



Problems with California health plans?

The Department of Managed Health Care has resources to help.

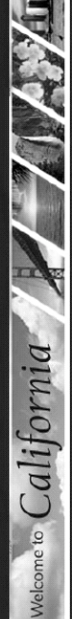


What is the Department of Managed Health Care?

The Department of Managed Health Care (DMHC) is a specialized regulator within the Executive Branch of the state government.

The Department is one of several governmental entities, federal and state, which regulate third party payers, providers, and Risk Bearing Organizations. This means that different health insurance products are regulated by different entities.





Which plans does the DMHC regulate?

The DMHC can help you in disputes with any of the HMOs licensed by the State of California, and certain Blue Cross and Blue Shield PPOs.

These include:

- Aetna Health of California, Inc.
- Blue Cross of California (dba Anthem Blue Cross)
- California Physicians' Service (dba Blue Shield of California)
- Cigna HealthCare of California, Inc.
- Health Net of California, Inc.
- Kaiser Foundation Health Plan, Inc.
- PacifiCare of California
- *And over a hundred others*

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How the DMHC can help

The DMHC offers two primary resources directly to providers:

- 1. The Help Center; and**
- 2. The Provider Complaint Unit**

Each one is specialized in handling certain types of problems.

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The Help Center

1-888-466-2219

www.healthhelp.ca.gov

The Help Center is a patient-centered resource for members who have a problem with their plan or are denied care (i.e. denial of authorization, risk of financial liability on the part of the patient).

As a general rule of thumb, when there is a **pre-service** issue, contact the Help Center.

The process can be started by patients **or** providers.

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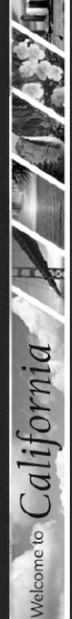
Contacting the Help Center

Patients or providers can start the process with a phone call to **1-888-466-2219**, or can get all the forms needed to start the process on the Department's website at **www.healthhelp.ca.gov**.

For clinically urgent issues, patients or providers should call the Help Center as soon as possible.

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The Help Center's Independent Medical Review: How it works

The DMHC sends disputes regarding medical necessity or experimental/investigational denials to an independent panel of physicians (Independent Medical Review). If the physician finds the denied service medically necessary—or for an experimental/investigational denial, a panel finds that the service is likely to be more beneficial to the enrollee than any available standard therapy—the DMHC orders the plan to provide it.

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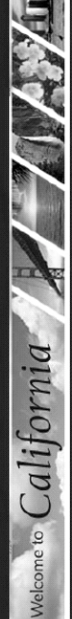


Independent Medical Review – Oncology Example A

- 59 year-old male, diagnosed with seminoma
- The plan denied a PET/CT scan as experimental/investigational
- Outcome: overturned decision of the health plan
- Findings: Two physician reviewers found that soft tissue abnormality will remain following 12 weeks of chemotherapy. However, a PET/CT scan will allow clinicians to estimate how much of the mass, if any, represents residual tumor. Thus, PET/CT scan is the most appropriate method to monitor this patient.

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Independent Medical Review – Oncology Example B

- 59 year-old female, diagnosed with large B-cell Non-Hodgkin's lymphoma
- The plan denied the use of Revlimid as not medically necessary
- Outcome: overturned decision of the health plan
- Findings: The physician reviewer found that Revlimid has been approved for use in MDS as well as multiple myeloma and is being very actively studied in Non-Hodgkin's lymphoma. A paper by Wiernik and colleagues described good clinical results. Tempescul and colleagues have also reported a complete remission in a patient with heavily pre-treated mantle cell lymphoma.

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Make sure the patient files a grievance with their plan first

Patients need to file a **grievance** with the plan before the Help Center can step in.

If there is an ***imminent and serious threat to the patient's health***, the patient can request an expedited review from their plan.

Then, if the patient is unhappy with the plan's decision, the patient or provider can appeal the decision to the Help Center. The Help Center is available to help you if you are not sure what to do.

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The Provider Complaint Unit

1-877-525-1295

<http://www.hmohelp.ca.gov/providers/>

The Provider Complaint Unit is a provider-centered resource for providers who have a problem with a plan regulated by the DMHC.

Call Andrew George at (916) 322-2750, if you have any questions.

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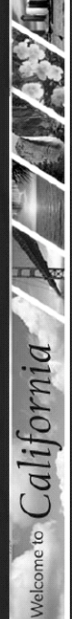
What kinds of complaints?

The Provider Complaint Unit is prepared to assist any provider of health care services who has a problem with a plan.

As a general rule of thumb, contact the Provider Complaint Unit regarding **post-service** issues (i.e. reimbursement, honoring contracts/authorizations, etc.)

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The Provider Complaint Unit: How it works

The Provider Complaint Unit will:

- Ask you for documentation regarding your complaint
- Verify that the DMHC has jurisdiction over the plan
- And contact the plan regarding your dispute

If the plan is found to be out of compliance with the Knox-Keene Act, the Department will instruct the plan accordingly and may refer the plan to the Office of Enforcement for investigation of further action against the plan.

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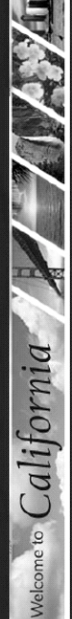


Do you have to exhaust your appeals before contacting the DMHC?

Generally, the provider should start with the plan's Provider Dispute Resolution process. But in instances where there appear to be serious systemic payment problems, or where the provider has already submitted previous complaints to this plan regarding the same issue, the provider can come directly to the Department.

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Help us to help you

Each time you or your patients file a complaint with the Department, it allows us to collect data that helps us to understand and address systemic problems involving specific plans.

The DMHC actively investigates and, where appropriate, issues penalties against plans that do not comply with their responsibilities to providers under the law.

We are eager to work with you to ensure that health plan enrollees get the right care at the right time.

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