PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3138 (previously MCUP3138)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: External Independent Medical Review</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/13/2018</td><td colspan="4">Next Review Date: 08/12/2027
Last Review Date: 08/12/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/12/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPUP3042 – Technology Assessment
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
D. MCRP4068 – Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Independent Medical Review process: Process in which an expert independent medical professional is selected to review a specific health service request and provide a fair and objective opinion based on his/her designated specialty.
B. Independent Medical Review Organization (IMRO): A third-party medical review resource which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.
C. Independent Review Entity (IRE): Specific to Partnership Advantage Members, an IRE refers to an independent organization contracted by the Centers for Medicare & Medicaid Services (CMS) to review Medicare Advantage (Part C) or Prescription Drug (Part D) plan decisions in the second level of appeal.
D. Life Threatening: Defined as a disease or condition where the likelihood of death is high unless the course of the disease is interrupted OR diseases or conditions with potentially fatal outcomes where the end point of the clinical intervention is survival.
E. Partnership Advantage: Effective January 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.
F. Seriously Debilitating: Defined as diseases or conditions causing major irreversible morbidity.

IV. ATTACHMENTS:

A. N/A

Policy/Procedure Number: MPUP3138 (previously MCUP3138)			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: External Independent Medical Review			☒**External Policy** ☐**Internal Policy**
Original Date: 06/13/2018		**Next Review Date: 08/12/2027** **Last Review Date: 08/12/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

V. PURPOSE:

To describe the process used by Partnership HealthPlan of California (Partnership) to provide a comprehensive and fair evaluation of health service requests. The external independent medical review process may be applied in circumstances for which nationally recognized evidenced-based criteria or Partnership medical policy does not provide ample guidance or where the Chief Medical Officer (CMO) or Physician Designee desires an additional opinion from an actively practicing, board-certified physician of like or similar specialty.

VI. POLICY / PROCEDURE:

A. Partnership contracts with Independent Medical Review Organizations (IMROs) to ensure qualified case-matched independent specialists are available to review health service requests as expeditiously as possible in deference to the Member's health condition. In addition to an IMRO, Partnership may also use qualified case-matched independent specialists to review on a case-by-case basis. An IMRO or qualified case-matched independent specialist may be used at the discretion of the CMO or Physician Designee for circumstances including, but not limited to the following:
   1. Assessment of health treatment efficacy and/or scope of application
   2. Service requests deemed Experimental or Investigational
   3. In the instance of an appeal (Note: For Partnership Advantage Members, the designated IRE would be used as described in III.C. above)
   4. Denial of an Experimental or Investigational therapy when a Member has a life threatening or seriously debilitating condition.
   5. Denial, modification or delay of health care services based in whole or part on the determination that the service requested is not medically necessary. The Member's contracted treating physician must certify that the condition has not responded to standard therapies AND must make written recommendation that another drug, device, procedure or therapy would be MORE beneficial than those that are standard.
   6. Existing technology/pharmacology used differently

B. With the exception of Experimental or Investigational Therapy, determinations to deny, delay or modify health care services based on a benefit exclusion, are not eligible for an independent medical review under this policy.

C. Partnership does not reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for Utilization Management (UM) decision makers to deny care, and Partnership does not encourage decisions which would result in under-utilization, but rather bases decisions solely on the appropriateness of care or service and the existence of coverage.

D. The IMRO conducting the independent medical review is contracted directly by Partnership. The cost of the independent medical review is the responsibility of the health plan. The Member or Provider requesting an independent medical review on the Member's behalf shall NOT be charged an application or processing fee.

E. Process for Referral to Independent Medical Review
   1. Partnership's CMO or Physician Designee will work with the Utilization Management (UM) Department to assemble and submit all necessary information to the contracted IMRO, IRE, or qualified case-matched independent specialist.
   2. The UM staff will submit a completed file for review by the Independent Medical Reviewer which will include, but is not limited to:
      a. Internal patient identifier for the purpose of the review
      b. Requested service/procedure to include specific CPT/HCPCS code(s)
      c. Member diagnosis (Using current ICD Code sets)
      d. All information provided relevant to the service requested
      e. All information submitted by the practitioner in support of the requested service

f. Pertinent medical history
g. Treatment or clinical data
h. Date response needed
i. Specific questions concerning treatment requiring clarification

3. The UM staff maintain contact with the IMRO and ensure timely resolution of the submitted case.
4. Upon receipt of the independent review, Partnership's CMO or Physician Designee will determine coverage of the requested service.
5. After the coverage decision has been reached and all parties notified, Partnership's CMO or Physician Designee will submit a copy of the case, including the final resolution, to UM department staff.
6. UM department staff uploads a summary of the case and all supporting documentation into the UM Department documentation system as an attachment to the Member's Treatment Authorization Request (TAR) file for which the review was completed.
7. UM staff maintain tracking/monitoring of all cases submitted to the IMRO.
8. IMRO information is available to the Partnership Quality/Utilization Advisory Committee (Q/UAC) upon request.
9. The CMO or Physician Designee is responsible for ensuring the timely processing and final resolution of the requested service. When independent medical review is sought, it must also occur in this time frame.

F. Time Frames

1. Standard Review: The IMRO shall review all relevant information and make a written determination within five (5) business days of receipt of the request in order to allow for timely resolution of non-urgent requests.
2. Expedited Review:
   a. An expedited independent medical review is initiated under the following conditions:
      1) The CMO or Physician Designee, or treating physician determines there is an imminent and serious threat to the health of the Member including, but not limited to, severe pain, the potential loss of life, limb or major bodily function, and or the immediate and serious deterioration of the health of the Member.
      2) The Member's physician has determined that the proposed therapy would be significantly less effective if not promptly initiated.
   b. The IMRO shall make their determination within 24 hours of the receipt of the request and provide supporting documentation to allow for a timely review within seventy-two (72) hours of date of receipt at Partnership. Partnership may extend the IMRO's determination deadline for an additional 24 hours in extraordinary circumstances or for good cause, which is in the best interest of the Member and still allows for a timely review or appeal resolution within seventy-two (72) hours of date of receipt.
3. Retrospective Review: In the case of a retrospective review, the IMRO shall review all relevant information and make a written determination within five (5) to seven (7) business days of receipt of the request to allow for timely review decision within 30 business days of the date of receipt at Partnership.
4. In all cases, Partnership will provide the Member and the Member's treating practitioner with the analysis and determination as well as a description of the qualifications of the medical professionals who reviewed the case. As part of the grievance process, Partnership provides a Member with a written determination to uphold a denial, delay or modification based on either medical necessity or the experimental or investigational nature of the request, and advises the Member of appeal rights and process.

Policy/Procedure Number: MPUP3138 (previously MCUP3138)			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: External Independent Medical Review			☒**External Policy** ☐**Internal Policy**
Original Date: 06/13/2018		**Next Review Date: 08/12/2027** **Last Review Date: 08/12/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VII. REFERENCES:

A. California Health and Safety Code, Division 2, Chapter 2.2 Health Care Service Plans, Article 5.55 Appeals Seeking Independent Medical Reviews Section 1374.30 - .36
B. Title 28 California Code of Regulations (CCR), Division 1, Chapter 2, Article 8 Section 1300.70.4 and 1300.74.30
C. In compliance with the California Department of Health Care Services (DHCS) contract
D. Title 22 California Code of Regulations (CCR)
E. National Committee for Quality Assurance (NCQA) Guidelines UM 4 Appropriate Professionals Element F
F. Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (11/18/2024)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer, Chief Medical Officer or Physician Designee

X. REVISION DATES:

08/14/19; 08/12/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24; (MPUP3138) 09/10/25; 08/12/26

PREVIOUSLY APPLIED TO:

N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.