State of California
Health and Human Services Agency
Department of Managed Health Care
**REQUEST FOR HEALTH PLAN INFORMATION ADDENDUM**
DMHC 20-097A New: 01/18 Rev: 09/23

Patient Name: Case #

**HEALTH PLAN INSTRUCTIONS**

**Please see the box(es) checked below (sections A through Additional Questions), and provide the information requested in the related section(s). All responses must be in writing.**

☐ SECTION A ☐ SECTION B ☐ SECTION C ☐ SECTION D ☐ SECTION E
☐ SECTION F ☐ SECTION G ☐ SECTION H ☐ SECTION I ☐ SECTION J
☐ SECTION K ☐ ADDITIONAL QUESTIONS

## SECTION A – QUALITY OF CARE AND SERVICE COMPLAINT

If the enrollee's complaint raised quality of care and/or service concerns, please explain how the health plan will address these concerns and confirm that the health plan referred the enrollee's concerns to its quality assurance program for investigation and corrective action where appropriate.

## SECTION B – PAYMENT DISPUTE/BALANCE BILLING COMPLAINT

1. Does the health plan contend that the enrollee is financially responsible for the service(s) in dispute?

   ☐Yes ☐No

   **If yes, please provide the following:**

   a) The amount for which the enrollee is financially responsible;
   b) Copy(ies) of any waiver(s) signed by the enrollee, a copy of the provider's contract with the health plan, if in network, and a written explanation by the health plan of why it believes the waiver is valid;
   c) If the enrollee has a deductible plan, please state how much of the deductible had been met prior to the date of the service in dispute and include any and all documentation in support of the health plan's position (e.g., Summary of Accumulation, etc.);
   d) The amount of the reasonable and customary/maximum allowed for the disputed service(s); and
   e) If applicable, please demonstrate the health plan's compliance with California Code of Regulations, title 28, section 1300.71(a)(3)(B) and provide any and all documentation in support of the health plan's response.

   **If no, please provide the following:**

2. A copy of the health plan's written notice to the provider(s) directing that the provider(s) cease any billing and/or collection activities against the enrollee.

## SECTION C – OUT-OF-NETWORK COMPLAINT

1. Will the health plan authorize coverage of the enrollee's requested out-of-network service(s) with the requested provider(s)?

   ☐Yes ☐No **If no, please continue to requests 2 and 3 below.**

2. Please provide a detailed explanation of the health plan's position and any documents which support the health plan's position.
3. Please provide the names, addresses, and telephone numbers of no more than three in-network health care providers who are:
   a) Appropriately qualified to treat the enrollee's condition;
   b) Located within a reasonable geographic distance from the enrollee's residence;
   c) Accepting new patients; and
   d) Available to perform the requested service(s) within the timeframes set forth in California Code of Regulations, title 28, section 1300.67.2.2.

**Please Note:** By responding to this request for information, the health plan is representing to the Department that it has confirmed that all of the information provided above is accurate for each in-network provider identified by the health plan in accordance with Health and Safety Code section 1396. If the Department subsequently determines that none of the proffered in-network providers meet all of the parameters set forth above, the Department will direct the health plan to authorize coverage of the disputed service(s) with the out-of-network provider requested by the enrollee and will likewise forward this complaint to its Office of Enforcement for further investigation and the possible imposition of administrative fines and penalties pursuant to Health and Safety Code section 1368, et seq. and California Code of Regulations, title 28, section 1300.68(h).

## SECTION D – COMPLETION OF COVERED SERVICE(S)/CONTINUITY OF CARE COMPLAINT

1. Will the health plan authorize completion of the covered service(s)/continuity of care for this enrollee with the requested provider(s)?

   ☐Yes ☐No **If no, please continue to requests 2, 3, and 4 below.**

2. Please provide a detailed explanation regarding the health plan's position and any documents which support the health plan's response.
3. Please provide the names, addresses, and telephone numbers of no more than three in-network health care providers who are:
   a) Appropriately qualified to treat the enrollee's condition;
   b) Located within a reasonable geographic distance from the enrollee's residence;
   c) Accepting new patients; and
   d) Available to perform the requested service(s) within the timeframes set forth in California Code of Regulations, title 28, section 1300.67.2.2.
4. Please provide details demonstrating how the health plan will ensure a safe transfer of the enrollee's care from their out-of-network provider to the in-network provider(s) consistent with good professional practice as required under Health and Safety Code section 1367(d), including:
   a) A detailed explanation as to how the safe transition will occur and who will ensure the coordination of care;
   b) What steps the health plan has or will take to ensure the enrollee's medical records from the out-of-network provider are provided to the new contracted providers in a timely manner;
   c) What steps the health plan has or will take to facilitate peer-to-peer conversation, if needed; and
   d) How the health plan will follow-up and ensure the safe transfer of care has occurred.

**Please Note:** By responding to this request for information, the health plan is representing to the Department that it has confirmed that all of the information provided above is accurate for each in-network provider identified by the health plan in accordance with Health and Safety Code section 1396. If the Department subsequently determines that none of the proffered in-network providers meet all of the parameters set forth above, the Department will direct the health plan to authorize coverage of the disputed service(s) with the out-of-network provider requested by the enrollee and will likewise forward this complaint to its Office of Enforcement for further investigation and the possible imposition of administrative fines and penalties pursuant to Health and Safety Code section 1368, et seq. and California Code of Regulations, title 28, section 1300.68(h).

## SECTION E – EXPEDITED GRIEVANCE

Please explain the factors considered by the health plan to determine why the enrollee's grievance did not qualify for expedited handling pursuant to Health and Safety Code section 1368.01(b) and California Code of Regulations, title 28, section 1300.68.01(a) et seq. and provide any documents relevant to that determination.

## SECTION F – ENROLLMENT CANCELLATION

1. Please provide the enrollee's mailing address, phone number, and e-mail address (if applicable) on record with the health plan.
2. Please advise if the enrollee is an Advanced Premium Tax Credit (APTC) or non-APTC enrollee.
3. Please provide the enrollee's original effective date of enrollment.
4. Please state the amount of the enrollee's monthly premium. If the enrollee's premium has varied during the past 12 months, please state the premium amount the enrollee was billed for each month.
5. Please identify the last day of the enrollee's paid coverage.
6. What is the current status of the enrollee's health plan coverage with the health plan? Please provide a detailed response and produce any and all documents supporting the health plan's response.
7. If the health plan terminated the enrollee's health plan coverage for nonpayment of premiums, please produce any and all documents that the health plan contends demonstrates its compliance with Health and Safety Code section 1365 and California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, and 1300.65.3.
8. Has the health plan received any claims for health care services for the enrollee between the last day of the enrollee's paid coverage and the present? If so, for each claim please identify:
   a) The service provided;
   b) The name and contact information for the provider;
   c) The date(s) of service; and
   d) The amount the enrollee will be financially liable for if their health plan coverage is not reinstated.
9. Please advise if the health plan will offer reinstatement of the enrollee's health plan coverage. If the health plan offers reinstatement, please confirm the following:

a) Total outstanding amount the health plan contends is due to bring the enrollee's health plan coverage current;
b) State how the health plan calculated that amount and please include a premium audit for the relevant period that includes monthly premium amounts owed, premium payments including date credited, refunds of premium payments, and missed or returned payments;
c) State how the enrollee can make a payment to bring his/her account current; and
d) Provide the inquiry tracking number, if any, that the enrollee may need to reference when he/she contacts the health plan to bring his/her health care service plan current.

10. Please advise whether the enrollee has initiated an informal and/or formal appeal of any of the issue(s) raised in the attached complaint with Covered California and/or the Department of Social Services. If the enrollee has initiated an informal and/or formal appeal, please provide a detailed explanation of the status of the appeal and any documents in the health plan's possession relating to the appeal including, specifically, the following:
    a) A copy of the enrollee's appeal;
    b) Documents and/or statements produced by the enrollee in support of his/her appeal;
    c) Documents produced by the health plan in response to the appeal;
    d) Documents produced by Covered California, including any Statement(s) of Position; and
    e) Documents produced by Covered California and/or the Department of Social Services relating to the fair hearing process, including any decisions relating to the appeal.

## SECTION G – PROVIDER DIRECTORY

1. Does the health plan dispute that the enrollee relied on materially inaccurate, incomplete, or misleading information listed in the health plan's provider directory?

    ☐Yes ☐No

    **If yes,** please provide a detailed explanation and produce all documents that support the health plan's response.

    **If no,** will the health plan authorize coverage for all of the health care services provided to the enrollee and reimburse the enrollee for any amount beyond what the enrollee would have paid had the services been delivered by an in-network provider under the enrollee's health plan contract, in compliance with Health and Safety Code section 1367.27(q)?

    ☐Yes ☐No

    **If no,** please provide a detailed explanation and provide all documents that support the health plan's response, including a copy of the relevant provider directory page(s) that contain(ed) the materially inaccurate, incomplete, or misleading information.

2. Has the health plan investigated and, if necessary, corrected the inaccurate, incomplete, or misleading information by incorporating updates to the health plan's online and/or printed provider directory?

    ☐Yes ☐No

    **If yes,** please explain the actions the health plan has taken to investigate and correct the provider directory information, including the date(s) of the investigation and correction, and provide all documents that support the health plan's response.

**If no,** please provide a detailed explanation as to why and provide any documents that support the health plan's response.

## SECTION H – WHEELCHAIRS FOR MEDI-CAL BENEFICIARIES

1. Did the health plan complete an evaluation that determined if a wheelchair, or power wheelchair, are medically necessary? The evaluation shall assess the enrollee's ability to perform one or more mobility related Activities of Daily Living or Instrumental Activities of Daily Living in or out of the home, including access to the community.

   ☐Yes ☐No

   **If yes**, please provide a detailed explanation and produce all documents (including the evaluation) that support the health plan's response.

   **If no,** will the health plan authorize coverage for the wheelchair or power wheelchair?

## SECTION I – APPROVAL OF REQUESTED SERVICES

If the health plan does not dispute the requested service is medically necessary and is not raising a benefit coverage exclusion:

1. Please identify (including name, address, and telephone number) no more than three in-network providers that meet the following parameters:
   a) Appropriately qualified to treat the enrollee's condition;
   b) Located within a reasonable geographic distance from the enrollee's residence;
   c) Accepting new patients;
   d) Available to consult with the enrollee regarding the requested service within the timeframes set forth in section 1300.67.2.2 et seq. of title 28 of the California Code of Regulations; and
   e) Please identify the soonest available appointment for each provider listed.

   Please note that in responding to this request for additional information, the Plan is representing to the Department that it has confirmed all of the above information is accurate for each provider identified by the Plan in accordance with Health and Safety Code section 1396. If the Department subsequently determines that none of the proffered in-network providers meet all of the parameters set forth in subparts a through e above, the Department will direct the Plan to authorize coverage of the disputed services with an out-of-network provider according to the enrollee's in-network benefits and likewise forward this complaint to its Office of Enforcement for further investigation and the possible imposition of administrative fines and penalties pursuant to section 1300.68(h) of title 28 of the California Code of Regulations and Health and Safety Code section 1368, et seq.

2. If the Plan is unable to identify an in-network provider who meets all of the parameters listed above, please advise whether the Plan will provide authorized coverage of the requested service with an out-of-network provider. If not, please provide a detailed explanation why and produce any and all documentation supporting the Plan's response.

## SECTION J – NON-URGENT/EMERGENT MEDICAL TRANSPORTATION CASES FOR MEDI-CAL BENEFICIARIES

1. Does the enrollee have a standing order for Non-Medical Transportation (NMT) or Non-Emergent Medical Transportation (NEMT) services? If so, what are the scheduled pick-up times?
2. Please produce all written correspondence including letters and emails between the Plan, the enrollee, and/or the enrollee's representatives and/or agents regarding the enrollee's request for timely NMT or NEMT services.
3. Please produce all call logs or other documentation of any telephone communication between the Plan, the enrollee, and/or the enrollee's representatives and/or agents regarding the enrollee's request for timely NMT or NEMT services.
4. Please identify all of the enrollee's scheduled NMT or NEMT transportation services in the last 6 months and state whether the provider arrived timely. Please provide documentation to support the Plan's response.

## SECTION K – MENTAL HEALTH OR SUBSTANCE USE DISORDER

### RELEVANT CALIFORNIA LAW

When a Plan receives a request for behavioral health services (mental health or substance use disorder services), the Plan, at minimum, is required to review the request utilizing the requirements noted in the following health and safety codes.

**A. Health Plan to Cover Mental Health and Substance Use Disorder:**

**Section 1374.72(a)(3)(A)** defines medically necessary treatment of a mental health or substance use disorder as a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

a) In accordance with the generally accepted standards of mental health and substance use disorder care.
b) Clinically appropriate in terms of type, frequency, extent, site, and duration.
c) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

**Section 1374.72(d)** states if services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

**B. Medical Necessity Determination; Utilization Review Criteria:**

**Section 1374.721(b)** states that when conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

**Section 1374.721(c)** states that when conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

1. Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

2. Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

**Section 1374.721(f)(1)** states that generally accepted standards of mental health and substance use disorder care means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

**C. Timely Access Requirements:**

**Section 1367.03(a)** states a health care service plan that provides or arranges for the provision of hospital or physician services, including a specialized mental health plan that provides physician or hospital services, or that provides mental health services pursuant to a contract with a full service plan, shall comply with the following timely access requirements:

**Section 1367.03(a)(1)** states a health care service plan shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. A plan shall establish and maintain provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. A health care service plan that uses a tiered network shall demonstrate compliance with the standards established by this section based on providers available at the lowest cost-sharing tier.

**Section 1367.03(a)(5)** states in addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health care service plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to **offer** enrollees appointments that meet the following timeframes:

1. Urgent care appointments for non-physician mental health services that do not require prior authorization; within 48 hours of request for appointment;
2. Urgent care appointments for non-physician mental health services that require prior authorization; within 96 hours of request for appointment;
3. Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment.
4. Non-urgent appointment with a non-physician mental health care provider; within 10 business days of request for appointment;
5. Non-urgent follow-up appointment with a non-physician mental health care; within 10 business days of the prior appointment when undergoing an ongoing course of treatment with a non-physician mental health care or substance use disorder provider. This timeframe does not limit coverage for non-urgent follow-up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

**PLEASE PROVIDE RESPONSES TO THE FOLLOWING QUESTIONS:**

1. Do the requested services require prior authorization?

2. Has or will the Plan authorize the requested services? If yes, please provide the authorization documentation. If no, please provide the basis for the denial?

3. Has the enrollee contacted the Plan or the Plan's delegate to request an initial or follow-up appointment for behavioral health services? If yes, please provide the first date the enrollee contacted the Plan or the Plan's delegate and requested an initial or follow-up appointment?

4. Did the Plan offer an appointment with an in-network provider within the applicable timely access standards? If yes, please provide documentation that the Plan offered the enrollee an appointment with an in-network provider within the applicable timely access standards after the enrollee's initial contact to the Plan or the Plan's delegate where the Plan confirmed the provider:

   a. Is appropriately qualified to treat the enrollee's condition;
   b. Is located within a reasonable geographic distance from the enrollee's residence;
   c. Is accepting new patients; and
   d. Is available to provide the requested service(s) within the timeframes set forth in Health and Safety Code Section 1367.03.

   **Offering an appointment does not mean providing the enrollee with a list of in-network providers. It also does not include providing a lookback period where an in-network provider previously had availability within the timely access standards.**

   **Please Note:** If the plan is unable to identify an in-network provider within the geographic and timely access standards, Health and Safety Code section 1374.72(d) requires the plan to

arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services, to the maximum extent possible, meet the geographic and timely access standards. This includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards.

By responding to this request for information, the plan is representing to the Department that it has confirmed that all of the information provided above is accurate for each in-network provider identified by the health plan in accordance with Health and Safety Code section 1396. If the Department subsequently determines that none of the offered in-network providers meet all of the parameters set forth above, the Department will direct the health plan to authorize coverage of the disputed service(s) or product(s) with an out-of-network provider and will likewise forward this complaint to its Office of Enforcement for further investigation and the possible imposition of administrative fines and penalties pursuant to Health and Safety Code section 1368, et seq. and California Code of Regulations, title 28, section 1300.68(h).

The waiting times are inclusive of provider and plan process, including utilization management processes set forth in Section 1367.01. In addition, the wait time for a particular appointment may be extended if the referring, treating, triage or screening licensed health care provider, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

5. If the health plan is attempting to transition the enrollee from an out-of-network provider to an in-network provider, the Plan is required to provide the Department with the general accepted standards of care the Plan utilized to determine it is within the generally accepted standards of care to transition the enrollee and an explanation how the transfer of the enrollee is not primarily for the economic benefit of the plan.

When responding to the department's RHPI, please produce an electronic copy of the medical policy, generally accepted standards of care, utilization review criteria, etc. that the health plan utilized to perform its review, as well as any and all other relevant documents, medical records, etc. the plan relied upon to arrive at its determination.

The Department will not return this matter to the Plan (RTP) as it qualifies for early review under Health and Safety Code section 1368, subdivision (b)(1)(A) and California Code of Regulations, Title 28, section 1300.68, subdivision (h). The Department expects receipt of the Plan's full and complete response to this Request for Health Plan Information Addendum (RHPI) by close of business on the due date indicated in the RHPI email.

## ADDITIONAL QUESTIONS

The Department requests the Plan respond to the following additional questions about the enrollee's complaint:

1.