DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

TECHNICAL ASSISTANCE GUIDE

GRIEVANCES AND APPEALS

ROUTINE DENTAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this May 5, 2023 Technical Assistance Guide renders all other versions obsolete.

GRIEVANCES AND APPEALS

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Requirement GA-001: Grievance System Description

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director and/or officer who has primary responsibility for the grievance system
- Manager of Member Services
- QM Director
- Director of Operations

DOCUMENTS TO BE REVIEWED

- Description of the grievance system
- Position description of the officer with primary responsibility for the grievance system
- Policy and procedure for generation and review of aggregated and tabulated grievances
- Grievance logs
- Grievance forms
- Policies and procedures to maintain a system of aging of grievances pending and unresolved for 30 calendar days or more
- Policy and procedure to report quarterly to the DMHC all grievances pending and unresolved for 30 calendar days or more
- Policies and procedures for the processing of grievances
- Committee Minutes (Governing Body, QA, Public Policy, Grievance Committee, etc.), including grievance reports reviewed
- Reports and analysis by Plan's grievance officer regarding emergent patterns of grievances for most recent 6-12 month period.
- Review licensing filing of the Plan's Grievance program and confirm submission of appropriate policies and procedures

GA-001 - Key Element 1:

1. **The Plan has a grievance system, approved by the Department, for the receipt, review, and resolution of grievances.**
   CA Health and Safety Code 1368(a)(1); 28 CCR 1300.68(a), (b)(3), (8) and (d)(6).

Assessment Questions	
1.1	Does the Plan have a written description of its grievance system?
1.2	Does the grievance system description include grievance **system structure** including personnel, lines of authority, forms, and grievance materials?

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1.3	Does the grievance system description include grievance **system scope** including a clear definition of the grievance system and use of terms (e.g., grievance, complaint, complainant, resolved, and pended), proper assistance provided to enrollees, length of time for filing grievances, consideration for the linguistic and cultural needs of the enrollee population and the needs of enrollees with disabilities?
1.4	Does the grievance system description include grievance **system processes** including filing a grievance, grievance filing and resolution timeframes, assistance provided to enrollees, logging and responding to a grievance, evaluating and resolving a grievance, and enrollee communications?
1.5	Does the grievance system description include **oversight** of **delegated** entities, as applicable, and **procedures** for oversight?
1.6	Does the grievance system description include grievance **system monitoring procedures** including a description of how the Plan's grievance officer continuously reviews the operation of the grievance system to identify any emergent patterns of grievances and how the Plan might use various grievance reports to improve service or care? (i.e., improve Plan policies and procedures)
1.7	Does the Plan's grievance system provide for the **maintenance** of **copies of grievances** and responses for five years, which shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision?
1.8	If the Plan has multiple levels of grievance/appeal, are all levels completed within 30 days?
1.9	Does the Plan assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance?

GA-001- Key Element 2:

2. **There is an officer of the Plan who has primary responsibility for the grievance process who identifies and reports emergent patterns of grievances to formulate policy changes and procedural improvements in the Plan's administration.**
   CA Health and Safety Code section 1367.01(j); **28 CCR 1300.68(b)(1), (5) and (d)(2).**

Assessment Questions	
2.1	Is there a designated Plan officer who has primary responsibility for oversight and evaluation of the grievance process?
2.2	Does this officer identify and report patterns of grievances to formulate policy changes and procedural improvements in Plan administration?
2.3	Does this officer regularly monitor Plan compliance with grievance regulations, policies and procedures?

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2.4	Does the Plan regularly conduct aggregate analysis of grievances and appeals to track and trend potential issues and barriers to care
2.5	Does the Plan's **grievance officer** or his designee review the written record of grievances periodically and document such review?
2.6	Does the Plan's **governing body** review the written record of grievances periodically and document such review?
2.7	Does the Plan's grievance process require that management responsible for the operational area that is the subject of the grievance review such grievances?

GA-001 - Key Element 3:

3. **The Plan has established an effective mechanism for documenting and tracking grievances.**
   CA Health and Safety Code section 1368(a)(4)(B); 28 CCR 1300.68(b)(5), (d)(8), (e) and (f)(1).

Assessment Questions	
3.1	Does the Plan keep a written record of each grievance received; including the date received, the plan representative recording the grievance, a summary or other documents describing the grievance, and its disposition?
3.2	Does the Plan's grievance system have the capability of indicating the total number of grievances received, pending, and resolved in **favor of the enrollee**?
3.3	Does the Plan's grievance system have the capability of indicating the total number of grievances received, pending, and resolved at all **levels of grievance review**?
3.4	Does the Plan's grievance system have the capability of indicating the **total number of grievances** received, pending, and resolved, and describing the issue or issues raised in grievances as **1)** coverage disputes, **2)** disputes involving medical necessity, **3)** complaints about the quality of care, **4)** complaints about access to care (including complaints about the waiting time for appointments), **5)** complaints about the quality of service, and **6)** other issues?
3.5	Does the Plan's grievance system track the number and percentage of grievances pending over 30 calendar days?
3.6	For grievances exempt from acknowledgement requirements (grievances received over the phone, by facsimile, by e-mail, or online through the Plan's internet Web site, resolved the next day, and not coverage, medical necessity or experimental/investigational disputes) does the Plan **maintain a log** of such grievances?
3.7	For grievances exempt from acknowledgement requirements (grievances received over the phone, resolved the next day, and not coverage, medical necessity or experimental/investigational disputes does the log include the date of the call, the **name and id number** of the complainant, the **nature** of the grievance, the **resolution**, and the **representative** who took the call and resolved the grievance?

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End of Requirement GA-001: Grievance System Description

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Requirement GA-002: Grievance Filing

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Officer with primary responsibility for the grievance system
- Information Technology Officer
- Manager of Member Services

DOCUMENTS TO BE REVIEWED

- Policies and procedures for the filing of grievances at each facility of the Plan, on the Plan's website and from each contracting provider's office or facility
- Policies and procedures that describe how the Plan addresses the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities
- Grievance forms and description of the grievance procedure that are made available at Plan and provider sites
- Grievance forms and other materials for those with limited English proficiency or with a visual or other communicative impairment
- Plan website
- Website system documentation, flow charts, and protocols
- Evidence of toll-free or local numbers for each service area
- Toll-free or local telephone number wait-time and abandonment rate reports

GA-002 - Key Element 1:

1. **The Plan ensures that grievance forms and a description of the grievance procedure are readily available at each contracting provider's office, contracting facility, or Plan facility.**
   28 CCR 1300.68(b)(6) and (7).

Assessment Questions	
1.1	Are **grievance forms** and description of the grievance procedure readily available at each Plan **facility**?
1.2	Are **grievance forms** and description of the grievance procedure readily available at each contracting **provider's office**?
1.3	Are **grievance forms** and description of the grievance procedure readily available at the **Plan's website**?

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GA-002 - Key Element 2:

**2. The Plan maintains a toll-free or local telephone number in each service area, for the filing of grievances.
28 CCR 1300.68(b)(4).**

Assessment Questions	
2.1	Does the Plan have at least one toll-free or local telephone number for the filing of grievances located within each service area?
2.2	Is the telephone number reasonably accessible?

GA-002 - Key Element 3:

**3. The Plan's grievance system effectively addresses the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities.
28 CCR 1300.68(b)(3).**

Assessment Questions	
3.1	Does the Plan provide assistance for those with limited English proficiency?
3.2	Does the Plan provide assistance for those with a visual, hearing, or other communicative impairment?
3.3	Does the Plan's assistance include translations of grievance procedures, forms, and Plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate?

GUIDANCE

- Review grievance procedures, forms and template letters
- Review applicable policies and procedures for addressing linguistic and cultural needs of its enrollee population and the needs of enrollees with disabilities
- Determine how Plan responds to grievances written in a language other than English. Review samples of such grievances and Plan's response(s) including acknowledgment and resolution

GA-002 - Key Element 4:

**4. The Plan has an online grievance submission procedure.
CA Health and Safety Code section 1368.015; CA Health and Safety Code section 1368.02(b).**

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Assessment Questions	
4.1	Does the Plan have an online grievance submission process?
4.2	Is the process easily accessible through a hyperlink on the website's home page or member services portal clearly identified as, "GRIEVANCE FORM?"
4.3	Does the process utilize an online grievance form that allows the user to enter required information directly into the form?
4.4	Does the process allow the grievant/complainant to preview and edit the grievance form prior to submission?
4.5	Does the process include a hyperlink to the DMHC website?
4.6	Does the process include a statement in a legible font and size clearly distinguishable from other content on the page containing the statement from 1368.02(b) in which URL, hyperlink, and telephone numbers are updated as necessary?
4.7	Is all information submitted online done through a secure server?

End of Requirement GA-002: Grievance Filing

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Requirement GA-003: Grievance Receipt, Review and Resolution

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Officer with primary responsibility for the grievance system
- Information Technology Officer
- Manager of Member Services

DOCUMENTS TO BE REVIEWED

- Policies and procedures that describe the grievance system and processes
- Sample of grievance and appeal template letters
- Documentation of translated Plan responses to grievances in languages other than English
- Sample of grievance/appeal files to be reviewed

GA-003 - Key Element 1:

**1. The Plan acknowledges grievances and appeals in writing within five (5) calendar days of receipt.
28 CCR 1300.68(d)(1).**

Assessment Question	
1.1	Does the Plan consistently acknowledge grievances and appeals in writing **within five (5) calendar days** of receipt (except as noted in 28 CCR 1300.68(d)(8))?

GA-003 - Key Element 2:

**2. The Plan's written acknowledgment contains all required information.
CA Health and Safety Code section 1368.02(b); 28 CCR 1300.68(b)(3), (d)(1) and (7).**

Assessment Questions	
2.1	Does the Plan's written acknowledgment advise the grievant of the date the Plan received the grievance?
2.2	Does the Plan's written acknowledgment provide the name, address, and telephone number of the Plan representative who may be contacted about the grievance?

2.3	Does the Plan's written acknowledgment display the Plan's telephone number, the Department's telephone number, TDD line, and internet address in 12-point boldface type with the required statement contained in subsection (b) of Section 1368.02 of the Act?
2.4	Do acknowledgements address the language and disability needs of enrollees by providing assistance? Including translation and interpretation services, access to telephone relay services, and other devices to aid disabled enrollees)

GA-003 - Key Element 3:

3. The Plan resolves grievances (all levels) in a timely manner.
CA Health and Safety Code section 1368(a)(4)(B); CA Health and Safety Code section 1368.01(a); 28 CCR 1300.68(a)(4)(A), (b)(3) and (d)(3).

Assessment Questions	
3.1	Does the Plan consistently resolve non-urgent grievances (all levels) and send its written resolution to the grievant **within 30 calendar days** of Plan receipt of the grievance?
3.2	If the Plan cannot resolve the grievance within 30 calendar days, does the Plan report the grievance as pending or unresolved in its quarterly report to the Department?

GA-003 - Key Element 4:

4. The Plan's written response contains all required information.
CA Health and Safety Code section 1367.01(e); CA Health and Safety Code section 1368.02(b); CA Health and Safety Code and section 1370.2; CA Health and Safety Code section 1374.30(m); 28 CCR 1300.68(b)(3), (d)(4), (5), and (7).

Assessment Questions	
4.1	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does each response contain a **clear and concise** explanation of the Plan's decision?
4.2	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does each response contain the **criteria**, clinical guidelines, or medical policies used in reaching the determination?
4.3	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does each response contain **notification** that the determination may be considered by the Department's **independent medical review** system?
4.4	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does each response contain an **application** for independent medical review **(IMR)** and instructions?

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4.5	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does each response contain the **Department's** toll-free **telephone number** for further information?
4.6	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does each response contain an **envelope** addressed to the **Department of Managed Health Care**, Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814?
4.7	For grievances involving **medical necessity** or other clinical issues, does the Plan appropriately refer the grievance for **review** to a licensed **healthcare professional** competent to evaluate the clinical issues of the grievance?
4.8	For grievances involving a determination that the requested service is **not a covered benefit**, does each response contain the **specific provision** in the contract, **EOC** or member handbook that excludes the services (either by identifying the document and page where the provision is found, by directing the grievant to the applicable section of the contract or by providing a copy of the provision)?
4.9	For grievances involving a determination that the requested service is **not a covered benefit**, does each response contain **clear and concise** language that explains how the exclusion applied to the specific health care service or benefit requested by the enrollee?
4.10	For grievances involving a determination that the requested service is **not a covered benefit**, does each response contain **notice** that if the **enrollee believes** the decision was denied on the grounds that it was **not medically necessary**, the Department should be contacted to determine whether the decision is eligible for an **independent medical review**?
4.11	For grievances involving **contested claims**, does the Plan appropriately refer the claim for review to a **licensed** and competent health care provider to **evaluate** the clinical issues of the appealed claim, as applicable?
4.12	Does the written response display the Department's telephone number, the CA Relay Service's telephone numbers, the Plan's telephone number and the Department's internet address in 12-point boldface type with the statement contained in section 1368.02(b) of the Act?
4.13	Do Plan responses address the language and disability needs of enrollees by providing assistance (including translation and interpretation services, access to telephone relay services, and other devices to aid disabled enrollees)?
4.14	Does the Plan ensure adequate consideration and rectification of enrollee grievances when appropriate?
4.15	Do the Plan's resolution letters address all grievance issues?

End of Requirement GA-003: Receipt, Review, and Resolution

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Requirement GA-004: Enrollee Education/Notification Requirements

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Officer designated with having primary responsibility for the grievance system
- Staff involved in the grievance process
- Staff of Member Services
- Officer or staff responsible for member education

DOCUMENTS TO REVIEW

- Enrollee/Member handbook
- Evidence of Coverage (EOC)
- Copies of Plan grievance procedure
- Grievance forms (Including availability at each facility of the Plan, on the Plan's Web site, and from each contracting provider's office or facility)
- Denial letter templates (claims, prior authorization, etc.)
- Documents used by the Plan to communicate to enrollees the telephone numbers for filing grievances (i.e., informational brochures, enrollee handbook, etc.)
- Documents used by the Plan to notify subscribers and enrollees of the grievance system upon enrollment and annually thereafter

GA-004 - Key Element 1:

1. **The Plan informs its enrollees upon enrollment and annually thereafter of the procedure for processing and resolving grievances.**
   CA Health and Safety Code section 1368(a)(2); 28 CCR 1300.68(b)(2) and (9).

Assessment Questions	
1.1	Does the Plan provide enrollees upon enrollment and on an annual basis with the Plan's **procedures** for filing and **resolving grievances**?
1.2	Does the Plan provide enrollees upon enrollment and on an annual basis with the **locations and telephone numbers** (i.e., a toll-free number or a local telephone number in each service area) for filing complaints and grievances?
1.3	Does the Plan provide enrollees with **information** regarding the Department's review process, the **independent medical review system**, and the **Department's** toll-free telephone **number** and Web site address?
1.4	Does the Plan provide enrollees with information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address?

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GA-004 - Key Element 2:

2. The Plan displays the required notice set forth at section 1368.02(b) in all relevant written materials.
CA Health and Safety Code section 1368.02(b).

Assessment Questions	
2.1	Does the Plan display the required notice set forth at section 1368.02(b) in all relevant informational materials including **enrollee handbook**?
2.2	Does the Plan display the required notice set forth at section 1368.02(b) in every **Plan contract**?
2.3	Does the Plan display the required notice set forth at section 1368.02(b) in every **evidence of coverage**?
2.4	Does the Plan display the required notice set forth at section 1368.02(b) in copies of Plan **grievance procedures**?
2.5	Does the Plan display the required notice set forth at section 1368.02(b) in Plan **complaint/grievance forms**?
2.6	Does the Plan display the required notice set forth at section 1368.02(b) in any written communications to an enrollee that offer the enrollee the **opportunity to participate** in the grievance process of the Plan?

GA-004 - Key Element 3:

3. The Plan includes the information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in all relevant informational materials and all written communications to enrollees.
CA Health and Safety Code section 1374.30(i).

Assessment Questions	
3.1	Does the Plan include the information concerning the **right** of an enrollee to **request** an **independent medical review** in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers in all relevant informational materials including **enrollee handbook**?
3.2	Does the Plan include the information concerning the **right** of an enrollee to **request** an **independent medical review** in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers in every **Plan contract**?
3.3	Does the Plan include the information concerning the **right** of an enrollee to **request** an **independent medical review** in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan or by one of its contracting providers in every evidence of coverage (**EOC**)?

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3.4	Does the Plan include the information concerning the **right** of an enrollee to **request** an **independent medical review** in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers in copies of Plan **grievance procedures**?
3.5	Does the Plan include the information concerning the **right** of an enrollee to **request** an **independent medical review** in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers in Plan **complaint/grievance forms**?
3.6	Does the Plan include the information concerning the **right** of an enrollee to **request** an **independent medical review** in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in any **written communications** to an enrollee that offer the enrollee the opportunity to **participate** in the **grievance process** of the Plan?

End of Requirement GA-004: Enrollee Health Education/ Notification Requirements

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Requirement GA-005: Expedited Review of Urgent Grievances

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Officer with primary responsibility for the grievance system
- Member Services Manager
- Plan's designated representative(s) for DMHC contacts
- QM Director

DOCUMENTS TO BE REVIEWED

- Policies and procedures for expedited/urgent review
- Policies and Procedures providing for Plan contacts for the DMHC to utilize regarding expedited urgent grievances
- Schedule of Plan contacts for expedited/urgent grievances
- Copies of Plan's notification letter(s) to the DMHC and complainant regarding expedited/urgent grievances
- Policies and procedures regarding reporting responsibilities (including timeframes) to the DMHC and complainant regarding expedited/urgent grievances
- Expedited/Urgent grievance logging system
- Sample of expedited/urgent files to be reviewed

GA-005 – Key Element 1:

1. **The Plan's grievance system has policies and procedures for the expedited review of grievances for cases involving imminent and serious threat to the health of the patient ("urgent grievances").**
   CA Health and Safety Code section 1368.01(b); 28 CCR 1300.68.01(a) and (b).

Assessment Questions	
1.1	Does the Plan's grievance system include procedures for the expedited review of urgent grievances?
1.2	Do the Plan's procedures include the criteria (severe pain, potential loss of life, limb, or major bodily function) for cases to be included in expedited review?
1.3	Do the Plan's procedures for expedited review of urgent grievances specify that there is no requirement that the enrollee participate in the Plan's grievance process prior to applying to the Department for review of the urgent grievance?
1.4	Do the Plan's procedures provide for the receipt of Department contacts regarding urgent grievances 24 hours a day, 7 days a week?
1.5	Do the Plan's procedures provide for the scheduling of qualified Plan representatives including back-up Plan representatives as necessary to be available 24 hours a day, 7 days a week?

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1.6	If the Plan revises the urgent grievance system established pursuant to1300.68.01 (b), does the Plan notify the Department at least 30 days in advance of implementing the revisions?

GA-005 - Key Element 2:

**2. The Plan's grievance system allows for the Department to contact the Plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the Plan responds to the Department within 30 minutes after initial contact from the Department. During non-work hours, the Plan responds to the Department within one hour after initial contact from the Department.
28 CCR 1300.68.01(b).**

Assessment Questions	
2.1	Does the Plan respond to the Department within 30 minutes after initial contact from the Department during normal working hours?
2.2	Does the Plan respond to the Department within one hour after initial contact from the Department during non-work hours?
2.3	Does the Plan provide a Plan representative with authority on the Plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's Plan contract in a medically appropriate and timely manner?
2.4	Does the Plan representative's authority include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the Plan?

GA-005 - Key Element 3:

**3. The Plan reviews, resolves, and responds to urgent grievances in a timely and appropriate manner.
CA Health and Safety Code section 1368.01(b); CA Health and Safety Code section 1368.02(b); 28 CCR 1300.68(d)(3)-(5); 28 CCR 1300.68.01(a) and (b).**

Assessment Questions	
3.1	Upon receipt of an urgent grievance, does the Plan immediately inform the complainant of his/her right to contact the Department regarding the urgent grievance?
3.2	Does the Plan consider the enrollee's medical condition when determining the response time?
3.3	Is the expedited appeal reviewed by appropriate personnel?

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3.4	Does the Plan consistently provide a written statement to the complainant on the disposition or pending status of the urgent grievance **within three (3) calendar days** from receipt of the grievance?
3.5	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does the Plan's response contain a **clear and concise** explanation of the Plan's decision?
3.6	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does the Plan's response contain a clear statement of the **criteria**, **clinical guidelines, or medical policies** used in reaching the determination?
3.7	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does the Plan's **response contain (1)** an IMR application and instructions; **(2)** the Department's toll-free telephone number; and **(3)** an envelope addressed to the Department?
3.8	For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is **not medically necessary**, does the Plan's **response contain (1)** the Department's telephone number; **(2)** the CA Relay Service's telephone number; **(3)** the Plan's telephone number; **(4)** the Department's internet address; **(5)** a response in 12-point boldface type; and **(6)** the 1368.02(b) statement?
3.9	For grievances involving a determination that the requested service is **not a covered benefit**, does each response contain the **specific provision** in the contract, **EOC** or member handbook that excludes the services (either by identifying the document and page where the provision is found, by directing the grievant to the applicable section of the contract or by providing a copy of the provision)?
3.10	For grievances involving a determination that the requested service is **not a covered benefit**, does each response contain **clear and concise** language that explains how the exclusion applied to the specific health care service or benefit requested by the enrollee?
3.11	For grievances involving a determination that the requested service is **not a covered benefit**, does each response contain notice that if the enrollee believes the **decision was denied** on the grounds that it was **not medically necessary**, the Department should be contacted to determine whether the decision is eligible for an **independent medical review**?
3.12	Does the Plan resolve the urgent grievance and send notification to the enrollee in a timely manner considering the enrollee's medical condition?

End of Requirement GA-005: Expedited Review of Urgent Grievances

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Requirement GA-006: Independent Medical Review (IMR)

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Utilization Management Director
- Dental Director
- Officer with primary responsibility for the grievance system

DOCUMENTS TO BE REVIEWED

- Documents that demonstrate the Plan provides opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part, on a finding that the proposed health care services are not medically necessary, or on a determination that a therapy is experimental or investigational.

GA-006 - Key Element 1:

1. The Plan provides its enrollees opportunity to seek independent medical review (IMR) and prominently displays information concerning the right to an IMR in all required documents.
CA Health and Safety Code sections 1374.30(a), (e), (h), (i) and (l); 28 CCR 1300.68(d)(4).

Assessment Questions	
1.1	Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in the **member handbook/informational brochures**?
1.2	Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in every **Plan Contract**?
1.3	Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in all **enrollee evidence of coverage forms**?
1.4	Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review on copies of **grievance procedures**?
1.5	Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in all of the **denial letters** issued by either the Plan, or by one of its contracting organizations?
1.6	Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in all of the **grievance forms** required under section 1368?

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1.7	Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in all **written responses to grievances**?
1.8	Are enrollees informed that the IMR is at no cost?

GA-006 - Key Element 2:

2. The Plan submits required information to the IMR organization in a timely manner.
CA Health and Safety Code section 1374.30(n); CA Health and Safety Code section 1374.31(a); 1300.74.30(j) and (k).

Assessment Questions	
2.1	In cases of reimbursement of services already rendered in which a disputed health care is found to be medically necessary, did the Plan **reimburse the provider or enrollee**, whichever applies, **within five working days**?
2.2	In cases in which services have not been rendered, did the Plan **authorize the services within five working days** of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition?
2.3	In decisions to approve, modify, or deny requests by providers for authorization **prior** to, or **concurrent** with, the provision of health care services to enrollees, did the Plan **communicate** such **decision** to the requesting provider **within 24 hours** of the decision?
2.4	For concurrent review decisions pertaining to **care** that is **underway**, did the Plan **communicate** such **decision** to the enrollee's treating provider **within 24 hours**?
2.5	Did the Plan **communicate decisions** resulting in denial, delay, or modification of all or part of the requested health care service to the **enrollee** in writing **within two business days** of the decision? (This does not include concurrent review decisions pertaining to care that are underway, which shall be communicated to the enrollee's treating provider within 24 hours as noted above)

End of Requirement GA-006: Independent Medical Review

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Statutory/Regulatory Citations

CA Health and Safety Code section 1367.01(e) and (j)

…

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

…

(j) Every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

CA Health and Safety Code section 1367.03

(a) 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:

(1) 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 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.

(2) A health care service plan shall ensure that all plan and provider processes necessary to obtain covered health care services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with this section.

(3) If it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with this section and the regulations adopted thereunder.

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(4) Interpreter services required by Section 1367.04of this code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment. This subdivision does not modify the requirements established in Section 1300.67.04 of Title 28 of the California Code of Regulations, or approved by the department pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations for a plan's language assistance program.
(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health care service plan shall ensure that its network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:
(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subparagraph (H).
(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subparagraph (H).
(C) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).
(D) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).
(E) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).
(F) Commencing July 1, 2022, nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subparagraph (H). This subparagraph does not limit coverage for nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.
(G) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).
(H) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, 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.
(I) Preventive care services, as defined in subdivision (e), and periodic followup care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as

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determined by the treating licensed health care provider acting within the scope of their practice.
(J) A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard in subparagraph (A), (B), or (D), unless the requirements in subparagraph(H) or (I) are met, and shall be subject to the other provisions of this section.
(K) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subdivision through implementation of standards, processes, and systems providing advanced access to primary care appointments, as defined in subdivision (e).
(6) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that dental networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:
(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, if consistent with the enrollee’s individual needs and as required by professionally recognized standards of dental practice.
(B) Nonurgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subparagraph (C).
(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.
(7) A plan shall ensure it has sufficient numbers of network providers to maintain compliance with the standards established by this section.
(A) This section does not modify the requirements regarding providerto-enrollee ratio or geographic accessibility established by Section 1300.51, 1300.67.2, or 1300.67.2.1 of Title 28 of the California Code of Regulations.
(B) A plan operating in a network service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring an enrollee to, or, in the case of a preferred provider network, by assisting an enrollee to locate available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee’s health needs.
(C) A plan shall arrange for the provision of covered services from providers outside the plan’s network if unavailable within the network if medically necessary for the enrollee’s condition. A plan shall ensure that enrollee costs for medically necessary referrals to nonnetwork providers shall not exceed applicable in-network copayments, coinsurance, and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee’s preference to wait for a later appointment from a specific network provider. If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a health care service plan shall arrange

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coverage outside the plan's network in accordance with subdivision (d) of Section 1374.72.
(8) A plan shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone, as defined in subdivision (e).
(A) A plan shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.
(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services, telephone medical advice services pursuant to Section 1348.8, the plan's primary care and mental health care or substance use disorder network, or another method that provides triage or screening services consistent with this section.
(i) A plan that arranges for the provision of telephone triage or screening services through network primary care, mental health care, and substance use disorder providers shall require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that shall inform the caller of both of the following:
(I) Regarding the length of wait for a return call from the provider.
(II) How the caller may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.
(ii) A plan that arranges for the provision of triage or screening services through network primary care, mental health care, and substance use disorder providers who are unable to meet the time-elapsed standards established in subparagraph (A) shall also provide or arrange for the provision of plan-contracted or operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.
(iii) An unlicensed staff person handling enrollee calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the enrollee may be referred to licensed staff. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.
(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that network providers employ an answering service or a telephone answering machine during nonbusiness hours, which provide instructions regarding how an enrollee may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.
(10) A plan shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed 10 minutes.

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(b) With regard to subdivision (a), dental, vision, chiropractic, and acupuncture plans shall comply with paragraphs (1), (3), (4), (7), (9), and (10).
(c) The obligation of a plan to comply with this section shall not be waived if the plan delegates to its provider groups or other contracting entities any services or activities that the plan is required to perform. A plan’s implementation of this section shall be consistent with the Health Care Providers’ Bill of Rights, and a material change in the obligations of a plan’s network providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) and paragraph (2) of subdivision (h) of Section 1375.7.
(d) A health care service plan shall incorporate the standards set forth in subdivision (a) into the health plan’s quality assurance systems and the processes set forth in Sections 1367 and 1370 of this code and Title 28 of the California Code of Regulations, including Sections 1300.67.2, 1300.67.2.2, 1300.68, and 1300.70. A plan shall not prevent, discourage, or discipline a network provider or employee for informing an enrollee or subscriber about the timely access standards.
(e) For purposes of this section:
(1) “Advanced access” means the provision, by a network provider, or by the provider group to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician’s assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or the next business day.
(2) “Appointment waiting time” means the time from the initial request for health care services by an enrollee or the enrollee’s treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers.
(3) “Preventive care” means health care provided for prevention and early detection of disease, illness, injury, or another health condition and, in the case of a full service plan includes all of the basic health care services required by Sections 1345, 1367.002, 1367.3, and 1367.35 of this code and subdivision (f) of Section 1300.67 of Title 28 of the California Code of Regulations.
(4) “Provider group” has the meaning set forth in subdivision (g) of Section 1373.65.
(5) “Triage” or “screening” means the assessment of an enrollee’s health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care for the purpose of determining the urgency of the enrollee’s need for care.
(6) “Triage or screening waiting time” means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care.
(7) “Urgent care” means health care for a condition that requires prompt attention, consistent with paragraph (2) of subdivision (h) of Section 1367.01.
(f)(1) Contracts between health care service plans and health care providers shall ensure compliance with the standards developed under this chapter. These contracts shall

require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.
(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their network providers in complying with the standards, as well as changes in the compliance of plans with these standards.
(3) The department shall develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with this section and any regulations adopted pursuant to it, including demonstration of the average waiting time for each class of appointment regulated under this section, except the department may develop methodologies to demonstrate compliance with, and the average appointment wait time for, each class of appointments regulated under paragraph (6) of subdivision (a). The methodologies shall be sufficient to determine compliance with the standards developed under this section for different networks of providers if a health care service plan uses a different network for Medi-Cal managed care products than for other products or if a health care service plan uses a different network for individual market products than for small group market products. The development and adoption of these methodologies shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2025. The department shall consult with stakeholders in developing standardized methodologies under this paragraph.
(4) Notwithstanding paragraph (3), the department may take compliance or disciplinary action, including assessment of administrative penalties, on the basis of noncompliance with any of the provisions of this section, including, but not limited to, timeframes for appointments and followup appointments.
(5) The department may review and adopt standards, in addition to those specified in this article, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices, as well as the nature of the plan network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Health pursuant to subdivision (i). The development and adoption of standards under this paragraph shall not be subject to the Administrative Procedure Act until December 31, 2028. The department shall consult with stakeholders in developing the standards and methodologies described in this section.
(g)(1) The director may investigate and, by order, take enforcement action against plans, including, but not limited to, assessing administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397, regarding noncompliance with the requirements of this section. The director shall consider, as an aggravating factor when assessing administrative penalties, if harm to an enrollee,

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including financial or health impacts to an enrollee or substantial harm as defined in Section 3428 of the Civil Code, has occurred as a result of plan noncompliance. The director has the discretion to determine what harm constitutes harm to an enrollee. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. When taking enforcement action against a plan, the director may consider patterns of noncompliance. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.
(2) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:
(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.
(B) Repeated failure to act promptly and reasonably to require network providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the network provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.
(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.
(3) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.
(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.
(i) The department shall annually review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees. Commencing no later than December 1, 2015, and annually thereafter, the department shall post its final findings from the review on its internet website.
(j) The department shall post on its internet website any waivers or alternative standards that the department approves under this section on or after January 1, 2015.
(k) This section applies to a licensed health care service plan that provides services to Medi-Cal beneficiaries. Except for appointment wait time standards set forth in paragraph (5) of subdivision (a) of this section and in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, this section does not alter the requirements or standards of the State Department of Health Care Services specified in Section 14197 of the Welfare and Institutions Code.

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(*l*) This section does not prevent the department from developing additional standards to improve timely access to care and network adequacy.

CA Health and Safety Code section 1368(a)(1)-2), (a)(4)(B)
(a) Every plan shall do all of the following:
(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.
(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.
…
(4)(B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan's website pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:
(i) The date of the call.
(ii) The name of the complainant.
(iii) The complainant's member identification number.
(iv) The nature of the grievance.
(v) The nature of the resolution.
(vi) The name of the plan representative who took the call and resolved the grievance.

CA Health and Safety Code section 1368.01(a) and (b)
(a) The grievance system shall require the plan to resolve grievances
(b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to thehealth of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notifythe department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance, except as provided in subdivision (c).Paragraph (4) of subdivision (a) of Section 1368 shall not apply to grievances handled pursuant to this section.

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CA Health and Safety Code section 1368.015
(a) Effective July 1, 2003, every plan with an internet website shall provide an online form through its internet website that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.
(b) The internet website shall have an easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the internet website's home page or member services portal clearly identified as "GRIEVANCE FORM." All information submitted through this process shall be processed through a secure server.
(c) The online grievance submission process shall be approved by the Department of Managed Health Care and shall meet the following requirements:
(1) It shall utilize an online grievance form in HTML format that allows the user to enter required information directly into the form.
(2) It shall allow the subscriber or enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal.
(3) It shall include a current hyperlink to the Department of Managed Health Care internet website, and shall include a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:
"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 (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online."
The plan shall update the URL, hyperlink, and telephone numbers in this statement as necessary.
(d) A plan that utilizes a hardware system that does not have the minimum system requirements to support the software necessary to meet the requirements of this section is exempt from these requirements until January 1, 2006.
(e) For purposes of this section, the following terms shall have the following meanings:
(1) "Home page" means the first page or welcome page of an internet website that serves as a starting point for navigation of the internet website.

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(2) “HTML” means Hypertext Markup Language, the authoring language used to create documents on the world wide web, which defines the structure and layout of a web document.
(3) “Hyperlink” means a special HTML code that allows text or graphics to serve as a link that, when clicked on, takes a user to another place in the same document, to another document, or to another internet website or page.
(4) “Member services portal” means the first page or welcome page of an internet website that can be reached directly by the internet website’s home page and that serves as a starting point for a navigation of member services available on the internet website.
(5) “Secure server” means an internet connection to an internet website that encrypts and decrypts transmissions, protecting them against third-party tampering and allowing for the secure transfer of data.
(6) “URL” or “Uniform Resource Locator” means the address of an internet website or the location of a resource on the world wide web that allows a browser to locate and retrieve the internet website or the resource.
(7) “Internet website” means a site or location on the world wide web.
(f)(1) Every health care service plan, except a plan that primarily serves Medi-Cal or Healthy Families Program enrollees, shall maintain an internet website. For a health care service plan that provides coverage for professional mental health services, the internet website shall include, but not be limited to, providing information to subscribers, enrollees, and providers that will assist subscribers and enrollees in accessing mental health services as well as the information described in Section 1368.016.
(2) The provision in paragraph (1) that requires compliance with Section 1368.016 shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its internet website to an internet website operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with Section 1368.016.

CA Health and Safety Code section 1368.02(b)

…

(b) Every health care service plan shall publish the Department’s toll-free telephone number, the Department’s TDD line for the hearing and speech impaired, the plan’s telephone number, and the Department’s Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The Department’s telephone number, the Department’s TDD line, the plan’s telephone number, and the Department’s Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

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"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 (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online."

CA Health and Safety Code section 1374.30 (a),(e), (i), (k), (l), (m), (n)
(a) Commencing January 1, 2001, there is hereby established in the department the Independent Medical Review System.
…
(e) Every plan contract that is issued, amended, renewed or delivered in this state (California) on or after January 1, 2000, shall, effective January 1, 2001, provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part, on a finding that the proposed health care services are not medically necessary. An enrollee may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the enrollee in seeking an independent medical review and may advocate on behalf of the enrollee.
…
(i) No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.
…
(k) An enrollee may apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six

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months of any of the qualifying periods or events under subdivision (j). The director may extend the application deadline beyond six months if the circumstances of a case warrant the extension.
(*l*) The enrollee shall pay no application or processing fees of any kind.
(m) As part of its notification to the enrollee regarding a disposition of the enrollee's grievance that denies, modifies, or delays health care services, the plan shall provide the enrollee with a one-page application form approved by the department, and an addressed envelope, which the enrollee may return to initiate an independent medical review. The plan shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the enrollee's diagnosis or condition, the nature of the disputed health care service sought by the enrollee, a means to identify the enrollee's case, and any other material information. The form shall also include the following:
(1) Notice that a decision not to participate in the independent medical review process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.
(2) A statement indicating the enrollee's consent to obtain any necessary medical records from the plan, any of its contracting providers, and any out-of-plan provider the enrollee may have consulted on the matter, to be signed by the enrollee.
(3) Notice of the enrollee's right to provide information or documentation, either directly or through the enrollee's provider, regarding any of the following:
(A) A provider recommendation indicating that the disputed health care service is medically necessary for the enrollee's medical condition.
(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the enrollee's medical condition.
(C) Reasonable information supporting the enrollee's position that the disputed health care service is or was medically necessary for the enrollee's medical condition, including all information provided to the enrollee by the plan or any of its contracting providers, still in the possession of the enrollee, concerning a plan or provider decision regarding disputed health care services, and a copy of any materials the enrollee submitted to the plan, still in the possession of the enrollee, in support of the grievance, as well as any additional material that the enrollee believes is relevant.
(n) Upon notice from the department that the health care service plan's enrollee has applied for an independent medical review, the plan or its contracting providers shall provide to the independent medical review organization designated by the department a copy of all of the following documents within three business days of the plan's receipt of the department's notice of a request by an enrollee for an independent review:
(1)(A) A copy of all of the enrollee's medical records in the possession of the plan or its contracting providers relevant to each of the following:
(i) The enrollee's medical condition.
(ii) The health care services being provided by the plan and its contracting providers for the condition.
(iii) The disputed health care services requested by the enrollee for the condition.

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(B) Any newly developed or discovered relevant medical records in the possession of the plan or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The plan shall concurrently provide a copy of medical records required by this subparagraph to the enrollee or the enrollee's provider, if authorized by the enrollee, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.
(2) A copy of all information provided to the enrollee by the plan and any of its contracting providers concerning plan and provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the plan and to the plan's contracting providers in support of the enrollee's request for disputed health care services. This documentation shall include the written response to the enrollee's grievance, required by paragraph (4) of subdivision (a) of Section 1368. The confidentiality of any enrollee medical information shall be maintained pursuant to applicable state and federal laws.
(3) A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The plan shall concurrently provide a copy of documents required by this paragraph, except for any information found by the director to be legally privileged information, to the enrollee and the enrollee's provider. The department and the independent review organization shall maintain the confidentiality of any information found by the director to be the proprietary information of the plan.

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CA Health and Safety Code section 1374.31 (a)
(a) If there is an imminent and serious threat to the health of the enrollee, as specified in subdivision (c) of Section 1374.33, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the department may waive the requirement that the enrollee follow the plan's grievance process in extraordinary and compelling cases, where the director finds that the enrollee has acted reasonably.

28 CCR 1300.68(a), (b)(3)-(b)(8), (d)(1)-(8), (e) and (f)(1)
Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.
(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:
(1) Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
(2) "Complaint" is the same as "grievance."
(3)"Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
(4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.
(A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.
(B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.
(b) The plan's grievance system shall include the following:
(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

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(2) Each plan's obligation for notifying subscribers and enrollees about the plan's grievance system shall include information on the plan's procedures for filing and resolving grievances, and the telephone number and address for presenting a grievance. The notice shall also include information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address.
(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. (Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.)
(4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.
(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other documents describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or his designee. This review shall be thoroughly documented.
(6) The plan grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A "patient advocate" or ombudsperson may be used.
(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request.
(8) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.
(9) The grievance system shall allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction.
(d) The plan shall respond to grievances as follows:
(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, about the grievance.
(2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

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(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.
(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.
(5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.
(6) Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision.
(7) The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act.
(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).

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(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:
(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.
(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.
(f) Quarterly Reports
(1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.

28 CCR 1300.68.01(a) and (b)
(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:
(1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
(2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.
(3) Consideration by the plan of the enrollee's medical condition when determining the response time.

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(4) No requirement that the enrollee participate in the plan’s grievance process prior to applying to the Department for review of the urgent grievance.
(b) Each plan’s grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.
(1) The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.
(2) Plans shall provide the Department with the following information concerning urgent grievances:
(A) A description of the system established by the plan to resolve urgent grievances. The description shall include the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.
(B) A description of how the Department may access the grievance system established by the plan.
(3) If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least 30 days in advance of implementing the revisions.

28 CCR 1300.74.30 (j) and (k)
(j) Following receipt of the Department’s notification that an application for independent medical review has been assigned to an independent medical review organization, the plan shall provide the organization with all information that was considered in relation to the disputed health care service, the enrollee’s grievance and the plan’s determination. The plan shall forward all information to the medical review organization within three (3) business days for a regular review and within one (1) calendar day in the case of an expedited review.
(1) Unless otherwise advised in the notification or by the assigned review organization, the plan shall submit a complete set of the materials described below for the independent review organization.
(A) A copy of all correspondence from and received by the plan concerning the disputed health care service, including but not limited to, any enrollee grievance relating to the requested service;

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(B) A complete and legible copy of all medical records and other information used by the plan in making its decision regarding the disputed health care service. An additional copy of medical records shall be submitted for each reviewer.
(C) A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted or underlined sections, if the evidence of coverage was referenced in the plan's resolution of the enrollee's grievance;
(D) The plan's response to any additional issues raised in the enrollee's application for independent medical review.
(2) The plan shall promptly provide the enrollee with an annotated list of all documents submitted to the independent medical review organization, together with information on how copies may be requested.
(k) Plans shall be responsible for providing additional information as follows:
(1) Any medical records or other relevant matters not available at the time of the Department's initial notification, or that result from the enrollee's ongoing medical care or treatment for the medical condition or disease under review. Such matters shall be forwarded as soon as possible upon receipt by the health plan, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases.
(2) Additional medical records or other information requested by the IMR organization shall be sent within five (5) business days in routine cases or one (1) calendar day in expedited cases. In expedited reviews, the health care plan shall immediately notify the enrollee and the enrollee's health care provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of the plan or its contracting providers.