CA

51014.1 Fair Hearing Related to Denial, Termination or Reduction in Medical Services

(a)

In addition to any notice mailed pursuant to section 50179, 53261, 53452, 56261, or 56452, each beneficiary shall be informed in writing, at the time of application to the program and by the Department on a quarterly basis thereafter, of the right to a fair hearing upon receipt of notice of:(1) Any action, other than approval, including but not limited to deferral or denial, taken by the Department or a Medi-Cal managed care plan on a request by a provider for any medical service. (2) Any intended action by the Department or a Medi-Cal managed care plan to terminate or reduce any medical service.

(1)

Any action, other than approval, including but not limited to deferral or denial, taken by the Department or a Medi-Cal managed care plan on a request by a provider for any medical service.

(2)

Any intended action by the Department or a Medi-Cal managed care plan to terminate or reduce any medical service.

(b)

The written notice of the right to a fair hearing shall specify: (1) The method by which a hearing may be obtained. (2) That the beneficiary may be either:(A) Self

represented. (B) Represented by an authorized third party such as legal counsel, relative, friend or any other person. (3) The circumstances under which the medical service shall be continued pending decision on the fair hearing. (4) The time limit for requesting fair hearing.

(1)

The method by which a hearing may be obtained.

(2)

That the beneficiary may be either:(A) Self represented. (B) Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(A)

Self represented.

(B)

Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(3)

The circumstances under which the medical service shall be continued pending decision on the fair hearing.

(4)

The time limit for requesting fair hearing.

(c)

Except as provided in (d), notice of intended action to reduce or terminate authorization for a medical service prior to expiration of the period covered by the authorization shall be mailed by the Department or by the Medi-Cal managed care plan to the beneficiary at least 10 days before the effective date of action. The notice shall include: (1) A statement of the action the Department or Medi-Cal managed care plan intends to take. (2) The reason for the intended action. (3) A

citation of the specific regulations or Medi-Cal managed care plan authorization procedures supporting the intended action. (4) An explanation of the beneficiary's right to request a fair hearing for the purpose of appealing the Department's or Medi-Cal managed care plan's decision. (5) An explanation of the procedure to request a hearing. (6) An explanation of the circumstances under which a medical service shall be continued if a hearing is requested.

(1)

A statement of the action the Department or Medi-Cal managed care plan intends to take.

(2)

The reason for the intended action.

(3)

A citation of the specific regulations or Medi-Cal managed care plan authorization procedures supporting the intended action.

(4)

An explanation of the beneficiary's right to request a fair hearing for the purpose of appealing the Department's or Medi-Cal managed care plan's decision.

(5)

An explanation of the procedure to request a hearing.

(6)

An explanation of the circumstances under which a medical service shall be continued if a hearing is requested.

(d)

The Department or Medi-Cal managed care plan may dispense with the 10 day mailing requirement in (c), but shall mail the notice of action before the date of action and shall meet all other requirements, when any of the following

circumstances occur: (1) The Department or Medi-Cal managed care plan receives a clear written statement signed by the beneficiary stating that the beneficiary no longer wishes to receive continuous medical service. (2) The beneficiary has been admitted or committed to an institution and is no longer eligible for Medi-Cal benefits or, for a Medi-Cal managed care plan member, is no longer enrolled in the Medi-Cal managed care plan. (3) The beneficiary has been accepted for medical assistance in another state or a new jurisdiction and that fact has been established by the jurisdiction presently providing assistance. (4) A change in level of medical care is prescribed by the beneficiary's physician. (5) The Department, or Medi-Cal managed care plan with the concurrence of the Department, obtains facts indicating the medical service should be terminated because of the probable fraud of the beneficiary. In this case notice shall be mailed at least 5 days before the action becomes effective.

(1)

The Department or Medi-Cal managed care plan receives a clear written statement signed by the beneficiary stating that the beneficiary no longer wishes to receive continuous medical service.

(2)

The beneficiary has been admitted or committed to an institution and is no longer eligible for Medi-Cal benefits or, for a Medi-Cal managed care plan member, is no longer enrolled in the Medi-Cal managed care plan.

(3)

The beneficiary has been accepted for medical assistance in another state or a new jurisdiction and that fact has been established by the jurisdiction presently providing assistance.

(4)

A change in level of medical care is prescribed by the beneficiary's physician.

(5)

The Department, or Medi-Cal managed care plan with the concurrence of the Department, obtains facts indicating the medical service should be terminated because of the probable fraud of the beneficiary. In this case notice shall be mailed at least 5 days before the action becomes effective.

(e)

Except as provided in (g), notice of a reduction or termination as defined in (e)(1) and (2) shall be mailed by the Department or Medi-Cal managed care plan to the beneficiary or to the person identified as the beneficiary's authorized representative in records submitted by the health care provider requesting the services. The notice shall contain the information required by (c), except that it shall describe the action the Department or Medi-Cal managed care plan has taken rather than an action it intends to take. It shall be deposited with the United States postal service in time for pick-up no later than the third working day after the reduction or termination.(1) "Termination" as used in this subdivision means denial by the Department or Medi-Cal managed care plan of a request for non-acute continuing services, as defined in section 51003(c)(1). (2) "Reduction" as used in this subdivision means approval by the Department or Medi-Cal managed care plan of a request for non-acute continuing services as defined in section 51003(c)(1), at less than the amount or frequency requested and less than the amount or frequency approved on the immediately preceding authorization. There is no reduction if a shorter time period of services than requested is approved, as long as the amount or frequency of services during that period has not been reduced from the previously approved level.

(1)

"Termination" as used in this subdivision means denial by the Department or Medi-Cal managed care plan of a request for non-acute continuing services, as defined in section 51003(c)(1).

(2)

"Reduction" as used in this subdivision means approval by the Department or Medi-Cal managed care plan of a request for non-acute continuing services as defined in section 51003(c)(1), at less than the amount or frequency requested and less than the amount or frequency approved on the immediately preceding authorization. There is no reduction if a shorter time period of services than requested is approved, as long as the amount or frequency of services during that period has not been reduced from the previously approved level.

(f)

Except as provided in (g), notice of a termination as defined in (f)(1), shall be personally delivered or mailed as provided below. Notice shall be personally delivered to the beneficiary in his or her hospital room unless the beneficiary's treating physician has certified in writing that such personal delivery may result in serious harm to the beneficiary. If the treating physician has so certified, notice shall be mailed to the mailing address of the beneficiary or the person, if any, identified as the beneficiary's authorized representative in hospital medical records or documents submitted by the hospital to the Department or Medi-Cal managed care plan. Notice required by this subdivision shall contain the information required by (c) except that it shall describe the action the Department or Medi-Cal managed care plan has taken rather than an action it intends to take. It shall be personally delivered or be mailed no later than the first working day after termination.(1) "Termination" as used in this subdivision means denial by the Department or Medi-Cal managed care plan of a request by a provider for acute

continuing services, as defined in section 51003(c)(2). There is no termination when the field office consultant or Medi-Cal managed care plan approves less than the full number of acute care days requested.

(1)

"Termination" as used in this subdivision means denial by the Department or Medi-Cal managed care plan of a request by a provider for acute continuing services, as defined in section 51003(c)(2). There is no termination when the field office consultant or Medi-Cal managed care plan approves less than the full number of acute care days requested.

(g)

Notice of termination or reduction as provided for in (e) and (f) is not required in any of the following circumstances:(1) By the date that notice would otherwise be personally delivered or mailed; (A) Non-acute services requested for a limited time period are provided in full or, (B) In the case of acute care services, the beneficiary is discharged from the hospital. (2) The only days of acute care denied have already been provided to the beneficiary. (3) The Department or Medi-Cal managed care plan authorized acute care days subject to specific services being performed during a specified time, and the Department or Medi-Cal managed care plan retroactively denies these previously authorized days because such services were delayed or not performed.

(1)

By the date that notice would otherwise be personally delivered or mailed; (A) Non-acute services requested for a limited time period are provided in full or, (B) In the case of acute care services, the beneficiary is discharged from the hospital.

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(B)

In the case of acute care services, the beneficiary is discharged from the hospital.

(2)

The only days of acute care denied have already been provided to the beneficiary.

(3)

The Department or Medi-Cal managed care plan authorized acute care days subject to specific services being performed during a specified time, and the Department or Medi-Cal managed care plan retroactively denies these previously authorized days because such services were delayed or not performed.

(h)

Notice of action taken, or intended action other than approval for either a written or verbal request by a provider for medical service, other than those specified under subdivisions (c), (e) and (f) or sections 53261 or 56261, shall be transmitted by the Department or Medi-Cal managed care plan to the provider of service. The method of transmittal of the notice of action taken or intended action may be either written or verbal. Should the beneficiary not receive notification from the provider of the Department's or Medi-Cal managed care plan's decision, the beneficiary may contact the provider to obtain such notification.

(i)

For the purposes of this section, "medical service" means those services that are subject to prior authorization pursuant to section 51003 or the Medi-Cal managed care plan's authorization procedures.

(j)

For the purposes of this section, "Medi-Cal managed care plan" means a prepaid health plan as defined in section 50071.5 or a primary care case management plan as defined in section 50071.8.

(k)

The provisions of this section apply to Medi-Cal managed care plans only for beneficiaries who are enrolled in the Medi-Cal managed care plan and for medical services that are covered in the contract between the Department and the Medi-Cal managed care plan. The provisions of this section do not apply to the decisions of providers serving beneficiaries enrolled in Medi-Cal managed care plans when prior authorization of the service by the Medi-Cal managed care plan's authorization procedures is not a condition of payment for the medical service.