**<Plan name>**

**Cal MediConnect Member Handbook**

**ERRATA / ADDENDUM**

**Effective April 1, 2014**

<Insert date>

[*Plans may add a greeting (e.g., Dear Member, Dear Mrs.* [*insert name*])*.*]

<Plan name> has made changes to your Member Handbook effective April 1, 2014. The additions are noted by underlined text and deletions by ~~strike-out text~~. Please read these changes and keep this document with the Member Handbook you received.

If you have any questions regarding the Member Handbook, please call <plan name> at <toll-free number> (TDD/TTY users can call <TTY number>), <days and hours of operation>. We have staff who speak your language.

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***Additions to page(s) <page number(s)>***

***Chapter 2, Section L: How to contact the California Department of Managed Care***

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. The DMHC Help Center can help you with appeals and complaints against your health plan about Medi-Cal Services.

|  |  |
| --- | --- |
| CALL | 1-888-466-2219  DMHC representatives are available between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday. |
| TTY | 1-877-688-9891  This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| WRITE | Help Center  California Department of Managed Health Care  980 Ninth Street, Suite 500  Sacramento, CA 95814-2725 |
| FAX | 1-916-255-5241 |
| WEBSITE | <http://www.hmohelp.ca.gov> |

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***Additions to page(s) <page number(s)>***

***Chapter 9, Section 2.1: Where to get more information and help***

**You can get help from the California Department of Managed Health Care**

*The following paragraph is a required disclosure under California Health & Safety Code Section 1368.02(b). In this paragraph, the term “grievance” means an appeal or complaint about Medi-Cal services.*

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at [*insert health plan's telephone number*] and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

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***Additions to page(s) <page number(s)>***

***Chapter 9, Section 4.2: Getting help with coverage decisions and appeals***

You can ask any of these people for help:

* Call the **Help Center at the** **Department of Managed Health Care (DMHC)** for free help. The DMHC is responsible for regulating health plans. The DMHC helps people enrolled in Cal MediConnect with appeals about Medi-Cal services. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891.

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***Changes to page(s) <page number(s)>***

***Chapter 9, Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)***

**NOTE: You are not required to appeal to the plan for Medi-Cal services including long-term services and supports. If you do not want to first appeal to the plan, you can ask for a State Fair Hearing or, in special cases, an Independent Medical Review. Go to page <page number> for more information.**

### How do I make a Level 1 Appeal?

* To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at <phone number>. For additional details on how to reach us for appeals, see Chapter 2, page <xx>.
* You can ask us for a “standard appeal” or a “fast appeal.”
* If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
* You can submit a written request to the following address:

<insert address>

* You can submit your request online at: <insert plan’s online appeal address>
* You may also ask for an appeal by calling us at <toll-free number>.
* You will receive a letter from us within 5 calendar days of receiving your appeal letting you know that we received it.

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***Changes to page(s) <page number(s)>***

***Chapter 9, Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)***

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### When will I hear about a “standard” appeal decision?

We must give you our answer within ~~45~~ 30 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

* However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you by letter.
* If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
* If we do not give you an answer within ~~45~~ 30 calendar days or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a Medicare service or item. You will be notified when this happens. If your problem is about a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.
* **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within ~~45~~ 30 calendar days after we get your appeal.
* **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about aMedicareservice or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

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***Chapter 9, Section 5.4: Level 2 Appeal for services, items, and drugs (not Part D drugs)***

**2) Independent Medical Review (IMR)**

You can ask for an Independent Medical Review (IMR) for Medi-Cal covered services and items that are medical in nature (not including IHSS). An IMR is a review of your case by doctors who are not part of our plan. IMRs are conducted by the Help Center at the California Department of Managed Health Care (DMHC). You pay no costs for an IMR.

You can apply for an IMR if <plan name>:

* Denies, changes, or delays a Medi-Cal service or treatment (not including IHSS) because <plan name> determines it is not medically necessary.
* Will not cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
* Will not pay for emergency or urgent Medi-Cal services that you already received.
* Has not resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours for a fast appeal.

You cannot ask for an IMR if you already ~~asked for~~ had a State Fair Hearing on the same issue.

In most cases, you must file an appeal with us before requesting an IMR. See page <page number> for information about <plan name>’s Level 1 appeal process. If you disagree with our decision, you can ask the DMHC Help Center for an IMR.

* If your treatment was denied because it was experimental or investigational, you do not have to take part in <plan name>’s appeal process before you apply for an IMR.
* If your problem is urgent and involves an immediate and serious threat to your health, you may bring it immediately to the DMHC’s attention. The DMHC may waive the requirement that you first follow <plan name>’s appeal process in extraordinary and compelling cases.

You must apply for an IMR within 6 months after we send you a written decision about your appeal. The DMHC may accept your application after 6 months if it determines that circumstances kept you from submitting your application in time.

To request an IMR:

* Fill out the Complaint/Independent Medical Review (IMR) Application Form available at http://www.dmhc.ca.gov/dmhc\_consumer/pc/pc\_forms.aspx or call the DMHC Help Center at 1-888-466-2219. TDD users should call 1-877-688-9891.
* If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return any documents.
* Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at http://www.dmhc.ca.gov/dmhc\_consumer/pc/pc\_forms.aspx or by calling the DMHC Help Center at 1-888-466-2219. TDD users should call 1-877-688-9891.
* Mail or fax your forms and any attachments to:

Help Center

Department of Managed Health Care

980 Ninth Street, Suite 500

Sacramento, CA 95814-2725

FAX: 916-255-5241

For non-urgent cases involving Medi-Cal services (not including IHSS), you will receive an IMR decision from the DMHC within 30 days of receipt of your application and supporting documents. For urgent cases that involve an immediate or serious risk to your health, you will receive an IMR decision within 3 to 7 days.

If the IMR is decided in your favor, we must give you the service or item you requested. If you are not satisfied with the result of the IMR, you can still ask for a State Fair Hearing.

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***Additions to page(s) <page number(s)>***

***Chapter 9, Section 5.4: Level 2 Appeal for services, items, and drugs (not Part D drugs)***

### If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal was a State Fair Hearing, you may ask for a rehearing within 30 days after you receive the decision. You may also ask for judicial review of a State Fair Hearing denial by filing a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after you receive the decision. You cannot ask for an IMR if you already had a State Fair Hearing on the same issue.

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***Additions to page(s) <page number(s)>***

***Chapter 9, Section 10.1: Details and deadlines***

* Call Member Services at <phone number>.
* If there is anything else you need to do, Member Services will tell you.
* You can also write your complaint and send it to us.If you put your complaint in writing, we will respond to your complaint in writing.
* You must file your complaint with us or the provider within 180 calendar days from the day the incident or action occurred that caused you to be dissatisfied.
* If we cannot resolve your complaint within the next business day, you will receive a letter from us within 5 calendar days of receiving your complaint letting you know that we received it.
* If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours. If you have an urgent problem that involves an immediate and serious risk to your health, you can request a “fast complaint” and we will respond within 72 hours.

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***Additions to page(s) <page number(s)>***

***Chapter 9, Section 10.6: You can tell the California Department of Managed Health Care about your complaint***

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. You may contact the DMHC if you need help with a complaint involving an emergency, you disagree with <plan name>’s decision about your complaint, or <plan name> has not resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

* Call 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll free TTY number, 1-877-688-9891. The call is free.
* Visit the Department of Managed Health Care’s website (http://www.hmohelp.ca.gov).

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***Additions to page(s) <page number(s)>***

***Chapter 12: Definitions of important words***

**Department of Managed Health Care (DMHC)**: The State department in California that is responsible for regulating health plans. The DMHC helps people in Cal MediConnect with appeals and complaints about Medi-Cal services. The DMHC also conducts Independent Medical Reviews (IMR).

**Independent Medical Review (IMR)**: If we deny your request for medical services or treatment, you can file an appeal with us. If you disagree with our decision and your problem is about a Medi-Cal service, you can ask the ~~state of~~ California Department of Managed Health Care for an IMR. An IMR is a review of your case by doctors who are not part of our plan. If the IMR is decided in your favor, we must give you the service or treatment you requested. You pay no costs for an IMR.

[Insert plan’s legal or marketing name] is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

You can get this information for free in other languages. Call <toll-free number>. The call is free. [This disclaimer must be placed in both English and all non-English languages that meet the Medicare and state thresholds for translation. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]