QUICK REFERENCE INTERNAL / EXTERNAL GRIEVANCE & APPEAL TIMELINES

	INTERNAL APPEAL			EXTERNAL REVIEW		
PLAN (Regulator)	**Available for:**	**Deadline to request appeal**	**Deadline for decision**	**Available for:**	**Deadline to request**	**Deadline for decision**
Medi-Cal Managed Care (DMHC)	*Grievances* & *Appeals*[1] *Appeal:* Any *adverse benefit determination (ABD)* by the health plan adverse services determination (denial, delay, reduction, modification, suspension, or termination of services or payment, failure to act within required timelines for grievances and appeals, denial of request for out-of-network services, denial of request to dispute financial liability) *Grievance:* Any other grievance or dissatisfaction with plan not subject to a notice of adverse benefit determination (In Medi-Cal, an "*appeal*" is used for problems with an "*adverse benefit determination,*" while a "*grievance*" is used for other issues, including "*complaints*") (KKA uses "*appeal*," "*grievance*" and "*complaint*" interchangeably)	Appeal: *60 days* from NOA[2] Grievance: *At any time*[3]	Urgent: *72 hours*[4] Standard: *30 days*[5]	*Independent medical Review (IMR):* Denial / modification / delay of service or treatment due to lack of medical necessity; refusal to cover experimental or investigational treatment for serious medical condition; refusal to pay for emergency/urgent medical services already received.[6] No IMR after Fair Hearing.[7] *DMHC Complaint:* for any adverse benefit determination /dissatisfaction, subject or not subject to IMR[8] *Fair Hearing*: For any denial, termination, reduction or delay of services or payment.[9]	*IMR: 6 months* after unsuccessful internal appeal OR internal appeal pending for *30 days*[10] Urgent cases can be reviewed without exhausting internal appeal[11] *Complaint:* After unsuccessful internal appeal OR internal appeal pending for *30 days*[12] Urgent cases can be reviewed without exhausting internal appeal[13] *Fair Hearing: 120 days* from NOA[14] Expedited—72 hours[15] Aid pending appeal—within 10 days of NOA or before effective date of ABD[16]	*IMR & Complaint:* Urgent: *3 days*[17] Standard: *30 days*[18] *30 days* from receipt by DMHC of request for review[19] *Fair Hearing: 90 days* from NOA[20]

QUICK REFERENCE INTERNAL / EXTERNAL GRIEVANCE & APPEAL TIMELINES

	INTERNAL APPEAL			EXTERNAL REVIEW		
PLAN (Regulator)	**Available for:**	**Deadline to request appeal**	**Deadline for decision**	**Available for:**	**Deadline to request**	**Deadline for decision**
Commercial HMOs; Blue Cross of CA PPO; Blue Shield PPO (DMHC)	*Grievance/complaint*= Any expressed dissatisfaction with the health plan or provider, including adverse benefits determinations, quality of care, rescission, etc.[21]	*180 days*[22]	Urgent: *3 days*[23] Standard: *30 days*[24]	*IMR*: Denial/modification/delay or service or treatment due to lack of medical necessity; refusal to cover experimental or investigational treatment for serious medical condition; refusal to pay for emergency/urgent medical services already received.[25]	*6 months* after unsuccessful internal appeal OR internal appeal pending for *30 days*[26] Urgent cases can be reviewed without exhausting internal appeal[27]	Urgent: *3 days*[28] Standard: *30 days*[29]
				Complaint: for any adverse benefit determination /dissatisfaction, whether or not subject to IMR[30]	After unsuccessful internal appeal OR internal appeal pending for *30 days*[31] Urgent cases can be reviewed without exhausting internal appeal[32]	*30 days*[33]
All other PPOs; individual policy (CDI)	*Complaint* re the handling of a claim or other obligation under a health insurance policy of an insurer or with respect to alleged misconduct by a health insurer (e.g. delay or denial of claim, termination of a policy, etc.).[34]	No deadline in statute or regulation	Urgent: *3 days*[35] Standard: *30 days*[36]	*IMR*: Denial, modification, or delay in services due to determination that services are not medically necessary[37] *Disputed health care service* defined[38]	*6 months* after internal appeal denied or internal appeal pending for *30 days*[39]	Urgent: *3 days*[40] Standard *30 days*[41]
			No deadline in statute or regulation	*Complaint*: Denial or delay in settlement of claim; termination or cancellation of policy[42]		*60 days from receipt*[43]

QUICK REFERENCE INTERNAL / EXTERNAL GRIEVANCE & APPEAL TIMELINES

	INTERNAL APPEAL			EXTERNAL REVIEW		
PLAN (Regulator)	**Available for:**	**Deadline to request appeal**	**Deadline for decision**	**Available for:**	**Deadline to request**	**Deadline for decision**
Self-insured (federal government/ Dept. Of Labor) **Non-gov't/churches**	"*Adverse benefit determinations*" (denial/termination/reduction of benefits, and failure to make a payment) and rescission of coverage.[44] *Adverse benefit determination* defined[45] *Rescission of coverage* defined[46]	180 days[47]	Urgent: ASAP, no later than *72 hours*[48] Standard: 30 days for denial of care[49]; *60 days* for denial of payment[50]	"*Adverse benefits determinations*" and *rescission* of coverage involving medical judgment[51]	*4 months* after exhausting internal appeal[52]	Urgent: "as expeditiously as possible;" no later than *72 hours*[53] Standard: *45 days*[54]

[1] 42 C.F.R. §§ 438.400-424; Letter from Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans 2 (Apr. 17, 2009) [hereinafter APL 17-006], http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf; CAL. HEALTH & SAFETY CODE §1368.03(a); CAL. CODE REGS., tit. 28, §1300.68(a)(1).
[2] 42 C.F.R. § 438.402 (c)(2)(ii).
[3] APL 17-006, *supra*, note 1.
[4] 42 C.F.R. §§.408(b)(3), 438.410(a); CAL. HEALTH & SAFETY CODE §1368.01(b); CAL. HEALTH & SAFETY CODE § 1368.03(a), §1374.30(j)(3); CAL. CODE REGS., tit. 22, § 53858(e)(7) [2-Plan; no GMC equivalent]; APL 17-006, *supra*, note 1.
[5] 42 C.F.R. § 438.408(b)(2); CAL. CODE REGS., tit. 28, § 1300.68(a); CAL. CODE REGS., tit. 22, § 53858(g)(1) [2-Plan], § 53914(g)(1) [GMC]; APL 17-006, *supra*, note 1.
[6] CAL. HEALTH & SAFETY CODE §1374.30.
[7] CAL. CODE REGS., tit. 28, § 1300.74.30(f)(3).

[8] CAL. HEALTH & SAFETY CODE § 1368(b)(1)(A), (B).
[9] 42 C.F.R. § 438.408(f), § 431.220; CAL. CODE REGS., tit. 22, § 50951.
[10] CAL. HEALTH & SAFETY CODE §1374.30(k).
[11] *Id.*
[12] *Id.* § 1368(b)(1)(A).
[13] *Id.*
[14] 42 C.F.R. § 438.408(f)(1) and (2); *see also* APL 17-006, *supra*, note 1.
[15] 42 C.F.R. § 438.408(b)(3).
[16] *Id.* § 438.420(a),(b); CAL. HEALTH & SAFETY CODE § 1367.01(h)(4).
[17] CAL. HEALTH & SAFETY CODE §1374.33(c) (can be extended 3 days by Dir. For good cause).
[18] *Id.*
[19] *Id.* § 1368(b)(5).
[20] 42 C.F.R. § 431.221(d).
[21] CAL. HEALTH & SAFETY CODE §1368; §1368.015, 1368.02, 1368.03(a); CAL. CODE REGS., tit. 28, § 1300.68(a)(1).
[22] CAL. CODE REGS., tit. 28, § 1300.68(b)(9).
[23] CAL. HEALTH & SAFETY CODE §1368; §1368.01(b); CAL. CODE REGS., tit. 28, § 1300.68.01.
[24] CAL. HEALTH & SAFETY CODE §1368; §1368.03(a); CAL. CODE REGS., tit. 28, § 1300.68(a).
[25] CAL. HEALTH & SAFETY CODE §1374.30.
[26] *Id.*§ 1374.30(k).
[27] *Id.*
[28] *Id.* § 1374.33(c) (can be extended 3 days by Dir. For good cause).
[29] *Id.*
[30] *Id.* § 1368.02.
[31] *Id.* § 1368(b)(1)(A).
[32] *Id.*
[33] *Id.*
[34] CAL. INS. CODE § 10133.661(c).
[35] *Id.* § 10169(j)(3).
[36] *Id.*
[37] *Id.* § 10169(d)(1).
[38] *Id.* § 10169(b).
[39] *Id.* § 10169(k).
[40] *Id.* §10169 (j)(1)(C)(3)(can be extended 3 days by commissioner for good cause).
[41] *Id.*
[42] *Id.* § 12921.1.
[43] *Id.* § 10133.661(c).
[44] 29 C.F.R. § 2590.715-2719(b)(2)(i) [DOL Rule on Internal Appeals and External Review under the ACA]; *Id.* § 2560.503-1(b) [ERISA Claims Procedure Rule].
[45] *Id.* § 2590.715-2719(a)(2)(i) [DOL Rule on Internal Appeals and External Review under the ACA]; *Id.* § 2560.503-1(m)(4) [ERISA Claims Procedure Rule].

[46] *Id.* § 2590.715-2712(a)(2) [DOL Rule on Internal Appeals and External Review under the ACA]; *Id.* § 2560.503-1(m)(4)(ii) [ERISA Claims Procedure Rule].
[47] *Id.* § 2590.715-2719(b)(2)(i) [DOL Rule on Internal Appeals and External Review under the ACA]; *Id.* § 2560.503-1(h)(3)(i) [ERISA Claims Procedure Rule].
[48] *Id.* § 2590.715-2719(b)(2)(i) [DOL Rule on Internal Appeals and External Review under the ACA]; *Id.* § 2560.503-1(i)(2)(i) [ERISA Claims Procedure Rule].
[49] *Id.* § 2590.715-2719(b)(2)(i) [DOL Rule on Internal Appeals and External Review under the ACA]; *Id.* § 2560.503-1(i)(2)(ii) [ERISA Claims Procedure Rule].
[50] *Id.* § 2590.715-2719(b)(2)(i) [DOL Rule on Internal Appeals and External Review under the ACA]; *Id.* § 2560.503-1(i)(2)(iii) [ERISA Claims Procedure Rule].
[51] *Id.* § 2590.715-2719(d)(1)(i).
[52] *Id.* § 2590.715-2719(c)(2)(vi), (d)(2)(i).
[53] *Id.*
[54] *Id.* § 2590.715-2719(c)(2)(xii).