Bayou Health Operational Guide

Appeal Reporting

Federal law requires Medicaid MCOs to administer a grievance system for members, including the ability to file an internal appeal regarding actions as well as additional protections afforded by a State Fair Hearing. All states are required to review MCO reports on the frequency and nature of appeals filed, as well as the steps MCOs take to remedy such appeals. DHH considers complete and accurate identification, tracking, investigation, analysis, and reporting of appeals by Bayou Health Plans to be of paramount importance in **improving access to care, quality of care, and patient experience with care for Louisiana Medicaid enrollees.`**

CMS defines an appeal as "*a request to review an action*" and action is defined as:

> (1) The denial or limited authorization of a requested service, including the type or level of service;
>
> (2) The reduction, suspension, or termination of a previously authorized service;
>
> (3) The denial, in whole or in part, of payment for a service;
>
> (4) The failure to provide services in a timely manner, as defined by the State;
>
> (5) The failure of an MCO or PIHP to act within the timeframes provided in §438.408(b); or
>
> (6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

The Bayou Health Contract further defines an action as:

Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner as defined by Sections 13.6.1 of this RFP (finalized 1/26/15); or the failure of the MCO to act within the timeframes provided in Section 13.7.3 of this RFP.

Bayou Health Plans must:

- Document and treat **all** oral inquiries seeking to appeal an action as an appeal (to establish the earliest possible filing date for the appeal) and these requests for appeals must be confirmed by the MCO to the member in writing, unless the enrollee or the provider (acting on behalf of the member and with the member's written consent) requests expedited resolution. The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required. (*See RFP 13.4.2.1*)

- Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution). (*See RFP 13.4.2.2*)
- Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process. (*See RFP 13.4.2.2*)
- Have a system that complies with 42 CFR Part 438, Subpart F. The MCO shall establish and maintain a procedure for the receipt and prompt internal resolution of all appeals in accordance with all applicable state and federal laws. (*See RFP 13.0, 1st paragraph*) The system should be designed to collect all information needed for completion of required monthly reporting to DHH.
- Classify as an "action"/appeal—including actions of subcontractors (rather than a grievance)any --
    - Denial, partial denial, reduction, suspension, or termination of a requested **service,** or
    - Non-adherence to DHH requirements for timeliness of prior authorization.
- Provide notice of action and notice of resolution of appeal to the member (*See RFP 13.5-13.8*) ;
- Include easy to find links on the Bayou Health Plan's "Home" page, "For Members" home page (if applicable) and "Forms" home page (if applicable) that inform members what they can do if they are not satisfied with an aspect of the Plan. (See RFP 13.2.4.2) ***It is not sufficient to have the information and forms in the electronic copy of the Member Handbook only as DHH does not consider that to meet the requirement of "easily available."***
- Submit a monthly Appeal & State Fair Hearing Report & Appeal & State Fair Hearing Logs to DHH
- Prepare for and attend meetings with Medicaid Executive Management to discuss Grievances and Appeals as needed.
- If the appeal involves an entity **other than** the Health Plan, a subcontractor of the Health Plan, or a network provider, referral should be made to the appropriate entity. Examples include other BHSF contractors and DHH.

Monthly Appeals Reporting

The monthly Appeal Report shall be submitted to DHH by the 15th of the month reflecting all activity from the first day through the last day of the previous month (Report Month). The complete submission consists of:

1) **Cover Letter** completed in Word template and submitted electronically to BHSF as a PDF which constitutes pages 1 & 2 of complete report , and
2) **Detailed Appeal & State Fair Hearing Logs Worksheets** submitted both electronically to BHSF as an Excel file [*please do not resize columns in template*] **and** in pdf form as subsequent pages of complete report.

The pdf of the entire report should have pages in the following order: Appeals Cover Letter, State Fair Hearing Cover Letter (both formatted in 8 ½ x 11 portrait) and Appeals and State Fair Hearing detailed workbook (8 ½ x14 landscape view).

Appeals Report Cover Letter must include:

- a summary of all new appeals received during the report month, resolved during the report month (including those pending from the prior month), and still pending at the end of the report month;
- an analysis of all appeals and their resolution including trends (upward or downward) and any plans for interventions to address the issues; and
- name of person to contact for follow-up questions about the contents of the report and their contact information.

State Fair Hearing Cover Letter must include:

- A summary of State Fair Hearing requests received during the report month, hearings held by the Division of Administrative Law and any pending SFH request at end of report month;
- Analysis of State Fair Hearing requests and their final decisions and SFH requests greater than 60 days without final decisions
- Name of person to contact for follow-up questions about the contents of the report and their contact information.

Detailed Appeal and State Fair Hearing Worksheet shall be completed for all Health Plan appeals and Division of Administrative Law State Fair Hearing requests.

#	Date	Medicaid ID	Source	Type of Service Denied	Request for Expedited Appeal	Narrative Explanation of Appeal	Appeal Category	Summary Of Investigation	Appeal Resolution category	Date Resolved	Appeal Pending
UN XXXXX	2/1/15	xxxxxxxxx xxxx	Member Parent Spouse Provider etc								

Fields to Be Displayed on PDF Version of Reports

- Internal **Tracking #** with first two characters
  - AE for Aetna
  - AG for Amerigroup
  - AC for Amerihealth Caritas
  - LH for Louisiana Healthcare Connections
  - UN for United
- Third through sixth character MMYY, last three characters sequential beginning at 001
- **Date** First Rec'd
- 13 digit **Medicaid ID#** of member
- **Source** (this may be member, family member (specify relationship such as mother, spouse) provider, or other (specify)
- **Type of Service Denied-** Specify type of service denied using the drop down selection (not applicable for Benefit Limitation and Inpatient Admission tabs).
- **Request for Expedited Appeal** – Yes or No
- **Narrative Explanation of Appeal** [three to five sentences in length including the most relevant details and requested resolution/relief sought by member *if a provider, acting as member's representative, include provider name*]. If the member requested an expedited review, provide summary and determination of expedited request.
- **Appeal Category** (Short Title as Defined by DHH Below)
- **Summary of Investigation** [include steps taken including if applicable, referral to Quality Management Section, Network Management, Medical Director; any extension of timeframe, notification to subject of appeal and their response; and date notice was sent to member. Include any attempts to provide oral notification, date of notification and individual contacted.
- **Appeal Resolution Category** (Include code for Resolution Category as Defined by DHH Below)
- **Date Resolved –** date final decision rendered
- **Appeal Pending**- appeal carried from previous report or received and in process

Categories for Appeal Logs

Denial of Service *– Narrative Explanation of Denial of service* shall include the length of time, provider type, provider name/NPI, if applicable, date of denial, date of notice, and reason for denial.

Partial Denial of Service *– Narrative Explanation of partial denial of service* shall include the service and amount and frequency requested, provider type, provider name/NPI, if applicable, date of authorization/denial, date of notice, amount and frequency authorized and reason for denial.

Reduction of Service *- Narrative Explanation of Reduction of service* shall include the previously authorized service and amount and frequency, provider type, provider name/NPI, date of original authorization; date of reduction, date notice sent, new amount and frequency authorized and reason for change.

Termination of Service *- Narrative Explanation of Termination of service* shall include the previously authorized service and amount and frequency, time, provider type, provider name/NPI, if applicable, date of termination, date notice sent and reason for termination.

Suspension of Service *– Narrative Explanation of Suspension of service* shall include the previously authorized service and amount and frequency, time, provider type, provider name/NPI, if applicable, date of suspension, date notice sent and reason for suspension.

Denial or Limited Authorization of Payment *- Narrative Explanation of Denial or limited authorization for a payment of a service already provided to a member* shall include the service, provider type, provider name/NPI, if applicable, date of denial or adjustment in payment, date of notice, and reason for denial or limited authorization of payment.

Service Not Acted upon within required timeframe *- Narrative Explanation of service not acted upon within timeframe* shall include service and amount and frequency requested, as applicable, provider type, provider name/NPI, if applicable, date of original request for authorization, actions taken regarding review of authorizations.

Appeal Not Acted upon within required timeframe *- Narrative Explanation of appeal not acted upon within timeframe* shall include summary of appeal, status of appeal, including extensions, and actions taken regarding appeal.

Categories for Resolution of Appeal Logs

1- Action Upheld
2- Action Overturned
3- Action Partially Upheld
4- Appeal Withdrawn or Discontinued by Member or Representative
5- Denied – Appeal request determined to be unacceptable for timeliness or inappropriate filing (such as by a provider without member's written consent)