Instrucciones para llenar la solicitud de exención temporal de la inscripción en un plan por razones médicas

¿Quién debe llenar este formulario?

Debe inscribirse en este momento en un Medi-Cal Managed Care Plan (es decir, un plan).

Debe llenar este formulario si:

- Necesita seguir recibiendo la atención médica que recibe de su doctor en Medi-Cal Regular (Tarifa-por-Servicio) (los médicos y parteras pueden llenar la Parte II de este formulario);
- Su doctor no es parte de un Plan en el condado donde usted vive; Y
- Su único seguro de salud es Medi-Cal.

Debe llenar este formulario si usted está inscrito en un programa de exención de Medi-Cal. Estos programas de exención son: AIDS, Home and Community Based Services (HCBS), In Home Operations (IHO) y Nursing Facility/Acute Hospital (NF/AH) u otros programas de exención. Puede seguir recibiendo servicios de exención de Medi-Cal incluso si está inscrito en un plan de atención administrada de Medi-Cal. Si ha estado inscrito en un plan de atención administrada de Medi-Cal por más de 90 días no puede recibir una exención médica y no debería presentar este formulario.

Puede obtener una exención por razones médicas si:

- Sufre de una enfermedad compleja; Y
- La atención que usted recibe de su doctor de Medi-Cal Regular para tal enfermedad compleja no puede ser cambiada porque su estado podría empeorar; Y
- **Su médico de Medi-Cal Regular NO es parte de un plan en su condado. Puede ver a más de un médico de Medi-Cal Regular. Si es así, pida al doctor que visite más a menudo que llene el formulario. Pregúntele a su doctor de Medi-Cal Regular si él o ella es parte de un plan en su condado. Esto debe hacerse antes de enviar este formulario.**

Si se aprueba la exención por razones médicas:

Puede ver a su doctor de Medi-Cal Regular hasta que su enfermedad compleja ya no sea un problema. Esto lo decide el Department of Health Care Services. Esto puede continuar hasta 12 meses (o 90 días después del parto). Deberá obtener otra exención por razones médicas después de que termine la primera de ellas. El departamento le enviará por correo un formulario de exención para que usted lo llene cuando sea el momento de solicitar una nueva exención.

Si se deniega la exención por razones médicas:

Usted y su doctor recibirán una copia de la carta de rechazo. Usted puede apelar la negación. La información sobre cómo presentar una apelación estará incljuida en la carta de rechazo. Su nuevo plan de Medi-Cal tendrá conocimiento sobre la negación e intentará programar que usted pueda visitar a su doctor de Medi-Cal Regular.

(ver página siguiente)

Continuación de las instrucciones:

Parte I — Debe ser llenada y firmada por el miembro de Medi-Cal.

Le pedimos que responda a las preguntas 1-10, y a continuación que firme y coloque la fecha en el formulario. Después de finalizar la Parte I, entregue el formulario a su doctor de Medi-Cal Regular. Su doctor llenará la Parte II.

Parte II — Debe ser llenada y firmada por su doctor de Medi-Cal Regular

Cuando el formulario esté completo, se enviará a su doctor de Medi-Cal Regul para que termine de llenarlo. Se le puede pedir a su doctor de Medi-Cal Regular que envíe más información para explicar por qué usted no podrá ser trasladado en este momento a un Medi-Cal Managed Care Plan. Si su doctor de Medi-Cal Regular no envía toda la información, su solicitud de exención será rechazada.

Toda la información en este formulario de exención médica es privada. Solo el programa de Medi-Cal, sus empleados y contratistas usarán esta información.

- Si tiene alguna pregunta sobre este formulario, llame a Health Care Options al 1-800-430-3003.

SOLICITUD DE EXENCIÓN TEMPORAL DE LA INSCRIPCIÓN EN UN PLAN POR RAZONES MÉDICAS

Presente esta solicitud en caso de que su enfermedad pueda empeorar si usted se inscribe en un Medi-Cal Managed Care Plan.

Se debe llenar cada área de la solicitud de exención de la inscripción en un plan. Si no lo hace, será denegada la exención médica. **Le Pedimos que Escriba a Mano o Llene a Máquina (Usando Tinta Unicamente).**

Parte I: Debe ser llenada y firmada por el miembro de Medi-Cal

Para recibir ayuda con este formulario, llame a: Health Care Options al 1-800-430-3003. La llamada es gratis.

1. Nombre: (Escribir en letra imprenta)

Apellido _____ Primer Nombre _____ Inicial _____

2. Número de la Tarjeta de Identificación de Beneficiario (BIC) _____

3. Fecha de nacimiento: ___ ___ / ___ ___ / ___ ___ ___ ___
Mes Dia Año

4. Marque uno: ☐ Mujer ☐ Hombre

5. Número de seguro social _____

6. ¿Es usted miebro de un plan de salud de Medi-Cal? ☐ Sí ☐ No

7. ¿Alguna persona que no sea el beneficiario es quien llena esta sección?
☐ Sí ☐ No

En caso afirmativo, proporcione la siguiente información:

Nombre en letra imprenta: _____

Relación _____ Número de teléfono _____

8. Solicito que mi doctor envíe una solicitud para recibir una **exención por razones médicas** de Medi-Cal Managed Care en mi nombre.

Nombre del doctor (Escribir en letra imprenta): _____

9. Firma del beneficiario: _____

Firma del beneficiario o de los padres del beneficiario si es menor

10. Fecha de firma:
___ ___ / ___ ___ / ___ ___ ___ ___
Mes Dia Año

El Department of Health Care Services solicita esta información de conformidad con el Title 22, Código de Reglamentos de California, Secciones 53887 o 53923.5, para poder cumplir con los requisitos establecidos para continuar con la atención de salud en el modelo de tarifa por servicio (FFS). Es obligatorio llenar este formulario para poder solicitar una exención de la inscripción en la atención médica administrada por razones médicas. Los formularios incompletos serán devueltos y esto podría provocar que se le inscriba en un Plan de Salud de Managed Care.

*Su **Doctor** DEBE llenar Y FIRMAR esta sección.*

Part II – Doctor's Certification for Medical Exemption

11. Date you started treating beneficiary for this condition:
___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

12. Estimated date of completion of treatment or therapy for condition requiring exemption:
___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

For State Use Only	13. Please check the following as appropriate. (ICD code must be included in column 14 to the right, or the exemption will be considered incomplete and returned and could result in enrollment in a Managed Care Health Plan.) See included instructions for further detail.	14. ICD Codes
P	❑ A. Pregnant with complications or in third trimester. Due Date ___ ___ / ___ ___ / ___ ___ ___ ___ Month Day Year	1. _____ 2. _____
F	❑ B. HIV+ or has been diagnosed with AIDS.	1. _____ 2. _____
D	❑ C. Receiving chronic renal dialysis treatment under your supervision.	1. _____ 2. _____
E	❑ D. Undergoing one of three transplant classifications (see included instructions for further details). Classification: _____ Medi-Cal designated transplant center: _____	1. _____ 2. _____

PART II — To Be Filled Out and Signed By the Member's Regular Medi-Cal Doctor (Doctors and Midwives fill out Part II)

ATTENTION: You should not complete this form if you are a doctor contracted with any Medi-Cal Managed Care Health Plan in the county where the beneficiary lives because the medical exemption request will be denied.

Dear Regular Medi-Cal (Fee-for-Service) Doctor: If the beneficiary requests a medical exemption, you and the beneficiary must fill out this form, sign it, attach required documentation, and mail or fax it (Part I and Part II) to the Health Care Options office:

MAIL COMPLETED FORM to:	Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850	or FAX this form to: (916) 364-0287
Questions? Call 1 (800) 430-4263		

Both you and the beneficiary should retain a copy of the completed form.

The doctor and the beneficiary will receive a written decision from Health Care Options.

The medical exemption is granted only until the beneficiary's medical condition has stabilized and the beneficiary is able to receive care from a Medi-Cal Managed Care Plan doctor. An exemption can be requested for a maximum of 12 months, at which time a renewal may be requested. The renewal form will be sent directly to the beneficiary.

Conditions meeting the criteria for a complex medical exemption may include, but are not limited to:

- Conditions requiring temporary continuation of treatment with the current Fee-for-Service doctor, such as high risk or advanced pregnancy;
- Under active evaluation for or awaiting organ transplant;
- New diagnosis and treatment for cancer or other complex and/or progressive disorder that cannot be interrupted;
- Awaiting an approved surgical procedure (approved TAR) or immediately post-operative.

Routine ongoing treatment of chronic disorders does NOT constitute grounds for approval of a medical exemption.

A request for exemption from plan enrollment shall be denied if:

1. The beneficiary has been a Medi-Cal Managed Care beneficiary on a combined basis for more than 90 consecutive calendar days prior to the submission of the medical exemption request,
2. The submitted form was completed by a current Medi-Cal doctor who is contracting with a Medi-Cal Managed Care Plan in the county where the beneficiary lives,
3. The beneficiary began or was scheduled to begin treatment after the date of plan enrollment.
4. The beneficiary does not meet eligibility requirements as set forth in Title 22, California Code of Regulations, Sections 53887, and/or
5. The doctor submitting the exemption request did not provide adequate documentation, as described in regulation or other Department issued guidance, for the Department to evaluate the exemption request.

INSTRUCTIONS FOR COMPLETING BOXES 13-D THROUGH 13-I:

ITEM 13-D

Please list on the line provided which of the following transplant situations is relevant. Please specify the Medi-Cal designated transplant center involved in the evaluation, transplant procedure or current follow-up. Please specify ICD code for the organ transplanted/to be transplanted and any codes for complications in box 14. *(Please note: this exemption will not be granted to beneficiaries who are medically stable on post-transplant therapy.)*

Transplant classifications:

- Beneficiary is under active evaluation for the need for an organ transplant by a Fee-for-Service doctor
- Beneficiary has been approved for and is awaiting an organ transplant
- Beneficiary has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant performed

ITEM 13-E

The type of therapy must be described on the line provided, and both the start date and the expected duration of therapy must be listed in boxes 11 and 12. *Beneficiaries in long-term remission without signs of disease are not eligible for medical exemption.*

Cancer classifications:

- Beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer
- Beneficiary has been approved for such therapy and is awaiting initiation of approved therapy

		14. ICD Codes
C	❑ E. Undergoing one of two cancer classifications (see included instructions for further details). Classification: _____ Medi-Cal designated transplant center: _____	1. _____ 2. _____
G	❑ F. Has been approved for and is awaiting a major surgical procedure (see instructions for details). CPT code(s) for pending procedure(s): _____	1. _____ 2. _____
A	❑ G. Has a complex neurological disorder, such as multiple sclerosis.	1. _____ 2. _____
B	❑ H. Has a complex hematological disorder, such as hemophilia or sickle cell disease.	1. _____ 2. _____
M	❑ I. Has other complex and/or progressive disorder not covered above which requires on-going medical supervision (see included instructions for further details). Describe treatment: _____	1. _____ 2. _____

15. Doctors who assess that the severity of a condition(s) preventing a beneficiary from receiving treatment from an in-network provider of the same specialty without deleterious medical effects should explain the deleterious medical effects that could be reasonably expected to occur and provide the basis for their assessment. See included instructions for further details. Doctors **MUST** provide all of the following items:

Check each box to confirm you have submitted the required documentation. See included instructions for further details.

☐ **Notes from up to the five most recent office visits** (if not available, please provide detailed information stating why you believe the medical exemption is necessary.)

☐ **Current medical history and physical**

☐ **Treatment Plan**

☐ **Justification of medical exemption request.** You should explain both why the beneficiary's condition is complex and how much the beneficiary's medical condition could be reasonably expected to worsen if he or she is transferred into a Medi-Cal Managed Care Plan, and include any examples. If available, provide information about complex medical conditions being treated by other Fee-for-Service doctors to the extent you have that information.

You should also submit any additional documentation that you believe is necessary to show that the beneficiary could be reasonably expected to suffer deleterious medical effects due to enrollment in a Medi-Cal Managed Care Plan. Deleterious medical effects mean the severity of the beneficiary's medical condition could be reasonably expected to worsen in terms of increasing illness, disability, or pain and/or prolong necessary treatment, if the beneficiary is requested to change doctors due to enrollment in a Medi-Cal Managed Care Plan.

16. Are you affiliated with any Medi-Cal Managed Care Health Plan(s) in the beneficiary's county of residence?

☐ Yes _____ ☐ No
Print the name of health plan

17. Rendering Provider's National Provider Identification (NPI) number: _____

18. Doctor or Midwife Medi-Cal Provider:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

FAX: _____

19. Medi-Cal Billing Information: (If different from box 18)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

FAX: _____

For State Use Only	For State Use Only
20.	21.

I have read this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Care Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care Health Plan(s) and/or to determine whether the Medi-Cal beneficiary's listed medical condition constitutes grounds for a medical exemption.

22. Signature (No Stamp):

_____
(Authorized Rendering Provider) Doctor or Midwife

23. Date Signed:

___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

MAIL COMPLETED FORM to: Health Care Options, P.O. Box 989009, West Sacramento, CA 95798-9850 Or FAX this form to: (916) 364-0287

ITEM 13-F

Please check this item if beneficiary has been approved for and is awaiting a major surgical procedure, **including surgery for cancer.**
List both ICD code (in box 14) and appropriate CPT code(s) for pending procedure(s) on the line provided. If the beneficiary is immediately post-operative, estimate the duration of time necessary for recovery under your supervision in box 12.

ITEM 13-I

The ICD code must be listed in box 14, and the treatment must be stated on the line provided.

Please check this item if the beneficiary has a complex and/or progressive disorder not covered above which requires ongoing medical supervision, such as:

- Cardiomyopathy
- Amyotrophic lateral sclerosis and/or has been approved for or is receiving ongoing complex medical treatment for the disorder, the administration of which cannot be interrupted

INSTRUCTIONS FOR COMPLETING BOX 14:

Box 14 should contain the applicable ICD Code(s) for each medical condition in Items 13-A-I that form the basis for the request for a medical exemption from mandatory enrollment in a Medi-Cal Managed Care Plan.

INSTRUCTIONS FOR COMPLETING BOX 15:

Doctors who believe that the complexity of a condition(s) prevents a beneficiary from transitioning into a Medi-Cal Managed Care Plan without possible deleterious medical effects or consequences must complete this box, provide the requested documentation, and include an explanation as to why the medical exemption is justified. Deleterious medical effects means the complexity of the beneficiary's medical condition could be reasonably expected to worsen in terms of increasing illness, disability or pain and/or prolong necessary treatment, if the beneficiary is required to change doctors due to enrollment in a Medi-Cal Managed Care Plan. The documentation submitted in this section should demonstrate that the beneficiary's medical condition is not sufficiently stable so that she or he could be reasonably expected to safely transfer to a doctor in a Medi-Cal Managed Care Plan without risk of suffering deleterious medical effects. Information provided should be in accordance with any guidance issued by the Department about exemption requests. You should specify if the beneficiary has a relatively rare medical condition. You may also provide information about complex medical conditions being treated by other Fee-for-Service doctors to the extent you have that information.

It is important that you specify the probable consequences if the patient is required to change doctors due to enrollment in a Medi-Cal Managed Care Plan or if there is an interruption in care. Include the basis for your conclusions about why you believe the beneficiary could be reasonably expected to have deleterious medical effects as a result of such a change in care. In most cases, it will not be sufficient to only provide the medical records, unless those records clearly indicate that the beneficiary's condition is unstable. You need to indicate the possible consequences that could be reasonably expected to occur from the transfer of the patient to a Managed Care Health Plan.

Check the box next to each field to confirm that the documentation is attached to the exemption. *(Please note, a medical exemption request may be returned or denied if it lacks the required documentation and additional information is not provided).*

- **Notes from the five most recent office visits**. These notes should support your justification for the medical exemption request. If the beneficiary has not seen you for five visits, you should submit your notes for as many office visits as he or she has attended. **Illegible notes will not be accepted and may cause the medical exemption request to be denied.**
- **Current medical history and physical**. To qualify for a medical exemption request, you must explain how the beneficiary's health is likely to worsen if he or she is transferred to a Managed Care Health Plan.
- **Treatment Plan**. The medical exemption request will be denied if the beneficiary is not receiving treatment or monitoring for his or her complex medical condition.
- **Justification of medical exemption request**. You should explain both why the beneficiary's condition is complex and how the beneficiary's medical condition could be reasonably expected to worsen if he or she is transferred into a Medi-Cal Managed Care Plan, and include any examples.

If the medical exemption request is denied, you can continue to see the beneficiary for up to 12 months, as determined by the Plan, as long as you are willing to agree to the Medi-Cal Managed Care Plan's Continuity of Care policies. The beneficiary's Medi-Cal Managed Care Plan will contact you to determine whether you will agree to continue to treat the beneficiary under its Continuity of Care policies. You may continue to see the beneficiary after the Continuity of Care period ends if you enter into an agreement with the Medi-Cal Managed Care Plan that the beneficiary is assigned to.