service(s) Provided:

CPT Codes:

5. Does the complaint concern the payment of a specific claim? Yes No

If yes, provide: Billed Amount \$ Paid Amount \$ Amount in Dispute \$

Have you contacted the insurance company and exhausted the Dispute Resolution Process?

Yes (Provide copies of all correspondence) No

7. Have you reported this to any other governmental agency? Yes No

Name of agency: _____ File number, if known: _____

Have you previously written to the Department of Insurance about this matter?

Yes No File number (if available) _____

9. Is there attorney representation in this matter? Yes No

10. Has a lawsuit been filed? Yes No If yes, our ability to mediate this matter is limited, but we will investigate your inquiry for any regulatory issues. We may defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of law by the insurer that you or your attorney are willing to provide.

11. Briefly describe the disputed issue. Use additional paper as needed.

The following documents must accompany this form. Failure to provide all or any part of the information requested may preclude or delay the Consumer Services Division of the Department of Insurance from reviewing your complaint.

- Copy of the patient's (signed) Assignment of Benefits, if applicable
- Copy of claim forms submitted to the insurance company (UB 92, HCFA 1500, etc.)
- Copies of all correspondence between the provider and the insurance company, including all related EOBs
- Copy of the Dispute Resolution Process determination letter
- Copy of the patient's insurance identification card – both sides
- Copy of the provider's contract with the insurance company, if any

Provider's Signature

Date

DEPARTMENT OF INSURANCE

CONSUMER SERVICES AND MARKET CONDUCT BRANCH
CLAIMS SERVICES BUREAU
00 SOUTH SPRING STREET
LOS ANGELES, CA 90013
www.insurance.ca.gov



To: _____ From: _____
Fax: _____ Fax: _____
Email: _____ Date: _____

PROVIDER COMPLAINT
REQUEST FOR HEALTH COVERAGE INFORMATION (RHCI)

The California Department of Insurance has received a request for assistance from the following health care provider.

Provider name: _____
Patient Name: _____ Insured/Member Name: _____
Insurance Company: _____
Insured/Member ID: _____ SSA# _____
Group Name: _____ Group#: _____
Date(s) of Service: _____
Claim Number(s): _____
Case Reference Number: _____

Health Insurer to Complete this Section

Is the patient's Health Plan an insured plan that was issued in California? Yes / No
If No please select from the following:

- a. Self Funded Plan? Yes / No If yes provide Name of Plan: _____
b. Under the jurisdiction of the Department of Managed Health Care? Yes / No
c. Sitused or issued from another state? Yes / No
If yes please provide name of other state: _____
d. Medicare plan? Yes / No
e. Other type of plan? Please explain: _____

Please attach documentation form the policy/plan that identifies jurisdiction

Was the coverage in force on the date of service for the disputed claim? Yes / No
If no provide: Termination date: ___/___/___
Has an internal dispute resolution been requested? Yes / No Provide date initiated: _____
Was the internal dispute resolution process completed? Yes / No If Yes, Briefly
Explain: _____

Provide a copy of the insurer's dispute resolution letter responding to a request for resolving the specific dispute noted above. (If applicable, please attach and underline relevant segments of the insurance policy.)

Insurer's response time for RHCI Requests is 5 calendar days from date of fax.

Please fax this form and attachments to DOI: Fax # (213) 897-5891,
ATTN: Health Care Provider Complaint Unit

If you have any questions, please contact: _____

CONSUMER: HEALTH CARE PROVIDERS GUIDE TO THE COMPLAINT PROCESS

(June 22, 2006)

INTRODUCTION

Existing law provides for the Insurance Commissioner to establish a program to investigate and respond to complaints concerning health insurers. Under existing law, a health insurer is required to reimburse a provider's claim within a specified timeframe or to provide a notice to the provider explaining its reasons for denying or contesting the claim. This guide was created to inform health care providers of their right to file a complaint with the California Department of Insurance (CDI) regarding the handling of a claim or other obligation under a health insurance policy by a health insurer or agent, or regarding the alleged misconduct by a health insurer or agent.

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WHO REGULATES WHAT TYPE OF HEALTH PLAN?

The majority of California's health plans are regulated by either the California Department of Insurance (CDI) or the California Department of Managed Health Care. The CDI regulates point-of-service health plans and certain Preferred Provider Organization (PPO) health plans underwritten by health insurance companies authorized by the CDI.

The CDI does not regulate Health Maintenance Organizations (HMOs) or certain PPOs, which fall under the Knox-Keene Act (i.e. Blue Cross of California or Blue Shield of California). Complaints against these types of health plans should be submitted to:

Department of Managed Health Care (DMHC)
980 Ninth Street #500
Sacramento, CA 95814-2725
Web site: www.dmhc.ca.gov
Provider Complaints (877) 525-1295

For a list of health insurance companies regulated by the Department of Insurance, visit our website at: www.insurance.ca.gov. For a list of the HMOs and other health care service plans regulated by the Department of Managed Health Care, please

visit the DMHC website, as shown above.

The California Department of Insurance does not regulate self-insured health plans, even in cases where the plan is administered by a health insurance company. Most self-insured health plans fall under the jurisdiction of Employee Retirement Income Security Act (ERISA). ERISA is federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). If you have a complaint against a self-insured health plan through an employer or union, then contact the DOL-EBSA for assistance at 1(866) 275-7922 or you can visit their website at: www.dol.gov/ebsa. However, the DOL-EBSA does not regulate self-insured health plans that are sponsored through school districts, other municipalities, and churches. If the insured is a member of this type of plan, he/she can file a complaint with the plan directly or may seek a legal remedy through a court of law.

BEFORE YOU SUBMIT A PROVIDER COMPLAINT

Dispute Resolution Mechanism

Before you file a complaint with the California Department of Insurance, you must first submit the dispute to the insurer's Dispute Resolution Mechanism. Under the Dispute Resolution Mechanism process, disputes must be submitted to the insurer in writing and include the following information: provider name, provider tax identification number, patient name, insurer's identification information, dates of service, description of dispute, and if applicable, billed and paid amounts.

Insurers must provide the procedures for submitting a dispute through the Dispute Resolution Mechanism, including the location and telephone number where information regarding disputes may be submitted.

Insurers must also ensure that a Dispute Resolution Mechanism is accessible to non-contracting providers for the purpose of resolving billing and claims disputes.

Insurers are required to resolve each dispute and issue a written determination within 45 working days of the receipt of the provider's dispute.

FILING A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE

Once you have determined that the plan is regulated by the CDI and have submitted a dispute to the insurer for review under the Dispute Resolution

Mechanism process, and you disagree with the decision or would like the California Department of Insurance to review an issue, you may submit a complaint by completing a Health Care Provider Request for Assistance (HPRFA). To ensure proper review of the case, the following documents should be sent to the Department:

- A copy of the completed Health Care Provider Request for Assistance Form.
- Copy of the patient's Assignment of Benefits documentation.
- Copy of claim forms submitted to the insurance company.
- Copies of all correspondence between the provider and the insurance company, including all related Explanation of Benefits (EOB).
- Copy of the Dispute Resolution Mechanism process determination letter.
- Copy of the patient's insurance identification card.
- Copy of the provider's contract with the insurance company, if any.

Examples of the Types of Problems That You Can Submit to the CDI

- Improper denial or delay in payment of a claim
- Other claims handling issues
- Dispute Resolution Mechanism difficulties
- Misconduct of the health insurer

Examples of Complaints Which Do Not Fall Within the Jurisdiction of the CDI

- Workers Compensation Claims
- Knox-Keene Health Care Service Plans
- Medi-Cal
- Medicare
- Self-funded Employee Benefit Plans

How to Submit a Complaint to the CDI

You may submit a complaint to the Department of Insurance by completing a Health Care Provider Request for Assistance (HPRFA) for each claim submitted to the insurer. You may request a HPRFA to be mailed to you by calling our Consumer Hotline toll-free number 1(800) 927-HELP (4357). You may also download the HPRFA by visiting our website at: www.insurance.ca.gov

DEPARTMENT OF INSURANCE300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013www.insurance.ca.gov

06/23/06



Information and Instructions Regarding Health Care Provider Request for Assistance (HPRFA)

Providers may submit complaints for health insurance services rendered on or after January 1, 2006. The California Insurance Code defines health insurance as an individual or group insurance policy that provides coverage for hospital, medical, or surgical benefits. Before you file a complaint with the California Department of Insurance (Department), you must first submit the dispute to the insurer's Dispute Resolution Mechanism for a minimum of 60 calendar days or until receipt of the insurer's written determination, whichever period is shorter. You must submit a separate HPRFA for each claim form submitted to the insurer.

EXAMPLES OF THE TYPES OF PROBLEMS THAT YOU MAY SUBMIT TO THIS DEPARTMENT

1. Improper denial or delay in payment of a claim
2. Other claims handling issues
3. Dispute Resolution Mechanism difficulties
4. Misconduct of the health insurer

EXAMPLES OF COMPLAINTS WHICH DO NOT COME WITHIN THE JURISDICTION OF THIS DEPARTMENT

Type of Claim	Regulatory Agency
Workers Compensation Claims	Department of Industrial Relations Division of Workers Compensation Information and Assistance Unit Phone: 800-736-7401
Knox-Keene Health Care Services Plans, such as Blue Cross of California	Department of Managed Health Care 980 Ninth Street, Suite 500 Sacramento, CA 95814 Phone: 888-466-2219 Web site: www.hmohelp.ca.gov
Medi-Cal	Local County Welfare Department Web site: www.medi-cal.ca.gov
Medicare	Medicare Phone: 800-633-4227 Web site: www.medicare.gov
Self-funded Employee Benefit Plans	U.S. Department of Labor Employee Benefits Security Administration Web site: www.dol.gov/ebsa Southern California 1055 E. Colorado Blvd. Suite 200 Pasadena, CA 91106-2341 Phone: 626-229-1000 or 866-444-3272 Northern California 71 Stevenson Street, Suite 915 San Francisco, CA 94105 Phone: 415-975-4600 or 866-444-3272

A copy of the completed Health Care Provider Request for Assistance form and other documentation submitted by you will be provided to the insurance company, agent or broker. To ensure proper review of the case, the following documents should be sent to the Department:

- A copy of the completed Health Care Provider Request for Assistance form
- Copy of the patient's (signed) Assignment of Benefits, if applicable
- Copy of claim forms submitted to the insurance company
- Copies of all correspondence between the provider and the insurance company, including all related EOBs
- Copy of the Dispute Resolution Process determination letter
- Copy of the patient's insurance identification card – both sides
- Copy of the provider's contract with the insurance company, if any

Do not send us originals of any documents, photographs or other evidence as we are not responsible for lost records or other items. The more complete the information we receive, the quicker we can identify the issues and begin our review. You may inspect the information you submit at any time as long as the Department's case is maintained.

The time it takes to handle a Health Care Provider Request for Assistance can vary greatly, depending on how complex the matter is. Please be assured, your request will be handled as quickly as possible. If more than ten business days have passed without contact from us, please call our Consumer Hotline at 1(800) 927-HELP.

**THIS IS FOR INFORMATION ONLY
DO NOT RETURN WITH YOUR REQUEST FOR ASSISTANCE**

ENGLISH



The Independent

MEDICAL REVIEW

Program

The Independent Medical Review Program

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The Independent Medical Review Program

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THE INDEPENDENT MEDICAL REVIEW PROGRAM

What Is an Independent Medical Review?

An Independent Medical Review (IMR) is a process where expert independent medical professionals are selected to review specific medical decisions made by the insuring company. The California Department of Insurance (CDI) administers an Independent Medical Review program that enables you, the insured, to request an impartial appraisal of medical decisions within certain guidelines specified by the law.

Sections 10169 through 10169.5 of the California Insurance Code (CIC), which became effective January 1, 2001, explain the IMR process in detail. An IMR can be requested only if the insurance company's decision involves:

- The medical necessity of a treatment,
- An experimental or investigational therapy for certain medical conditions, or
- A claims denial for emergency or urgent medical services.

It is important to note that the IMR process cannot be used for an insurance company decision that is based on a coverage issue. Only decisions regarding a disputed health care service, as it relates to the practice of medicine, that do not involve a coverage issue are qualified for the IMR program.

Unlike current review procedures available under CIC Section 10145.3 and through the internal appeals/grievance process of health insurance companies and health plans, the IMR request is received, reviewed, and processed by the CDI. You are required to exhaust the internal appeals/grievance process of your particular insurance company before applying for an IMR with the CDI.

Who Can Request an Independent Medical Review?

Any person who is insured by a health insurance company has the opportunity to seek an IMR whenever health care services have been denied, modified, or delayed by the health insurer if the decision was based in whole or in part on a finding that the health care service was not medically necessary. As the insured, you can designate a person to act as your advocate and request an IMR if you are unable to do so. Also, a health care professional (such as your doctor) is allowed to join with you and assist you with the IMR request.

When Can an Independent Medical Review Be Requested?

It is necessary in most situations to go through the appeals/grievance process with your health insurance company before applying for an IMR with the CDI. If the insurance company upholds its decision or has not provided a ruling within 30 days of filing the appeal/grievance, then you can file an IMR request. Your request for an IMR must be made within 6 months of the insurance company upholding its decision within the appeals/grievance process. If special circumstances are present, the law allows the Insurance Commissioner to consider extending the filing deadline beyond 6 months.

What Issues Are Eligible for an Independent Medical Review?

All insurance company decisions involving a disputed health care service are eligible for an IMR as long as they qualify under the following three categories:

- Health claims that have been denied, modified, or delayed by the insurance company because a regularly covered service or treatment was not considered medically necessary;
- Health claims that have been denied for urgent or emergency services; or
- Health claims that have been denied for investigational or experimental therapies.

You can request an IMR when services or treatments have been performed or when they have been proposed only (a preauthorization denial).

What Issues Are Not Eligible for an Independent Medical Review?

All other insurance company decisions that are not included in the above three categories are not eligible for an IMR. These decisions may include, but are not limited to, the following:

- Health claims that have been denied by the insurance company because the service or treatment is not covered under the insurance contract. Denials due to coverage issues or other related underwriting policy issues do not qualify for the IMR program.

- Legal interpretations of policy language, provisions, and terms do not qualify for the IMR program.
- Bad faith allegations and other demands for extra payments under the health insurance contract do not qualify for the IMR program.

How Does the Independent Medical Review Program Work?

The First Step – Notification

You or any person you have designated may request an IMR if you disagree with a health insurer's decision regarding a disputed health care service that has been determined not to be medically necessary or has been denied as experimental or investigational. Your insurance company is required to send you an IMR application with its denial letter. If you do not receive an application from your insurance company, you can request one from the CDI by calling 1-800-927-HELP.

The Second Step – The Agreement

Since making a request for an IMR is voluntary, you must give the CDI written consent indicating that you wish to participate in the IMR program. The application form includes a consent statement which when signed gives your permission to obtain any necessary medical records in order to proceed with the IMR.

The Third Step – Eligibility

When your completed application with any additional information is received, the CDI will determine if your request

qualifies for the IMR program. If your request does qualify, you will be notified. If your request does not qualify for the IMR program, then your claims review request will be referred to the complaint/mediation program within the CDI.

The Fourth Step – The Review Process

When your request qualifies as an IMR, the case is then sent to the IMR organization designated by the CDI. The CDI notifies the health insurance company involved and requires them to provide the IMR organization with copies of all documents necessary to conduct the IMR. In most cases, your insurance company must provide all relevant documents including medical records to the IMR organization within three business days. The IMR organization is required to complete its review in writing within 30 days.

The Fifth Step – The Determination

Once the IMR organization has made its determination, the written determination will be provided to you, to your insurance company, and to the Insurance Commissioner. The determination must contain your medical condition, the important documents reviewed, and the findings that are relevant to your request.

The Sixth Step – Implementation

Upon receiving the IMR determination, the Insurance Commissioner adopts the recommendation from the IMR organization immediately. A written decision will be issued by the CDI to you and to your insurance company explaining that the recommendation is binding on the insurance company.

What Is the Criteria Used in an Independent Medical Review Determination?

When the IMR organization has completed its review of your particular case, they will have determined whether the disputed health care service is medically necessary. This determination is based upon your specific medical needs and any of the following factors:

- Peer-reviewed scientific and medical evidence regarding the effectiveness of the contested health care service
- Nationally recognized professional standards
- Expert opinion
- Treatments that are likely to be effective for your medical condition rather than other treatments that are not

Is There a Way to Process an Independent Medical Review More Quickly in Extraordinary Circumstances?

The IMR process allows for exceptions to be made when there is a serious or imminent threat to your health. CIC Section 10169.3(c) states that if the “insured’s provider [your doctor/ medical professional] or the department [CDI] certifies in writing that an imminent and serious threat to the health of the insured [you] may exist, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the insured,” the IMR organization must make its determination within three

days of receiving the proper case information. Moreover, your insurance company must deliver the necessary information and documents to the IMR organization within 24 hours of approval from the CDI of your IMR request.

When the CDI reviews your request for an IMR, the Department may waive the requirement that you first go through your insurance company’s appeals/grievance process when an extraordinary or compelling case exists. The Insurance Commissioner may make exceptions based on the criteria listed in CIC Section 10169.3(c) above and based on the Insurance Commissioner finding that you have acted reasonably in the dispute with your insurance company.

Will an Independent Medical Review be Costly?

You will not be required to pay any kind of application or processing fee for an IMR. The cost of the IMR is paid completely by your insurance company after it has been decided that your request qualifies for an IMR by the CDI.

Does Independent Medical Review Participation Prevent Future Legal Action?

Submitting, being approved for, or participating in an IMR does not prevent you from seeking other legal resolution to your dispute. However, if you decide not to participate in an IMR, you may waive any right you have to pursue legal action against your insurance company in the future regarding the contested health care service. You may wish to seek the advice of an attorney in this matter.

Are Medical Records Kept Confidential in the Independent Medical Review Process?

All medical records are confidential throughout the IMR process. The confidentiality of medical records and review materials is subject to all applicable state and federal laws.

How Do I Request an Independent Medical Review from the California Department of Insurance?

To request an IMR it is necessary for you to send in the IMR application that your insurance company is required to enclose with its denial letter. If you have questions or concerns regarding the application, the IMR process, or you have not received an application from your insurance company, then you may reach the CDI by phone, mail, or e-mail. Please see the last page of this brochure for specific CDI contact information.

Health Insurance Terms and Phrases

Assignment of Benefits

Your signed authorization to your doctor or hospital (medical provider) to collect monies for your medical treatment from your health insurance company.

Business Day

Every day that insurance companies are open for business which excludes Saturday, Sunday, and state and federal holidays.

Calendar Day

Every day of the calendar month which includes Saturday, Sunday, and state and federal holidays. However, if any action tied to a time frame in an insurance policy or CDI regulation or code falls on a Saturday, Sunday, or state or federal holiday; then the action is postponed to the next calendar day that does not fall on a Saturday, Sunday, or state or federal holiday.

Certificate of Coverage

A document issued to a member of a group health insurance plan showing evidence of participation in the insurance.

Claim

A notification to your insurance company that payment is due under the policy provisions.

Copayment

The portion of charges you pay to your provider for covered health care services in addition to any deductible.

Coverage

The scope of protection provided by an insurance contract which includes any of the listed benefits in an insurance policy.

Health Insurance Terms and Phrases

Denial

An insurance company decision to withhold a claim payment or preauthorization. A denial may be made because the medical service is not covered, not medically necessary, or experimental or investigational.

Deductible

A fixed amount which is deducted from eligible expenses before benefits from the insurance company are payable.

ERISA

The Employee Retirement Income Security Act (1974). Administered by the U.S. Department of Labor, ERISA regulates employer sponsored pension and insurance plans (self-insured plans) for employees.

Exclusions and/or Limitations

Conditions or circumstances spelled out in an insurance policy which limit or exclude coverage benefits. It is important to read all exclusion, limitation, and reduction clauses in your health insurance policy or certificate of coverage to determine which expenses are not covered.

Experimental and/or Investigational Medical Services

A drug, device, procedure, treatment plan, or other therapy which is currently not within the accepted standards of medical care.

In Writing

The language in an insurance contract, code, or regulation which requires a request or action to be authorized by written correspondence and/or signature. Written correspondence includes letters, notes, and facsimile (fax) transmissions.

Health Insurance Terms and Phrases

Medically Necessary

A drug, device, procedure, treatment plan, or other therapy that is covered under your health insurance policy and that your doctor, hospital, or provider has determined essential for your medical well-being, specific illness, or underlying condition.

Policy

The written contract between an individual or group policyholder and an insurance company. The policy outlines the duties, obligations, and responsibilities of both the policyholder and the insurance company. A policy may include any application, endorsement, certificate, or any other document that can describe, limit, or exclude coverage benefits under the policy.

Preexisting Condition

Any illness or health condition for which you have received medical advice or treatment during the six months prior to obtaining health insurance. Group healthcare policies cover preexisting conditions after you have been insured for 6 months, and individual policies cover preexisting conditions after you have been insured for 1 year. CIC Section 10198.7.

Prior Qualifying Coverage or Credible Coverage

The health insurance you had in place before your current or new policy became effective must be credited towards any preexisting condition exclusion in either a group or individual policy.

Usual, Reasonable, and Customary

The amount that your insurance company determines is the normal payment range for a specific medical procedure performed within a given geographic area. If the charges you submit to your health insurance company are higher than what is considered normal for the covered health care services, then your health insurance company may not allow the full amount charged to you, and you may be responsible for the balance.

Talk to us

Do you have a question, comment or concern?
There are several ways to talk to us:



- Call our Consumer Hotline at **(800) 927-HELP**
- Telecommunication Device for the Deaf dial **(800) 482-4TDD**
- Telephone lines are open from **8:00 AM to 6:00 PM Pacific Time, Monday through Friday, excluding holidays**



- Write: **California Department of Insurance**
300 South Spring St., South Tower
Los Angeles, CA 90013



- E-mail us through our Web site at:
www.insurance.ca.gov



- Visit us in person on the 9th Floor at the address above. **Office Hours: Monday through Friday 8:00 AM to 5:00 PM Pacific Time, excluding holidays**

Personal Notes

Personal Notes

CALIFORNIA DEPARTMENT OF INSURANCE
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

800-927-HELP