

DEPARTMENT OF HEALTH SERVICES

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August 3, 1999

**MMCD All Plan Letter 99011**

TO: Medi-Cal Managed Care Health Plans

SUBJECT: NEW MEDI-CAL MANAGED CARE EXEMPTION FORMS

The purpose of this letter is to provide information to contracting health plans regarding new Medi-Cal Managed Care Exemption Certification Forms that will be implemented by Health Care Options (HCO) program, effective August 2, 1999—one for Medical Exemption Certifications and the other for Non-Medical Exemption Certifications (copies enclosed).

As you know, beneficiaries in mandatory enrollment categories can request exemption from enrollment in a Medi-Cal managed care plan for the following reasons:

- The beneficiary is currently under treatment for a complex or chronic medical condition by a Medi-Cal fee-for-service provider who is not a participating provider with a Medi-Cal managed care plan in the beneficiary's county of residence.
- The beneficiary is a Native American, Alaskan Native or a qualifying non-Indian who chooses to receive healthcare services through an Indian Health Service facility.
- The beneficiary is enrolled in one of four Medi-Cal waiver programs.

To be certified for one of these three types of exemptions, the beneficiary must have an exemption request form completed by the treating physician and submitted to the HCO program.

New Forms Part of Department's Anti-Fraud Initiative

These new exemption forms were developed as part of the Department of Health Service's anti-fraud initiative and will replace the current one-page "Medi-Cal Managed Care Exemption Certification for Medical Conditions and Indian Health Program Exemption" form. The new forms will help the Department achieve a number of goals related to the exemption process:

August 3, 1999

Implementation of New Forms

The HCO program will begin using the new forms no later than August 2, 1999. These forms will be included in HCO enrollment packets, available at HCO program sites, and provided to beneficiaries upon request by telephone, facsimile, or in writing. Exemption requests submitted on the previous form will be processed by HCO through August 31, 1999. Requests submitted on the previous form after August 31, 1999, will be denied, and HCO will instruct requestors to submit the request on the new forms. Medi-Cal providers will be sent a notice in early August regarding these new forms.

These new forms not only will reduce the likelihood of fraud and abuse in the exemption process, but also will make it easier for beneficiaries and providers to understand the required information and for providers to complete the forms. The Department wants to ensure continued access to legitimate exemptions from managed care plan enrollment to allow for continuity of care outside the managed care program when medically necessary or to afford access to specific facilities.

If you have questions or comments about these new exemption forms, please contact your contract manager.

Original Signed by

Susanne M. Hughes

Acting Chief

Medi-Cal Managed Care Division

Enclosures

MEDI-CAL MANAGED CARE MEDICAL EXEMPTION CERTIFICATION

• See other side for the Medical Exemption Certification Form •

Dear Medi-Cal Beneficiary: If you or a family member is receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. If you or a family member has a **complex medical condition** AND your doctor or clinic DOES NOT belong to a Medi-Cal Managed Care health plan, you may NOT have to join a plan.

To continue receiving medical services from your doctor, clinic or other primary care provider, you must have your doctor complete this form. If approved, you will NOT have to join a Medi-Cal Managed Care health plan for up to **12 months**. At the end of 12 months, if an extension is required, your doctor must submit a new form. Your approval for medical exemption will allow you to continue to receive medical services through fee-for-service Medi-Cal by using your white Medi-Cal card.

CERTIFICACIÓN DE EXCEPCIÓN DE ATENCIÓN MÉDICA ADMINISTRADA DE MEDI-CAL

• Vea el reverso de este formulario para información sobre la Excepción por Razones Médicas •

Estimado beneficiario de Medi-Cal: Si usted o un miembro de su familia está recibiendo beneficios de Medi-Cal, es posible que deba inscribirse en un Plan de Salud Administrado de Medi-Cal. Sin embargo, si usted o un miembro de su familia tiene una **condición médica compleja** Y su médico o clínica NO pertenece a un plan de salud de Atención Médica Administrada de Medi-Cal, tal vez NO tenga que inscribirse en un plan.

Para continuar recibiendo servicios médicos a través de su médico, clínica u otro proveedor de atención médica primaria, debe solicitarle a su médico que llene este formulario. Si se aprueba su solicitud, NO tendrá que inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal durante un período de hasta **12 meses**. Al cumplirse los 12 meses, si se requiere una extensión, su médico deberá presentar un nuevo formulario. Su aprobación para una excepción por razones médicas le permitirá continuar recibiendo servicios médicos mediante el sistema de pago por servicio de Medi-Cal (fee-for-service), utilizando su tarjeta blanca de Medi-Cal.

Dear Medi-Cal Physician: If you are currently providing medical services to a Medi-Cal beneficiary who has a **complex/chronic medical condition** AND you are NOT affiliated with any Medi-Cal Managed Care health plans in the county of residence of the beneficiary, you may be able to continue providing services to the individual by completing this form and sending it to the Health Care Options office. Note the Medi-Cal beneficiaries under 21 years of age who are being treated for an eligible condition under the California Children's Services (CCS) program are still required to enroll in a Medi-Cal Managed Care health plan unless they have some other condition which qualifies them for a medical exemption.

This exemption is valid until the date you indicate the individual will be stabilized enough to allow enrollment in a Medi-Cal Managed Care health plan or the condition is resolved (up to a maximum of 12 months). Extensions may be requested at the end of 12 months by submitting a re-certification (new exemption form).

MEDI-CAL MANAGED CARE MEDICAL EXEMPTION CERTIFICATION FORM

Each area of the Medi-Cal Managed Care Medical Exemption Certification form must be completed or the form will be returned unprocessed – Please Print or Type

1. Beneficiary Name <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Last Name First Name M.I.			2. Beneficiary Medi-Cal I.D. Number (BIC) _____		
3. Beneficiary Social Security Number _____		4. Date you started treating beneficiary for complex or high-risk condition ____ Month ____ Day ____ Year		5. Estimated completion date ____ Month ____ Day ____ Year	
6A. Please check the following as appropriate (ICD-9-CM code must be included in section 6B or the form will be rejected.)					
P. <input type="checkbox"/> Pregnant and currently under your care/ Due Date _____					6B. ICD-9-CM code(s) 1. _____ 2. _____ 1. _____ 2. _____ 1. _____ 2. _____ 1. _____ 2. _____ 1. _____ 2. _____ 1. _____ 2. _____
E. <input type="checkbox"/> Had an organ transplant and is in specialty care or is currently being evaluated for an organ transplant					
D. <input type="checkbox"/> Receiving chronic renal dialysis treatment					
F. <input type="checkbox"/> HIV+ or has been diagnosed with AIDS					
C. <input type="checkbox"/> Receiving ongoing therapy for cancer					
G. <input type="checkbox"/> Has been approved for and is awaiting surgery or treatment for a specified complex condition					
A. <input type="checkbox"/> Has a complex neurological disorder, such as multiple sclerosis					
B. <input type="checkbox"/> Has a complex hematological disorder, such as hemophilia or sickle cell disease					
M. <input type="checkbox"/> Has another complex and/or chronic medical condition, including those which affect multiple organ systems and/or which require ongoing complicated therapy					
I have read both sides of this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care health plan and whether the Medi-Cal beneficiary's medical condition listed is complex or high-risk.					
7. Do you affiliate with any Medi-Cal Managed Care plans in the county of residence of the beneficiary? Yes <input type="checkbox"/> No <input type="checkbox"/>					
8a. Medi-Cal Provider Billing Name, Address, Zip Code					
Name _____					
Address _____					
City _____		State _____		Zip Code _____	
8b. Primary Medi-Cal Provider Number used to bill the Medi-Cal Program for this beneficiary _____			9a. Physician's Medical License Number _____		
9b. Printed Name of Rendering Medical Physician <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Last Name First Name M.I.			9c. Authorized Signature of Rendering Medical Physician _____		
9d. Telephone Number of Medical Physician (____) _____		9e. Fax Number of Medical Physician (____) _____		10. Date Signed ____ Month ____ Day ____ Year	

MAIL this document to: **Health Care Options**
P.O. Box 989009
West Sacramento, CA 95798-9850

or FAX this document to: (916) 364-0287

If you have questions regarding this form, please call HCO at 1-800-430-4263

MEDI-CAL MANAGED CARE NON-MEDICAL EXEMPTION CERTIFICATION

• See other side for the Non-Medical Exemption Certification Form •

Indian Health Program Exemption:

Dear Medi-Cal Beneficiary: If you or a family member is receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. However, if you or a family member is a Native American, Alaskan Native or qualified non-Indian and you want to receive medical services through an Indian Health Service (IHS) facility, you may request to be excused from Medi-Cal Managed Care health plan enrollment in order to receive services through an Indian Health Service facility.

To be excused from plan enrollment you must have an Indian Health Services facility representative complete this form, certifying that you are or will be receiving services from an Indian Health Service facility. The facility representative must submit this completed form to the HCO program.

Medi-Cal Waiver Program Exemption:

Dear Medi-Cal Beneficiary: If you are enrolled in a Medi-Cal waiver program which allows you to receive skilled nursing services at home or are enrolled in any of the waiver programs listed below, you may NOT have to join a plan.

If you are enrolled in a Medi-Cal waiver program and wish to continue receiving medical services from your doctor, clinic or other primary care provider, you must have your doctor complete this form. If approved, you will NOT have to join a Medi-Cal Managed Care health plan for up to 12 months. At the end of 12 months, if an extension is required, your doctor must submit a new form. Your approval for medical exemption will allow you to continue to receive medical services through fee-for-service Medi-Cal by using your white Medi-Cal card.

Medi-Cal Waiver Programs:

- AIDS Waiver Program *not for SAC GMC/HSP*
- Model Waiver Program
- In-Home Medical Care (IHMC) Waiver Program
- Skilled Nursing Facility (SNF) Waiver Program

CERTIFICACIÓN DE EXCEPCIÓN POR RAZONES NO MÉDICAS PARA ATENCIÓN MÉDICA ADMINISTRADA DE MEDI-CAL

• Vea el reverso de este formulario para información sobre la Excepción por Razones Médicas •

Excepción para el Programa Indian Health Program:

Estimado beneficiario de Medi-Cal: Si usted o un miembro de su familia está recibiendo beneficios de Medi-Cal, es posible que deba inscribirse en un Plan de Salud Administrado de Medi-Cal. Sin embargo, si usted o un miembro de su familia es de origen Indígena Americano, Nativo de Alaska o reúne los requisitos para personas de origen no indígena y desea recibir servicios médicos a través de un centro de Indian Health Service (IHS), puede solicitar que esté excluido de inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal para recibir los servicios a través del centro de Indian Health Service.

Para que esté excluido de inscribirse en el plan, debe solicitarle a un representante del centro de Indian Health Services que llene este formulario, en el que certifica que usted recibe o recibirá servicios a través de un centro de Indian Health Service. El representante del centro debe enviar este formulario completo al programa HCO.

Excepción para los programas de renuncia a Medi-Cal:

Estimado beneficiario de Medi-Cal: Si está inscrito en un programa de renuncia a Medi-Cal que le permite recibir servicios de atención médica especializada en el hogar o en cualquiera de los programas de renuncia que figuran a continuación, tal vez NO tenga que inscribirse en un plan.

Si está inscrito en un programa de renuncia a Medi-Cal y desea continuar recibiendo servicios médicos a través de su médico, clínica, u otro proveedor de atención médica primaria, debe solicitarle a su médico que llene este formulario. Si se aprueba su solicitud, NO tendrá que inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal durante un período de hasta 12 meses. Al cumplirse los **12 meses**, si se requiere una extensión, su médico deberá presentar un nuevo formulario. Su aprobación para una excepción por razones médicas le permitirá continuar recibiendo servicios médicos mediante el sistema de pago por servicio de Medi-Cal (fee-for-service), utilizando su tarjeta blanca de Medi-Cal.

Programas de renuncia a Medi-Cal:

- Programa de renuncia para SIDA (AIDS Waiver Program)
- Programa de renuncia modelo (Model Waiver Program)
- Programa de renuncia para atención médica en el hogar (In-Home Medical Care (IHMC) Waiver Program)
- Programa de renuncia para atención médica especializada (Skilled Nursing Facility (SNF) Waiver Program)

MEDI-CAL MANAGED CARE NON-MEDICAL EXEMPTION CERTIFICATION FORM INDIAN HEALTH PROGRAM EXEMPTION CERTIFICATION

Each area of the Indian Health Program Exemption Certification form must be completed or the form will be returned unprocessed – Please Print or Type

Dear Indian Health Service Facility: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal benefits and that individual is required to enroll in a health plan, completion of this form will enable the individual to receive services through your facility as an alternative to enrollment in a Medi-Cal Managed Care health plan. The Indian Health exemption is valid until the individual chooses to enroll in a Medi-Cal managed Care health plan.

1. Beneficiary Name			2. Beneficiary Medi-Cal I.D. Number (BIC)		
_____	_____	_____	_____		
<small>Last Name First Name M.I.</small>					
3. Name of Indian Health Facility					
I certify that the information I have provided on this form is correct. I understand that the Department of Health Services may audit this form to determine if the information provided is accurate.					
4a. Authorized Signature of Medi-Cal Provider			4b. Date Signed		
_____			_____		
<small>Last Name First Name M.I.</small>			<small>Month Day Year</small>		
4c. Printed Name of Medi-Cal Provider			4d. Medi-Cal Provider Number used to bill the Medi-Cal Program for this beneficiary		
_____			_____		
<small>Last Name First Name M.I.</small>					
5. Telephone Number of Medical Provider			6. Fax Number of Medical Provider		
(____) _____ - _____			(____) _____ - _____		

MEDI-CAL WAIVER PROGRAM EXEMPTION CERTIFICATION

Each area of the Medi-Cal Waiver Program Exemption Certification form must be completed or the form will be returned unprocessed – Please Print or Type

Dear Medi-Cal Physician: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal Waiver Program benefits, please complete this portion of the form.

1. Beneficiary Name			2. Beneficiary Medi-Cal I.D. Number (BIC)		
_____	_____	_____	_____		
<small>Last Name First Name M.I.</small>					
3. Medi-Cal Provider Number		4. Medi-Cal Waiver Program:			
_____		u. <input type="checkbox"/> AIDS Waiver Program w. <input type="checkbox"/> In-Home Medical Care (IHMC) Waiver Program v. <input type="checkbox"/> Model Waiver Program y. <input type="checkbox"/> Skilled Nursing Facility (SNF) Waiver Program			
I certify that the information I have provided on this form is correct. I understand that the Department of Health Services may audit this form to determine if the information provided is accurate.					
5. Authorized Signature of Medical Physician			6. Date Signed		
_____			_____		
<small>Last Name First Name M.I.</small>			<small>Month Day Year</small>		
7. Printed Name of Medical Physician			8. Medi-Cal Provider Number used to bill the Medi-Cal Program for this beneficiary		
_____			_____		
<small>Last Name First Name M.I.</small>					
9. Telephone Number of Medical Physician			10. Fax Number of Medical Physician		
(____) _____ - _____			(____) _____ - _____		

MAIL this document to:

**Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850**

or FAX this

document to: (916) 364-0287

If you have questions regarding this form, please call HCO at 1-800-430-4263