



California
Department of
Health Services

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Director

State of California—Health and Human Services Agency
Department of Health Services

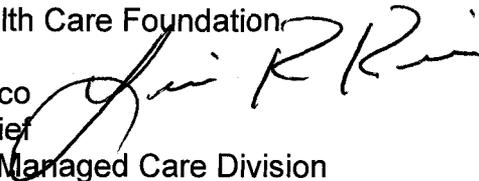


ARNOLD SCHWARZENEGGER
Governor

November 1, 2004

MMCD All Plan Letter No. 04006

TO: County Organized Health System Plans (COHS)
Geographic Managed Care (GMC) Plans
Prepaid Health Plans (PHP)
Two-Plan Model Plans
AIDS Health Care Foundation

FROM: Luis R. Rico 
Acting Chief
Medi-Cal Managed Care Division

SUBJECT: SB 59 (Stats. 1999, Chapter 539) Required Notices of Action

Purpose:

The purpose of this letter is to provide health plans with forms and instructions for use when notifying enrollees of denials, delays, modifications and terminations of treatment, pursuant to Senate Bill (SB) 59, chaptered September 28, 1999. The enclosed forms have been developed in response to regulations implementing the Federal Balanced Budget Act of 1997 (BBA). The BBA regulations became effective on August 13, 2002, with compliance required by August 13, 2003. Also enclosed is a list of legal help lines in the counties for use in the "Your Rights" notification.

Electronic copies of these files for your mail merge programs will be sent to you by your Contract Manager in the Medi-Cal Managed Care Division's (MMCD) Plan Management Branch, within 30 days of the date of this letter.

Background:

SB 59 (Stats. 1999, Chapter 539) added Section 14087.41 to the Welfare and Institutions Code requiring the Department of Health Services (DHS) to develop a simple Notice of Action form, consistent with the notice requirements of Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations. Pursuant to Section 14087.41, Medi-Cal managed care plans must use the form to notify a Medi-Cal enrollee of a denial, termination, delay or modification in benefits, as a condition of participation in Medi-Cal managed care pursuant to any contract negotiated after the effective date of Section 14087.41.

A task force comprised of Medi-Cal managed care health plans, advocate groups, and MMCD representatives developed and finalized the Notice of Action documents.

Required Actions:

1. The forms must be used by all Medi-Cal managed care health plans whose contracts were negotiated on or after January 1, 2000. This requirement includes those subcontracting entities issuing notices on behalf of plans.
2. There are four distinct NOA forms developed to accommodate five distinct types of action:
 - a. Action to deny a treatment or service.
 - b. Action to modify a treatment or service.
 - c. Action to delay a treatment or service.
 - d. Action to terminate or reduce the level of treatment or service currently being received.

These forms have been constructed to work most effectively with your mail merge software.

3. Decisions to terminate, deny, or modify must be made within five business days of the plan's receipt of information reasonably necessary and requested by the plan to make the decision, but not to exceed 14 calendar days from receipt of the service request. **Exception:** The decision must be made within 72 hours of the receipt of the information in cases where the enrollee faces imminent and serious threat to health, including but not limited to the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process as set forth in sentence one of this paragraph, would be detrimental to the

enrollee's life or health, or could jeopardize the enrollee's ability to regain maximum function.

4. For authorization decisions involving an initial request for a service/treatment, a form notifying the enrollee of a decision to deny or modify must be sent to the enrollee as expeditiously as the enrollee's health condition requires and no later than two business days after the decision by the plan. For authorization decisions involving termination or modification of a current service/treatment, notice must be provided within the time frames specified in Title 42, CFR, Sections 431.211, 431.213 and 431.214. In cases where the review is retrospective, the form must be sent to the enrollee within 30 days of the receipt of information that is reasonably necessary to make a decision.
5. The forms contain a section, to be completed by the health plan, which requires a clear and concise explanation of the reasons for the plan's decision. The detail must contain a description of the criteria or guidelines used, including a citation of the specific regulations or plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity. MMCD will not prescribe how these reasons should be phrased because of the extraordinary variety of possible reasons. However, we request that the plans provide us with the 15 most frequently used rationale statements so that MMCD can develop a "best practices" approach on what kinds and levels of detail should be included. We ask that the plans forward those 15 most frequently used rationale statements to MMCD within 30 days of the date of this letter.
6. Occasions arise where plans do not have all the information needed to make a decision within the required time frames. When this occurs, the plan must send the "delay" form to the enrollee within the five business day or 72-hour time frames, or as soon as the plan knows that it cannot meet those time frames, whichever is earlier. The plan shall insert specifics about what it has not yet received, what consultation it needs, and/or what additional tests it needs to make the decision. Unless requested by the member, any delay/deferral must be in the member's interest and must not exceed 14 calendar days beyond the authorization deadline (i.e. standard or expedited) otherwise applicable to the enrollee's condition. Service authorization decisions not reached within this time frame constitute a denial, and a denial notice must be sent to the enrollee.
7. Plans are responsible for regularly reviewing the phone numbers cited in the NOA forms and the "Your Rights" form to ensure that they are current and correct.

November 1, 2004

8. As required by MMCD Policy Letter 99-04, plans are responsible for fully translating these notices, including the information in the "inserts" sections of the notices, and the "Your Rights" form, into the appropriate threshold languages (refer to MMCD All Plan Letter 02003 for a listing of the threshold and concentration standard languages in Medi-Cal managed care counties as of June 2002).
9. All COHS plans, except Health Plan of San Mateo (HPSM), should use the "Your Rights" notice labeled "For non Knox-Keene plans." Members of these plans are not eligible for expedited State fair hearings. HPSM should use the standard "Your Rights" notice since its members are eligible for an expedited State fair hearing.

Optional Actions:

1. Plans not covered by Knox-Keene requirements may use the "Your Rights" notice that omits reference to the Independent Medical Review.
2. Plans may use the NOA forms for notifying providers. If they do, they must include the name and direct telephone number of the health care professional responsible for the decision to deny, delay, terminate or modify.
3. Plans may include the name, title and phone number of:
 - The medical director
 - The enrollee's provider
 - The enrollee's caseworker
4. Plans may include State Fair Hearing forms and Independent Medical Review forms that contain tracking numbers for ease in identifying and administering the requirements of enrollees' rights. The tracking numbers should contain initials, acronyms, or names that identify the plan.
5. Plans are not required to include Independent Medical Review forms.

If you have any questions or require additional information, please contact your Contract Manager.

Enclosures

"Denial"

(Health Plan Letterhead)

(Health Plan Tracking Number - optional)

NOTICE OF ACTION About Your Treatment Request

(Date)

(Member's Name)
(Address)
(City, State Zip)

(Treating Provider's Name)
(Address)
(City, State Zip)

Identification Number

RE: (insert type of treatment)

(insert name of requesting provider) has asked (name of health plan) to approve (insert type of treatment requested). This request is denied because (Insert a clear and concise explanation of the reasons for the decision. The detail must contain a description of the criteria or guidelines used including a citation of the specific regulations or plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity).

You may appeal this decision. The enclosed 'Your Rights' information notice tells you how. It also tells you where to go to get help, including free legal help.

The State Medi-Cal Managed Care 'Ombudsman Office' is available to answer questions and help you with this notice. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at (insert Plan's member services telephone number).

This notice does not affect any other Medi-Cal services.

(Medical Director's Name)

Enclosed: "Your Rights Under Medi-Cal Managed Care"
(Enclose notice with each letter)

"Modify"

(Health Plan Letterhead)

(Health Plan Tracking Number - optional)

**NOTICE OF ACTION
About Your Treatment Request**

(Date)

*(Member's Name)
(Address)
(City, State Zip)*

*(Treating Provider's Name)
(Address)
(City, State Zip)*

Identification Number

RE: *(insert type of treatment)*

(insert name of requesting provider) has asked (name of health plan) to approve (insert type of treatment requested). We cannot approve this treatment as asked. We will instead approve: (Insert a clear and concise explanation of the reasons for the decision The detail must contain a description of the criteria or guidelines used including a citation of the specific regulations or plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity).

You may appeal this decision. The enclosed 'Your Rights' information notice tells you how. It also tells you where to go to get help, including free legal help.

The State Medi-Cal Managed Care 'Ombudsman Office' is available to answer questions and help you with this notice. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *(insert Plan's member services telephone number)*.

This notice does not affect any other Medi-Cal services.

(Medical Director's Name)

Enclosed: "Your Rights Under Medi-Cal Managed Care"
(Enclose notice with each letter)

"Delay"

(Health Plan Letterhead)

(Health Plan Tracking Number - optional)

**NOTICE OF ACTION
About Your Treatment Request**

(Date)

*(Member's Name)
(Address)
(City, State Zip)*

*(Treating Provider's Name)
(Address)
(City, State Zip)*

Identification Number

RE: *(insert type of treatment)*

(insert name of requesting provider) has asked (name of health plan) to approve (insert type of treatment requested). We cannot make a decision at this time because (Insert a clear and concise explanation of the reasons for the decision. The detail must contain a description of the criteria or guidelines used including a citation of the specific regulations or plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity and when the enrollee can expect a ruling).

You may appeal this decision. The enclosed 'Your Rights' information notice tells you how. It also tells you where to go to get help, including free legal help.

The State Medi-Cal Managed Care 'Ombudsman Office' is available to answer questions and help you with this notice. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *(insert Plan's member services telephone number)*.

This notice does not affect any other Medi-Cal services.

(Medical Director's Name)

Enclosed: "Your Rights Under Medi-Cal Managed Care"
(Enclose notice with each letter)

"Terminate"

Use also for modifying
a current treatment.

(Health Plan Letterhead)

(Health Plan Tracking Number - optional)

**NOTICE OF ACTION
About Your Treatment Request**

(Date)

(Member's Name)
(Address)
(City, State Zip)

(Treating Provider's Name)
(Address)
(City, State Zip)

Identification Number

RE: (insert type of treatment)

(insert name of requesting provider) has asked (name of health plan) to approve (insert type of treatment requested). We can no longer approve this treatment (if this is a modification of an existing treatment, insert 'unless' and describe the modification). (Insert a clear and concise explanation of the reasons for the decision. The detail must contain a description of the criteria or guidelines used including a citation of the specific regulations or plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity).

Payment for this treatment will stop on (insert date).

You may appeal this decision. And you may keep this treatment going. The enclosed 'Your Rights' information notice tells you how. It also tells you where to go to get help, including free legal help.

Note: If you and (insert name of requesting provider) want to keep your treatment going, you must file for a State Hearing within 10 days from the date this letter was postmarked or personally delivered to you or before the effective date of the action which you are disputing.

The State Medi-Cal Managed Care 'Ombudsman Office' is available to answer questions and help you with this notice. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at (insert Plan's member services telephone number).

This notice does not affect any other Medi-Cal services.

(Medical Director's Name)

Enclosed: "Your Rights Under Medi-Cal Managed Care" *(Enclose notice with each letter)*

YOUR RIGHTS UNDER MEDI-CAL MANAGED CARE

If you do not agree with this decision, you may:

- Ask for a "State Hearing"
- File a grievance with your health plan

You can file a grievance with your health plan **and** ask for a State Hearing at the same time.

You will not have to pay for either of these.

STATE HEARINGS

You may ask for a State Hearing in writing. Fill out the enclosed form or send a letter to:

**California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430**

Alternatively, you may call **1-800-952-5253** to ask for a State Hearing. This number can be very busy so you may get a message to call back later. If you have trouble hearing or speaking, you can call **TDD 1-800-952-8349**.

If you want a State Hearing, you must ask for it within 90 days from the date of this letter, **UNLESS you and** *(insert the name of the treating provider)* **want to keep your treatment going** that this Notice of Action is stopping or reducing. **Then, you must ask for a State Hearing within 10 days from the date this letter was postmarked or personally delivered to you or before the effective date of the action which you are disputing.** Please state that you want to keep getting your treatment during the hearing process.

If you use the enclosed form or write a letter to ask for a State Hearing, be sure to include your name, address, phone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address and phone number to the form or letter. If you need a free interpreter, tell us what language you speak.

LEGAL HELP

You may speak for yourself at the State Hearing or have someone else speak for you, including a relative, friend or attorney. You must get the other person yourself. You may be able to get free legal help. Call the *(insert the name and phone number of the county's consumer rights hotline)*. You may also call the local Legal Aid Society in your county *(insert phone number or reference to "Legal Services" in yellow pages)*.

GRIEVANCES

You may ask for a grievance by calling *(insert health plan's name)* at *(insert telephone number)* or by sending a letter to *(insert plan address)*. Your doctor will have grievance forms. *(insert health plan's name)* will review its decision based on your grievance and you will get an answer within 30 days. If you think that waiting 30 days will harm your health, be sure to say why when you ask for your grievance. Then you might be able to get an answer within 3 calendar days.

OTHER INFORMATION

***(Health plan name)* wants to try to help you with your problem, so we hope you will call us first.**

"YOUR RIGHTS"

YOUR RIGHTS UNDER MEDI-CAL MANAGED CARE

If you do not agree with this decision, you may:

- Ask for a "State Hearing"
- File a grievance with your health plan
- Ask for an "Independent Medical Review (IMR)"

You can file a grievance with your health plan **and** ask for a State Hearing at the same time.

You may have to file a grievance with your health plan **before** you can ask for an IMR, except in some cases.

You will not have to pay for any of these.

STATE HEARINGS

You may ask for a State Hearing in writing. Fill out the enclosed form or send a letter to:

**California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430**

Alternatively, you may call **1-800-952-5253** to ask for a State Hearing. This number can be very busy so you may get a message to call back later. If you have trouble hearing or speaking, you can call **TDD 1-800-952-8349**.

If you want a State Hearing, you must ask for it within 90 days from the date of this letter, **UNLESS you and** *(insert the name of the treating provider)* **want to keep your treatment going** that this Notice of Action is stopping or reducing. **Then, you must ask for a State Hearing within 10 days from the date this letter was postmarked or personally delivered to you, or before the effective date of the action which you are disputing.** Please state that you want to keep getting your treatment during the hearing process.

If you use the enclosed form or write a letter to ask for a State Hearing, be sure to include your name, address, phone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address and phone number to the form or letter. If you need a free interpreter, tell us what language you speak.

After you ask for a hearing, it could take up to 90 days for your case to be decided and an answer sent to you. If you believe waiting that long will seriously jeopardize your life or health or ability to attain, maintain or regain maximum function, ask your doctor or *(insert name of health plan)* for a letter. The letter must explain how waiting for up to 90 days for your case to be decided will seriously jeopardize your life or health or ability to

attain, maintain or regain maximum function. Then ask for an **expedited hearing** and provide the letter with your request for hearing.

LEGAL HELP

You may speak for yourself at the State Hearing or have someone else speak for you, including a relative, friend or attorney. You must get the other person yourself. You may be able to get free legal help. Call the *(insert the name and phone number of the county's consumer rights hotline)*. You may also call the local Legal Aid Society in your county *(insert phone number or reference to "Legal Services" in yellow pages)*.

GRIEVANCES

You may ask for a grievance by calling *(insert health plan's name)* at *(insert telephone number)* or by sending a letter to *(insert plan address)*. Your doctor will have grievance forms. *(insert health plan's name)* will review its decision based on your grievance and you will get an answer within 30 days. If you think that waiting 30 days will harm your health, be sure to say why when you ask for your grievance. Then you might be able to get an answer within 3 calendar days.

INDEPENDENT MEDICAL REVIEW (IMR)

You may ask for an IMR if this Notice of Action says your treatment is "not medically necessary" or "experimental" or "investigational."

If your treatment is "experimental," "investigational," or your health may be seriously harmed without it, you may ask for an IMR right away. If not, you must file a grievance with your health plan before you ask for an IMR. Ask for your IMR:

- 30 days after you file a grievance with *(insert health plan name)*, or
- as soon as your grievance is denied, if that comes sooner.

You must ask for the IMR within 6 months after your grievance has been denied.

- To ask for an IMR, call the Department of Managed Health Care (DMHC) at **1-888-466-2219**. If you have trouble hearing or speaking, call **1-877-688-9891 (TDD)**, or the California Relay Service at **1-800-735-2929 (TDD)** and www.IP-relay.com.
- The DMHC also has an Internet website with forms and instructions at <http://www.hmohelp.ca.gov>.

Your medical records will be sent to an IMR doctor outside the health plan who will say whether he/she agrees that the treatment is necessary. You will receive the decision on your IMR within 30 days, or within 3 to 7 days if your treatment is "experimental," "investigational," or your health may be seriously harmed without it.

The DMHC is in charge of making sure all managed care health plans do what the law says they should do. You may call them with any complaints you have about us.

OTHER INFORMATION

***(Health plan name)* wants to try to help you with your problem, so we hope you will call us first.**

Legal Services Offices for Assistance for Medi-Cal Managed Care Enrollees

Two-Plan Counties (From North to South)

| County | Organization | Phone Number |
|----------------|-----------------------------------------------------------------------|------------------------------|
| Contra Costa | Bay Area Legal Aid | 800 551 5554 |
| Alameda | Bay Area Legal Aid | 800 551 5554 |
| San Francisco | Bay Area Legal Aid | 800 551 5554 |
| Santa Clara | Bay Area Legal Aid | 800 551 5554 |
| San Joaquin | California Rural Legal Assistance, Inc. Stockton Office | 209 946 0605 |
| Stanislaus | California Rural Legal Assistance, Inc. Modesto Office | 209 577 3811 |
| Fresno | Fresno Health Consumer Center | 800 300 1277 |
| Tulare | Central California Legal Services, Visalia Office | 800 350 3654 |
| Los Angeles | Health Consumer Center of Los Angeles | 800 896 3203 |
| Riverside | Inland Counties Legal Services, Indio Office Riverside Office | 800 226 4257 888 455 4257 |
| San Bernardino | Inland Counties Legal Services, San Bernardino Rancho Cucamonga | 800 677 4257 800 977 4257 |

GMC Counties

| | | |
|------------|---------------------------------------------------|--------------|
| Sacramento | Health Rights Hotline | 888 354 4474 |
| San Diego | Consumer Center for Health Education and Advocacy | 877 734 3258 |

County Organized Health Systems

| | | |
|--------|----------------------------|---------------|
| Napa | Bay Area Legal Aid | 800 551 5554 |
| Yolo | Health Rights Hotline | 888 354 4474 |
| Solano | Legal Services of Northern | 707 643 0054. |

| | | |
|---------------|-------------------------------------------------------------------|--------------|
| | California, Solano Office | |
| San Mateo | Health Consumer Center of San Mateo County | 800 381 8898 |
| Santa Cruz | California Rural Legal Assistance, Inc Watsonville Office | 831 724 2253 |
| Santa Cruz | California Rural Legal Assistance, Inc Santa Cruz Office | 831 458 1089 |
| Monterey | California Rural Legal Assistance, Inc Monterey Office | 831 375 0505 |
| Monterey | California Rural Legal Assistance, Inc Salinas Office | 831 757 5221 |
| Santa Barbara | California Rural Legal Assistance, Inc Santa Barbara Office | 805 963 5981 |
| Santa Barbara | California Rural Legal Assistance, Inc Santa Maria Office | 805 922 4563 |
| Orange | Orange County Health Consumer Action Center | 800 834 5001 |
| | | |
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INDEPENDENT MEDICAL REVIEW APPLICATION

DMHC/IMR 11/00

YOUR CONTACT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Date of Birth ____ / ____ / ____

HMO or Health Plan _____ Membership I.D. _____ Social Security Number _____

Address _____ Telephone # _____

City _____ State _____ Zip _____ E-Mail _____

(If a representative of the enrollee is filling out this form, please provide your contact information on a separate sheet.)

Are you a Medi-Cal Managed Care beneficiary? YES NO (circle one)

- Are you a Medicare or Medicare Plus Choice beneficiary? (circle one)
- Have you participated in your HMO's or health plan's grievance process? YES NO (circle one)
- Has the requested medical treatment or service already been received? YES NO (circle one)

YOUR CONDITION

(For this section, please feel free to continue on a separate page. Also include all supporting and related documents.)

- Please provide a short description of your medical condition or diagnosis _____
- What is the medical treatment or service you are requesting? _____
- How would you like to see this case resolved? _____
- Do you have a condition that is a serious threat to your health? YES NO If YES, please explain _____
- Why did your HMO or health plan say it was denying, modifying or delaying services, treatment or reimbursement for emergency care? (check one below)

____ Not Medically Necessary ____ Experimental or Investigational Other: _____

Please list the physicians who have treated you for this condition. Include their contact information and note whether they were within or outside of your HMO or health plan's network. (Again, feel free to continue on a separate page.)

"I hereby request Independent Medical Review of my dispute with the Health Plan. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the enrollee's Health Plan, the California Department of Managed Health Care and its consultants, and any Independent Medical Review Organization or reviewers authorized by the Department of Managed Health Care to review grievances regarding health care services. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a grievance or complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously released pursuant to this authorization. I attest that the information provided is accurate and truthful."

Enrollee's Signature _____ Date _____



INDEPENDENT MEDICAL REVIEW APPLICATION INSTRUCTIONS

Thank you for contacting the Department of Managed Health Care regarding your HMO coverage. We know this is a difficult time and we're here to help.

- **This one page application form is all you need to apply for an Independent Medical Review.** Providing the requested documents will likely help accelerate the review process. If you need assistance in completing this application form, please contact us at 1-888-HMO-2219.
- Our Independent Medical Review process can help you when treatment or services have been denied, delayed, or modified by your HMO because the HMO claims that the service is not medically necessary or is experimental. We can also help if your HMO denied reimbursement for urgent or emergency services that you received.
- Under our Independent Medical Review process, one or more independent physicians will determine these issues and their decision will be binding on your HMO.
- **You do not pay anything for this review!**
- Please be aware that failing to apply for Independent Medical Review may forfeit other statutory rights to pursue legal action against your HMO regarding the disputed health care service. Your application may be rejected if it is not submitted within six months of being denied the disputed health care service.

THE APPLICATION

- Please complete the application as fully and accurately as possible. We encourage you to attach additional sheets as necessary to explain and/or describe the situation and disagreement with your HMO. Please identify the information you put on additional sheets to match the sections on the form.
- You can, and should, also submit any additional records, documents, or information related to the HMO's or health plan's denial, or which you consider relevant to your situation. **Please submit copies, as originals cannot be returned.**
- We may also request pertinent medical records from your HMO.
- When describing your medical condition, list the physician's diagnosis, e.g., diabetes, cancer, and stroke. Please give us the name of the denied medical service or treatment, or describe it as closely as you can. Please enclose a copy of your HMO's or health plan's denial letter, if available.
- When listing physicians, list all those who have seen or treated you for this condition, or from whom you have requested medical service or treatment, or who have recommended for or against you receiving the medical service or treatment. Also identify which physician is your primary care provider (regular physician). List all those physicians who have seen you and recommended that you receive the medical service or treatment. Please note whether or not these physicians are within your HMO's network.
- **Please forward documentation and this form, by facsimile or mail, to: Department of Managed Health Care, HMO Help Center, IMR Unit, 980 Ninth Street, Suite 500, Sacramento, CA 95814. If you have any questions, the Department can be reached at 888-HMO-2219, or by fax at 916-229-4328.**