

**From:** DMHC Licensing eFiling

**Subject:** APL 23-006 – Independent Medical Review (IMR) Application/Complaint Form (DMHC 20-224)

**Date:** Friday, February 24, 2023 9:05 AM

**Attachments:** APL 23-006 – Independent Medical Review Application Form (2.24.23)

Dear Health Plan Representative:

The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-006 to inform all licensed health care service plans that the Department has revised the Independent Medical Review Application/Complaint Form (DMHC 20-224).

Thank you.



Gavin Newsom, Governor  
State of California  
Health and Human Services Agency  
**DEPARTMENT OF MANAGED HEALTH CARE**  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814  
Phone: 916-324-8176 | Fax: 916-255-5241  
[www.HealthHelp.ca.gov](http://www.HealthHelp.ca.gov)

## ALL PLAN LETTER

**DATE:** February 24, 2023  
**TO:** All Licensed Health Care Service Plans  
**FROM:** Rachel Long, Deputy Director Help Center  
**SUBJECT:** APL 23-006 – Independent Medical Review (IMR) Application/Complaint Form (DMHC 20-224)

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The Department of Managed Health Care (Department) issues this All-Plan Letter (APL) to inform all licensed health care service plans that the Department has revised the Independent Medical Review Application/Complaint Form (DMHC 20-224).

In accordance with Health & Safety Code (HSC) sections 1368(b) and 1374.30, and Title 28, California Code of Regulations (CCR) sections 1300.68 and 1300.74.30, the Department has revised the Independent Medical Review Application/Complaint Form.

Included with this APL is the revised IMR Application/Complaint Form in English. The revised form is available in English and the 16 threshold languages on the Department's public website at [DMHC IMR/Complaint Form](#). All health plans are required to use the revised form effective **March 1, 2023**.

If you have questions regarding this APL, please contact Michael Dutra, Assistant Deputy Director, Help Center at [michael.dutra@dmhc.ca.gov](mailto:michael.dutra@dmhc.ca.gov).

## INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

### IMPORTANT INFORMATION

You can submit your IMR Application/Complaint Form online at: [www.HealthHelp.ca.gov](http://www.HealthHelp.ca.gov)

- ❖ **FREE:** The IMR/Complaint process is free.
- ❖ **FAST:** IMRs are usually decided within 45 days, or within 7 days if the health issue is urgent.
- ❖ **SUCCESSFUL:** Approximately **68** percent 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  Something Else \_\_\_\_\_

Name of Parent or Guardian if Filing for Minor Child \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Email Address \_\_\_\_\_

Would you like communication/correspondence sent to this email?  Yes  No

Health Plan Name \_\_\_\_\_ Patient's Membership # \_\_\_\_\_

Medical Group Name (if enrolled in a medical group) \_\_\_\_\_

Employer \_\_\_\_\_

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:

### YOUR HEALTH PROBLEM

(Use a separate sheet and attach other documents, if needed.)

Do you want your health plan to pay for future services?  Yes  No

What is your medical condition or doctor's diagnosis (Please be specific) \_\_\_\_\_

What medical treatment(s)/service(s) and/or medication(s) are you asking for? (Please be specific)

Did your health plan deny, delay or modify your treatment?  Yes  No

If yes, please check the reason given: (Check one)

- Not Medically Necessary     Experimental or Investigational     Not an Emergency/Urgent  
 Not a Covered Benefit     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 bill, trouble getting an appointment or medication, or if your coverage has been cancelled by the health plan.

### MEDICAL RELEASE

I request the Department of Managed Health Care (Department) to make a decision about my problem with my health plan. I request the Department to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or the Department'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 Department 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 Department 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 Name (Print) \_\_\_\_\_

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 Department identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the Department 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: \_\_\_\_\_

Would you like us to communicate/correspond with you in your primary language?  Yes

Race/Ethnicity: \_\_\_\_\_

### 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 or 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: COMPLETED BY 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 (Department). I allow the Department 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 Name (Print) \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

#### PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Primary Phone # \_\_\_\_\_ Secondary 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.

### Before You File:

In most cases, you must complete your plan's complaint or grievance process before you file a complaint or IMR request to the Department. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental/investigational, you do not have to take part in your plan's complaint or grievance process before you file an IMR application.

You must apply for an IMR within six months after your health plan sends you a written response to your appeal. The Department 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 DEPARTMENT for an 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](http://www.HealthHelp.ca.gov). [This is the fastest way.]

**OR**

Fill out and sign the IMR Application/Complaint 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 IMR Application/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 Department will obtain this 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:

Department of Managed Health Care 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 sent to 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 decision about your issue will be made within 30 days. You will be notified in writing of the decision.

## IMR Application/Complaint Form Instruction Sheet

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

- California's Knox-Keene Act gives the Department the authority to regulate health plans and investigate the complaints of health plan members.
- The Department's Help Center uses your personal information to investigate your problem with your plan and to provide an IMR if you qualify for one.
- You provide the Department this information voluntarily. You do not have to provide this information. However, if you do not, the Department may not be able to investigate your complaint or provide an IMR.
- The Department may share your personal information, as needed, with the plan and providers who conduct the IMR.
- The Department 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 Department Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.