

GETTING THE (MANAGED) CARE YOU NEED

A Medi-Cal Appeals Guide for Managed Care Denials



**LEGAL AID
FOUNDATION**
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ABOUT THIS HANDBOOK

This handbook was created by the Legal Aid Foundation of Los Angeles (LAFLA) to provide general information about how Medi-Cal managed care recipients can appeal denials of medical services and equipment.

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The information in this handbook applies only to California. Rules and procedures may differ in other states or programs, and some information applies specifically to Los Angeles.

The requirements, regulations, and deadlines in this handbook are subject to change at any time. Always contact the appropriate government agency for the most accurate and updated information.

This handbook doesn't replace legal or technical advice. For advice on a specific problem, contact an attorney or technical expert. For a list of free legal aid organizations, please visit: <https://www.lawhelpca.org/find-legal-help/directory/area>

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INTRODUCTION

If you are reading this guide, you were probably denied a medical service or medical equipment that your doctor prescribed for you, and you think your managed care health insurance plan got it wrong. The purpose of this guide is to demystify the Medi-Cal appeal process.

If your Managed Care health insurance plan denies you medical services or equipment that you need to stay healthy and functional, you have the due process right to challenge that decision and have it reviewed, first by the plan itself, and then by a neutral reviewer outside the plan. This guide will walk you through the steps involved and give you information to steer you in the right direction and help you focus on what is important and have the best chance of success in your appeal.

Disclaimer: The health care system is complicated! No single guide can cover all the nuances and specific circumstances that can arise. This guide is a starting place to help you orient how to approach the process and hopefully make it less daunting, but it cannot provide every answer to every question. Check below in the “Getting Help” section for links and resources if think you may need in-depth assistance with your specific issue.

The Basics: What are Medi-Cal and Managed Care?

Medi-Cal is California’s version of the national Medicaid program, a free (or sometimes low-cost) public health insurance program for people who financially qualify based on their income and savings. Medi-Cal is different than insurance plans purchased through Covered California or provided through an employer. Medi-Cal is also different from Medicare, which is a national health insurance program for seniors and some younger people who receive certain disability benefits through Social Security. This guide only covers Medi-Cal appeals.

Managed Care vs. Fee-For-Service Models

Medi-Cal was originally designed as a statewide “fee-for service” model where you could directly receive care from any medical provider in the state who accepted Medi-Cal. Today, virtually all counties in California have moved to some form of a “managed care” model. In managed care, you enroll with a specific health plan and must utilize the medical provider network contracted to that plan (similar to HMO-style health insurance). Managed care plans also control the authorization process for things like specialist referrals, prosthetics and durable medical equipment (DME), medical testing, medical procedures, and other treatments.

Fee-for-service Medi-Cal still exists but is now severely restricted. Some patients whose care needs are too complex or specialized for a managed care plan to handle can submit a “Medical Exemption Request” (or “MER” for short) to stay out of managed care and receive fee-for-service Medi-Cal. Once in a managed care plan for more than 90 days, it is extremely difficult to get back into fee for service Medi-Cal. See the section below for where to get legal advice if you want more information about how to get out of managed care.

The state agency that oversees Medi-Cal and Managed Care Plans is the Department of Health Care Services (DHCS).

Managed Care Plans in Los Angeles County

In Los Angeles County there are three main Managed Care Plans that Medi-Cal patients are enrolled with:

- L.A. Care
- Health Net
- Kaiser Permanente (with special enrollment limits)

This guide focuses on the appeal process provided by L.A. Care and Health Net because they cover the large majority of Medi-Cal patients in Los Angeles County. But in some cases, L.A. Care and Health Net may subcontract their administration to other health plans like Molina, Anthem Blue Cross, or Blue Shield.

Beyond Los Angeles: To look up which managed care plans serve your county, visit <https://www.dhcs.ca.gov/individuals/medi-cal-managed-care-health-plan-directory/>

The Denial Notice (Adverse Benefit Determination)

Nearly every Medi-Cal appeal starts with a denial notice, also called an “Adverse Benefit Determination,” or ABD for short. Any time your doctor recommends medical treatment or equipment that requires approval, your Managed Care Plan must provide you with written notice of their decision.

Get the written denial. If you learn about the denial from medical staff or an insurance representative rather than a written notice, you should immediately request a copy of the written denial notice so you can see the exact reason for the denial and check the date of denial so you know how much time you have to appeal.

Common types of denial notices

- Full Denial: The service or equipment is totally denied.
- Partial Approval: A lesser (and usually less expensive) version of what was requested is approved. Even though the notice may not directly use the word “denial,” it still operates as a denial of the full service originally requested, and can be appealed just like a denial notice.
- Service reduction, suspension, or termination: A previously authorized service may be reduced, temporarily paused, or permanently ended.

- Deferrals: Not strictly a denial, but when the plan believes there is necessary information missing, they can “defer” an authorization to allow more time to submit what is missing before making a decision.

Common denial reasons

Not “Medically necessary”: Health insurance law limits the services covered by Medi-Cal to only those that are “medically necessary.” This is a somewhat vague concept that is open to interpretation and argument in many cases, but is defined as services that are “reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.” [Welfare & Institutions Code § 10459.5](#).

Eligibility criteria not met: Many services have defined eligibility criteria, and the plan may decide that your medical situation does not meet them. This denial is often seen with partial authorizations, where the plan approves a lesser version of the service that it thinks you qualify for instead.

Utilization management (frequency limits): In addition to eligibility rules, there are also rules about how often a patient can receive certain services or equipment. For example, replacement wheelchairs are generally only allowed once every 5 years. It is important to remember, however, that medical necessity overrides these time limits in most cases, and a plan’s failure to consider your specific needs when denying equipment or services based on timing rules may be a good reason to appeal.

Trying to “Work It Out” Before Appealing

Contact your doctor’s office: Some service denials are caused by basic mistakes or paperwork oversights that can be sorted out with a few phone calls. As a first step, it is usually a good idea to contact your doctor’s office to let them know about the denial and check if their staff can look at it and contact the plan to figure out if there was an error or other easily resolvable issue.

Ombudsman’s Office: The Department of Health Care Services has a special office that tries to resolve issues that patients have with their managed care plans, called the “Medi-Cal Managed Care and Mental Health Office of the Ombudsman” (or just “Ombudsman” for short). While some issues will require an appeal, the Ombudsman’s office can often help resolve many problems, especially those involving administrative errors or lack of communication from the plan.

Here is how to reach the Ombudsman's office:

Website: <https://www.dhcs.ca.gov/services/mental-health-services-division-default/medi-cal-managed-care-and-mental-health-office-of-the-ombudsman/>

Phone: (888) 452-8609

Email: MMCDOmbudsmanOffice@dhcs.ca.gov

Pay attention to your appeal deadline! If you try to resolve your issue informally, remember that this does not stop the clock from ticking on your appeal deadline.

The Medi-Cal Appeal Process

The Medi-Cal appeal process involves two basic steps: 1. The Plan Appeal, and 2. State Fair Hearing and/or Independent Medical Review (IMR).

First Step – Plan Appeal

You have **60 days** to appeal an Adverse Benefit Determination (denial notice) with your managed care plan. This 60-day period runs from the date shown on the notice in most cases. You are required to file a Plan Appeal and get the plan's decision before you can request a State Fair Hearing or an Independent Medical Review (IMR)(see "Second Step" below).

Within 5 days of submitting your appeal, your plan must acknowledge receiving your appeal, and must give you a decision within 30 days. Their decision will be called a "Notice of Appeal Resolution" (NAR). If the plan fails to give you a response within 30 days, you can treat that as a constructive denial and request a hearing or IMR.

"Grievance" vs. "Plan Appeal": Some appeals terminology can be confusing, so take note that a "Grievance" is different than a "Plan Appeal." A grievance can be submitted at any time to complain about the quality of service you are receiving from the plan or from a provider. In contrast, a plan appeal is a necessary step in the appeal process to challenge a denial notice or other Adverse Benefit Determination (ABD), and must be filed by the 60-day deadline mentioned above. Some forms are also titled "grievance" or "complaint" forms but are used to submit either a grievance or a plan appeal.

Expedited Appeals: If you are at urgent risk to your health, you can ask for an expedited appeal, which the plan must respond to within 72 hours (though subject to 14-day extension if the plan requests it). It is highly advisable to work with your doctor to support an expedited appeal request, including providing supplemental notes or a letter explaining the urgent need for the plan to approve the medical service. Examples of when

an expedited appeal is warranted include severe pain or potential loss of life, limb, or major bodily function if medical care is delayed.

How to file your plan appeal

L.A. Care, Health Net, and Kaiser offer a variety of methods to appeal. Whichever method you choose, take care to keep documentation to prove how and when you submitted your appeal. If the plan loses your appeal or claims they never got it, you will want to have your own proof of filing to show them.

If you receive a denial from a subcontracted plan or IPA (Independent Practice Association or Independent Physician Association), you should read and follow the appeal rights section closely and contact your Medi-Cal plan if you are confused about what to do. If you still have problems, see the list of [legal resources](#) at the end of this guide.

L.A. Care

Website: <https://lacare.org/members/handbook/appeals>

Online Appeal: <https://lacare.org/members/file-grievance/grievance-appeal-form>

Appeal Form Link:

https://lacare.org/sites/default/files/la6703_member_grievance_and_appeal_form_en_202602.pdf

Translated versions of this form are at the bottom of the [Online Appeal page](#)

Phone Number: 1-888-839-9909

Fax Number: 213-438-5748 (Attention: Appeals & Grievances)

Mail:

Attention: Appeals & Grievances

L.A. Care Health Plan

1200 W. 7th Street

Los Angeles, CA 90017

Health Net

Website: https://www.healthnet.com/content/healthnet/en_us/members/appeals-and-grievances/medi-cal-appeals-and-grievances.html

Online Appeal: https://www.healthnet.com/content/healthnet/en_us/members/appeals-and-grievances/medi-cal-appeals-and-grievances/medi-cal-appeal-grievance-form.html

PDF Upload (different than Online Appeal):

https://www.healthnet.com/content/healthnet/en_us/members/appeals-and-grievances/medi-cal-appeals-and-grievances.html

Appeal Form Link:

<https://www.healthnet.com/content/dam/centene/healthnet/pdfs/member/ca/medi-cal/hn-medi-cal-member-grievance-form.pdf>

Translated versions of this form are available at [this link](#).

Phone Number: 1-800-675-6110

Fax Number: (877) 831-6019

Mail:

Health Net of California
Member Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

Kaiser Permanente

- Phone Number: 1-800-464-4000
- Expedited (Emergency) Review: 1-888-987-7247
- Online Appeal or Complaint:
<https://healthy.kaiserpermanente.org/southern-california/support/submit-a-complaint#/tellus>
- Appeal/Grievance Form Link (Southern California):
<https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/scal/ever/member-grievance-appeal-form-non-medicare.pdf>
- Appeal/Grievance Form Link (Northern California):
<https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/ncal/ever/non-medicare-grievance-form-en.pdf>
- Translated versions of these form are available here:
<https://healthy.kaiserpermanente.org/southern-california/support/forms>
<https://healthy.kaiserpermanente.org/northern-california/support/forms>
(select the “Forms” tab and click the plus (+) sign next to “Grievance forms”).
- The local mailing address to submit a paper version of the plan appeal/grievance form can be found at the end of the Northern or Southern California Appeal/Grievance forms

Second Step – State Fair Hearing / Independent Medical Review

State Fair Hearing Request

If you receive a Notice of Appeal Resolution (NAR) upholding the plan's denial, you then have 120 days to request a State Fair Hearing through the California Department of Social Services (CDSS), which oversees the State Hearings Division (SHD).

The hearing is overseen by an Administrative Law Judge (ALJ). ALJs are almost all experienced attorneys and they are not employed by your managed care plan. You will have the chance to submit documents and arguments to the judge before the hearing, and at the hearing you will be able to explain to the judge why the managed care plan was wrong to deny you.

Hearings are usually scheduled within 4-6 weeks after you request them, though you can also request an expedited hearing if your issue is urgent. The hearing decision is then usually released within another month or so.

For more detailed information about preparing for a state hearing, please see our specialized guide, "Representing Yourself at a State Hearing."

Independent Medical Review (IMR)

You also have the option to request an Independent Medical Review (IMR) if the plan denies a requested service because they think it is not "medically necessary," and then upholds the denial of medical necessity after you submit a plan appeal. In an IMR, an independent doctor reviews the requested service and any supporting documentation, and makes a new decision about whether the service is medically necessary or not. You can ask for an IMR up to 6 months after the plan's Notice of Appeal Resolution (NAR).

Timing quirks: The hearing process and IMR process are separate and you can choose to do either one. However, you cannot request an IMR if you have already attended a hearing. On the other hand, you can still ask for a hearing after receiving an IMR decision, but keep in mind that the results of the IMR may be introduced at the hearing (and may be held against you in the hearing if the IMR was unsuccessful). Also, requesting an IMR does not pause the clock for your 120-day deadline to request a hearing. In practice, it can be difficult to pursue both an IMR and then also a hearing, and it is generally recommended to choose one of these appeal options to focus your efforts on.

So which one should I pick?

There isn't always a clear answer here, but there are a few things to keep in mind when making this choice:

- IMRs focus on the issue of medical necessity, so if that is not the issue in your case, you should request a hearing instead.
- If a medical service is being cut and you want it to continue during the appeal process, you can request "Aid Paid Pending" when filing for a hearing, but not an IMR. Keep in mind that you generally have to request Aid Paid Pending before the service is cut.
- You should think about whether the issue in your case would be better understood and decided in your favor by a medical professional or a legal professional. Keep in mind that the judge in a hearing is also able to decide issues related to medical necessity, they may just have a different point of view than a doctor when reviewing the evidence. Doctors may be inclined to view medical evidence through the lens of their medical training and experience. Lawyers (i.e. judges) are trained to apply rules and regulations to facts and evidence, and may have more experience dealing with issues of procedural fairness, taking witness testimony, and sorting through factual disputes.

Ultimately, you have to use your best judgment in deciding which appeal option to choose. But you may want to consult these resources for more information about each process:

(IMR) - Disability Rights California, "[Medi-Cal Managed Care: An Independent Medical Review \(IMR\) Can Change a Plan's No to Yes.](#)"

(Hearing) – Legal Aid Foundation of Los Angeles, "[Representing Yourself in a State Hearing.](#)"

How to Request an Independent Medical Review (IMR)

Independent Medical Reviews are received and processed by the Department of Managed Health Care (DMHC), which is a branch of the Department of Health Care Services (DHCS).

Website and online appeal form:

<https://www.dmhc.ca.gov/FileaComplaint/SubmitanIndependentMedicalReviewComplaintForm.aspx>

PDF Appeal Form Link:

<https://www.dmhc.ca.gov/Portals/0/Docs/HC/AccessibleIMRFormEnglish.pdf>

Translated versions of this form are available at [this link](#).

Phone Number: 1-888-466-2219

Fax Number: 916-255-5241

Mail:

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

How to Request a State Fair Hearing

State Fair Hearings are overseen by the State Hearings Division (SHD), a branch of the California Department of Social Services (CDSS).

You can ask for a hearing by phone, mail, or online. Here is the CDSS website with information about these options: <https://www.cdss.ca.gov/hearing-requests>

Online:

- Visit the California Department of Social Services (CDSS)'s [Appeals and Case Management System \(ACMS\)](#) at: <https://acms.dss.ca.gov/acms/>.
- You do not need an account to ask for a hearing. In the section called "Need More Information?" near the bottom of the page, click "[Submit Appeal without an Account.](#)"
- Via email: SHDCSU@dss.ca.gov

By phone:

- Call CDSS State Hearing Division at (800) 743-8525.
- Tell them all the programs you are having a problem with (for example, Medi-Cal), and explain that you received a Notice of Appeal Resolution (NAR) from your managed care plan, and are seeking to appeal that. Have the NAR ready to provide the date.
- If you will need an interpreter at the hearing, ask for one now.

By mail:

- Fill out the appeal request form, cryptically called an NA Back-9:
<https://www.cdss.ca.gov/cdssweb/entres/forms/English/NABACK9.PDF>
- Translated versions of this form can be found at this page, clicking the desired language, and then scrolling down to find "NA Back-9" link:
<https://www.cdss.ca.gov/inforesources/translated-forms-and-publications>

- Check the Medi-Cal box and explain that you got a Notice of Appeal Resolution (NAR) from your managed care plan and are seeking to appeal that.
- Don't try to explain all your reasons for wanting a hearing on this form. Keep it simple, such as, "The decision to deny my medical equipment was wrong."
- If you need an interpreter, check the box to ask for one. Fill in your language or dialect.
- Before you mail the form, make a copy to keep.
- Send your form by certified mail, with a return receipt, to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-442
Sacramento, California 94244-2430

Conclusion and where to get more help

You can do it! You've already done a lot by getting this far. An appeal can feel intimidating, but it's your chance to explain what's going on and have a fair chance to be heard. If you take your time and stay organized, you can get through it. You don't have to do everything perfectly—just do your best. And if you feel stuck or want some support, you can always reach out to your local legal aid office.

You can find legal aid offices that work in your local county at this website:

<https://www.lawhelpca.org/find-legal-help/directory/area>.

In Los Angeles, you can contact:

- Legal Aid Foundation of Los Angeles
- Health Consumer Center (Neighborhood Legal Services of Los Angeles County)
- Bet Tzedek
- Public Counsel
- Center for Health Care Rights
- Disability Rights California
- Alliance for Children's Rights (for cases involving children or those under age 21)