51014.2 Medical Assistance Pending Fair Hearing Decision

(a)

Continued medical assistance as set forth in (b), (c), and (d) below, pending a hearing decision shall be provided only if the beneficiary appeals in writing to the Department for a hearing within 10 days of the mailing or personal delivery of the notice of action pursuant to section 51014.1(c), (e) or (f), or before the effective date of action.

(b)

In the case of a termination or reduction pursuant to section 51014.1(c), authorization shall be maintained until the period covered by the existing authorization expires, the date a hearing decision is rendered, or the date on which the hearing is otherwise withdrawn or closed, whichever is earliest.

(c)

In the case of a termination of acute care services pursuant to section 51014.1(f), acute care authorization pending a hearing shall begin: (1) The first day after the previously approved length of stay for continuing acute care if the request for extension by a provider was submitted to the on-site Medi-Cal reviewer during the first on-site visit after the previously approved length of stay expired. (2) The sixth day of hospitalization if a request for extension pursuant to section 51003(c)(2)(B)5. was submitted to the on-site Medi-Cal reviewer during the first on-site visit after the first five days of hospitalization. (3) The day the request for

extension was submitted to the Department or to the Medi-Cal managed care plan if neither (1) nor (2) apply. (4) The date of the termination decision if a decision on the request for extension was initially deferred pending the receipt of additional information. Authorization pending a hearing pursuant to this subdivision shall end on the date a hearing decision is rendered, the date on which the hearing appeal is withdrawn or closed, the date the treating physician documents that the beneficiary is ready for lower level of care, or the date of discharge, whichever is earliest.

(1)

The first day after the previously approved length of stay for continuing acute care if the request for extension by a provider was submitted to the on-site Medi-Cal reviewer during the first on-site visit after the previously approved length of stay expired.

(2)

The sixth day of hospitalization if a request for extension pursuant to section 51003(c)(2)(B)5. was submitted to the on-site Medi-Cal reviewer during the first on-site visit after the first five days of hospitalization.

(3)

The day the request for extension was submitted to the Department or to the Medi-Cal managed care plan if neither (1) nor (2) apply.

(4)

The date of the termination decision if a decision on the request for extension was initially deferred pending the receipt of additional information. Authorization pending a hearing pursuant to this subdivision shall end on the date a hearing decision is rendered, the date on which the hearing appeal is withdrawn or closed, the date the treating physician documents that the beneficiary is ready for lower level of care, or the date of discharge, whichever is earliest.

(d)

In the case of a termination or reduction of non-acute care services pursuant to section 51014.1(e), authorization shall begin: (1) Upon expiration of the previous authorization if the request by a provider for reauthorization is submitted prior to such expiration, or (2) The day of receipt of a completed request for reauthorization not requiring additional information from the provider, or (3) The date of deferral of a decision on a request for reauthorization, when such deferral was necessary because of an incomplete request or because additional medical information is needed. Authorization pending a hearing pursuant to this subdivision ends on the date through which services were requested by the treating physician, the date a hearing decision is rendered, or the date on which the hearing appeal is withdrawn or closed, whichever is earliest.

(1)

Upon expiration of the previous authorization if the request by a provider for reauthorization is submitted prior to such expiration, or

(2)

The day of receipt of a completed request for reauthorization not requiring additional information from the provider, or

(3)

The date of deferral of a decision on a request for reauthorization, when such deferral was necessary because of an incomplete request or because additional medical information is needed. Authorization pending a hearing pursuant to this subdivision ends on the date through which services were requested by the treating physician, the date a hearing decision is rendered, or the date on which the hearing appeal is withdrawn or closed, whichever is earliest.

(e)

Notwithstanding (a), (c), and (d), continued medical assistance pursuant to (c) or (d): (1) is not required at a greater amount or frequency of services than approved for the immediately preceding period of authorization, (2) is not required in the case of acute care services if the beneficiary has been discharged from the hospital at the time that continued authorization would otherwise be put into effect, (3) is not required in the case of non-acute care services requested for a limited time period, if they have been provided in full at the time that continued authorization would otherwise be put into effect.

(1)

is not required at a greater amount or frequency of services than approved for the immediately preceding period of authorization,

(2)

is not required in the case of acute care services if the beneficiary has been discharged from the hospital at the time that continued authorization would otherwise be put into effect,

(3)

is not required in the case of non-acute care services requested for a limited time period, if they have been provided in full at the time that continued authorization would otherwise be put into effect.

(f)

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.

(g)

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.