From: DMHC Licensing eFiling

Subject: New Independent Medical Review Application/Complaint Form

Date: Thursday, December 10, 2015 1:20:00 PM

Attachments: All Plan Letter IMR form.doc
20-224 IMR Application Complaint Form FINAL.doc
20-224 IMR Application Complaint Form FINAL.pdf

Please see attached, the All Plan Letter regarding the New Independent Medical Review Application/Compliant Form.

State of California
Health and Human Services Agency
Department of Managed Health Care

ALL PLAN LETTER

DATE: December 10, 2015

TO: Full Service and Specialized Health Plans

FROM: Nancy P. Wong
Deputy Director, Office of Plan Licensing

SUBJECT: **New Independent Medical Review Application/Complaint Form**

The Department of Managed Health Care (DMHC) has approved the attached Independent Medical Review Application/Complaint form for use beginning immediately. Plans are reminded that this form and an addressed envelope must be included in all responses to enrollee grievances. Transition to the newform must be complete by February 10, 2016. After that date, Plans that do not use the attached form willbe cited for non-compliance with the applicable laws. (1374.30(m); 1374.20(i) and 1300.74.30(d)).

Please contact me at (916) 323-1228 if you have any questions regarding this letter.

State of California
Health and Human Services Agency
Department of Managed Health Care
INDEPENDENT MEDICAL REVIEW APPLICATION/COMPLAINT FORM – English HP
DMHC 20-224 New: 11/15

INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

IMPORTANT INFORMATION

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

- **FREE:** The IMR/Complaint process is free.
- **FAST:** IMRs are usually decided within 30 days, or within 7 days if the health issue is urgent.
- **SUCCESSFUL:** Close to **60%** of patients receive the requested service through IMR.
- **FINAL:** Health plans must follow the IMR decision and promptly provide the service.

PATIENT INFORMATION

First Name Middle Initial Last Name

Patient's Date of Birth (mm/dd/yyyy) Gender: Male ☐ Female ☐

Name of Parent or Guardian if Filing for Minor Child

Street Address

City State Zip

Daytime Phone # Evening Phone #

Email Address

Health Plan Name Patient's Membership #

Medical Group Name (if enrolled in a medical group)

Employer Not Employed ☐

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

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

Do you have Medi-Cal? ☐ Yes ☐ No

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

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

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

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

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

Are you seeking authorization for future services? ☐ Yes ☐ No

Do you need help with daily activities or consider yourself to have a disability? ☐ Yes ☐ No

INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

YOUR HEALTH PROBLEM **(Use a separate sheet and attach other documents, if needed.)**

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

What medical treatment(s)/service(s) and/or medication(s) are you requesting? (please be specific)

Did the plan say that the treatment you want is (check one):

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

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

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

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

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

MEDICAL RELEASE

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

Patient or Parent Signature Date

Please see the instruction sheet for mailing or faxing information.

STATISTICAL INFORMATION ONLY

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

Primary Language Spoken: ☐ Choose not to provide

Race/Ethnicity: ☐ Choose not to provide

AUTHORIZED ASSISTANT FORM

- **If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.**

- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.

- If you are filing this IMR/Complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: PATIENT

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

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

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

Patient Signature _____ Date _____

PART B: PERSON ASSISTING PATIENT

Name of Person Assisting (print) _____

Signature of Person Assisting _____

Address _____

City _____ State _____ Zip _____

Relationship to Patient _____

Daytime Phone # _____

Evening Phone # _____

Email Address _____

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

IMR Application/Complaint Form Instruction Sheet

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

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

How to File:

1) File online at www.HealthHelp.ca.gov. **This is the fastest way.or**

   Fill out and sign the enclosed IMR Application/Complaint Form. Use the envelope provided with the form.
2) If you want someone to help you with your IMR or complaint, complete the "Authorized Assistant Form".
3) If you have medical records from ***out of network*** *providers*, please include them with your IMRApplication/Complaint Form. Your plan will provide medical records from network providers.
4) You may include other documents that support your request. However, there is no need to provide any documents or correspondence between you and your plan relating to this complaint. The DMHC will obtainthis information directly from your plan as part of the investigation.
5) If you are not submitting online, please mail or fax your form and any supporting documents to:DMHC Help Center
   980 9th Street, Suite 500
   Sacramento, CA 95814-2725
   FAX: 916-255-5241

What Happens Next?

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

You will be notified in writing of the decision.

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

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

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