

Chapter 19: Notice, Appeals and Fair Hearings

Due Process Basics

As an entitlement program, a Medicaid beneficiary has a vested, property right in her Medicaid coverage and benefits. This property right is at least as valid as a wealthy person's right to own property and to count on U.S. Constitutional protections of due process of law whenever the government wants to limit the full use of the property or to take it away. If anything, protecting the low-income person's rights to Medicaid and its life-sustaining care is of more consequence to a human being, than protecting property rights of the wealthy.

Because of significant court cases recognizing this important right, Medi-Cal applicants and recipients have a right to adequate notice and to an administrative fair hearing when an adverse action is taken against them. These rights are guaranteed by the Due Process Clause of the United States Constitution¹ as expressed in *Goldberg v. Kelly*, which held that when welfare benefits are terminated, the beneficiary has due process rights to an effective notice and pre-termination hearing.²

Notice

Adequate notice requires that applicants and recipients receive timely notice of any adverse agency determinations or other actions that affect a person's Medicaid claim.³ An action that requires a notice includes a termination, suspension or reduction of Medicaid eligibility or covered services.⁴ In California, this notice is referred to as a Notice of Action (NOA). An action requiring a notice includes any change in the beneficiary's share of cost.⁵ A Notice of Action is also required if the state or a managed care plan takes an action, other than an approval, including a denial or a deferral, on a provider's request for any medical service.⁶ To be considered adequate, the notice must be in writing and contain a statement of the intended action, as well as the reasons and specific legal support for the action.⁷ In addition, the notice must contain an explanation of the individual's hearing rights, rights to representation and to continued benefits.⁸ To be considered timely, a notice generally must be sent at least ten days before the date of the action.⁹ The notice may be mailed no

¹ U.S. Const. amend. XIV, § 1; 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200- 431.250.

² *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970).

³ 42 C.F.R. §§ 431.206(b), 435.912, 435.919; Cal. Code Regs. tit. 22, § 50179(a).

⁴ 42 C.F.R. § 431.201, Cal. Welf. & Inst. Code § 11004(e), Cal. Code Regs. tit. 22, §§ 50179 (Eligibility), 51014.1 (Services). Note, however, that notices are *not* limited to actions which are adverse to the applicant or beneficiary's interests. 42 C.F.R. §§ 431.201, 431.206(c)(2), Cal. Code Regs. tit. 22, § 50179(a).

⁵ Cal. Code Regs. tit. 22, §§ 50179(a), (c).

⁶ Cal. Code Regs. tit. 22, § 51014.1(a)(1). This definition would include an approval of only part of a request, which, in effect is a partial denial.

⁷ 42 C.F.R. §§ 431.206(b); 431.210, Cal. Code Regs. tit. 22, §§ 50179(c), 51014.1(c).

⁸ 42 C.F.R. §§ 431.206(b); 431.210, Cal. Code Regs. tit. 22, §§ 50179(c), 51014.1(c).

⁹ 42 C.F.R. §§ 431.211, 431.213, 431.214; Cal. Code Regs. tit. 22, §§ 50179(d), 51014.1(c).

later than the day of the action only in exceptional circumstances.¹⁰ In cases of verified fraud, the period of advance notice may be shortened to five days.¹¹

Advocacy Tip ► Advocates should ensure that clients received adequate notice of any changes in their Medi-Cal coverage. If a notice is not adequate, it can be challenged allowing additional time to resolve the underlying issues. Inadequate notice is a legitimate reason to require a county to restart an adverse action from the beginning. Things to watch for include notices that do not state the reason for the adverse action and those that are not sent ten days before the proposed action.

Requesting a Medi-Cal Fair Hearing

An applicant or beneficiary has the right to challenge eligibility determinations, reductions, delays and denials in services and other adverse actions that the state, the county, or a managed care plan takes. The process of challenging these actions begins with requesting a fair hearing.¹² Individuals have 90 days from the date of the mailing of the NOA to request a hearing.¹³ Although the state or managed care plan is required to provide an applicant or beneficiary with notice, a notice of action is not required in order to request a fair hearing.

Advocacy Tip ► If a beneficiary is not sure whether she received a NOA or has lost the NOA, she should immediately file for a fair hearing in order to preserve her filing date. If she received a NOA and the 90-day period for filing for a hearing has passed, she may wish to renew her request for eligibility or the service that was denied. If that request is denied, she should promptly file for a fair hearing.

An applicant, recipient, or her representative, can ask for a fair hearing by making a clear expression that she wants the opportunity to present her case to the reviewing authority.¹⁴ This may be as simple as writing on the fair hearing request form, “I disagree with the county’s decision, and I want a fair hearing.” Counties are obliged to assist an applicant or beneficiary, if she requests assistance.¹⁵ A person may request a fair hearing by completing the reverse side of the Notice of Action they are challenging and mailing it to the State Hearings Division address below. Alternatively, a hearing can be requested by phoning or faxing the form or a letter to one of the phone numbers below:

¹⁰ 42 C.F.R. § 431.213, Cal. Code Regs. tit. 22, §§ 50179(d), 51014.1(d). *Frank v. Kizer*, 213 Cal. App. 3d 919 (1989), Settlement order, March 1990, CCH Medi-Cal Guide 7195. See Medi-Cal Eligibility Procedures Manual, Article 6I regarding NOAs for people who are institutionalized.

¹¹ 42 C.F.R. § 431.214, Cal. Code Regs. tit. 22, § 51014.1(d)(5).

¹² Cal. Code Regs. tit. 22, § 50951.

¹³ 42 C.F.R. § 431.221(d), Welf. & Inst. Code § 10951. However, the 90-day limit does not apply if the beneficiary receives no written notice or the NOA is inadequate. *Morales v. McMahon*, 223 Cal. App. 3d 184 (1990).

¹⁴ 42 C.F.R. § 431.201

¹⁵ Cal. Code Regs. tit. 22, § 50955.

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430.
1-800-952-5253 (Voice)
1-800-952-8349 (TDD)
(916) 229-4110 (fax)

Regardless of the manner of the request for a fair hearing, the communication should include a general statement that a fair hearing is requested, the reason for the request, the person's name, her Medi-Cal number or social security number, and her address and phone number. If the person is limited English speaking, she should also note her preferred language on the fair hearing request. If she sends the NOA with the reverse side filled out, she should always make and keep a copy of both sides of the NOA before mailing it. She may have an authorized representative, who may be an attorney or a non attorney.¹⁶

The hearing must be set within 30 working days of filing the request, and written notice of the time and place of the hearing must be sent at least 10 days prior to the hearing.¹⁷

Aid Paid Pending

Aid paid pending, or continued medical assistance, refers to continuing the same level of benefits for a beneficiary while she is in the fair hearing process and awaiting a decision from the administrative law judge (ALJ).¹⁸ If an individual or her representative requests a fair hearing within 10 days from the date of the notice or before the date of the action that is the subject of the NOA, Medi-Cal eligibility and benefits will continue until the ALJ issues a hearing decision.¹⁹ Medi-Cal has the option of reinstating services to an individual who requests a hearing after the adverse action has taken place, if the request is made no more than 10 days after the date of the action.²⁰ In addition, if Medi-Cal failed to provide proper and timely advance notice of the adverse action, a recipient requesting a hearing within 10 days of the mailing of a proper notice of action must be reinstated and allowed to have services continue while a decision is pending.²¹

Advocacy Tip ► If at all possible, request a hearing within the first 10 days so that the beneficiary can receive aid paid pending. Even if it appears that the problem will be quickly resolved, this ensures that she can continue to receive services without a break in the continuity of her care, without incurring unnecessary medical debt, and without the risk of foregoing necessary care.

Under certain circumstances, Medi-Cal services can continue pending a hearing decision when Medi-Cal refuses to reauthorize the services. Some non-acute hospital services can continue

¹⁶ Cal. Welf. & Inst. Code § 10950; *Welfare Rights Organization v. Crisan*, 33 Cal. 3d 766, 190 Cal. Rptr. 919 (1983).

¹⁷ Cal. Welf. & Inst. Code § 10952.

¹⁸ 42 C.F.R. § 431.230; Cal. Code Regs. tit. 22, § 51014.2.

¹⁹ 42 C.F.R. §§ 431.230, 431.231(c), 431.231(d); Cal. Code Regs. tit. 22, § 51014.2(a).

²⁰ 42 C.F.R. § 431.231.

²¹ 42 C.F.R. § 431.231(c).

pending a hearing decision provided that the (a) reauthorization treatment authorization request (TAR) is submitted to the Medi-Cal field office before (or within 10 days after) expiration of a prior authorization; and (b) the request for hearing is submitted within 10 days of mailing the denial notice or before the expiration of the prior TAR, whichever is later.²² This includes long-term care, chronic hemodialysis, in-home medical care services, skilled nursing facility waiver services, model community based waiver services, and all other non-acute services, when the treating doctor substantiates that services should continue because the treatment goal of the original TAR has not been met.

What an Applicant or Beneficiary May Challenge in a Fair Hearing

An applicant or beneficiary has a right to a fair hearing in most instances in which the Medi-Cal program is proposing to take an adverse action against her. Actions that can be challenged in a fair hearing include:²³

- Refusal to process a Medi-Cal application
- Delay in processing a Medi-Cal application²⁴
- Determination that an applicant is not eligible for Medi-Cal
- Determination that the beneficiary no longer eligible for Medi-Cal
- Inadequate notice
- An incorrect amount for the monthly share of cost or other incorrect calculation of eligibility for a Medi-Cal program
- Denial of a treatment authorization request (TAR) or a managed care authorization for a service or referral
- Denial of a TAR in part or approval of fewer or less service than requested
- An unreasonable delay in receiving services
- Discharge or transfer decisions of a nursing home
- Reduction in services
- Termination or denial of a Medi-Cal covered service.

There is no right to a fair hearing when the sole issue is a Federal or State law requiring an automatic change adversely affecting all or some beneficiaries.²⁵ For example, if the state were to eliminate coverage for an optional category of beneficiaries, there would be no individual right to a fair hearing to challenge the elimination of that coverage. If this change in the law is the sole issue in the fair hearing, the aid paid pending may be ended.²⁶

Treatment Authorization Request (TAR)

Just as with the denial of other services, when the Medi-Cal program denies a TAR, the program must send a notice of action to the beneficiary and to the provider explaining the reason

²² Cal. Code Regs. tit. 22, §§ 51014.2(a), 51003(c)(1).

²³ This is not an exclusive list but rather a list of some of the most common reasons for a fair hearing.

²⁴ A county has 45 days from the date of application to make most eligibility determinations, 90 days if the application requires a disability determination. 42 C.F.R. § 435.911.

²⁵ 42 C.F.R. §§ 431.220(b), 431.233; Cal. Welf. & Inst. Code § 10950; Cal. Code Regs. tit. 22, § 50951(a).

²⁶ 42 C.F.R. § 431.230(a)(1).

for the denial, citing the regulation(s) upon which the denial is based, and explaining the beneficiary's appeal rights.²⁷ Medi-Cal must also send a notice of action when it modifies a TAR or defers it by delaying approval until the doctor submits additional information.²⁸

When deciding whether to appeal a TAR denial, a beneficiary or her advocate should review the TAR request and the supporting documentation that the provider submitted to Medi-Cal. When making a determination, Medi-Cal only looks at the TAR and the supporting documents submitted with the TAR.²⁹ If this package did not include a letter from the treating physician explaining in detail why the beneficiary needs the service, or did not include other documents about why the service is medically necessary, it may be faster to file a new TAR with adequate letters and documentation. If the TAR is resubmitted, the beneficiary should make sure the documentation addresses the applicable medical necessity standard discussed in Chapter 11 of this manual. However, if the TAR contains adequate documentation, she should request a fair hearing immediately.

Preparing for a Fair Hearing

Just as with anything else, being prepared in advance for a fair hearing is vital to success. If an advocate will be assisting a beneficiary, the advocate must learn all of the facts from the client, discuss the hearing process with the client, secure appropriate witnesses, obtain any necessary documentation including income verification, citizenship verification or medical records, and review applicable policies, rules and regulations. If the client is trying to get coverage for a particular treatment, the advocate should acquaint herself with the client's condition and read up on current treatment protocols. Family members, neighbors, friends, or others in the client's household may be able to offer important information to establish a client's eligibility or need for a service.

Medi-Cal is required to make available to an individual or her representative, a copy of the specific policy materials necessary to decide whether to request a fair hearing and/or to prepare for a hearing.³⁰ The county must also make available contents of the individual's case file and all documents and records that the state or county or nursing facility will be using at the hearing.³¹ An applicant or beneficiary and her representative should be able to get access to the case file by contacting the eligibility worker or the department that handles fair hearings. If the county or nursing home does not cooperate in providing access to these documents, a beneficiary or her advocate should contact the local hearings office and ask that the presiding judge request the documents or contact the holder of the documents.³² If a subpoena becomes necessary, the beneficiary or her advocate will likely need to fill out a form or compose a short memo about why

²⁷ 42 C.F.R. § 431.206, 431.210; Cal. Code Regs. tit. 22 § 51014.1, *Jackson v. Rank*, No. CIV 83-1451 LKK (E.D. Cal. June 9, 1986) described in ACWDL # 86-08 (Mar. 6, 1986), CCH Medi-Cal Guide, 7199 (available from NHeLP, Los Angeles). Note that notice to the beneficiary is not required when a TAR for a prescription drug is denied and the same drug is available as a generic without a TAR. ACWDL # 86-08 (Mar. 6, 1986).

²⁸ *Jackson v. Rank*, No. CIV 83-1451 LKK (E.D. Cal. June 9, 1986) described in ACWDL # 86-08 (Mar. 6, 1986), CCH Medi-Cal Guide, 7199.

²⁹ However, in more populous counties, Medi-Cal must consider "all relevant information," which would include the beneficiary's medical records. Cal. Welf. & Inst. Code § 14133.6.

³⁰ 42 C.F.R. § 431.18(e).

³¹ 42 C.F.R. § 431.242(a).

³² Department of Social Services (DSS) Manual of Policies & Procedures (MPP) Section 22-05. The Manual of Policies and Procedures containing the rules for fair hearings may be found at: www.cdss.ca.gov/ord/PG319.htm.

she needs the subpoena. The advocate or the beneficiary has the responsibility for having the subpoena served.³³

The state, county, or nursing home is required to write a position paper concerning the issues in question in the fair hearing.³⁴ The position statement often provides useful information concerning the reason(s) for the adverse action. The position statement can be very helpful in focusing on the issues for the hearing as well as revealing any weaknesses that either side may have, thus providing insight into areas in which the beneficiary or advocate may need to obtain additional documentation or support. The position statement must be made available to the opposing side two days prior to the hearing.³⁵ Whenever possible, the beneficiary or advocate should also prepare a hearing brief to set forth the facts, issues of law, and other matters important to the applicant or beneficiary's case. If the applicant, beneficiary, or advocate is not provided the position statement at least two days prior to the hearing, she may request a postponement of the hearing.³⁶

For the hearing, the beneficiary or her advocate should be sure to bring copies of any applicable federal and state laws or regulations that are relevant to the hearing issues. Advocates should not assume that the hearing officer will have the provisions on hand, even though they were referred to in the notice of action. It may also be useful to bring other fair hearing decisions approving services similar to those that the client requested. Although the hearing judge does not have to follow other hearing decisions, she may find them persuasive.³⁷ Fair hearing decisions must be publicly available, subject to privacy considerations.³⁸

For hearings concerning service delays, denials or reductions, it may be useful to start with the California Code of Regulations and the Manual of Criteria to see if the service or equipment at issue is covered. Also review Chapters 11 and 12 of this manual. The Manual of Criteria is part of the Medi-Cal regulations and sets out the criteria the field office should use in deciding whether to authorize services in a particular case.³⁹

Although it is unlikely that a physician or other health care professional will be able to appear in person, she may be able to participate by telephone. If this can be arranged, fax a memo to the presiding judge with a copy to the state or county representative to notify her of the health care professional's participation.

An applicant or beneficiary who is limited English speaking should always request interpretation services for the hearing. These are free services. However, they should be requested ahead of time to ensure that they are available at the time of the hearing.⁴⁰ Also, if the applicant or

³³ DSS MPP 22-051.6.

³⁴ Cal. Welf. & Inst. Code § 10952.5.

³⁵ Cal. Welf. & Inst. Code § 10952.5.

³⁶ Cal. Welf. & Inst. Code § 10952.5.

³⁷ The State Hearing Division maintains precedent decisions, available on the Web site at:

www.dss.cahwnet.gov/shd/PG1019.htm. In addition, the Western Center on Law & Poverty maintains a bank of fair hearing decisions as well as helpful materials such as fair hearing briefs. For those materials, contact the WCLP at (213) 487-7211. WCLP also publishes significant hearing decisions in its task force mailings.

³⁸ 42 C.F.R. § 431.244(g).

³⁹ The Manual of Criteria is available on the Web at:

www.dhcs.ca.gov/formsandpubs/publications/Documents/Medi-Cal_PDFs/Manual_of_Criteria.pdf.

⁴⁰ MPP § 22-049.6.

beneficiary is unable to attend the hearing, the representative must be sure to have a signed authorized representative form. If the advocate knows the client will be unable to attend, it is useful to send the authorization form ahead of time.

For more information, advocates may wish to visit the State Hearing Web site at www.cdss.ca.gov/shd/. The Bench Book, which the Administrative Law Judges (ALJ) use as a guide, may be found at this site. It includes language articulating the standards to be used at fair hearings, the paraphrased regulations, and Notes from the Training Bureau.

Conditional Withdrawals

Conditional withdrawals are commonly used in the fair hearing process. In these instances, the beneficiary or her representative comes to a tentative agreement with the eligibility or appeals worker prior to the fair hearing. A conditional withdrawal is filed when the beneficiary states that she will dismiss the request for a fair hearing at the completion of a certain action. Conditional withdrawals are useful because they allow the parties to continue to work on the problem while waiting for the hearing without losing any appeal rights.

Requests for a fair hearing can be withdrawn at any point up to the time the decision is received, by contacting the Medi-Cal State Hearings Division.

The Fair Hearing

Federal law requires that the hearing be conducted at a reasonable time, date and place, after adequate notice, and by an impartial official who was not directly involved in the initial determination of the action in question.⁴¹ Medi-Cal hearings are heard by Administrative Law Judges (ALJs) from the State Hearings Division of the Department of Social Services. The hearings are held during regular business hours, in at least one location per county.⁴²

During the hearing, the claimant must be allowed to present witnesses, evidence, arguments, and confront and cross-examine adverse witnesses.⁴³ Medi-Cal hearings include giving testimony under oath and submitting evidence into the record. The process is designed to be fair to unrepresented laypersons and is therefore more relaxed than a formal court proceeding. Formal rules of evidence do not apply, but evidence is admitted, “if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.”⁴⁴ The issues are limited to those reasonably related to the request for a hearing, as well as any that both sides have agreed to prior to or at the hearing.⁴⁵ The proceedings are recorded and quiet-spoken witnesses should be prompted to speak loudly enough to have their testimony captured by the recording equipment.⁴⁶

⁴¹ 42 C.F.R. § 431.240(a)

⁴² Locations of hearing sites are listed on the Web at: www.cdss.ca.gov/shd/PG1166.htm.

⁴³ 42 C.F.R. §§ 431.242(b)-(e), MPP § 22-049.7.

⁴⁴ Cal. Welf. & Inst. Code § 10955; MPP § 22-050.2.

⁴⁵ Cal. Welf. & Inst. Code § 10958.1.

⁴⁶ Cal. Welf. & Inst. Code § 10956.

If a hearing involves the need for particular medical services or care, an independent medical assessment must be obtained at agency expense and made part of the hearing record, if the hearing officer considers it necessary to have an additional medical assessment.⁴⁷

If the applicant, beneficiary or witness has difficulty getting to the hearing, Medi-Cal may be able to pay for the cost of transportation to and from the hearing.⁴⁸

After a Fair Hearing

After a fair hearing, a decision will be sent to the claimant and her representative. The hearing decision must be in writing and completed within 90 days of the fair hearing request.⁴⁹ It can be based only on the evidence presented at the hearing.⁵⁰ The decision must summarize the facts, identify the regulations supporting the decision, and inform the individual of the reason for the decision and the right to request a rehearing or judicial review.⁵¹

The decision issued by the ALJ in a Medi-Cal hearing is a proposed decision, which within 75 days, is filed with the Director of the Department of Health Care Services who reviews the proposed decision.⁵² The proposed decision is adopted, changed, or set for further hearing.⁵³ If the Director takes no action within 30 days of receiving the proposed decision, it is deemed adopted.⁵⁴ If the Director decides the matter differently, that decision is served on the claimant and the county.⁵⁵ If Director orders a further hearing, the hearing is conducted in the same way and with the same timeframes as the original hearing.⁵⁶

If the decision is favorable to the claimant or if the agency decides in her favor prior to the hearing, the county must comply with the decision within 30 days.⁵⁷ If applicable, corrective payments must be made retroactive to the date that the incorrect action was taken.⁵⁸

If the decision rules against the claimant, the county can stop aid immediately.⁵⁹ The state may also recover the costs of continued benefits or of “aid paid pending” from the beneficiary.⁶⁰ However, the counties rarely pursue these claims.

If the claimant loses at the fair hearing level, she has two options. First, within 30 days of receiving the ALJ’s proposed decision, she may request a rehearing by sending a written request to the Rehearing Unit located at the same address as the State Hearings Department listed above.⁶¹

⁴⁷ 42 C.F.R. § 431.240(b).

⁴⁸ 42 C.F.R. § 431.250(f)(1), MPP § 22-052.

⁴⁹ 42 C.F.R. §§ 431.244(f), 431.245.

⁵⁰ 42 C.F.R. §§ 431.244(a).

⁵¹ 42 C.F.R. §§ 431.232, 431.244 (d), (e), 431.245.

⁵² Cal. Welf. & Inst. Code § 10958.

⁵³ Cal. Welf. & Inst. Code § 10959.

⁵⁴ Cal. Welf. & Inst. Code § 10959.

⁵⁵ Cal. Welf. & Inst. Code § 10959.

⁵⁶ Cal. Welf. & Inst. Code § 10959.

⁵⁷ 42 C.F.R. § 431.246; Cal. Welf. & Inst. Code § 10961.

⁵⁸ 42 C.F.R. § 431.246; Cal. Welf. & Inst. Code § 10961.

⁵⁹ 42 C.F.R. § 431.232(d).

⁶⁰ 42 C.F.R. § 431.230(b).

⁶¹ Cal. Welf. & Inst. Code § 10960.

The request should include the date of the decision, why a rehearing should be granted, whether additional evidence will be presented, what that evidence is, and why it was not presented at the initial hearing. The claimant's may not be granted a rehearing, but if she is granted a rehearing, she will be granted no more than one. The Director must grant or deny the rehearing request within 15 days of its receipt.⁶² If no action is taken, it is deemed denied.⁶³

The second option after receiving an adverse decision is to ask for judicial review, by filing a petition in the Superior Court within one year after receiving the Director's final decision.⁶⁴ There is no requirement that a person ask for a rehearing before requesting judicial review. There are no filing fees for filing this action, and if successful, the claimant is entitled to attorney's fees and costs.⁶⁵

Beneficiaries in Medi-Cal Managed Care

Beneficiaries enrolled in Medi-Cal managed care have the same right to a fair hearing as beneficiaries in fee for service Medi-Cal. In addition, managed care beneficiaries have the right to pursue a grievance within the managed care plan.⁶⁶ A grievance and a fair hearing request can be filed at the same time or consecutively. It is usually preferable to file both at the same time, since even if the grievance does not fix the problem, the grievance process will give the beneficiary a better understanding of the managed care plan's position before the fair hearing. If the beneficiary decides to pursue the grievance first, the 90-day time period to request a fair hearing is not stopped. Therefore, it is important to ask for a fair hearing even if the problem is subsequently resolved and the hearing request needs to be withdrawn.

In addition, most, if not all, Medi-Cal managed care plans are subject to the Knox-Keene Act, and thus the beneficiary may, if her grievance is unsuccessful, choose to file for an independent medical review (IMR) with the DMHC. The IMR process may be useful if services were denied on the basis of being either "investigational" or "experimental" and the beneficiary has a life threatening or seriously debilitating condition. The beneficiary also may be entitled to an expedited grievance and an expedited independent medical review of the denial.⁶⁷ However, the DMHC has decided that a Medi-Cal beneficiary cannot have both an IMR decision and a fair hearing decision. For more information on the Knox-Keene Act and managed care, see Chapter 20 of this manual.

⁶² 42 C.F.R. § 431.232(b); Cal. Welf. & Inst. Code § 10960.

⁶³ Cal. Welf. & Inst. Code § 10960.

⁶⁴ Cal. Welf. & Inst. Code § 10962; Cal. Civ. Proc. Code § 1094.5.

⁶⁵ Cal. Welf. & Inst. Code § 10962.

⁶⁶ 42 C.F.R. § 438.402(a)(b); Cal. Health & Safety Code § 1368(a).

⁶⁷ Cal. Health & Safety Code §§ 1368.01(b), 1374.30(f), 1374.31.

Advocacy Tip ► In fee for service Medi-Cal, the beneficiary and the provider are generally on the same side, but this is not necessarily the case in managed care. A beneficiary or her advocate needs to be sure she is clear on whether the disagreement is over whether something is medically necessary or whether the plan or Medi-Cal will cover the requested service. If the dispute is over whether the service is medically necessary, it is wise to ask for a second opinion from another physician in the plan. Be sure that the plan is applying the appropriate Medi-Cal definition of “medical necessity,” not the plan’s often narrower definition. If the dispute is whether something is covered by Medi-Cal or the plan, ask for a fair hearing and file a grievance with the plan.