Policy:	GG.1510
Title:	**Member Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 02/14/2025*
Effective Date:	01/01/2007
Revised Date:	02/01/2025
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This Policy describes the process by which CalOptima Health reviews, addresses, and resolves standard and expedited, pre-service and post-service, Member Appeals of Adverse Benefit Determinations, which also includes the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.

II. POLICY

A. CalOptima Health shall establish and maintain an Appeal Process pursuant to applicable statutory, regulatory, and contractual requirements.

B. A Member, or a Provider or Authorized Representative acting on behalf of the Member, and with the Member's written consent, has the right to file an Appeal in the timeframes set forth in this Policy.

C. CalOptima Health's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

D. CalOptima Health shall assist a Member requiring assistance with filing an Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs and in accordance with Section II.R.1.a-c. of this Policy.

E. CalOptima Health shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

F. Subject to the provisions of this Policy, CalOptima Health shall resolve a standard Appeal request within thirty (30) calendar days after receipt of the Appeal, regardless of whether the oral Appeal is followed by a written Appeal.

G. Subject to the provisions of this Policy, CalOptima Health shall resolve an expedited Appeal no later than seventy-two (72) hours after receipt of such Appeal request.

H. CalOptima Health shall refer all Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima Health's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

I. CalOptima Health shall inform a Member during the Appeal Process of their right to request a State Hearing after the internal Appeal Process has been exhausted or should have been exhausted, and of their right to Aid Paid Pending (i.e., continuation of benefits), in accordance with CalOptima Health Policies HH.1108: State Hearings Process and Procedures, and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

J. Continuation of Benefits Pending an Appeal (i.e., Aid Paid Pending)

1. CalOptima Health shall advise and assist the Member with the provision of Aid Paid Pending, regardless of whether the Member makes a separate request to CalOptima Health during the Appeal process, if all of the following conditions are met:

    a. The Member filed their Appeal within the required timeframes for Aid Paid Pending (within ten (10) calendar days of when the Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) was sent or before the intended effective date of the proposed action, whichever is later), as set forth in Title 42 of the Code of Federal Regulations (CFR) Section 438.420;

    b. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

    c. The Covered Services were ordered by the Member's Provider; and

    d. The period covered by the original authorization has not expired.

2. If CalOptima Health, at the Member's request, continues or reinstates the provision of disputed services while an Appeal is pending, those services must continue until one (1) of the following occurs:

    a. Member withdraws their request for an Appeal or a State Hearing;

    b. The Member fails to request a State Hearing and continuation of disputed services within ten (10) calendar days of when the NOA was sent; or

    c. The final State Hearing decision is adverse to the Member.

K. CalOptima Health or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal or State Hearing was pending. CalOptima Health shall ensure the Member is not billed for the continued services even if the State Hearing or Independent Medical Review (IMR) finds the disputed services were not Medically Necessary.

L. Neither CalOptima Health, nor any of its Health Networks, Practitioners, or other Providers shall discriminate against a Member, or a Provider or Member's Authorized Representative on the grounds that they filed an Appeal, in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

M. A NABD/ NOA sent by CalOptima Health or a Health Network notifying a Provider or a Member of a CalOptima Health or Health Network decision to delay, deny, modify, or recommend an

alternative option to a requested service, shall inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.

N. The Member Appeal Process set forth in this Policy is a separate process from the Member Grievance Process in CalOptima Health Policy HH.1102: Member Grievance, and Member State Hearing Process in CalOptima Health Policy HH.1108: State Hearing Process and Procedures. It is also separate from Provider processes in CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

O. Any changes to CalOptima Health's Grievance and Appeals Policies and Procedures shall be communicated to its Providers, Subcontractors and Downstream Subcontractors in accordance with CalOptima Health Policy EE.1103: Provider Network Training.

P. A Provider may request an Appeal on their own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

Q. A Provider, with the Member's written consent, may request an Appeal on behalf of the Member, for services rendered to that CalOptima Health Member, by submitting a written request to CalOptima Health within sixty (60) calendar days from the date of the NABD/NOA from CalOptima Health or a Health Network, in accordance with the provisions of this Policy.

R. CalOptima Health shall give a Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and law in support of the Appeal. CalOptima Health shall inform the Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Appeals.

1. Timeframes are as follows:

Appeal Request Type	Timeline Requirements	Extension
Standard Pre-Service	Thirty (30) calendar days	N/A
Standard Post Service	Thirty (30) calendar days	N/A
Expedited Pre-Service	Seventy-two (72) hours	N/A
Expedited Post Service	Seventy-two (72) hours	N/A

S. CalOptima Health and its Health Networks shall provide culturally and linguistically appropriate notices of the Appeals process to Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services, including but not be limited to, Acknowledgement Letters and Notices of Appeal Resolution.

1. CalOptima Health shall provide assistance to Members or a Member's Authorized Representative, with disabilities, limited English proficiency, vision disorders, or other communicative impairments, when completing Appeal forms and other procedural steps, including but not limited to, providing all documents relied on for CalOptima Health's decision to the Member, in addition to the following services in accordance with CalOptima Health Policy DD.2002 Cultural and Linguistic Services:

a. Alternative formats (as set forth in All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services),

b. Providing Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability; and

c. Assistance in the Appeal Process, or to provide translation of Appeal correspondence.

T. A Member may be represented by anyone they choose during the Appeal Process, including a legal representative.

U. The Member has the right to request an Appeal in the event CalOptima Health or a Health Network fails to issue a NABD/NOA within the required time frame, which shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

V. CalOptima Health shall provide, upon request by the Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, before and during the Appeals Process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals Process. CalOptima Health shall provide records at no cost.

W. CalOptima Health shall ensure that the person reviewing the Appeal was not involved in the initial determination and they are not the subordinate of any person involved in the initial determination.

X. CalOptima Health shall ensure that for Appeals, the person making the final decision for the proposed resolution of an Appeal has not participated in any prior decisions related to the Appeal.

Y. All Medical Appeals are referred to the Chief Medical Officer (CMO) or to their Designee who has the authority to require corrective action and is of the same or similar specialty, has clinical expertise in treating the Member's condition or disease, and is able to treat complications that may result from the service or procedure, if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity or experimental/clinical investigation; and

2. Any Appeal involving clinical issues.

Y. Upon notice of a CalOptima Health decision to deny an authorization request, a Member, or a Provider or Authorized Representative acting on behalf of the Member, and with the Member's written consent, may request an expedited Appeal in accordance with Section III.D. of this Policy, when it is determined or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Z. CalOptima Health and a Health Network shall provide the CalOptima Health Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract, on an annual basis, and when CalOptima Health's relevant grievance and appeals policies and procedures are updated.

AA. CalOptima Health shall provide language assistance to Members, by CalOptima Health staff or language line interpreter services, for Threshold Languages to register and resolve Appeals.

BB. In addition to any rights set forth in this Policy, a Member or a Member's Authorized Representative shall also have the right to:

1. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Health Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

2. CalOptima Health shall inform a Member of such State Hearing rights annually, and in every Notice of Appeal Resolution (NAR) letter.

CC. If CalOptima Health fails to provide adequate notice to a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within applicable federal or state timeframes, and in accordance with CalOptima Health Policy: DD.2002: Cultural and Linguistic Services, then the Member is deemed to have exhausted CalOptima Health's internal Appeal process and may immediately request a State Hearing, in accordance with CalOptima Health Policy HH.1108: State Hearings Process and Procedures.

DD. Responsible staff-

1. CalOptima Health's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Appeal Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima Health's administration of the program.

2. CalOptima Health's Director of GARS shall have primary responsibility for the oversight of the Appeal Process.

III. PROCEDURE

A. Assistance to Members

1. CalOptima Health and a Health Network shall make Grievance and Appeal forms and procedures for filing an Appeal available to facilities that provide Covered Services to Members.

2. CalOptima Health shall provide the Grievance and Appeal forms and procedures to a Member upon request.

3. CalOptima Health's Customer Service Department shall assist a Member with questions regarding the procedures for filing an Appeal and shall triage Member calls and route Appeals to GARS via an electronic system.

B. Request for a Pre-Service Appeal (Standard and Expedited)

1. A CalOptima Health Member, or a Provider or Authorized Representative acting on behalf of a Member, and with the Member's written consent, may request a standard or expedited Appeal within sixty (60) calendar days from the date of the NABD/NOA from CalOptima Health or a Health Network orally or in writing by the following methods:

   a. Make a request to CalOptima Health's Customer Service Department, by telephone, or in person; or

b. Make a request to CalOptima Health GARS, by facsimile, in writing, or through the CalOptima Health Website at www.caloptima.org.

C. Pre-Service Appeal Processing (Standard and Expedited)

1. Standard and Expedited Pre-Service Appeal Processing

a. Upon receipt of a request for Appeal, GARS shall:

i. Date stamp and document the substance of the Appeal, and any action taken, in the GARS database, verifying demographics, and network affiliation.

ii. Determine the category of Appeal (coverage dispute, Medical Necessity, non-coverage appeal, and other) based on the Appeal, assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

b. GARS staff shall review and immediately process all Appeals of an imminent and serious threat to the health of a Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima Health shall provide oral notice of the resolution of an expedited review as required in the CalOptima Health contract with the Department of Health Care Services (DHCS), in accordance with procedures outlined in Section III.D. of this Policy.

c. If CalOptima Health extends the timeframe for an expedited Appeal determination by denying the request for an expedited Appeal, then GARS staff shall notify the Member as follows:

i. Verbal Notification: Notify the Appealing Party and all involved parties of the decision to extend the timeframe for an Appeal determination, verbally, no later than one (1) business day of such decision; and

ii. Written Notification: Notify the Member of the decision, in writing, no later than two (2) calendar days of the verbal notice and include:

a. The reason for the extension; and

b. The Member's right to file a Grievance, in accordance with CalOptima Health Policy HH.1102: Member Grievance Process, if they disagree with CalOptima Health's decision to extend the timeframe.

2. Standard Pre-Service Appeal Processing

a. GARS staff shall process the Appeal regardless of whether a signed written Appeal request is received subsequently from the Member.

b. GARS staff shall send a Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, an Acknowledgment Letter within five (5) calendar days after receipt of an Appeal, that includes the following information:

i. An acknowledgement that the Appeal was received;

ii. The name, telephone number, and address of the GARS staff member who may be contacted regarding the Appeal;

iii. An estimated completion date of resolution;

iv. Notice that the appealing party may submit additional information (written or in person) and/or request to review or obtain a copy of the records in connection with the Appeal.

c. GARS staff shall send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member.

i. The date of the oral Appeal establishes the filing date for the Appeal.

d. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Appeal.

e. Ensure an appeals nurse specialist in CalOptima Health's GARS Department investigates the Appeal, including any aspects of clinical care involved, by:

i. Reviewing the initial decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records, or other information supplied by a Provider, or Member without regard to whether such information was submitted or considered in the initial action;

ii. Obtaining and reviewing the Health Network's initial decision and supporting documentation, including relevant Medical Records; and

iii. Preparing the case file for review by CalOptima Health's CMO or their Designee.

f. CalOptima Health shall utilize specialist consultants, as appropriate.

g. Escalate the Appeal for review of the factual findings, proposed resolution, and any other relevant information, in accordance with CalOptima Health Policy HH.1109: Complaint Decision Matrix and shall issue a decision with respect to the Appeal.

h. Send the Member a NAR letter within thirty (30) calendar days after receipt of the Appeal.

i. The NAR letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a) The results of the resolution and the date it was completed;

b) If CalOptima Health upholds a denial determination that is based in whole or in part on Medical Necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

c) If CalOptima Health upholds a denial based on a determination that the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service:

1) Identify the document and page or section containing the provision, or provide a copy of the provision;

2) If the requested service is a code listed as a non-benefit in the Medi-Cal Treatment Authorization (TAR) and Non-Benefit list of codes, then this shall not be the sole reason for denial and any other reason(s) must also be included in the explanation (for example, the services were determined to be not medically necessary and/or did not meet other criteria considered).

d) If CalOptima Health overturns the denial determination, a clear and concise explanation of why the decision was overturned;

e) Any referrals to the Quality Improvement (QI) Department for quality of care review;

f) Alternative resources or references, when applicable;

g) The State Hearing process and Member's right to request and receive Aid Paid Pending while the State Hearing is pending and instructions on how to request Aid Paid Pending, including the timeframe in which the request shall be made; and

h) For Appeals in which CalOptima Health holds a denial determination, the "Your Rights" template.

i. Translate NAR letters into Threshold Languages and offer oral interpretation for a NAR letter for all other languages, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

j. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the NAR letter in the electronic file and document any oral notification provided to the Member.

3. Expedited Pre-Service Appeal Processing

a. If CalOptima Health determines, for a request from a Member, or when the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, or a Provider or Member's Authorized Representative acting on behalf of the Member and with the Member's written consent, may request an expedited Appeal to CalOptima Health as follows:

i. A CalOptima Health Member, or a Provider or Member's Authorized Representative acting on behalf of the CalOptima Health Member and with the Member's written consent, may request an expedited Appeal by contacting CalOptima Health's Customer Service Department by telephone or in-person, or contacting CalOptima Health's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Health Website at www.caloptima.org.

ii. CalOptima Health staff shall inform the Member of limited time to present evidence in person or writing to support the Appeal.

b. Upon receipt of a Member request for an expedited Appeal, CalOptima Health's CMO or Designee shall review the request to determine if the expedited review criteria is met and shall conduct a medical review, as deemed necessary, based on whether a delay:

i. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or

ii. In the opinion of a Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

c. CalOptima Health shall grant expedited Appeal requests concerning admission, continued stay or other health care services for a Member who has received emergency services but, has not been discharged from a facility.

d. Expedited Appeals filed by a physician shall be processed as expedited without further review.

e. CalOptima Health shall utilize specialist consultants, as appropriate.

f. CalOptima Health shall resolve an expedited Appeal as quickly as the medical decision requires but no later than seventy-two (72) hours after CalOptima Health receives the expedited Appeal request.

g. CalOptima Health shall notify a Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, within twenty-four (24) hours, by telephone, and written notice within two (2) calendar days of the oral notice if the Appeal does not meet expedited Appeal criteria.

h. CalOptima Health shall notify the Member, or a Provider or Authorized Representative acting on behalf of the CalOptima Health Member with the Member's written consent, of the expedited Appeal decision through oral notice or in writing within seventy-two (72) hours after receiving the expedited Appeal request. CalOptima Health shall provide a written notice within one (1) business day after an oral notice.

4. Pre-service Appeals Resolution (Standard and Expedited)

a. Except as otherwise provided in Section III.C.3. of this Policy, CalOptima Health shall send to the Member and Providers, as appropriate, a NAR within thirty (30) calendar days after receipt of the Appeal.

b. If CalOptima Health completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima Health shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

c. If CalOptima Health does not completely overturn the denial, such written notice shall include information including: the title, qualification and specialty of the person making the decision, how the Member or Provider may obtain copies of the Appeal file documentation or criteria used to make the Appeal decision, the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Health Policy HH.1108: State Hearing Process and Procedures, and the Member's right to have a representative act on their behalf for an Appeal.

d. If CalOptima Health upholds a decision involving the delay, denial, or modification of health care services, the NAR shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal

decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

e. If CalOptima Health upholds an Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the NAR shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested, or at a minimum, must include:

   i. The Member's rights to request a State Fair Hearing;

   ii. How to request a State Fair Hearing;

   iii. The right to continue to receive Covered Services pending a State Fair Hearing;

   iv. How to request Aid Paid Pending and requirements to file a continuation within ten (10) calendar days of when the NABD/NOA was sent or before the intended effective date of the proposed action; and

   v. The DHCS-approved "Your Rights" attachment.

f. CalOptima Health and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

D. Post-service Appeal Processing

1. CalOptima Health Grievance and Appeals Resolution Services staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the Member, provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative or Provider.

2. A Grievance and Appeals Resolution Services Appeals nurse shall investigate, review and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or their Designee for review.

3. All medical Appeals are referred to the CMO or their Designee who has the authority to require corrective action, is of the same or similar specialty, is able to treat complications that may result from the service or procedure and did not make the initial utilization management decision.

4. CalOptima Health shall utilize specialist consultants as appropriate.

5. Post-service Appeals Resolution

   a. CalOptima Health shall send to the Member and Providers, as appropriate, a NAR within thirty (30) calendar days after receipt of the Appeal

   b. If CalOptima Health completely overturns the decision, the NAR shall state the decision and the date of the decision. CalOptima Health shall also ensure the written response sent to the appealing party contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

c. If CalOptima Health does not completely overturn the decision, such written notice shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the right to continue to receive benefits pending a State Hearing, and the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Health Policy HH.1108: State Hearing Process and Procedures and the Member's right to have a representative act on their behalf when they appeal.

d. If CalOptima Health upholds an Appeal decision, in whole or in part, the NAR shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member, or at a minimum, must include:

   i. The Member's right to request a State Fair Hearing;

   ii. How to request a State Fair Hearing;

   iii. The right to continue to receive benefits pending a State Fair Hearing (Aid Paid Pending);

   iv. How to request the continuation of benefits (Aid Paid Pending) and requirements to file a continuation within ten (10) calendar days of when the NABD/NOA was sent or before the intended effective date of the proposed action; and

   v. The DHCS-approved "Your Rights" attachment.

e. CalOptima Health and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

6. External Appeals

a. CalOptima Health shall annually inform Members of the right to a State Hearing through the Medi-Cal Member Newsletter, including that the information is also available on the CalOptima Health Website at www.caloptima.org. CalOptima Health must also advise Members of their right to file an expedited State Hearing.

b. CalOptima Health shall include written or electronic notifications to Members in the resolution letter detailing the State Hearing rights, time limitations and processes, including the contact information for the California Department of Social Services.

c. In the event CalOptima Health fails to meet or respond to the thirty (30) calendar day resolution timeline or comply with the notice requirements of Title 42 C.F.R. section 438.10, the Member is deemed to have exhausted CalOptima Health's internal Appeal Process and may initiate a State Hearing, in accordance with CalOptima Health Policy HH.1108: State Hearing Process and Procedures.

d. A Member eligible with California Children's Services (CCS) and transitioned into the Whole-Child Model (WCM) Program, the Member's family or designated caregiver may appeal a Continuity of Care limitation, in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services and this Policy.

E. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima Health shall inform a Member, in writing, of the locations and telephone numbers where an Appeal should be submitted, and related procedures regarding these processes. CalOptima Health shall provide these notices in Threshold Languages, as required by CalOptima Health's contract with the Department of Health Care Services (DHCS).

2. CalOptima Health shall maintain written records of each Appeal, including the date of receipt, Member's name, description of the problem, names of the CalOptima Health staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima Health's contract with DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima Health shall continually evaluate and analyze Appeal data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.

4. CalOptima Health shall submit a monthly report of complete, accurate, reasonable, and timely aggregated Appeal data within ten (10) calendar days following the end of each month or as otherwise agreed upon by DHCS, and in the format specified with DHCS, in accordance with this Policy and CalOptima Health Policy AA.1270: Certification of Document and Data Submissions.

5. CalOptima Health shall submit, on a quarterly basis, aggregate and detailed Appeals data to the Quality Assurance Committee.

6. CalOptima Health shall submit a report of Appeals related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima Health shall not be responsible for reporting Appeals or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Appeal was reported to the County of Orange or MSSP site.

7. CalOptima Health shall establish and maintain a system of aging of Appeals that are pending and unresolved for thirty (30) calendar days or more.

8. The written record of Appeals shall be reviewed periodically by CalOptima Health's Governing Board, the Member Advisory Committee (MAC), and Provider Advisory Committee (PAC) and the Chief Operations Officer (COO) or designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.

    a. GARS shall present to the QIHEC on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1270: Certification of Document and Data Submissions
C. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
CalOptima Health Policy EE.1103: Provider Network Training
D. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
E. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
G. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
H. CalOptima Health Policy HH.1102: Member Grievance
I. CalOptima Health Policy HH.1104: Complaints of Discrimination
J. CalOptima Health Policy HH.1108: State Hearing Process and Procedures
K. CalOptima Health Member Handbook
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-017: Requirements for Reporting Managed Care Program Data (Supersedes APLs 14-013 (Revised) and 14-012)
M. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Template (Supersedes APL 17-006)
N. Department of Health Care Services All Plan Letter (APL) 22-002: Alternative Format Selection For Members With Visual Impairments
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-012: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX (Supersedes APL 20-020)
P. Department of Health Care Services All Plan Letter (APL) 23-032: Enhanced Care Management Requirements (Supersedes APL 21-012)
Q. Title 22, California Code of Regulations (C.C.R.), §§ 51014.2, and 53858
R. Title 28, California Code of Regulations (C.C.R.), §§ 1300.68 (except Subdivision 1300.68(c)(g) and (h)), and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
S. Title 42, Code of Federal Regulations (C.F.R.), § 438.10, 438.402-424

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/22/2015	Department of Health Care Services (DHCS)	Approved as Submitted
02/03/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
07/01/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/31/2025	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	06/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2011	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2012	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	09/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	11/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	04/01/2016	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/07/2019	GG.1510	Appeal Process	Medi-Cal
Revised	05/01/2021	GG.1510	Appeal Process	Medi-Cal
Revised	05/05/2022	GG.1510	Member Appeal Process	Medi-Cal
Revised	06/01/2022	GG.1510	Member Appeal Process	Medi-Cal
Revised	11/01/2022	GG.1510	Member Appeal Process	Medi-Cal
Revised	07/01/2024	GG.1510	Member Appeal Process	Medi-Cal
Revised	09/01/2024	GG.1510	Member Appeal Process	Medi-Cal
Revised	02/01/2025	GG.1510	Member Appeal Process	Medi-Cal

IX. GLOSSARY

Term	Definitions
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
Adverse Benefit Determination	Any of the following actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or Level of Service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR section 447.45(b) is not an Adverse Benefit Determination. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. For a resident of a rural area with only one MCP, the denial of the Member's request to obtain services outside the network. 7. The denial of a Member's request to dispute financial liability.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Appeal Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver

Term	Definitions
	authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;

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	12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Governing Board	CalOptima Health's board of directors or a similar body, and/or its executive management, that has the authority to manage and direct CalOptima Health's affairs and activities, including, but not limited to, approving initiatives and establishing CalOptima Health's policies and procedures.
Grievance	Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to members.
Independent Medical Review (IMR)	A review of CalOptima Health's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on CalOptima Health but not the Member who may still request a State Hearing after an IMR pursuant to H&S section 1374.30 and 28 CCR section 1300.74.30.

Term	Definitions
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.
State Hearing	A hearing with an Administrative Law Judge to resolve a Member's dispute about an action taken by CalOptima Health, its Network Providers, Subcontractors, or Downstream Subcontractors.
Threshold Languages	The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.