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 health plans, insurers, and other types of managed care organizations. Enrollees apply for an IMR through the DMHC or the CDI. There is no cost to the enrollee.

IMRs are for:
- Disputes concerning the medical necessity of health care services;
- Denied claims for reimbursement for medically necessary emergency or urgent care services; or
- Denials of requested treatment considered experimental or investigational.

The IMR consists of a review of the pertinent medical records and patient's history by impartial medical specialists. They provide a written decision that decides whether or not the requested service should be provided. Their determination is based on the specific needs of the patient.

The CDI requires an application to be completed by the consumer requesting the Independent Medical Review. Consumers submit this application along with supporting documentations surrounding their claim to the CDI. Decisions reached as a result of an Independent Medical Review are binding. For detailed information, please see the “Additional Resources” section of www.californiamentalhealth.org. You may also call the CDI for assistance at 800-927-HELP (4357).

Providers: Filing a Complaint Against a Health Plan or Insurer

For more information, call or go online:
- Your health plan provider
- The Department of Managed Health Care Help Center: www.healthhelp.ca.gov or 888-466-2219
- Department of Insurance Help Line Number: 800-927-HELP (4357) or 213-897-8921 www.insurance.ca.gov/0100-consumers
- For more information, see companion brochures Speak Up for Your Rights and Mental Health Parity
**Why a Brochure for Providers on the Complaint Process?**

Available data indicate few grievances or complaints are filed against health plans and insurers with respect to mental health coverage. Anecdotal reports, however, from both patient and providers indicate there are significant challenges in obtaining necessary mental health care and treatment. The lack of data may be indicative of the challenges individuals face when advocating for their right to care and treatment. The California Health & Safety Code, Section 1368, encourages providers to not only assist a subscriber or enrollee with filing a grievance but also allows a provider to advocate on behalf of the individual seeking treatment. This brochure is intended to help you help your patients obtain medically necessary mental health care and treatment.

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**Patient Complaints**

Providers are encouraged to assist enrollees and/or subscribers in grievances they may have with their health plans or insurers. Grievances must be signed by patients or “authorized assistants” for patients. To act as an authorized assistant to a patient, both the complaint form and the authorized assistant form must be completed. DMHC forms are located at: www.dmhc.ca.gov/dmhc_consumer/downloads/complaint.pdf. CDI forms are at www.insurance.ca.gov/contact-us/0200-file-complaint/index.cfm.

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**Provider Complaints**

State law and its implementing regulations require each health plan or insurer to provide a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan. Before complaining to the DMHC or CDI, first try to resolve your concern by using the health plan or insurer’s dispute resolution process. If you disagree with the response, you may submit a complaint through the DMHC or CDI websites.

The CDI requires providers are to complete a Health Care Provider Request for Assistance (HPRFA) form and submit specific, required information to the California Department of Insurance. For detailed information surrounding provider complaints please see the “Additional Resources” section of www.californiamentalhealth.org.

All complaints submitted regarding claims must have been for services rendered no more than four years prior to the date the complaint is submitted. The complaint must have been reviewed by the Plan’s dispute resolution process or it must have been pending within that process for more than 45 working days. If a complaint is submitted prior to participating in the health plan or insurer’s dispute resolution process, it will be closed without review.

Appropriate supporting documentation is a prerequisite for review of any issue. Documentation includes claim forms submitted, any correspondence sent or received, any records submitted, any written determination from the health plan or insurer, and an explanation of your disputed claim. Any information you submit in your complaint may be forwarded to the health plan or insurer, and an explanation of your disputed claim. Any information you submit in your complaint may be forwarded to the health plan or insurer, and an explanation of your disputed claim. Any information you submit in your complaint may be forwarded to the health plan or insurer.

Providers may also wish to report misconduct of the health plan or insurer, such as:

- Excessive delays in obtaining authorization;
- Repeated requests for supporting documentation;
- Challenges in obtaining enrollee coverage information.

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**The Grievance Process**

State law requires that every health plan or insurer must have a grievance process. The DMHC has established an Independent Dispute Resolution Process (IDRP) to afford non-contracted providers of certain emergency services a way to resolve claim payment disputes involving “reasonable and customary” reimbursements. A provider may submit an individual claim or multiple claims (up to 50) in a single filing that are substantially similar. Like with other complaint mechanisms, the provider is encouraged to utilize the plan’s internal dispute resolution process prior to submitting a dispute through the IDRP. However, this is not a requirement for providers other than hospitals who are required to first complain to the plan.

The CDI has a Health Care Provider Complaints Section. Before you file a case with the CDI for review, you should use the insurer’s dispute resolution process. Insurers are required to resolve provider disputes and issue a written determination within 45 days. To ensure proper review of the case, copies of the following documents that should be sent to the CDI:

- The completed Health Care Provider Request for Assistance (HPRFA);
- The patient’s (signed) Assignment of Benefits (if applicable);
- The claim forms submitted to the insurer;
- All correspondence between the provider and the insurer, including all related Explanation of Benefits (EOBs);
- The Dispute Resolution Process determination letter;
- Both sides of the patient’s insurance identification card; and
- The provider’s contract with the insurer, if any.