

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

TECHNICAL ASSISTANCE GUIDE

GRIEVANCES AND APPEALS

ROUTINE SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this September 21, 2026, Technical Assistance Guide renders all other versions obsolete

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This Technical Assistance Guide (TAG) serves as a guide for medical surveys which are conducted under the Health and Safety Code medical survey statutes and regulations. This TAG may be revised as appropriate, to incorporate new or updated relevant legal requirements as they impact the surveys, or for any other reason as determined by the Department. Health plans are responsible for complying with applicable statutes and regulations upon their effective dates and, therefore, are deemed to have prior notice of all statutes and regulations effective during the medical survey period. Health plans may be assessed for compliance with those requirements even when they have not yet been added to the TAG. The Department's medical survey authority is broad, and includes, but is not limited to, reviewing books and records, conducting interviews, making site visits, and making telephone calls to verify information as part of the survey assessment of any Key Element question in this TAG. The recipients of these telephone calls may include, but not be limited to, health plan and delegate physicians/medical directors, plan customer service representatives, triage nurses, and/or network/contracted provide

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

The Department may interview staff responsible for the activities described below, including, but not limited to, the following:

- Plan officer designated with having primary responsibility for the grievance system
- Medical Director(s)
- Director or Manager of Member Services/Call Center
- Director or Manager of Quality Assurance Program
- Director or Manager of Language Assistance Program
- Director or Manager of Delegation Oversight

DOCUMENTS TO BE REVIEWED

The Department may request records documenting the Plan's grievance system processes, including, but not limited to, the following:

- Grievance and appeal policies and procedures (Exhibit W-1)
- Complaint forms (Exhibit W-2)
- Written explanation of the Plan's grievance procedure made available to enrollees (Exhibit W-2)
- Description of key personnel responsible for carrying out the Plan's grievance procedures (Exhibit W-3)
- Policies, procedures, and internal guidance describing how the Plan maintains written records of all grievances and appeals
- Job description of the Plan officer designated as having primary responsibility for the Plan's grievance system
- Policies, procedures, and internal guidance describing:
 - How the Plan tracks and monitors grievances and appeals, including the number of grievances pending over 30 calendar days,
 - How the Plan's designated grievance officer continuously monitors grievance system operations to identify emergent patterns of grievances,
 - How the Plan uses grievance reports to improve policies and procedures,
 - How the Plan provides for prompt review by management and/or supervisory staff responsible for the services or operations which are the subject of a grievance,
 - How the Plan utilizes grievances and appeals data within the Plan's quality assurance program,
 - How the Plan's governing body reviews grievance records and reports
 - How the Plan's public policy body reviews grievance records and reports,

- How the Plan provides assistance to enrollees with limited English proficiency and to enrollees with a visual or other communicative impairment to ensure all enrollees have access to and can fully participate in its grievance system,
 - How the Plan tracks enrollee complaints received by the Plan and/or the Department involving an assertion plan staff did not provide trans-inclusive health care services,
 - How the Plan ensures staff repeat evidence-based cultural competency training after a grievance about their failure to provide trans-inclusive care is decided in favor of the complainant, and
 - How the Plan oversees entities delegated to perform call center, member services and/or grievance functions on its behalf.
- Evidence demonstrating the Plan completed activities described in the policies, procedures, and internal guidance outlined above
- Policies, procedures and other internal guidance describing how the Plan:
 - Informs its subscribers and enrollees upon enrollment, and annually thereafter, of its procedures for processing and resolving grievances,
 - Ensures call center and/or member services staff identify and process all expressions of dissatisfaction as grievances,
 - Processes exempt, expedited, and standard grievances,
 - Processes grievances involving a determination, in whole or in part, that the requested service is not medically necessary,
 - Processes grievances involving a determination, in whole or in part, that the requested service is not a covered benefit, and
 - Identifies and reviews potential quality issues in grievances.
- Meeting minutes and materials for the Plan's governing body
- Meeting minutes and materials for the Plan's public policy body
- Meeting minutes and materials of committee(s) responsible for overseeing the Plan's grievance system and/or receiving grievance reports
- Meeting minutes and materials of committee(s) responsible for overseeing the Plan's delegates
- Log of all grievances against Plan staff alleging failure to provide trans-inclusive care
- Training roster of Plan staff who completed evidence-based cultural competency re-training
- Copies of grievance procedure information provided to enrollees upon enrollment and annually thereafter
- Website address of the Plan's online grievance submission procedure
- Evidence of Coverage and/or Member Handbook

- Templates of written enrollee notices offering the opportunity to participate in the Plan's grievance process
- Templates of the Plan's written responses to grievance, including acknowledgement and resolution letters
- Quality Assurance Program Description
- Language Assistance Program Description
- Log of all inquiries, grievances, and appeals received and/or processed by the Plan and its delegates.

Requirement GA-001: Grievance System

GA-001 - Key Element 1: Recording, Reporting, and Monitoring Capabilities

1. The Plan maintains a grievance system capable of tracking, monitoring, and reporting all grievances received by the Plan.
CA Health and Safety Code [1368\(a\)\(4\)\(B\)\(i\)\(I\)-\(VI\)](#), (c); 28 CCR [1300.68\(b\)\(5\)](#), (d)(8), (e)(1)-(6).

Assessment Questions	
1.1	Does the Plan's grievance system maintain a written record for each grievance received by the Plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition? Rule 1300.68(b)(5)
1.1 Comments	
1.2	Does the Plan's grievance system maintain a written record of exempt grievances with all the following information: • the date of the call, • the name of the complainant, • the member identification number, • the nature of the grievance, • the nature of the resolution, • and the name of the plan representative who took the call and resolved the grievance? Section 1368(a)(4)(B)(i)(I)-(V); Rule 1300.68(d)(8)
1.2 Comments	
1.2	Does the Plan's grievance system track and monitor all grievance types, including exempt, expedited, and standard grievances? Section 1300.68(e)(1)
1.3 Comments	
1.3	Does the Plan's grievance system track and monitor grievances types by line of business under categories of commercial and Medi-Cal/other contracts? Section 1300.68(e)(1)
1.3 Comments	
1.4	Does the Plan's grievance system track and monitor the number of grievances received and resolved? Section 1300.68(e)(1)
1.4 Comments	
1.5	Does the Plan's grievance system track and monitor the number of grievances pending over 30 calendar days? Section 1300.68(e)(1)
1.5 Comments	

1.6	Does the Plan's grievance system track and monitor the number of grievances resolved in favor of the enrollee or the Plan? Rule 1300.68(e)(1)
1.6 Comments	
1.7	Does the Plan's grievance system indicate whether an enrollee's grievance is pending at the Plan's internal grievance system? Rule 1300.68(e)(1)(1)
1.7 Comments	
1.8	Does the Plan's grievance system indicate whether an enrollee's grievance is pending at the Department's consumer complaint process? Rule 1300.68(e)(1)(2)
1.8 Comments	
1.9	Does the Plan's grievance system indicate whether an enrollee's grievance is pending at the Department's Independent Medical Review system? Rule 1300.68(e)(1)(3)
1.9 Comments	
1.10	Does the Plan's grievance system indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review? Rule 1300.68(e)(2)
1.10 Comments	
1.11	Does the Plan's grievance system describe 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? Rule 1300.68(e)(2)-(6)
1.11 Comments	
1.12	FILE REVIEW: Do the Plan's grievance files demonstrate the Plan categorizes all issues raised within a grievance? Rule 1300.68(e)(2)
1.12 Comments	
1.13	FILE REVIEW: Do the Plan's grievance files demonstrate the Plan accurately categorizes the nature of each issue raised within a grievance? Rule 1300.68(e)(2)
1.13 Comments	

GA-001- Key Element 2: Grievance Officer

2. The Plan designated an officer as having primary responsibility for its grievance system, whether administered directly by the Plan or delegated to another entity, including continuously monitoring operation of the grievance system to identify emergent patterns of grievances and ensure compliance with applicable legal requirements.
 Health and Safety Code section [1368\(a\)\(1\)](#), (a)(4)(B)(i)(I)-(VI), (c); Rule [1300.68\(a\)](#), (b)(1) and (5), (c), (d)(2) and (8), (e)(1)-(2), (f); Rule [1300.70\(a\)\(1\)](#), (b)(2)(B)-(C)

Assessment Questions	
2.1	Does the Plan have an officer designated as having the primary responsibility for the Plan's grievance system? Rule 1300.68(b)(1)
2.1 Comments	
Name and Title of designated Plan officer:	
2.2	Does the officer continuously review the operation of the grievance system to identify any emergent patterns of grievances? Rule 1300.68(b)(1)
2.2 Comments	
2.3	If an emergent pattern is identified, does the Plan take corrective actions to resolve problems and perform follow-up where indicated? Rule 1300.70(a)(1)
2.3 Comments	
2.4	Does the Plan use grievance reports to improve policies and procedures? Rule 1300.68(b)(1)
2.4 Comments	
2.5	Does the Plan's grievance system provide for prompt review by Plan management or supervisory staff responsible for the services or operations which are the subject of the grievance? Rule 1300.68(d)(2)
2.5 Comments	
2.6	Do the Plan's records demonstrate the Plan completes all quality assurance activities related to its grievance system in a manner consistent with the required methodology, scope, and levels of activity described in its quality assurance program description? Section 1368(a)(1); Rule 1300.68(a) and (c); Rule 1300.70(b)(2)(B) and (C); Section 1368(b)(1)
2.6 Comments	

GA-001 - Key Element 3: Governing Body and Public Policy Committee

3. The Plan's governing body and public policy body periodically receive and review a written record of all grievances received by the Plan.
Health and Safety Code section [1368\(a\)\(1\)](#); 28 CCR [1300.68\(b\)\(5\)](#) and (d)(8); [1300.69\(f\)](#); [1300.70\(b\)\(2\)\(C\)](#).

Assessment Questions	
3.1	Does the Plan's governing body periodically review a written record of all grievances received by the Plan? Rule 1300.68(b)(5); Rule 1300.70(b)(2)(C)
3.1 Comments	
3.2	Does the Plan's governing body periodically review its log of exempt grievances? Rule 1300.68(d)(8)
3.2 Comments	
3.3	Are the grievance records reviewed by the governing body sufficiently detailed to include findings and actions taken as a result of the Plan's quality assurance program? Rule 1300.70(b)(2)(C)
3.3 Comments	
3.4	Does the Plan thoroughly document the governing body's review of grievance records? Rule 1300.68(b)(5)
3.4 Comments	
3.5	Does the Plan's public policy body periodically review a written record of all grievances received by the Plan? Rule 1300.68(b)(5); Rule 1300.69(f)
3.5 Comments	
3.6	Do the grievance records periodically reviewed by the Plan's public policy body include information about the specific nature and volume of complaints received by the Plan and their disposition? Rule 1300.69(f)
3.6 Comments	
3.7	Does the Plan thoroughly document the public policy body's review of grievance records? Rule 1300.68(b)(5)
3.7 Comments	

GA-001 - Key Element 4: Linguistic and Cultural Competency

4. The Plan's grievance system addresses the linguistic, cultural, and accessibility needs of its enrollees with limited English proficiency, disabilities, and/or who identify as transgender, gender diverse, or intersex. Health and Safety Code section [1367.043\(a\)\(4\)](#), [1368\(a\)\(1\)](#); 28 CCR [1300.68\(b\)\(3\)](#).

Assessment Questions	
4.1	Does the Plan offer translated versions of its grievance procedures? Rule 1300.68(b)(3)
4.1 Comments	
4.2	Does the Plan offer translated versions of its grievance forms? Rule 1300.68(b)(3)
4.2 Comments	
4.3	Does the Plan provide translated versions of its responses to grievances? Rule 1300.68(b)(3)
4.3 Comments	
4.4	Does the Plan's grievance system provide access to interpreters? Rule 1300.68(b)(3)
4.4 Comments	
4.5	Does the Plan's grievance system ensure enrollees with visual or communicative impairments have access to and can fully participate in the grievance system? Rule 1300.68(b)(3)
4.5 Comments	
4.6	Does the Plan's grievance system provide telephone relay systems? Rule 1300.68(b)(3)
4.6 Comments	
4.7	Does the Plan's grievance system provide other devices that help individuals with disabilities to communicate? Rule 1300.68(b)(3)
4.7 Comments	
4.8	Does the Plan's grievance system track enrollee complaints received by the Plan and/or the Department involving an assertion plan staff did not provide trans-inclusive health care services? Section 1367.043(a)(4) <i>Effective February 14, 2025</i>
4.8 Comments	
4.9	Do the Plan's records demonstrate it required plan staff against whom a complaint has been made for failure to provide trans-inclusive care, and for which a decision is made in favor of the complainant, to repeat its evidence-based cultural competency training within 45 days of making its decision? Section 1367.043(a)(4); DMHC APL 24-018 <i>Effective February 14, 2025</i>
4.9 Comments	

End of Requirement GA-001: Grievance System

Requirement GA-002: Enrollee Grievance Information

GA-002 - Key Element 1: *Notification Upon Enrollment and Annually Thereafter*

1. The Plan informs enrollees about its procedures for processing and resolving grievances.

Health and Safety Code section [1368\(a\)\(2\)](#); 28 CCR [1300.68\(b\)\(2\)](#).

Assessment Questions	
1.1	Does the Plan inform its subscribers and enrollees of its procedures for processing and resolving grievances? Section 1368(a)(2)
1.1 Comments	
1.2	Does the grievance information provided to subscribers and enrollees include the telephone number where grievances may be submitted? Section 1368(a)(2)
1.2 Comments	
1.3	Does the grievance information provided to subscribers and enrollees include the address where grievances may be submitted? Section 1368(a)(2); Rule 1300.68(b)(2)
1.3 Comments	
1.4	Does the grievance information provided to subscribers and enrollees include the DMHC's toll-free phone number? Rule 1300.68(b)(2)
1.4 Comments	
1.5	Does the grievance information provided to subscribers and enrollees include the DMHC's website? Rule 1300.68(b)(2)
1.5 Comments	
1.6	Does the Plan inform enrollees of grievance procedures upon enrollment? Section 1368(a)(2)
1.6 Comments	
1.7	Does the Plan inform enrollees of grievances procedures annually after enrollment? Section 1368(a)(2)
1.7 Comments	

GA-002 - Key Element 2: Online Grievance Submission Procedure

2. The Plan maintains an online grievance procedure easily accessible on its home page or member services through a hyperlink clearly identified as “GRIEVANCE FORM.”

Section [1368.015](#)(a)-(c)(1)-(3), (e)(1)-(7), (f)(1).

Assessment Questions	
2.1	Does the Plan provide an online form through its website enrollees can use to file a grievance? Section 1368.015(a)
2.1 Comments	
2.2	Is the online grievance submission procedure available through a hyperlink on the Plan’s website home page or member services portal? Section 1368.015(b)
2.2 Comments	
2.3	Is the hyperlink clearly identified as “GRIEVANCE FORM”? Section 1368.015(b)
2.3 Comments	
2.4	Is all information submitted through this online procedure processed through a secure server? Section 1368.015(b)
2.4 Comments	
2.5	Does the online grievance submission process allow enrollees to preview the grievance and include the opportunity to edit the form prior to submittal? Section 1368.015(c)(2)
2.5 Comments	
2.6	Does the online grievance submission process include a current hyperlink to the DMHC’s website? Section 1368.015(c)(3)
2.6 Comments	
2.7	Does the online grievance submission process include the required notice set forth in Section 1368.015(c)(3) ?
2.7 Comments	
2.8	Does the Plan include the required notice language in a manner that is clearly distinguishable from other content on the page? Section 1368.015(c)(3)
2.8 Comments	
2.9	Does the Plan include the required notice language in a legible font size and type? Section 1368.015(c)(3)
2.9 Comments	

GA-002 - Key Element 3: Notice Requirements

3. The Plan publishes the Department's toll-free telephone number, the Department's TDD line, the Plan's telephone number, and the Department's internet website on every plan contract, evidence of coverage, copies of Plan grievance procedures, complaint forms, and on all written notices to enrollees required under the Plan's grievance process, including any written communications to an enrollee that offer the opportunity to participate in the Plan's grievance process and all written responses to grievances.
Health and Safety Code section [1368.02\(b\)](#)

Assessment Questions	
3.1	Does the Plan display the required notice set forth in Section 1368.02(b) in copies of Plan grievance procedures?
3.1 Comments	
3.2	Does the Plan display the required notice set forth in Section 1368.02(b) in Plan complaint/grievance forms?
3.2 Comments	
3.3	Does the Plan display the required notice set forth in Section 1368.02(b) in any written communications to an enrollee offering the opportunity to participate in the Plan's grievance process?
3.3 Comments	
3.4	Does the Plan display the required notice set forth in Section 1368.02(b) in all written responses to grievances?
3.4 Comments	
3.5	Does the Plan display the Department's telephone number, Department's TDD line, Plan's Telephone number, and Department's internet website in 12-point boldface type in all required materials? Section 1368.02(b)
3.5 Comments	

GA 002 – Key Element 4: Plan's Website

4. The Plan's public website includes all elements required by Section 1368.016.

CA Health and Safety Code section [1368.016](#).

NOTE: Key Element 4 is not applicable to Employee Assistance Program (EAP), Chiropractic, Dental, and Vision Plans.

Assessment Questions	
4.1	Does the Plan include on its internet website, or provide a link to a telephone number that the enrollee or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information? Section 1368.016(a)(1)
4.2	Does the Plan include on its internet website, or provide a link to a detailed summary that describes the process by which the Plan reviews, approves, modifies, or denies requests for health care services as described in sections 1363.5 and 1367.01? Section 1368.016(a)(3)
4.3	Does the Plan include on its internet website, or provide a detailed summary of the enrollee grievance process as described in sections 1368 and 1368.015? Section 1368.016(a)(5)
4.4	Does the Plan include on its internet website, or provide a detailed description of how an enrollee may request Continuity of Care pursuant to subdivisions (a) and (b) of section 1373.95? Section 1368.016(a)(6)
4.5	Does the Plan include on its internet website, or provide information concerning the right, and applicable procedure, of an enrollee to request an independent medical review pursuant to section 1374.30? Section 1368.016(a)(7)

End of Requirement GA-002: Enrollee Education

Requirement GA-003: Grievance Receipt

GA-003 - Key Element 1: *Identifying All Expressions of Dissatisfaction as Grievances*

1. The Plan processes all written and oral expressions of dissatisfaction made by an enrollee or the enrollee's representative regarding the Plan and/or provider as grievances.

Health and Safety Code section [1368\(a\)\(1\)](#); 28 CCR [1300.68\(a\)\(1\)](#), (b)(5).

Assessment Question	
1.1	FILE REVIEW: Do the call inquiry files demonstrate the Plan identifies and processes all expressions of dissatisfaction as grievances? Rule 1300.68(a)(1)
1.1 Comments	

GA-003 - Key Element 2: *Immediate Notification to Enrollee for Expedited Grievance*

2. Upon notice of a case requiring expedited review, the Plan immediately informs the enrollee in writing of their right to notify the Department regarding the expedited grievance.

Health and Safety Code section [1368.01\(b\)](#)

Assessment Questions	
2.1	FILE REVIEW: Do the Plan's expedited grievance files demonstrate the Plan immediately informs enrollees of their right to notify the DMHC of the grievance for grievances requiring expedited review? Section 1368.01(b)
2.1 Comments	

GA-003 - Key Element 3: *Acknowledgment Letter*

3. The Plan provides written acknowledgment of all grievances within five calendar days of receipt, advising the enrollee that a grievance has been received, the date of receipt, the name of the Plan representative who may be contacted about the grievance, and the telephone number and address of the Plan representative. Section [1368\(a\)\(1\)](#) and (4)(A)(i)-(iii); Rule [1300.68\(d\)\(1\)](#).

Assessment Questions	
3.1	FILE REVIEW: Do the standard grievance files demonstrate the Plan sends a written acknowledgement letter within five calendar days of the receipt of a grievance? Section 1368(a)(4)(A)
3.1 Comments	

3.2	FILE REVIEW: Do the Plan's standard grievance files demonstrate the acknowledgment letter includes the date the Plan received the grievance? Section 1368(a)(4)(A)(ii)
3.2 Comments	
3.3	FILE REVIEW: Do the Plan's standard grievance files demonstrate the acknowledgment letter includes the name, address and telephone number of the Plan representative who may be contacted about the grievance? Section 1368(a)(4)(A)(iii)
3.3 Comments	

End of Requirement GA-003: Receipt

Requirement GA-004: Grievance Review and Resolution

GA-004 - Key Element 1: *Adequate Consideration of All Issues Raised*

1. The Plan ensures adequate consideration of all issues raised within each grievance.

Section [1368\(a\)\(1\)](#); Rule [1300.68\(a\)](#), (d)(2), (e)(2); Rule [1300.70\(a\)\(1\)](#), (b)(2)(C).

Assessment Questions	
1.1	FILE REVIEW: Do the grievance files demonstrate the Plan's identifies all issues raised within the grievance? Section 1368(a)(1) ; Rule 1300.68(a) , (e)(2)
1.1 Comments	
1.2	FILE REVIEW: Do the grievance files demonstrate the Plan's adequately considers and reviews all issues raised within the grievance? Section 1368(a)(1) ; Rule 1300.68(a) , (e)(2)
1.2 Comments	
1.3	FILE REVIEW: Do the grievance files demonstrate the Plan refers grievances involving quality issues for quality review? Rule 1300.68(d)(2) ; Rule 1300.70(b)(2)(C)
1.3 Comments	

GA-004 - Key Element 2: *Rectification of All Issues Raised*

2. The Plan ensures all issues raised within each grievance are resolved.

Section [1368\(a\)\(1\)](#), (c), Section [1368.01\(a\)](#); Rule [1300.68\(a\)\(4\)\(A\)](#), (e)(2)

Assessment Questions	
2.1	FILE REVIEW: Do the grievance files demonstrate the Plan ensures all issues raised in an enrollee's grievance are resolved? Rule 1300.68(a)(4)(a) , (e)(2)
2.1 Comments	

GA-004 - Key Element 3: *Standard Grievances*

3. The Plan's grievance system resolves all standard grievances within 30 calendar days.

Section [1368.01\(a\)](#); Rule [1300.68\(a\)\(4\)\(A\)](#)

Assessment Questions	
3.1	FILE REVIEW: Do the standard grievance files demonstrate the Plan resolves grievances within 30 calendar days? Section 1368.01(a)
3.1 Comments	

GA-004 - Key Element 4: Exempt Grievances

4. The Plan's grievance system accurately identifies exempt grievances and resolves exempt grievances by the close of the next business day.
Section [1368\(a\)\(4\)\(B\)\(i\)](#); Rule [1300.68\(d\)\(8\)](#)

Assessment Questions	
4.1	FILE REVIEW: Do the Plan's exempt grievance files demonstrate the Plan does not process (i) coverage disputes, (ii) disputed healthcare services involving medical necessity, or (iii) experimental or investigational treatment as exempt grievances? Section 1368(a)(4)(B)(i)
4.1 Comments	
4.2	FILE REVIEW: Do the exempt grievance files demonstrate the Plan resolves exempt grievances by the next business day following receipt? Section 1368(a)(4)(B)(i)
4.2 Comments	

GA-004 - Key Element 5: Expedited Grievances

5. The Plan's grievance system ensures expedited review of grievances involving an imminent and serious threat to the health of the patient.
Section [1368.01\(b\)](#); Rule [1300.68.01](#)

Assessment Questions	
5.1	FILE REVIEW: Do the Plan's expedited grievance files demonstrate the Plan immediately informs enrollees of their right to contact the Department regarding the expedited grievance? Section 1368.01(b), Rule 1300.68.01(a)(1)
5.1 Comments	
5.2	FILE REVIEW: Do the Plan's expedited grievance files demonstrate the Plan provides for the consideration of the enrollee's medical condition when determining a response time? Rule 1300.68.01(a)(3)
5.2 Comments	
5.2	FILE REVIEW: Do the Plan's expedited grievance files demonstrate the Plan provides enrollees with a written notice as to the disposition or pending status of their expedited grievance within three days from receipt of the grievance? Section 1368.01(b)
5.2 Comments	

GA-004 - Key Element 6: Written Responses to Grievances

6. The Plan provides enrollees with written responses to grievances containing a clear and concise explanation of the reasons for the Plan's response.
Section [1368\(a\)\(5\)](#); Rule [1300.68\(d\)\(4\)](#)

Assessment Questions	
6.1	FILE REVIEW: Do the standard and expedited grievance files demonstrate the Plan provides enrollees with written responses to grievances? Section 1368(a)(5)
6.1 Comments	
6.2	FILE REVIEW: Do the standard and expedited grievance files demonstrate the Plan's written responses to grievances include a clear and concise explanation of the reasons for the Plan's response? Section 1368(a)(5)
6.2 Comments	

GA-004 - Key Element 7: Medical Necessity Determination Resolution Letter

7. For grievances involving a determination, in whole or in part, that the service is not medically necessary, the Plan's written response describes the criteria used and the clinical reasons for its decision, advises the determination may be considered by the Department's independent medical review system, and includes an application for an independent medical review, instructions, and an envelope addressed to the DMHC.
Section [1368\(a\)\(5\)](#); Rule [1300.68\(d\)\(4\)](#)

Assessment Questions	
7.1	FILE REVIEW: Do the standard and expedited grievance files involving the delay, modification, or denial of services based on a determination, in whole or in part, that the service is not medically necessary demonstrate the Plan's written responses describe the criteria used? Section 1368(a)(5) ; Rule 1300.68(d)(4)
7.1 Comments	
7.2	FILE REVIEW: Do the standard and expedited grievance files involving the delay, modification, or denial of services based on a determination, in whole or in part, that the service is not medically necessary demonstrate the Plan's written responses describe the clinical reasons for its medical necessity determination? Section 1368(a)(5) ; Rule 1300.68(d)(4)
7.2 Comments	
7.3	FILE REVIEW: Do the standard and expedited grievance files regarding delay, modification, or denial of services based on a determination, in whole or in part, that the service is not medically necessary demonstrate the Plan's written responses advise the enrollee the determination may be considered by the Department's independent medical review system? Rule 1300.68(d)(4)
7.3 Comments	

7.4	FILE REVIEW: Do the standard and expedited grievance files regarding delay, modification, or denial of services based on a determination, in whole or in part, that the service is not medically necessary demonstrate the Plan's written responses include an application for an independent medical review and instructions, including the DMHC's toll-free number, and an envelope addressed to the DMHC, HMO Help Center, 980 Ninth St., 5th Floor, Sacramento, CA 95814? Rule 1300.68(d)(4)
7.4 Comments	

GA-004 - Key Element 8: Benefit Coverage Determination Resolution Letter

8. For grievances involving a determination, in whole or in part, that the service is not a covered benefit, the Plan's written response specifies the provisions of the contract excluding coverage, explains how the exclusion applied to the specific health care service or benefit requested by the enrollee, and advises the enrollee may contact the Department to determine whether the decision is eligible for independent medical review if the enrollee believes the requested services were denied based on medical necessity.
Section [1368\(a\)\(5\)](#); Rule [1300.68\(d\)\(5\)](#)

Assessment Questions	
8.1	FILE REVIEW: Do the standard and expedited grievance files regarding the delay, modification, or denial of services based on a determination the requested service is not a covered benefit demonstrate the Plan's written responses specify the provision in the contract, evidence of coverage, or member handbook that excludes the requested service? Rule 1300.68(d)(5)
8.1 Comments	
8.2	FILE REVIEW: Do the standard and expedited grievance files regarding the delay, modification, or denial of services based on a determination the requested service is not a covered benefit demonstrate the Plan's written responses explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee? Rule 1300.68(d)(5)
8.2 Comments	
8.3	FILE REVIEW: Do the standard and expedited grievance files regarding the delay, modification, or denial of services based on a determination the requested service is not a covered benefit demonstrate the Plan's written responses 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? Rule 1300.68(d)(5)
8.3 Comments	

End of Requirement GA-004: Grievance Review and Resolution

ROUTINE SURVEY TAG

Requirement GA-005: Delegation Oversight

GA-005 - Key Element 1: *Delegated Member Services Oversight*

1. The Plan conducts adequate oversight of delegated member services activities to ensure all expressions of dissatisfaction are processed as grievances.
Section [1368\(a\)\(1\)](#); Rule [1300.68\(a\)\(1\)](#), (b)(1), (c); Rule [1300.70\(b\)\(2\)\(c\)](#)

Assessment Questions	
1.1	Does the Plan maintain adequate oversight mechanisms to ensure its member services delegate identifies all expressions of dissatisfaction as grievances? Section 1368(a)(1); Rule 1300.68(a)(1), (b)(1), and (c)
1.1 Comments	
1.2	Does the Plain perform oversight of delegated member services activities consistent with the requirements of its quality assurance program and the terms of its delegation contract? Section 1368(a)(1); Rule 1300.70(b)(2)(C)
1.2 Comments	

GA-005 - Key Element 2: *Recording, Reporting, and Monitoring Capabilities of Grievances Received and/or Resolved By Delegates*

2. The Plan maintains a grievance system capable of tracking, monitoring, and reporting all grievances received by its delegates in accordance with the Department's regulations.
CA Health and Safety Code [1368\(a\)](#); Rule [1300.68\(a\)\(1\)](#), (b)(1), (d), (e); Rule [1300.69\(f\)](#); Rule [1300.70\(b\)\(2\)\(C\)](#)

Assessment Questions	
2.1	Does the Plan's grievance system track and monitor grievances delegated to another entity responsible for receiving and/or responding to grievances? Rule 1300.68(b)(1)
2.1 Comments	
2.2	Does the Plan include grievances received and/or responded to by its delegates when tracking and monitoring the number of grievances received and resolved? Rule 1300.68(e)(1)
2.2 Comments	
2.3	Does the Plan include grievances received and/or responded to by its delegates when tracking and monitoring whether grievances are resolved in favor of the enrollee or the Plan? Rule 1300.68(e)(1)
2.3 Comments	
2.4	Does the Plan include grievances received and/or responded to by its delegates when tracking and monitoring grievances pending over 30 calendar days? Rule 1300.68(e)(1)
2.4 Comments	

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2.5	Does the Plan include grievances received and/or responded to by its delegates when reporting the total number of grievances received, pending, and resolved in favor of the enrollee at all levels of grievance review, including the Department's consumer complaint process and Independent Medical Review system? Rule 1300.68(e)(1)-(2)
2.5 Comments	
2.6	Is the Plan's grievance system capable of describing the issue or issues raised in grievances received and/or responded to by its delegates 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? Rule 1300.68(e)(2)
2.6 Comments	
2.7	If the Plan delegates responsibility for receiving and/or responding to exempt grievances to another entity, does the Plan's grievance system maintain a written record of exempt grievance received and/or responded to by its delegates with the following information: • the date of the call, • the name of the complainant, • the complainant's member identification number, • the nature of the grievance, • the nature of the resolution, • and the name of the plan representative who took the call and resolved the grievance? Section 1368(a)(4)(B)(i)(I)-(V); Rule 1300.68(d)(8)
2.7 Comments	
2.8	Did the Plan demonstrate the plan officer designated as having primary responsibility for the Plan's grievance system includes grievances delegated to another entity in their continuous review of grievance system operations? Rule 1300.68(b)(1)
2.8 Comments	
2.9	Does the written grievance record periodically reviewed by the Plan's governing body include grievances received and/or responded to by its delegates? Rule 1300.68(b)(5); Rule 1300.70(b)(2)(C)
2.9 Comments	
2.10	Does the written grievance record periodically reviewed by the Plan's public policy body include grievance received and/or responded to by its delegates? Rule 1300.68(b)(5); Rule 1300.69(f)
2.10 Comments	

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GA-005 - Key Element 3: Delegated Grievance Functions

- 3. The Plan conducts adequate oversight of delegated grievance activities to ensure all expressions of dissatisfaction are processed consistent with the requirements of the Act and the Department's regulations.**

Section [1368\(a\)\(1\)](#); [1300.68\(a\)\(1\)](#), (b)(1); [1300.70\(a\)\(1\)](#), (b)(2)(c)

Assessment Questions	
3.1	Does the Plan maintain adequate oversight mechanisms to ensure its delegate processes all grievances consistent with applicable statutory and regulatory requirements? Section 1368(a)(1); Rule 1300.68(a) and (c)
3.1 Comments	
3.2	Does the Plan monitor grievances resolved by delegated entities for emergent patterns? Section 1368(a)(1); Rule 1300.68(b)(1)
3.2 Comments	
3.3	If any emergent patterns of grievances processed by its delegate are identified, does the Plan take appropriate action to correct the problems and, where indicated, perform follow-up to confirm the effectiveness of its remedial measures? Section 1368(a)(1); Rule 1300.68(b)(1); Rule 1300.70(a)(1)
3.3 Comments	
3.4	Does the Plan perform oversight of delegated grievance functions consistent with the requirements of its quality assurance program and the terms of its delegation contract? Section 1368(a)(1); Rule 1300.70(b)(2)(C); Section 1368(b)(1)
3.4 Comments	

End of Requirement GA-005: Delegation Oversight

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Statutory/Regulatory Citations

CA Health and Safety Code section 1367.01(e),(h)(3), and (j)

GA-001 KE2 (j); **GA-003 KE4** (e); **GA-005 KE3** (h)(3).

(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).

...

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

...

(j) A 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 1367.043(a)(4)

GA-001 KE4

(a)(1) Within six months after the department issues guidance pursuant to paragraph (1) of subdivision (e), and no later than March 1, 2025, a health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, but not including specialized health care service plan contracts that provide only dental or vision services, shall require all of its

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health care service plan staff who are in direct contact with enrollees in the delivery of care or enrollee services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI).

...

(4) After first-time completion of the evidence-based cultural competency training, in the form of initial basic training, an individual described in paragraph (1) shall complete a refresher course if a complaint has been filed with the health care service plan or the department pursuant to Section 1368, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary by the health care service plan or the department for purposes of providing trans-inclusive health care.

CA Health and Safety Code section 1368(a)(1), (a)(4)(B)

GA-001 KE1 (a)(1), **KE2**, **KE3**; **GA-003 KE2** (a)(4)(B); **KE3** (a)(4)(B); **GA-004 KE1** (a)(2).

(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)(i) 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.

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CA Health and Safety Code section 1368.01(a)

GA-003 [KE2](#) (a); [KE3](#) (a); **GA-004** [KE2](#), [KE3](#), [KE5](#); **GA-005** [KE1](#) (b); [KE3](#) (b).

(a) The grievance system shall require the plan to resolve grievances within 30 days, except as provided in subdivision (c).

(b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health 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 notify the 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.

CA Health and Safety Code section 1368.015

GA-002 [KE2](#), [KE4](#)

(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:

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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.”

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.

(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.

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(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 1368.016

GA-002 KE5

(a) A health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall, pursuant to subdivision (f) of Section 1368.015, include on its Internet Web site, or provide a link to, the following information:

(1) A telephone number that the enrollee or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.

(2) A link to prescription drug formularies posted pursuant to Section 1367.205, or instructions on how to obtain the formulary, as described in Section 1367.20.

(3) A detailed summary that describes the process by which the plan reviews and authorizes or approves, modifies, or denies requests for health care services as described in Sections 1363.5 and 1367.01.

(4) Lists of providers or instructions on how to obtain the provider list, as required by Section 1367.27.

(5) A detailed summary of the enrollee grievance process as described in Sections 1368 and 1368.015.

(6) A detailed description of how an enrollee may request continuity of care pursuant to subdivisions (a) and (b) of Section 1373.95.

(7) Information concerning the right, and applicable procedure, of an enrollee to request an independent medical review pursuant to Section 1374.30.

(b) Any modified material described in subdivision (a) shall be updated at least quarterly.

(c) The information described in subdivision (a) may be made available through a secured Internet Web site that is only accessible to enrollees.

(d) The material described in subdivision (a) shall also be made available to enrollees in hard copy upon request.

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(e) Nothing in this article shall preclude a health care service plan from including additional information on its Internet Web site for applicants, enrollees or subscribers, or providers, including, but not limited to, the cost of procedures or services by health care providers in a plan's network.

(f) The department shall include on the department's Internet Web site a link to the Internet Web site of each health care service plan and specialized health care service plan described in subdivision (a).

(g) This section shall not apply to Medicare supplement insurance, Employee Assistance Programs, short-term limited duration health insurance, Champus-supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health care service plans, except behavioral health-only plans.

(h) This section 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 Web site to an Internet Web site 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 this section or Section 10123.199 of the Insurance Code.

CA Health and Safety Code section 1368.02(b)

GA-002 [KE3](#), [KE4](#) (b); **GA-003** [KE2](#) (b); [KE4](#) (b); **GA-004** [KE2](#) (b); **GA-005** [KE3](#) (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 1370.2

GA-003 [KE4](#)

Upon an appeal to the plan of a contested claim, the plan shall refer the claim to the medical director or other appropriately licensed health care provider. This health care provider or the medical director shall review the appeal and, if he or she determines that he or she is competent to evaluate the specific clinical issues presented in the claim, shall make a determination on the appealed claim. If the health care provider or medical director determines that he or she is not competent to evaluate the specific clinical issues of the appealed claim, prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented in the claim. For the purposes of this section, “competent to evaluate the specific clinical issues” means that the reviewer has education, training, and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested claim. The requirements of this section shall apply to claims that are contested on the basis of a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized. The plan shall determine whether or not to use an appropriate specialist provider in the review of contested claims.

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CA Health and Safety Code section 1374.30(e), (i), (j)(1) and (3) (l), (m), (n)
GA-003 KE4 (m); GA-004 KE3 (i); GA-005 KE1 (e), (j)(1) and (3), and (l) KE2 (n).

(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.

...

(j) An enrollee may apply to the department for an independent medical review when all of the following conditions are met:

(1)(A) The enrollee's provider has recommended a health care service as medically necessary, or

(B) The enrollee has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.

For purposes of this article, the enrollee's provider may be an out-of-plan provider.

However, the plan shall have no liability for payment of services provided by an out-of-plan provider, except as provided pursuant to subdivision (c) of Section 1374.34.

(3) The enrollee has filed a grievance with the plan or its contracting provider pursuant to Section 1368, and the disputed decision is upheld, or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the plan's grievance process for more than 30 days. In the case of a grievance that requires expedited review pursuant to Section 1368.01, the enrollee shall not be required to participate in the plan's grievance process for more than three days.

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(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.

CA Health and Safety Code section 1374.31

GA-005 [KE1](#); [KE2](#) (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.

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(b) The department shall expeditiously review requests and immediately notify the enrollee in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefore. The plan shall promptly issue a notification to the enrollee, after submitting all of the required material to the independent medical review organization that includes an annotated list of documents submitted and offer the enrollee the opportunity to request copies of those documents from the plan. The department shall promptly approve enrollee requests whenever the enrollee's plan has agreed that the case is eligible for an independent medical review. The department shall not refer coverage decisions for independent review. To the extent an enrollee request for independent review is not approved by the department, the enrollee request shall be treated as an immediate request for the department to review the grievance pursuant to subdivision (b) of Section 1368.

(c) An independent medical review organization, specified in Section 1374.32, shall conduct the review in accordance with Section 1374.33 and any regulations or orders of the director adopted pursuant thereto. The organization's review shall be limited to an examination of the medical necessity of the disputed health care services and shall not include any consideration of coverage decisions or other contractual issues.

CA Health and Safety Code section 1374.34(a)

GA-005 KE3 (a).

(a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall 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, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

28 CCR 1300.68(a), (a), (b)(3)-(b)(8), (d)(1)-(8), (e) and (f)(1)

GA-001 KE1 (a), (b)(3), (b)(8), (d)(6); KE2 (b)(1) and (5), (d)(2); KE3 (b)(5), (d)(8), (e) and (f)(1); GA-002 KE1 (b)(6) and (7), KE2 (b)(4), KE3 (b)(3), GA-003 KE1 (d)(1), KE2 (a)(4)(A), (b)(3) and (d)(3); KE3 (a)(4)(A), (b)(3), (d)(3); KE4 (b)(3), (d)(4), (5) and (7); GA-004 KE1 (b)(2) and (9); GA-005 KE3 (d)(3), (4), and (5). (a)(4)(A), (b)(3) and (d)(3).

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:

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(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:

...

(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.

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(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.

...

(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, telephone number and address of the plan representative who may be contacted 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.

(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.

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(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).

(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

ROUTINE SURVEY TAG

(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)

GA-004 KE5; GA-005 KE1 (a)-(b); KE2 (b), KE3 (a)-(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.

(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:

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(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 1300.69(f)

GA-001 [KE 3](#)

Unless a plan complies with the requirements of the Health Maintenance Organization Act of 1973 in affording subscribers and enrollees procedures to participate in establishing the public policy of the plan, as defined in Section 1369 of the Act, it shall comply with each of the following requirements:

...

(f) Enrollees and subscribers participating in establishing public policy shall have access to information available from the plan regarding public policy, including financial information and information about the specific nature and volume of complaints received by the plan and their disposition.

28 CCR 1300.70(a)(1) and (b)(2)(C)

GA-001 [KE2](#), **GA-001** [KE3](#), **GA-004** [KE1](#); **GA-005** [KE1](#), [KE2](#), [KE3](#)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

...

(b) Quality Assurance Program Structure and Requirements.

...

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

...

ROUTINE SURVEY TAG

(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

28 CCR 1300.70.4(a)

GA-005 KE1 (a).

(a) Enrollees of a health care services plan may request an independent medical review pursuant to sections 1370.4, 1374.30 through 1374.34 of the Act and section 1300.74.30 of title 28 when the plan has denied a therapy or medical service that would otherwise be covered based on the plan's determination that the therapy or medical service is experimental or investigational. This eligibility also applies to Medicare enrollees to the extent it does not conflict with federal law.

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28 CCR 1300.74.30(a)-(c), and (d)(4)

GA-005 KE1 (a)-(c) and (d)(4); **KE2** (j)-(k).

(a) Plan enrollees may request independent medical review pursuant to this regulation for decisions that are eligible for independent medical review under Article 5.55 and section 1370.4 of the Act. The independent medical review process shall resolve decisions that deny, modify, or delay health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies. Specialized plans shall provide for independent medical reviews under this section if a covered service relates to the practice of medicine or is provided pursuant to a contract with a health plan providing medical, surgical and hospital services. The Department shall be the final arbiter when there is a question as to whether a dispute over a health care service is eligible for independent medical review, and whether extraordinary and compelling circumstances exist that waive the requirement that the enrollee first participate in the plan's grievance system.

(b) An enrollee may apply for an independent medical review under the conditions specified in Section 1374.30(j) of the Act. The Department may waive the requirement that the enrollee participate in the plan's grievance process if the Department determines that extraordinary and compelling circumstances exist, which include, but are not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the enrollee.

(c) In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the independent medical review shall determine whether the services were emergency or urgent services necessary to screen and stabilize the enrollee's condition. For purposes of this section "emergency services" are services for emergency medical conditions as defined in section 1300.71.4 of title 28, and "urgent services" are all services, except emergency services, where the enrollee has obtained the services without prior authorization from the plan, or from a contracting provider.

(d) Applications for independent medical review shall be submitted on a one-page form entitled Independent Medical Review Application (DMHC IMR 11/00), which is incorporated by reference, and shall be provided by the Department. The form shall contain a signed release from the enrollee, or a person authorized pursuant to law to act on behalf of the enrollee, authorizing release of medical and treatment information. Additionally, the enrollee may provide any relevant material or documentation with the application including, but not limited to:

...

(4) If expedited review is requested for a decision eligible for independent medical review pursuant to Article 5.55 of the Act, the application shall include a certification from the enrollee's physician or provider indicating that an imminent and serious threat to the health of the enrollee exists. If expedited review is requested for a decision eligible for independent medical review pursuant to section 1370.4 of the Act, the application shall include a certification from the enrollee's physician that the proposed therapy would be significantly less effective if not promptly initiated.

...

ROUTINE SURVEY TAG

(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;

(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 on-going 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.