

Contra Costa Health Plan

Utilization Management

Title: External Independent Medical Review

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Applies to:

- Medi-Cal
- BHC

- Medicare
- State Sponsored

- Commercial
- All N/A

Regulatory/Accreditation:

- DMHC
- Other Regulatory Ref:

- CMS:
- NCQA

- DHCS: CCR, Title 22, Section 51056.1(b), 51056.1(c), 51303(h)
- N/A

Units:

- Administration
- Business Services
- Marketing
- Provider Affairs

- Advice Nurses
- Case Management
- Member Services
- Quality Management

- All Staff
- Health Education
- Planning, Survey, Reg Affairs
- Utilization Management

POLICY

Per the State Department of Managed Health Care (DMHC), Contra Costa Health Plan (CCHP) shall provide members access to an external, independent medical review to examine coverage decisions made by the Plan regarding services denied, modified or delayed that were:

1. Considered experimental or investigational therapies.
2. Denied or modified on the basis of medical necessity.

DMHC is responsible for notifying CCHP of any changes involving the external independent review process.

DEFINITIONS

Life Threatening means either or both of the following:

1. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
2. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Seriously Debilitating means:

1. Diseases or conditions that cause major irreversible morbidity.

PURPOSE

This policy serves a dual purpose:

1. To provide members with life-threatening or seriously debilitating conditions, an opportunity to have an external independent review for services denied, modified or delayed by CCHP of drugs, devices, procedures, or other therapies, which CCHP deems experimental or investigational. AND
2. To provide members an opportunity to have an external independent review of any services denied, modified or delayed by CCHP on the basis of medical necessity.

PROCEDURE

Criteria for Accessing DMHC for an External Independent Review:

The denial, delay or modification must have been for a requested service that was:

1. Deemed investigational or experimental by the Plan OR
2. Denied, modified or delayed by CCHP on the basis of medical necessity.

At the discretion of the Chief Medical Officer or designee, the Health Plan may consult with an external independent review entity, separate from DMHC, prior to the initial CCHP determination. In the event the independent consultation results in an initial denial, the member may request a secondary independent review with DMHC.

Members will be notified of the availability of the external review process through member handbooks, EOCs and all written communications regarding appeal rights.

Members eligible for an independent medical review must meet all of the following criteria:

A. Experimental/Investigational Treatment:

1. A life threatening or seriously debilitating condition according to the current diagnosis documented by the member's physician, **and**
2. Coverage for a proposed therapy was denied on the basis that it was experimental and/or investigational (please refer to policy *UM15.033-Experimental or Investigational Services and Independent Medical Review Option* for additional information on reviewing such services); **and**
3. A certified attestation by the member's physician that
 - a) standard therapies have been ineffective, or
 - b) standard therapies would not be medically appropriate, or
 - c) no standard therapy covered by CCHP would be more beneficial than the proposed therapy.**and**
4. Either the member's physician has recommended a therapy or has certified in writing that the proposed therapy is likely to be more beneficial to the member than standard therapies, or the member or member's physician has requested a therapy, that, based on two documents from medical and scientific evidence-based literature, is likely to be more beneficial for the member than any available standard therapy. Documents from medical and scientific evidence-based literature may include any of the following:
 - a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and

submit most of their published articles to experts, who are not part of the editorial staff, for review.

- b) 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).
- c) Medical Journals recognized by the Secretary of Health and Human Services, under section 1861(t)(2) of the Social Security Act.
- d) 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.
- e) 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, Center for Medicaid and Medicare Services, 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.
- f) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

B. Services Denied, Modified or Delayed on the Basis of Medical Necessity:

- 1. The member's provider has recommended a health care service as medically necessary, **or**
- 2. The member has received urgent care or emergency services that a provider determined were medically necessary, **or**
- 3. The member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks external review by DMHC. The in-plan provider does not need to recommend the disputed health care service as a condition for the member to be eligible for an external review by DMHC,

and

- 4. The member has filed an appeal and participated in CCHP's appeal process until resolution or until 30 days have passed. For urgent cases involving imminent and serious threat for loss of life or major bodily function, severe pain, or immediate and serious deterioration of the member's health, the member may go directly to DMHC. In extraordinary cases, DMHC may waive the requirement to participate in the Health Plan's appeal process prior to accessing DMHC.

Standard Process

- 1. The member will be notified of their rights, in writing, within five business days of the Plan's decision to deny, modify or delay a service eligible for external independent medical review.

2. The written notice will include an independent medical review application along with an addressed envelope that the member returns to DMHC to initiate the review.
3. Within three business days of CCHP's receipt of DMHC notice of the case for an independent review, the plan will provide DMHC copies of the following:
 - Medical records in possession of the Plan, which are relevant to the condition of the member, the services being provided for the condition and the services in dispute.
 - All information the Plan has provided to the member and contracting providers regarding the member's condition and care.
 - Any information that was submitted to the Plan by the member or the member's provider in support of the request for services.
 - All written communications by the Plan regarding the member's appeal and grievance rights related to the disputed service.
 - Any other relevant documents or information the Plan or its contracting providers used in making its determinations regarding the service in dispute, including any document that explains the reasons for the decision.

The Plan will provide a notice to the member that includes a list of documents submitted to DMHC for review and offer the member an opportunity to obtain copies of any of the information. After the initial document submittal, the Plan will submit any other newly discovered, or developed information it receives to DMHC as soon as it is discovered or developed.

For those services that are recommended by DMHC, the Plan will apply the usual and customary deductibles and co-payments.

Expedited Process

If the member's physician deems that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations by DMHC shall be rendered within three business days of the expedited review request.

If DMHC determines that a case involves an imminent and serious threat to the health of the member, the member shall not be required to complete the appeal process or participate in the process for at least 30 days before submitting an appeal to the DMHC for review. Conditions listed below can qualify for an expedited review:

- severe pain (acute severe pain or acute exacerbation of chronic pain), or
- the potential loss of life, limb, sight, or major bodily function, or
- the immediate and serious deterioration of the health of the member, or
- if DMHC determines that an earlier review is warranted based on their findings

If there is an imminent and serious threat to the health of the member as defined above, all necessary information and documents shall be sent to DMHC within 24 hours upon DMHC's request for information and their decision to proceed with an independent medical review.

Review Panel Decision

DMHC must notify the Plan, the member and the provider in a timely manner of their determination, justification for their determination and upon request, provide copies of their review.

Implementation of External Review Decision

Upon receiving notice of DMHC determination that the requested service is medically necessary, CCHP will issue an approval notice to the member and provider, and if necessary reimburse the member expenses related to the approved service or arrange for the service to be rendered. See policy *UM15.015a- Timeliness of Utilization Review Decision and Communication* for processing timeframe.

Delegation

Entities that have partial or full UM delegation (CCHS Behavioral Health Services and Kaiser) shall comply with the requirements set forth in this policy. CCHP will monitor compliance through annual and ad hoc delegation oversight audits.