Disability Rights California

California's Protection & Advocacy System
Toll-Free (800) 776-5746

Private Insurance Appeals Including Independent Medical Review (IMR) for Health Plans under the Authority of the California Department of Managed Health Care (DMHC) or Department of Insurance (DI)

September 2012, Pub #F072.01

This publication outlines the steps to take if a request for a service or support is denied by your private health plan. Services and supports can include behavioral services, occupational therapy, or physical therapy just to list a few. See Question & Answer 3 below about the health plans without the state law benefit of IMRs.

What do I do if a request is denied by my health plan?

You can file a grievance under the health plan protocol.[1] This can be in writing (preferred), via phone, or on line via the plan's website. A standard grievance must be reviewed within 30 days. An expedited grievance must be reviewed within 72 hours.[2] The plan must give you a copy of the criteria or guidelines used to determine whether or not to authorize the requested service.[3] The initial authorization request and grievance review is required to be by a clinician who is "competent to evaluate the specific clinical

[1] Title 28 C.C.R. Section 1300.68
[2] Title 28 C.C.R. Section 1300.68.01
[3] Health & Safety Code Sections 1363.5, 1367.01; Insurance Code Section 10123.135(f).

issues" raised in your appeal.[4] The health plan then issues a decision either upholding or overturning the initial decision.

You can also request an Independent Medical Review (IMR)[5] through the Department of Managed Healthcare (DMHC) or the Department of Insurance (DI) if the service in dispute is a covered benefit. The IMR can be used if you requested a medically necessary treatment and received a decision from your health plan that **denied, delayed, or modified** the treatment as not medically necessary; or if the treatment was denied as experimental/investigational;[6] or reimbursement for emergency/urgent care is denied and you appeal within 6 months of your denial.

What is an IMR?

The IMR process is intended to resolve medical necessity issues, reimbursement for emergency services, and experimental/ investigational disputes only. The health plan pays for the IMR. The IMR application is reviewed by an analyst, clinical staff and legal counsel to determine benefit coverage.

Does the IMR process apply to everyone?

No, it is not for services denied by Medicare, Medi-Cal (fee for service), Medi-Cal Managed Care (where a state Medi-Cal fair hearing has already been filed), employer self-insured or union or union-employer ERISA plans, or worker's compensation claims.[7]

How do I file for an IMR?

Complete the IMR application, available at http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_imrapp.aspx. For plans subject to the Department of Insurance: http://www.insurance.ca.gov/0100-

---

[4] Health & Safety Code Section 1370.2; Insurance Code Section 10123.135(e).
[5] Title 28 C.C.R. Section 1300.74.30; DI http://www.insurance.ca.gov/0100-consumers/0020-health-related/0020-imr/#whatisimr
[6] Note – if the service was denied as experimental/investigational you do not have to go through the grievance process prior to requesting an IMR.
[7] Title 28 C.C.R. Section 1300.43 et seq.

consumers/0020-health-related/0020-imr/upload/HCB002IMR.pdf. For plans subject to the Department of Insurance, the notice of a denial from the plan will include information about filing an IMR

Attach relevant documents including:

- Medical records (including out-of-network providers),
- A copy of the health plan's denial letter,
- A statement from your provider establishing that the dispute is eligible for review,
- A statement from your provider indicating that the service or treatment request is medically necessary, and/or
- Medical articles that support your position.

Be specific about the treatment you are requesting including:

- Dates of service.
- Any payments made,
- Name of provider, and
- Any extenuating circumstances.[8]

What happens after I file the IMR?

The IMR is reviewed and a decision is issued and adopted by DMHC or DI. Once a decision is approved by DMHC or DI, it is final and cannot be appealed by either party. A written decision is sent to you, your doctor, and the health plan. The health plan must fully comply with the decision. If the

[8] For example, if no network provider is available, if no specialist with training on your condition is available and such.

denial is overturned the health plan must provide authorization for the service within 5 days.[9]

Can I research how similar IMR's have turned out?

Yes, you can review all DMHC IMR decisions going back to 2001. For DMHC IMR decisions see http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_imrdec.aspx. DI IMR results are categorized by diagnosis and treatment. See http://interactive.web.insurance.ca.gov/IMR/faces/search?_adf.ctrl-state=lqiun5a28_4

How long does an IMR take?

Generally, IMR's take 30 days after the file is complete. If it is an expedited IMR, it is usually decided within 3-7 days. Expedited IMR's relate to immediate threats to your health and your doctor must send written documentation that your need is urgent.[10]

What if the services are denied because of benefit coverage?

The IMR process does not apply to benefit coverage issues. However, DMHC also has a standard complaint process for those types of cases. The complaint form is at http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.aspx. If you file an IMR and it is about benefit coverage it will automatically be converted into a standard complaint.

Who can help me appeal?

---

[9] See this notice concerning the Department of Insurance's enforcement actions against plans who failed to comply with IMR decisions concerning behavioral therapy; http://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/Enforcement-of-Independent-Medical-Review-Statutes.pdf. See, also, http://www.insurance.ca.gov/0100-consumers/0070-health-issues/0025-autism/ and http://www.insurance.ca.gov/0400-news/0100-press-releases/2011/release096-11.cfm

[10] Title 28 C.C.R. Section 1300.74.30(d)(4); Insurance Code Sections 10145.3(c)(2), 10169(j)(3), 10169.2(c).

A variety of people can help you. Your regional center service coordinator is a good place to start. He or she can help you with your health plan and, if necessary, IMR appeal.[11] You can also contact your local advocate with the Office of Clients' Rights Advocacy.[12] You can also contact the Help Center at DMHC at 1 (888) 466 2219 or 1 (877) 688 9891 (TTY). The Help Center has staff that speak a variety of languages. Or, if the private health plan is subject to the Department of Insurance, contact the DI Help Center at 1-800-927-4357.

Disability Rights California is funded by a variety of sources, for a complete list of funders, go to http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html.

[11] Welfare & Institutions Code Section 4659(d)
[12] A listing of the Clients' Rights Advocate for each regional center is at http://www.disabilityrightsca.org/about/documents/CRALIST-APRIL30.2012.pdf