Chisholm Compliance Guide

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PRIOR AUTHORIZATION LIAISON

The managed care organization (MCO) shall meet court-ordered **Prior Authorization Liaison (PAL)** requirements for Chisholm enrollees.

The MCO shall have a PAL to assist the enrollee with the prior authorization process for all prior authorized services. There are two PAL functions that must be present within the MCO – The Coordinator PAL and the Utilization Management (UM) PAL. The Coordinator PAL's function is to assist in locating providers; ensuring that prior authorization requests are submitted and reviewed in a timely manner; and ensuring that services have started once the prior authorization is in place. The UM PAL assists in ensuring that authorization request decisions are made based on medical necessity not a technical defect.

The UM PAL shall communicate with Early Periodic Screening, Diagnostic, and Treatment (EPSDT) case managers, providers and enrollees on prior authorization requests for prior authorized services. For all requests from a provider that do not include the requested information or if the request has a technical defect, the PAL shall contact the enrollee, provider and EPSDT support coordinator to inform him/her of:

1) the information needed;
2) the type of provider from which they should obtain the information;
3) to whom the information should be returned; and
4) the timelines for returning the information

If the MCO's Prior Authorization Unit is informed that additional information is pending an appointment with a provider, the enrollee must inform the UM PAL of the appointment date. The UM PAL should follow up within five calendar days of the appointment, and then follow-up as necessary to obtain the needed information, unless the enrollee fails to keep the appointment.

The UM PAL shall assists with problems on each prior authorization request, unless the prior authorization unit fails to receive the requested information within 30 days after the MCO notified the provider, enrollee or EPSDT support coordinator that additional information was required; or the enrollee did not keep the medical necessity evaluation appointment with the provider.

MCOs shall not develop their own practices and policies outside of the PAL process to acquire missing information and/or remedy technical defects. If you cannot approve a request in the required timelines because of missing information, you must submit it to the PAL and go through the process including a 10-Day letter (Notice of Insufficient Documentation) when you cannot get the information through other means of contact.

PRIOR AUTHORIZATION REQUIREMENTS

The MCO's Prior Authorization Unit shall **eliminate unnecessary bureaucratic barriers** to obtaining prior authorization for all prior authorized services. They shall communicate with the EPSDT support coordinator if applicable.

If a part of the prior authorization request can be approved as medically necessary, but a medical necessity determination cannot be made for the remainder of the request, the MCO shall approve what is medically necessary and label the notice "**PARTIAL APPROVAL**." The remainder of the request is sent to the UM PAL to attempt to obtain additional information. Once the PAL process is exhausted, if the remaining portion of the request is denied, a new notice labeled "**PARTIAL DENIAL"** goes out and explains that it went to the UM PAL but the remainder was still denied and all the reasons why. The MCO's Prior Authorization Unit shall **provide notice of approval or denial of prior authorization to EPSDT case managers, providers, and enrollees**. The unit shall issue written decisions on prior authorization within 10 calendar days (medical appliances, equipment and supplies shall be issued within 25 days) of the enrollee's request, except when there is insufficient information to issue a decision.

If there is insufficient information to issue a decision, the UM PAL shall contact the EPSDT case manager, provider, and enrollee (if no case manager) by phone, explaining the documentation needed and possible sources of that documentation.

If 10 calendar days elapse after the PAL phone call, the PAL shall provide **written notice** to the EPSDT case manager, provider and enrollee that:

- Describes the missing information, how to obtain it, and how to contact the PAL with questions;
- Explains how health care professionals can contact the PAL at any time;
- States that the request will be denied unless "You notify the PAL within 30 days about an appointment you made with a health care professional of the type we specified, and you attend the appointment, or we have received all needed documentation within 30 days"; and
- Includes a form to return to the PAL with the date of the appointment and the name of the provider.

The MCO's Prior Authorization Unit may deny the request for any prior authorized service if no additional information is received within 30 days of the notice described above. The form for prior authorization shall include a space for the EPSDT case manager's name and contact information.

CHRONIC NEEDS

The MCO shall determine in each case if a prior authorized service can reasonably be expected to be required at the same level in future time periods; and if so, services for successive prior authorization requests shall be authorized upon receipt of the physician's prescription only. Enrollees and their case manager, if any, shall be required to report to the MCO any change in the enrollee's condition that reduces the level of services needed. If a case is labeled chronic needs, prior to the enrollee selecting an MCO, they must be maintained as a chronic needs case until the requested amount changes or their condition changes.

When a case is deemed **Chronic Needs,** the provider must be notified with the following information:

> "This is to advise that the enrollee referenced above has been deemed a chronic needs case. For your next request you will need to submit a prior authorization request form and a physician's script with a physician's statement indicating the condition of the patient has not changed and write CHRONIC NEEDS CASE at the top of the prior authorization request."

PROVIDER REFUSES TO SUBMIT PRIOR AUTHORIZATION REQUEST

The MCO must provide a mechanism to ensure that the enrollee can notify the MCO when a provider refuses to submit an enrollee's request for prior authorization of a service (only if prior authorization is required).

The MCO shall send a notice to the enrollee and his/her case manager of what was not submitted and shall inform them of a mechanism that can be used to access another provider if so desired. The notice shall state that if two providers have refused to submit the full request, or if there is no provider from whom to request the service, the enrollee can request a review by the MCO of their potential eligibility for the services not submitted.

The notice shall state that if two providers have refused to submit the full request, or if there is no one from whom to request the service, the enrollee can request a review by the MCO of their possible eligibility for the services not submitted. The notice shall advise where to send the request and that the request must be accompanied by a physician's written statement as to why the services not submitted are necessary, and shall list the enrollee's information that should be included.

If the enrollee requests the review described above and it includes a physician's statement, the MCO shall review the information provided to determine if the enrollee might meet the criteria to obtain prior authorization of the service sought. If the enrollee could not with further development of the information meet the criteria to receive the service, the MCO shall issue a notice denying prior authorization with the right to request a fair hearing regarding the denial. In all other instances, the determination shall be that with further information prior authorization might be granted. If this is the determination, then the MCO shall find a provider

to submit the request or take other steps to obtain a prior authorized decision as to whether the enrollee qualifies for the service.

DENIAL/PARTIAL DENIAL NOTICES/PARTIAL APPROVAL

A prior authorization denial/partial denial notice must:

- State specifically each reason for denial.
- If the same service was prior authorized for an enrollee for a period immediately preceding the request, the MCO shall consider whether there is evidence that the enrollee's condition has actually improved or if there are other changed circumstances that warrant a change in services. If, after such consideration, the MCO concludes that an enrollee should not continue to be authorized for a service or level of service that he or she was previously authorized to receive, the MCO shall document the reasons for the change in services and notify the Department's Chisholm Compliance Team before denying the prior authorization request.
- Whether there is evidence that the enrollee's condition has actually improved, or that the changed circumstances make less care necessary (the failure of documentation to recount all conditions previously listed shall not, without confirmation, justify a presumption that the condition no longer exits).
- The MCO obtaining a statement from the prescribing physician that he or she now agrees to a number of hours of services less than originally prescribed does not relieve the MCO of the obligations established above.
- If the service is denied on grounds that alternative service would be effective but less costly, the notice shall:

    - Identify the less costly service in sufficient detail to allow the enrollee/provider to assess the value of the service. Explain the less costly service will be approved and can be obtained pending appeal of denial of the requested service.

- If the MCO Prior Authorization Unit disagrees with the treating provider, the MCO shall:

    - Explain specific reasons for disagreement in enough detail for treating provider to submit additional information.

- If the request is duplicative, the denial should state that the provider withdrew the requests because these services have been approved through another request.
- For requests involving hours of services, clearly indicate how many hours were requested and are approved. The MCO shall not use units.
- Be in twelve-point font and not in all capital letters.
- **Clearly** state the Medicaid rule and/or policy relied upon for the denial and state with specificity all reasons why the criteria of the Medicaid rule and/or policy have not been met when denying services for Applied Behavior Analysis (ABA), Pediatric Day Health Care (PDHC) and Positron Emission Tomography (PET) scans.

- For all other services, **clearly** state the MCO policy relied upon for the denial and state with specificity all reasons why the criteria of the MCO policy have not been met when denying services.
- Language must be at a sixth grade reading level if possible.
- The notice must explain that an EPSDT support coordinator can assist them in obtaining services and how the enrollee can access an EPSDT support coordinator.
- If a prior authorization request is denied or partially denied, provide appeal rights and clearly notify enrollees of those rights.

All letters, notices, and forms required for enrollees shall be approved by the Louisiana Department of Health (LDH) prior to being implemented and/or used.

If a service is denied because it is not covered by the MCO, but covered by Medicaid Fee for Service, the notice must direct the enrollee and provider to seek the services from DXC Medicaid Fee For Service.

If a service is **partially approved** while pending with the PAL, the notice shall state that the remainder is pending with the PAL and list all the information the PAL is seeking and why the request could not be approved as submitted.

MULTIPLE SERVICES ON ONE NOTICE

For requests involving hours of services, clearly indicate how many hours were requested and how many hours were approved. If there are multiple services, please be sure to list a breakdown of each service separately.

Service 1

1. State the service the provider requested, listing how many hours, days a week, and number of weeks/months.
2. Specify what was denied by listing how many hours were denied of the requested service.
3. List how many hours were approved of the requested service.
4. Advise what needs to be done in order to obtain approval for services,
    a. To qualify for services you must meet criteria. List out all criteria needed to obtain approval.
    b. Advise what documentation submitted says about the member.
    c. Advise why the documentation does not show the member meets criteria.
    d. Conclusion. Explain why certain services were denied and some were approved.

Service 2

1. State the service the provider requested, listing how many hours, days a week, and number of weeks/months.

2. Specify what was denied by listing how many hours were denied of the requested service.
3. List how many hours were approved of the requested service.
4. Advise what needs to be done in order to obtain approval for services,
    a. To qualify for services you must meet criteria. List out all criteria needed to obtain approval.
    b. Advise what documentation submitted says about the member.
    c. Advise why the documentation does not show the member meets criteria.
    d. Conclusion. Explain why certain services were denied and some were approved.

REDUCTION IN SERVICES

If the same service was prior authorized for a member for a period immediately preceding the request, the MCO shall consider whether there is evidence that the member's condition has actually improved or if there are other changed circumstances that warrant a change in service. If after such consideration, the MCO concludes that a member should not continue to be authorized for a service or level of service that he or she was previously authorized to receive, the MCO shall document the reasons for the change in services and notify the Department's Chisholm Compliance Team before denying the prior authorization request. This can all be accomplished through the notice review process.

DUPLICATIVE SERVICES

If the request is duplicative, the denial should state that the provider withdrew the requests because these services have been approved through another request

FEE FOR SERVICE

If a service is denied because it is not covered by the MCO, but covered by Medicaid Fee For Service, the notice must direct the enrollee and provider to seek the services from DXC Medicaid Fee For Service.

ASSISTING IN FINDING SERVICE PROVIDERS (Coordinator PAL)

In the event that an individual class enrollee, or support coordinator acting on behalf of the enrollee, is **unable to locate a willing provider** who is able to promptly provide the necessary services to the enrollee, the MCO agrees to take all reasonable steps necessary to locate a provider to submit a request for prior approval for the services requested by the class enrollee (if the service has not already been prior approved) within 10 working days. If the service has already been prior approved, the MCO agrees to take all reasonable steps necessary to locate and arrange for services within 10 working days.

The MCO must have a **toll-free number** for the enrollee to access in order to alert the MCO that they cannot locate a provider. The toll-free number must be in operation from 8 a.m.

to 4:30 p.m. Central Time (CT) (CT encompasses both Central Standard Time and Central Daylight Time). There must be a voicemail message system for overflow and after-hours calls. All incoming calls must be documented. All calls that go to voicemail must be returned in one business day. Voicemails received after 4:30 p.m. CT will be deemed received on the next business day. MCO staff will contact as appropriate the family, enrollee, provider, and support coordinator no later than two business days from the initial call.

If the enrollee or support coordinator is **unable to locate a provider willing to submit a prior authorization**, the MCO will pull a list of all enrolled providers in the region and contact each provider to determine who may be willing to provide the service. If a provider cannot be found in that region, the MCO must make efforts to locate a provider outside the region. If contacts are unsuccessful, the MCO must take all other reasonable and necessary steps to locate a provider. Once the MCO has located a willing provider, the MCO must inform the enrollee of the providers they may choose. Once a provider is selected, the MCO must monitor the prior authorization request and contact the enrollee until services are delivered. If the MCO has been unable to locate a provider within 10 calendar days, the MCO must document why and continue trying to locate a provider until all reasonable avenues have been exhausted.

If services have already been prior authorized and there is **no staff to deliver the service**, the MCO will pull a list of all enrolled providers in the region and contact each provider to locate a willing provider. If a provider cannot be found in that region, the MCO must make efforts to locate a provider outside the region. If attempts are unsuccessful, the MCO must take all other reasonable and necessary steps to locate a provider. The MCO will assist in the transition of the prior authorization from the previous provider. If contacts to existing providers are unsuccessful, the MCO must take all reasonable and necessary steps to locate a willing and able provider. Once a provider is selected, the MCO must monitor the prior authorization request and contact the enrollee until services are delivered. If the MCO has been unable to locate a provider within 10 calendar days, the MCO must document the reason and continue trying to locate a provider until all reasonable avenues have been exhausted.

If the family has failed without good cause after 30 days to take necessary steps to obtain services, the MCO may cease its efforts without prejudicing future request.

The MCO must put a mechanism in place for enrollees to notify the MCO when a provider of service that has to be prior authorized **refuses to submit an enrollee's** request for prior authorization of a service.

EXTENDED HOME HEALTH SPECIFIC PROVISIONS

In addition to all the requirements for a denial/partial denial notice above, for Extended Home Health, the following also apply:

A. The notice specifies the additional information that would support the need for the prescribed hours (statements such as "submit medical information to justify the additional hours not approved," is not sufficient);
B. If requested hours of Extended Home Health services are denied or reduced because personal care services (or another service) would be effective and less costly, the Prior Authorization Unit will in the notice of denial, partial denial, or partial approval:
    1. Identify the less costly services;
    2. Include the number of hours that service will be approved based on the information already submitted.
    3. Specify the tasks and functions in the current request that the alternative service cannot perform;
    4. State the need for an adult caretaker to be on the premises during times of service, if applicable;
    5. Inform the enrollee and the provider that the less costly item or service will be approved, provided the recipient has an available provider submit only the appropriate prior authorization form and prescription for the item.

EPSDT PERSONAL CARE SERVICES (PCS) SPECIFIC PROVISIONS

For EPSDT PCS, MCOs must follow these guidelines found in Health Plan Advisory 15-8. Denial reasons for PCS must be in line with HPA 15-18.

EPSDT PCS notices must provide the enrollee and the provider with specific information about each task, including whether or not the service was approved for the task, time approved to complete the task, and when the service is not approved as requested, the reason the service was not approved.

Please note in the notice that the hours of PCS are approved/denied, in accordance with Louisiana Administrative Code LAC 50.XV. Chapter 73 and Louisiana Medicaid Program Provider Manual, Chapter 30:

Example language: Your provider requested [X]hours per day, (X) days a week of Personal Care Service (PCS) and this request is partially denied. We have approved for you to continue receiving [X] hours per day, [X] days a week of PCS. The additional [X] hour per day requested is denied (specify all reasons why it was denied).

See Example of breakdown of Requested Service below:

A. Activity of Daily Living (ADL) 1 amount of time [xxxx]
B. ADL 2 amount of time [xxxx]
C. ADL 3 amount of time [xxxx]
D. ADL 4 amount of time [xxxx]

E. ADL 5 amount of time [xxxx]

See example of breakdown for Approved Service below:

A. ADL 1 amount of time [xxxx]
B. ADL 2 amount of time [xxxx]
C. ADL 3 amount of time [xxxx]
D. ADL 4 amount of time [xxxx]
E. ADL 5 amount of time [xxxx]

WORKING WITH THE LDH INTERNAL PAL

The MCO's Coordinator PAL shall interact with the LDH internal PAL to resolve any issues that are forwarded to the LDH PAL. The LDH PAL contacts class enrollees who are approved to receive Extended Home Health and/or EPSDT PCS on a biweekly basis. If an enrollee is not receiving services as approved, the LDH PAL will contact the MCO's PAL to work towards coordinating the receipt of services as approved. The MCO's Coordinator PAL shall work with the provider and the enrollee to resolve the issues in service delivery. This may include assisting the enrollee in locating a new provider. Once the services are back in place, this should be communicated to the LDH internal PAL.

IDENTIFICATION OF THE MCO'S CHISHOLM PAL

The MCO must identify to LDH the person or persons who are working as their UM PAL and their Coordinator PAL (they can be the same person) so that the LDH PAL can communicate with them.

WORKING WITH EPSDT SUPPORT COORDINATORS

Enrollees may elect to utilize EPSDT Support Coordination. If an enrollee has a Support Coordinator, the MCO must communicate and work with the Support Coordinator to ensure that services are approved and provided within 60 days from the date on which the enrollee requested the services through the Support Coordinator. Statistical Resources and Guidance, Inc. will give the MCO's care managers access to the electronic plans of care for enrollees.

PROCESS FOR CHISHOLM NOTICE REVIEW AND APPROVAL

For all Chisholm denials, partial denials and partial approvals, the notices must be sent to LDH Chisholm Compliance staff for review and approval prior to being sent to the member.

Before sending the notice for review and approval, check the notice against the Chisholm Guide and fill out the Chisholm Notice Checklist to ensure that the notice being sent is in compliance and accurate.

Once you have reviewed the notice and checklist, submit an AD HOC Report, under "Submit New," to Salesforce with the log in credentials provided. Next, the category dropdown will appear and you will then select Chisholm from the category. Then, you will select your correct Managed Care Entity (MCE) from the name dropdown. In the notes section, you will enter the correct prior authorization number. Once you finish the category, name, and notes sections, you will then upload the full notice in PDF format, a word version of the notice, the Chisholm Notice Checklist, and any supporting documents related to the request for services. Once you have uploaded all needed documents, then you will finally click Submit Report. This will then trigger an email task to LDH staff to edit and comment on the content of the word document containing the notice and supporting documents before an approval is rendered. From the Managed Care Reporting screen, you can review any reports you submitted under Submit Ad Hoc Report/ Data Transfer.

Steps to Upload Documents into Salesforce:

1. Navigate to https://ldh.force.com/Reporting/s/and log in with credential provided.
2. Select "Submit New" under Submit Ad Hoc/ Data Transfer.
3. Select Chisholm from the Category dropdown.
4. Select your correct Managed Care Entity (MCE) name from dropdown.
5. Enter the correct Prior Authorization (PA) number in the notes section.
6. Upload all needed documents (PDF/ word version of notice, checklist, and any supporting documents).
7. Click Submit Report.

If there is an issue with Salesforce or connectivity, contact LDH Service Center at (225) 219-6900, option1 then option 4. If the connectivity issues are not resolved, you should not submit notices via the regular process until issues can be resolved. Please wait for instructions from LDH Chisholm Compliance staff member before taking any actions.

The reviewer will reply with an approval, denial, comments, questions, and or edits. If you do not hear from an LDH Chisholm Compliance staff member within 24 hours from submission, please email the team members and alert them that the notice is awaiting review. If LDH staff makes edits or comments to a proposed notice, a response is needed answering the questions, and making the changes necessary as requested. The notice cannot be sent until it is approved.

If necessary, you can email Rene Huff at Rene.Huff@la.gov , Danielle Boykin at Danielle.Boykin@la.gov, and Breante' Moore at Breante.Moore@la.gov, to discuss any issues you may have.

MCO Salesforce Upload Point of Contact

Plan Name	Point of Contact
Aetna Better Health	Karen Lake
AmeriHealth Caritas	Faye Colbert Jenkins, Lakeshia Dickerson, and Kathryn Cox
Healthy Blue	Robin Labranche and LaTonya Freeman
Humana Healthy Horizons	Adrian Obryant and Danielle Lee
Louisiana Healthcare Connections	Danielle Smith- Cage
UnitedHealthcare	Christal Anchord and Becky Ash

Medicaid Fee For Service Prior Authorization Point of Contact

Plan Name	Point of Contact
Gainwell	Inderjit Singh, Stephanie Guarino, Karen White, and Peggy Misner

Chisholm Notice Checklist

MEMBER INFORMATION	
Member Name:	
Address:	
CC: Support Coordinator	
Provider:	
Date of Notice:	
Medicaid ID:	
Initial Request	Yes ☐ No ☐

CHECKLIST		
☐	Cleary marked DENIAL, PARTIAL APPROVAL, OR PARTIAL DENIAL.	
☐	Clearly name the service or items requested.	
☐	Specify all reasons for denial or partial denial, which includes why the criteria of the Medicaid rule and/or policy have not been met. (A lay person should be able to read it and understand why the member didn't qualify for the service).	
☐	Include the specific language from the section of the Rule or policy they are using as a basis for denial.	
☐	Language must be at a sixth grade reading level if possible.	
☐	For requests involving hours of services, clearly indicate how many hours were requested and are approved.	
☐	Be in twelve point font and not in all capital letters.	
☐	Is Partial Approval correctly sent while pending PAL process and awaiting final decision.	
☐	In the notice for denial/partial denial of any services/items that are prior authorized, the notice must explain that an EPSDT support coordinator can assist them in obtaining services and how to access an EPSDT support coordinator.	
☐	If a prior authorization request is denied or partially denied, provide appeal rights and clearly notify members of those rights.	
	Reviewed by :	Date: