

## **COUNTY MEDICAL SERVICES PROGRAM (CMSP)**

### **BENEFIT APPEALS AND REQUEST FOR MEDICAL BENEFIT HEARING BY CMSP GOVERNING BOARD**

If you are notified by either Advanced Medical Management or MedImpact Health Systems, Inc. (MedImpact) that a medical service, including a prescription, has been denied or reduced, or a previously authorized service is being terminated, you, your authorized representative, or your provider on your behalf, may appeal this decision.

#### Medical Benefit Appeals (Medical, Dental or Vision Benefits)

For medical benefit appeals, please contact the Advanced Medical Management Utilization Management Department by calling (877) 589-6807, or write or fax Advanced Medical Management at:

Advanced Medical Management  
Attn: Grievance Coordinator  
5000 Airport Plaza Drive, Suite 150  
Long Beach, CA 90815-1260  
Fax: (562) 766-2005

You must ask for an appeal within sixty (60) calendar days from the postmark date of the Notice of Action letter from Advanced Medical Management advising you of the denial of service, reduction in service or termination of a previously authorized service, unless you want to keep your treatment going during the appeal process. In this case, you must ask for an appeal within ten (10) calendar days from the postmark date of the Notice of Action letter from Advanced Medical Management and state that you want to keep getting your treatment during the appeal process.

Advanced Medical Management will acknowledge receipt of your appeal, review the issues and send you a letter in writing of its decision within thirty (30) calendar days from the date it received your appeal. You may ask for an expedited review of your appeal and Advanced Medical Management will determine if your circumstances merit an expedited review.

#### Prescription Drug Benefit Appeals

For prescription drug appeals, contact MedImpact Customer Service at (800) 788-2949 and inform the Customer Service Representative that you want to make an appeal, or write or fax MedImpact at:

MedImpact Health Systems, Inc.  
Attn: Appeals Coordinator  
10680 Treena Street  
San Diego, CA 92131  
Fax: (858) 790-6060

You must ask for an appeal within sixty (60) calendar days from the postmark date of the decision letter from MedImpact advising you of the denial of service, reduction in service or termination of a previously authorized service, unless you want to keep your treatment going during the appeal process. In this case, you must ask for an appeal within ten (10) calendar days from the postmark date of the decision letter from MedImpact and state that you want to keep getting your treatment during the appeal process.

MedImpact will acknowledge receipt of your appeal, review the issues and send you a letter in writing of its decision within thirty (30) calendar days from the date it received your appeal. You may ask for an expedited review of your appeal and MedImpact will determine if your circumstances merit an expedited review.

## **Medical Benefit Hearing with the CMSP Governing Board**

If you are dissatisfied with any decision regarding a denial, reduction or termination of benefits under the County Medical Services Program (CMSP), you have the right to request a hearing by County Medical Services Program Governing Board **after** you have appealed the benefit decision by Advanced Medical Management or MedImpact. If you want a Medical Benefit Hearing, you must ask for it within thirty (30) calendar days from the date that Advanced Medical Management or MedImpact deny your appeal, unless you want to keep your treatment going during the Medical Benefit Hearing process. If you want to continue your treatment during the Medical Benefit Hearing process, you must ask for a Medical Benefit Hearing within ten (10) calendar days from the date of the notice of the denial by either Advanced Medical Management or MedImpact. Please state that you want to keep getting your treatment during the hearing process.

To file a written request for a CMSP Medical Benefit Hearing, follow these steps:

1. Please fill in the Request for Medical Benefit Hearing form and provide your signature on the bottom of the form.
2. Attach a copy of the appeal decision from Advanced Medical Management or MedImpact for which you are filing a CMSP Medical Benefit Hearing.
3. FAX or mail the completed and signed form to:

ATTN: CMSP Medical Benefit Hearings  
CMSP Governing Board  
1545 River Park Drive, Suite 435  
Sacramento, CA 95815  
Fax: (916) 848-3349

**NOTE:** A request for a CMSP Medical Benefit Hearing that does not include all of the information described above will be returned without review. You may resubmit the request for a CMSP Medical Benefit Hearing within the timeframe of thirty (30) calendar days from the date of receiving a benefit appeal decision by Advanced Medical Management or MedImpact or within ten (10) business days of receiving the returned request, whichever is later.

You will receive an acknowledgement of receipt of the request for a CMSP Medical Benefit Hearing within ten (10) business days of the date the CMSP Governing Board received your request. The CMSP Governing Board will schedule a CMSP Medical Benefit Hearing within thirty (30) calendar days of receiving a hearing request. The CMSP Governing Board will notify you of the scheduled hearing. *If the record has not been fully developed and/or the CMSP Governing Board cannot complete the record by obtaining additional information from the CMSP Member or Provider, Advanced Medical Management or MedImpact, then the scheduling of the hearing may be delayed up to thirty (30) calendar days in order to provide sufficient time for the development of a more complete record.*

You will receive a written notice of the time, date and location of the hearing and a written copy of the CMSP Governing Board's position at least ten (10) business days prior to the date of the hearing.

You have the right to be represented at the hearing by another person of your choice (an attorney, a friend, a relative, or other spokesperson). You may be able to receive legal advice by calling the nearest legal assistance/services agency. You may have witnesses at the hearing and you may present evidence.

A hearing decision will be issued within thirty (30) calendar days of the hearing's conclusion. You will receive a written copy of the hearing decision within ten (10) days of receipt of the decision by the CMSP. The hearing decision is the final determination of the matter.

### **INFORMATION PRACTICES ACT STATEMENT**

The information requested on the Request for Medical Benefit Hearing form will be used by the CMSP Governing Board to resolve your complaint regarding medical care provided under the CMSP. Completion of the form is voluntary, and the form should be submitted to the CMSP Governing Board if you wish to request a CMSP Medical Benefit Hearing. All information you submit is confidential, and it will be provided only to the CMSP Governing Board and your county welfare department. For more information regarding use of this information or access to your records, contact the CMSP Governing Board, 1545 River Park Drive, Suite 435, Sacramento, CA 95815 (telephone 916-649-2631).

**REQUEST FOR MEDICAL BENEFIT HEARING  
BY CMSP GOVERNING BOARD**

INSTRUCTIONS: Please complete all of the information below.

I, \_\_\_\_\_, daytime phone (     ) \_\_\_\_\_,  
address \_\_\_\_\_, hereby request a hearing of actions  
taken by Advanced Medical Management/ MedImpact (*please circle*) regarding benefits under the County Medical Services  
Program (CMSP).

Explain your complaint about medical care, authorizations, or payment under CMSP. Attach additional sheet if necessary.

A. What is the decision you would like us to review? (*Tell us about the decision you would like us to review and include a copy of the letter you got from Advanced Medical Management or MedImpact.*)

B. Why do you think this decision is wrong? (*Write your reason below.*)

C. What would you like us to do? (*Write your response below.*)

D. What else would you like us to know? (*Is there any other information you think would help us review our decision? Write the information below or send other papers that will help us understand.*)

3. Complaint date(s) (enter the month/day/year the problem occurred.)

4. Name of the Health Care Provider (HCP) (doctor, pharmacy, hospital) Involved

5. HCP phone number

6. Address of HCP

7. Name of the CMSP member's county welfare department worker

8. Phone number  
(     )

9. BIC Card Number (enter the ID number located on the fourth line, upper left-hand corner of the State of California BIC card)

10. Date valid

**The information I have given here is complete and accurate to the best of my knowledge. The CMSP Governing Board has my permission to obtain information about this case from the county welfare department and/or the health care provider.**

11. Signature

12. Date

13. Signature of the person helping the claimant (*if this form was completed by someone else*)

14. Date