Policy and Procedure No: UM 59.2	**Revision No: 2**
Division: Managed Care	
Department: Utilization Management	
Title: PHC-CA DMHC Independent Medical Review (IMR)	
Effective Date: 1/1/2019	
Supersedes Policy No: 93017, UM 33.0, UM 59.0, UM 59.1	
Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 12/28/2025**
Approving Committee: Utilization Management Committee	**Date: 12/28/2025**
Executive Oversight Committee Date: 12/28/2025	

Purpose:

To establish a process that meets the provisions of the Health and Safety Code sections 1374.30 to 1374.36, which provides an enrollee the opportunity to seek an Independent Medical Review (IMR) whenever the health services have been denied, modified, or delayed by PHC California (the Health Plan) if the decision was based in the whole or in part, on the finding that the proposed heath care services are not medically indicated.

Policy:

1. The Health Plan shall adhere to statutory guidelines outlined in section §1374.30 et al, of the Knox-Keene act and § 1300.70 and 1300.74.30 in Title 28 of the California Code of Regulations and establish an independent medical review (IMR) procedure for disputed health care services.

2. Enrollee Notification of IMR Process

    a. The Health Plan will inform enrollees of their right to request an IMR through the Department of Managed Health Care (DMHC). An enrollee may designate an agent to act on his or her behalf. If the Health Plan is notified by DMHC that an enrollee, or the enrollee's representative, or the rendering provider is requesting an IMR, the Health Plan will comply with the provisions of the Health and Safety Code Sections 1374.30 to 1374.36.

    b. The Health Plan notifies and/or presents the enrollee of the option to submit an IMR to DMHC in the following ways:

        i. The Enrollee Handbook (Evidence of Coverage)

        ii. The Health Plan's website

        iii. The utilization review nurse or designee processes and sends the enrollee a written appeal resolution letter in response to the upheld initial decision.

            1. The appeal resolution letter includes links to the DMHC website and instructions to file a request for an IMR, instructions on how to request an IMR, and a self-addressed envelope with the DMHC's IMR unit address.
            2. The resolution letter is sent to the requesting provider and enrollee. The letter informs the requesting provider that the denial was upheld and the reasons for the decision.

3. For appeals filed by the provider on behalf of an Enrollee, the correspondence is mailed to the provider and a copy is mailed to the Enrollee.

3. DMHC Enrollee Requirements for Filing an IMR

   a. A member may request an IMR, to the DMHC, to obtain an impartial review of the Health Plan's decision concerning:

      i. The medical necessity of a proposed treatment

      ii. Experimental or investigational therapies for a life threatening or seriously debilitating disease or condition; and

      iii. Denied claims for out-of-plan emergency or urgent medical services

   b. The following conditions must be met for members to exercise their right to request an IMR for a disputed decision to delay, deny, or modify services based on medical necessity:

      i. The enrollee's provider recommended a health care service as medically necessary; or

      ii. The enrollee received urgent care or emergency services that a provider determined was medically necessary; or

      iii. The enrollee was seen by a provider within the Health Plan's network for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review.

         1. The provider may be out-of-network when DMHC finds that the enrollee's decision to secure services out-of-network was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of the Health Plan's contract;

      iv. The Health Plan or one of its contracted providers denied, partially approved (modified) or terminated the disputed health care service, based in whole or in part on a decision that the health care service is not medically necessary; or

      v. The enrollee has filed an appeal with the Health Plan, and the disputed decision is upheld, or the appeal remains unresolved after thirty (30) calendar days. Enrollees are not required to participate in the Health Plan's grievance process for more than thirty (30) calendar days before applying for an IMR. If the grievance requires expedited review, enrollees are not required to participate in the grievance process for more than seventy-two (72) hours.

      vi. If the Health Plan denies an enrollee request for expedited resolution of an appeal, the Health Plan transfers to the standard timeframe of thirty (30) calendar day appeal process.

4. The enrollee shall not be required to participate in the Health Plan's grievance process for more than thirty (30) days if disputed decision is upheld or the grievance remains unresolved after thirty (30) days. For expedited review, the enrollee shall not be required to participate for more than three

(3) days.

5. Enrollees may apply for an IMR without first participating in the Health Plan's internal Appeal or Grievance process in extraordinary and compelling cases, as determined by DMHC, and in cases where Enrollee's request for experimental treatment was denied.

    a. Enrollees are notified in writing of the opportunity to request an IMR of a decision denying experimental within five (5) business days of the decision to deny coverage.

6. In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the independent medical review shall determine whether the services were emergency or urgent services necessary to screen and stabilize the enrollee's condition.

    a. Enrollees with life-threatening or seriously debilitating medical conditions who received a provider's decision to deny, partially approve (modify) or terminate experimental or investigational treatment or therapy are not required to participate in the Health Plan's grievance process prior to submitting their request for IMR to DMHC.

7. Enrollees have the right to appeal the Health Plan's decision by applying for an IMR if the Health Plan denies, changes, or delays request for medical services, denies payment for emergency treatment or refuses to cover experimental or investigational treatment for a serious medical condition. Enrollees must file an IMR within six (6) months after notification in writing of a decision from the Plan. The application shall include:

    a. Patient identification information including primary care physician and contact number;

    b. Treatment information including diagnosis, treatments requested, provider of service, identified facility and a narrative of services requested;

    c. Description or name of the denied medical service or treatment;

    d. A separate signed statement of consent from the member to obtain any necessary medical records is not necessary; and

    e. A copy of the Health Plan's denial letter.

8. Enrollees may not request an IMR if a State Fair Hearing has already been held on the issue.

9. An enrollee shall not pay any application or processing fees for an IMR.

10. An enrollee may designate someone to act on his, her or their behalf during the IMR process.

11. For expedited IMRs, the Health Plan shall submit all required information to the medical review organization within one (1) calendar day following the receipt of the Department's notification that an application for an IMR has been assigned to an external review organization. In addition, the Health Plan shall forward any additional medical records or other information not available at the time of the initial submission to the external review organization as soon as possible, but not to exceed one (1) calendar day.

12. During an IMR, physicians who are independent and do not work for the Health Plan examine the case to see if the Health Plan appropriately denied services, or if the enrollee should receive the

requested service or treatment. If the outcome of the IMR determines that the Health Plan should not have denied the enrollee's request, the plan must cover the service or treatment.

13. If DMHC determines that the request qualifies for IMR, DMHC designates an IMR organization to review the case. DMHC notifies the Health Plan that the Enrollee has requested an IMR.

    a. As expeditiously as possible, but no greater than two (2) business days from the receipt of the notification that enrollee has requested an IMR, the Plan completes a request for Health Plan Information form and submits the form to the IMR organization, along with the following documentation:

        i. A copy of the Enrollee's medical records in the Health Plan's possession, which must include the Enrollee's medical condition, the health care services being provided by the Plan and its Delegates, and the disputed health care service requested by the Enrollee;

        ii. Any newly developed or discovered relevant medical records in possession of the Plan or its affiliated Providers;

        iii. A copy of all the information provided to the Enrollee by the Health Plan and any of its Delegates regarding the Enrollee's condition and care, and a copy of any materials the Enrollee or the Enrollee's Provider submitted to the Plan or its affiliated Provider in support of the Enrollee's request; and

        iv. A copy of all other relevant documents or information used by the Health Plan or its Delegates in determining whether the disputed health care services should have been provided, and any statements by the Health Plan or its Delegates explaining the reasons for the decision to deny or partially approve (modify) the disputed health care service.

14. If the IMR organization determines that the disputed health care service is medically necessary, the Health Plan contacts the enrollee and authorizes the services within five (5) business days of receipt of the written decision from DMHC's Director, or sooner if appropriate for the nature of the Enrollee's medical condition.

    a. The Health Plan informs the Enrollee, Provider and Delegates of the authorization in writing within two (2) business days. Approved decisions pertaining to care that is underway are communicated within twenty-four (24) hours.

    b. If services have already been rendered, upon receiving the decision of the IMR that services are classified as medically necessary, then the Health Plan shall reimburse the provider or enrollee, whichever applies, within five (5) working days.

Procedure:

1. Upon notification from DMHC that the enrollee has applied for an IMR, the Health Plan's utilization review nurse or their designee submits all necessary and relevant medical records and documents to DMHC within three (3) business days in routine cases or one (1) business day in expedited reviews.

2. Once DMHC reaches a decision and notifies the Health Plan in writing, the Health Plan's utilization review nurse or their designee documents the IMR decision in the Utilization Management system.

a. If the IMR decision reverses the Health Plan's determination:

   i. The Plan's utilization review nurse or their designee contacts the enrollee and authorizes the services on the Utilization Management system within five (5) days or sooner based on the enrollee's medical condition.

   ii. The Health Plan's utilization review nurse or their designee communicates to the enrollee, provider, and delegates of the authorization within two (2) business days. For approved decisions relating to ongoing care, the utilization review nurse or their designee informs the enrollee, provider, and delegates within twenty-four (24) hours.

   iii. For services already provided, the Claims Department processes the payment to the enrollee or provider, whichever applies.

   iv. The Claims Department ensures that the reimbursement is made within five (5) working days.

b. If the IMR decision upholds the Health Plan's determination,

   i. The utilization review nurse or their designee closes the case in the Utilization Management system.

Definitions:

1. Disputed health care service is any health care service eligible for coverage and payment under a health care service plan contract that has been denied modified, or delayed by a decision of the plan, or one of its contracted 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 specialized health care service plan, except to the extent that the service (1) involves the practice of medicine, or (2) is provided pursuant to a contract with a health care service plan that covers hospital, medical, or surgical benefits. If a plan, 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 enrollee, the statement of decision shall clearly specify the provision in the contract that excludes that coverage.

2. Life- threatening medical conditions are those diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potential outcomes, where the end point of clinical intervention is survival.

3. Seriously debilitating medical conditions are diseases or conditions that cause major irreversible morbidity.

Monitoring:

This policy and procedure is reviewed and updated as often as required and approved annually by the Utilization Management Committee.

Reference(s):

1. CA Health and Safety Code section 1374.30(e), (j)(1) and (3), and (l); CA Health and Safety Code section 1374.31; 28 CCR (California Code of Regulations) 1300.70.4(a); 28 CCR 1300.74.30(a) through(c) and (d)(4).

2. CA Health and Safety Code section 1374.30(n);

3. CA Health and Safety Code section 1374.31(a); 1300.74.30(j) and (k).

4. Department of Managed Health Care (DMHC) All Plan Letter (APL) 23-006 Independent Medical Review (IMR) Application/Complaint Form (DMHC 20-224), dated February 24, 2023.