Date: **July 18, 2012**

To: **All Medi-Cal Providers**

Subject: **Provider Bulletin: Introduction and Supplemental Instructions for Form HCO 7101, Request for Medical Exemption from Plan Enrollment**

The provider bulletin that accompanies this letter details the policy of the Department of Health Care Services (DHCS) regarding Medical Exemption Requests (MERs).

A MER is a request for temporary exemption from enrollment into a Medi-Cal managed care plan only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer, without deleterious medical effects, from a physician in Fee-for-Service (FFS) Medi-Cal to a physician of the same specialty in a managed care plan.

To initiate the MER process, the treating physician must fill out form HCO 7101, Request for Medical Exemption from Plan Enrollment. The DHCS clinical staff then reviews and verifies the information in each MER form. For DHCS to complete its review and avoid a delay in processing, DHCS requests the healthcare providers of Medi-Cal beneficiaries to consider the following five points:

1. Only one MER form should be submitted for a beneficiary unless a previous MER was denied and the beneficiary's medical condition has since changed. Submitting multiple MERs for one beneficiary slows down the review and verification process.

2. The MER form should be filled out in its entirety and may be considered incomplete if necessary fields are left blank or responses are not legible. Examples of commonly missed fields include:

    - Beneficiary's Medi-Cal Client Identification Number (CIN).
    - ICD-9 Code(s).
    - Description of treatment plan that cannot be interrupted.
    - Estimated date of completion of treatment.
    - Requesting and rendering provider are not the same.
    - Rendering provider's NPI and Medical License Number.
    - Telephone number of the rendering provider's office.
    - Original signature of beneficiary or authorized representative.
    - Original signature of rendering physician (no stamp or staff signature allowed).

3. The MER must include documentation of the beneficiary's medical condition and evidence that it is unstable and that the beneficiary's treatment cannot safely be transferred to a managed care plan physician(s) of the same specialty or specialties. Supporting documents may include, but are not limited to legible copies of:

    - Notes from five most recent MD office visits.
    - Current medical history and physical exam results.
    - Treatment plan.

4. A MER will be returned as incomplete if it fails to meet the standards listed above. To be reconsidered, the missing information or completed form must be provided within 30 days of DHCS's request to the submitting provider for additional information. Any MER incomplete for over 30 days will be denied.

   While the MER is in an incomplete status for 30 days, the beneficiary will remain in FFS Medi-Cal, if not already enrolled in a managed care plan.

5. If a beneficiary has a provider affiliated with a managed care plan in the beneficiary's county of residence, the MER will be denied because the beneficiary can continue to receive services from his or her current provider as a member of the managed care plan with which the provider is currently affiliated.

Please read the accompanying provider bulletin for the detailed policy statement related to MERs. If you have questions regarding this provider bulletin, please contact Health Care Options at 800-430-4263.

Sincerely,

ORIGINAL SIGNED BY MARGARET TATAR

Margaret Tatar, Chief
Medi-Cal Managed Care Division

Provider Bulletin

Medical Exemption from Plan Enrollment Request Process

The purpose of this bulletin is to reaffirm the Medical Exemption Request (MER) process that exempts Medi-Cal beneficiaries from enrollment into managed care and ensure that providers are reminded that Seniors and Persons with Disabilities (SPDs) have the opportunity to request continued access to an out-of-network provider for up to 12 months after they have been enrolled in a managed care health plan. This bulletin also serves as notification that the MER form is in the process of being revised to better reflect the requirements for a MER to be processed.

Reminder: SPD Extended Continuity of Care

The recent implementation of mandatory enrollment of SPDs into managed care has generated a significant increase in requests for MERs. The Department of Health Care Services (DHCS) wants to remind providers that a MER might not be necessary for an SPD to continue to see their existing out-of-network provider, even if the SPD is enrolled in a managed care health plan. SPD beneficiaries have the opportunity to request continued access to see an out-of-network provider for up to 12 months after enrollment in a managed care health plan to assure continuity of care. Although certain requirements must be fulfilled, it is not necessary for the provider to contract with the managed care health plan to continue treating the beneficiary. Additional information is provided in the links below.

- Provider Bulletin: http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ProviderBulletinSept2011.pdf
- SPD Extended Continuity of Care Frequently Asked Questions: http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDHCPFAQ.aspx

MER Background

Per Title 22 of the California Code of Regulations, Section 53887, an eligible beneficiary in a Two Plan county, who is receiving fee-for-service (FFS) Medi-Cal treatment or services for a complex medical condition from a physician, certified nurse midwife, or licensed midwife who is participating in the Medi-Cal program but is not a contracting provider of the managed care health plans available in the eligible beneficiary's county of residence may request a medical exemption to temporarily continue treatment under FFS Medi-Cal to support the beneficiary's continuity of care. A beneficiary who has been granted a medical exemption from health plan enrollment shall remain with the

FFS provider only until the medical condition has stabilized to a level that would enable the individual to change to an in-network physician of the same specialty without deleterious medical effects.

MER Overview and General Considerations

The DHCS clinical staff reviews each MER to determine if the beneficiary can be safely transitioned into a managed care health plan where they will continue to receive all medically necessary covered services. A MER is not reviewed to determine if medical services should be provided or to determine if such services are medically necessary: **this is not a Treatment Authorization Request.**

In general, a beneficiary receiving maintenance care or being seen for routine follow-up of their complex medical condition(s) will not be granted an exemption from health plan enrollment. Additionally, per Title 22, a request for exemption shall not be granted for a beneficiary who has been a member of a health plan for more than 90 days; has a current provider who is contracting with a managed care health plan operating in the beneficiary's county of residence, including subcontracting plans, clinics, and/or Independent Physician Associations; or has begun or was scheduled to begin treatment after the date of health plan enrollment.

As beneficiaries with more complex medical conditions are being moved into managed care, DHCS has found that additional information is required for clinical staff to verify the complexity, validity, and status of the medical condition and treatment plan that necessitates the exemption. To expedite the review process, providers must supply this documentation to help verify that the beneficiary is unable to safely transfer to a health plan provider of the same specialty. The type of information that DHCS needs may include, but is not limited to, approved FFS TARs, progress notes, information from the last history and physical exam, a treatment plan, and any additional information that demonstrates that the beneficiary cannot safely transfer to a new provider. To help avoid delays in these important requests, DHCS asks that providers include the information described above as documentation in the initial MER request.

Additionally, DHCS cannot review incomplete MER forms. An incomplete MER will be sent back to the provider, which will delay the processing of the exemption request. The request review will be delayed if:

- All fields in the MER form are not complete when submitted.
- Necessary documentation is not provided with the initial submission of the MER that allows clinical staff to make a determination.

- The provider submitting the MER is not the same as the non-contracted provider actually providing the services that the MER is being requested for, such as specialty treatment centers or hospitals.

If the MER is returned as incomplete and additional information requested by DHCS is not received within 30 days of the date on the request for additional information, the MER will be administratively denied by DHCS.

Pregnancy Requests

Exemption requests for pregnancy will be reviewed as described above to determine if the beneficiary is eligible for an exemption and unable to safely change providers. Providers must supply the appropriate ICD-9 codes and any additional information to assist in the review of the request. An uncomplicated pregnancy is not considered a condition that requires a beneficiary to stay with the current physician for mother and infant safety. However, special consideration is given to women in their 3rd trimester who have an established relationship with a provider during their 1st and 2nd trimesters to ensure continuity of care for the delivery. Exemptions will not be granted for members assigned to a health plan clinic who request to receive services from a non-contracted provider affiliated with the clinic. The beneficiary's primary provider is considered the clinic.

Transplant Requests

Kidney and corneal transplants are the only transplants covered by managed care health plans in most counties. All other transplants are provided on a FFS basis, regardless of managed care enrollment. However, exemption requests for beneficiaries experiencing specific transplant situations will be reviewed and evaluated with the same criteria previously described.

General Guidelines

Exemption from plan enrollment or extension of an approved exemption due to a complex medical condition must be requested on the "Request for Medical Exemption from Plan Enrollment" form, which can be accessed by calling 1-800-430-4263 or online at:

http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Exception_to_Plan_Enrollment_Forms.aspx

Questions regarding these documents may be directed to Health Care Options at: 1-800-430-4263 or TDD/TTY 1-800-430-7077, or www.healthcareoptions.dhcs.ca.gov.