

Louisiana Medicaid State Fair Hearing Companion Guide For Managed Care Entities

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Contents

PART 1: GENERAL INFORMATION	3
Overview	3
PART 2: MCE Responsibilities.....	3
MCE Information	3
Administrative Controls.....	3
Witnesses and Documents	4
SFH Presentation and Documentation	4
Evidence	4
Summary of Evidence Format	5
Summary of Evidence Content	5
Reporting Changes	6
Postponement Requests	7
Withdrawals	7
No Shows	7
PART 3: DAL Responsibilities.....	7
Scheduling	7
Postponements	7
PART 4: Salesforce Site.....	8
Salesforce Document Uploads	8
Decisions.....	8

APPENDICES

Appendix A: State Fair Hearing Request Form *(This is an example.)*

Appendix B: Notice of Disposition *(This is an example.)*

Appendix C: State Fair Hearing Cover Memorandum

Appendix D: Summary of Evidence *(This is an example.)*

PART 1: GENERAL INFORMATION

OVERVIEW

The Managed Care Entity (MCE) shall inform Medicaid enrollees in writing on the Notice of Adverse Benefit Determination or Notice of Disposition (see example Appendix B) of their right to a State Fair Hearing (SFH). Information about SFHs, including forms (see example Appendix A) and methods for requesting an SFH, shall be available on the MCE's website, included in the MCE's Member Handbook, and mailed to the enrollee or their representative upon request.

The MCE shall provide a verbal explanation about the SFH process in any communication or discussion when such explanation is appropriate, particularly in communications concerning denials, rejections, terminations, or reduction of Medicaid covered services.

PART 2: MCE RESPONSIBILITIES

MCE INFORMATION

The MCE shall designate a single point of contact for LDH.

Once the MCE level appeal process has been exhausted and the claimant/appellant or authorized representative requests an SFH with the Division of Administrative Law (DAL), the DAL will notify the MCE by email requesting an SFH packet, which consists of a cover memorandum, summary of evidence and supporting documents.

For SFHs filed with the DAL, the MCE must provide the SFH packet to LDH within seven (7) business days of receipt of the Summary of Evidence request from DAL.

For SFHs filed with the MCE (written/verbal/fax), the MCE shall document the date of receipt and shall provide the request to LDH within one (1) business day of receipt, to obtain a docket number. The MCE shall submit the Summary of Evidence to LDH within seven (7) business days of receiving the appeal request.

All information shall be submitted to LDH via Salesforce, as described in the *Salesforce Site* section of this Guide.

NOTE: Except during the hearing, the DAL does not allow any direct communication with Administrative Law Judges (ALJs) by anyone with LDH or the MCE for any reason. This includes e-mail, telephone, or any other means of communication. Pursuant to instructions from the DAL General Counsel, all communications with the DAL by LDH or the MCE must go through the Clerk of Court. The telephone number is (225) 342-0443 or (225) 342-6291, and the email address is LDHProcessing@adminlaw.state.la.us.

ADMINISTRATIVE CONTROLS

Administrative controls must be maintained to ensure that the MCE acts promptly upon receipt of a request for an SFH. The MCE must maintain a central tracking system recording receipt of all SFH requests including:

- ❖ Requests made in writing when the enrollee visits the MCE's office;

- ❖ Written requests received by mail, fax, or e-mail;
- ❖ Requests expressed orally when the enrollee visits the MCE's office;
- ❖ Requests expressed orally over the telephone; and
- ❖ Requests forwarded from DAL.

Each SFH request must be recorded within one (1) business day of receipt of notification from the DAL or of the date the claimant/appellant's request was received by the MCE. Each entry must show the following information:

- ❖ Date of receipt of the SFH request;
- ❖ Date claimant/appellant's request forwarded to DAL (if applicable);
- ❖ Last date the appropriate response is due to the DAL, which shall be within seven (7) calendar days of receipt of the request;
- ❖ Claimant/appellant's name, Medicaid ID number, docket number (if known), and Social Security number; and
- ❖ Phone number of the head of the household.

Once the request is logged, the MCE shall utilize a tracking system to monitor the preparation of the Summary of Evidence and its timely submission to the DAL.

WITNESSES AND DOCUMENTS

The MCE must arrange for witnesses or documents when these are considered necessary and material to the case without being unduly repetitious of other evidence.

When the MCE's action and decision has been based on verbal collateral contacts, these persons must attend the SFH to substantiate the MCE's action.

If the presence of a witness or a document cannot be arranged voluntarily, the MCE shall submit a request for a subpoena to the DAL. The ALJ will evaluate requests and authorize the MCE to serve the subpoena, if appropriate, and will independently decide on the need to issue a subpoena.

SFH PRESENTATION AND DOCUMENTATION

An MCE representative is expected to present and document the MCE's case. This requires a complete knowledge of the case situation and a review of applicable regulations and policies. A conference between all involved MCE personnel may be held to prepare for the appeal. All decisions regarding a case presentation must be made by the MCE internally; LDH will not comment or advise the MCE on any case presentation decisions.

EVIDENCE

The following types of evidence are listed in the order of importance:

1. Medical information to support the MCE's decision to deny medical services/benefits.
2. Sworn testimony of a person's direct knowledge of the case.

3. Written information obtained from the claimant/appellant or authorized representative.
4. Verbal verification; however, verbal statements are given no weight if they are disputed by the claimant/appellant. Statements attributed to unidentified sources should not be mentioned. If a person has given information used in the MCE decision being appealed, that person should attend the SFH to present direct evidence and be cross-examined by the claimant/appellant or his authorized representative. The claimant/appellant or his authorized representative has the right to cross examine witnesses.

The MCE must organize all written and verbal evidence and plan for its presentation to avoid delays or duplication. Organization and preparation will improve the MCE's ability to present its case effectively and professionally.

STATE FAIR HEARING PACKET

The MCE shall prepare and submit a State Fair Hearing Packet, unless:

- ❖ The request for an SFH is not made within the time limits specified in the applicable policy, in which case the MCE shall notify the DAL of untimeliness and provide proof (e.g., copy of Notice);
- ❖ The claimant/appellant withdraws the request, in which case the MCE shall provide written confirmation from claimant/appellant to the DAL; or
- ❖ The appeal is subsequently resolved within MCE policy and the MCE has corrected the action and has confirmed this with the claimant/appellant in writing, in which case a copy of the written confirmation shall be submitted to the DAL.

The SFH Cover Memorandum (Appendix C), Summary of Evidence (Appendix D), and all documents referenced must be submitted to the DAL. One complete copy of the packet shall be retained in the MCE's enrollee record. One complete copy of the packet shall be mailed to the claimant/appellant.

The MCE shall utilize the Summary of Evidence sample (Appendix D) provided in this Guide unless an alternative version has been approved by LDH.

SUMMARY OF EVIDENCE FORMAT

The Summary of Evidence must be typewritten, labeled at the top, and signed and dated at the bottom. Do not use MCE letterhead. The Summary of Evidence is a critical document in the SFH packet. Its purpose is to support the MCE's decisions and to explain and provide information necessary to the claimant/appellant or his authorized representative in preparing for the SFH. It should be easy to read and understand. Abbreviations, acronyms, and terminology that may be unfamiliar to the claimant/appellant should be avoided. The claimant/appellant should be referred to by name rather than "the member," "the beneficiary," or "the enrollee." MCE actions being appealed should be explained in concise statements with precise references to policy and appropriate documents.

SUMMARY OF EVIDENCE CONTENT

- I. Identifying Information:
 - a. Claimant/appellant's name;

- b. Medicaid ID number;
 - c. Docket number, if known;
 - d. Last 4 digits of Social Security number;
- II. Action Appealed:
 - a. Basis of the claimant/appellant's appeal (e.g., denial of services, suspension or reduction in services, termination of services, failure of the MCE to act);
 - b. Statement that internal resolution process was followed;
 - c. General reason for the MCE's action or proposed action;
 - d. Effective date of the action; and
 - e. Status of the claimant/appellant's benefits. If benefits are continued at the same level because the enrollee appealed within the advance notice period, this fact must be stated.
- III. Explanation of Action and Applicable Policy:

(This section should blend with the documents section so details are not unnecessarily repeated. Emphasis must be placed on citing facts and their impact. Case activity should be detailed in chronological order as they occurred):

 - a. Concisely stated reason for the MCE action;
 - b. LDH and/or MCE policy authorizing this action by specific reference number.
- IV. Related Documents

This section must list all documents relevant to the action under appeal. Each document should be identified by its official name (rather than by a form number), date, and relevance. The copies of the documents must be labeled in the bottom right corner of the document with the word "Exhibit" and in alphabetical order, such as "Exhibit A page 1 of 10," "Exhibit A page 2 of 10," etc.

The Notice of Adverse Benefit Determination and Notice of Disposition (Appendix B) must always be included. The MCE notice or other document on which the appellant requested an SFH must be included, if applicable.

The complete packet shall be uploaded to Salesforce as described in the *Salesforce Site* section of this Guide. The MCE must also send a copy of the SFH packet to the claimant/appellant. If the claimant/appellant has retained legal representation, the MCE shall mail a copy of the SFH packet to that individual as well. If the MCE is notified of legal representation at a later date, the MCE must provide the SFH packet promptly to that individual.

REPORTING CHANGES

Once the SFH process begins and until a decision is rendered, the MCE must report changes in the claimant/appellant's circumstances to the DAL.

If there is a change in benefits for a reason other than the issue being appealed, or the Enrollment Broker notifies the MCE of the enrollee's disenrollment from the MCE, notice must be sent to the DAL. The MCE must also promptly report to the DAL any address change or other changes in circumstances which might affect the necessity of the SFH.

The MCE must report changes to the DAL in writing at any time during the hearing process as necessary.

POSTPONEMENT REQUESTS

Any postponement request must be in writing. If a claimant/appellant or authorized representative contacts the MCE to request a postponement of the SFH, the MCE shall inform the claimant/appellant that only the DAL can grant this request. The MCE shall relay the postponement request to the DAL on behalf of the claimant/appellant, unless the claimant/appellant requests to directly contact the DAL. The DAL will notify all interested parties of the rescheduled SFH date, if granted.

WITHDRAWALS

The claimant/appellant may withdraw his or her request for an SFH by notifying the DAL in writing at any time prior to the SFH.

It is not appropriate for an employee of the MCE to suggest that the appellant withdraw an SFH request.

NOTE: The MCE shall inform the enrollee that withdrawals over the telephone cannot be accepted unless on a recorded line. If a written withdrawal is not received, the MCE is responsible for submitting the SFH packet.

NO SHOWS

When a claimant/appellant or authorized representative does not attend a scheduled hearing, the ALJ and the MCE representative must go on record to confirm that the claimant/appellant or authorized representative did not appear for the scheduled SFH nor contact the MCE to reschedule the hearing, and that the claimant/appellant's notice was not returned to the DAL or MCE as undeliverable.

If the MCE does not call into the hearing within fifteen (15) minutes of the scheduled start time and the claimant/appellant calls in for the hearing, the DAL will proceed with the hearing and will issue a decision in favor of the claimant/appellant.

PART 3: DAL RESPONSIBILITIES

The DAL has the sole responsibility for accepting or rejecting all requests for an SFH in accordance with applicable rules, state statutes, and federal regulations. The DAL must acknowledge SFH requests made directly to that office by or for a claimant/appellant, or requests submitted by the MCE. The MCE and the claimant/appellant shall be notified in writing of the DAL's acceptance or denial of the request.

SCHEDULING

The DAL will schedule all SFHs during regular business hours. The claimant/appellant, authorized representative, and the MCE will be notified at least ten (10) days in advance of the time, place, and date of the SFH.

POSTPONEMENTS

The DAL may grant postponements of SFHs. All postponement requests must be directed in writing to the DAL.

If a postponement has not been arranged with the DAL and the claimant/appellant does not attend the SFH, a Conditional Order is sent to the claimant/appellant or authorized representative. The claimant/appellant has ten (10) calendar days to respond and show good cause for the absence. The hearing may be rescheduled if the claimant/appellant provides good cause. If the claimant/appellant fails to respond by the tenth day of the Conditional Order, the appeal will be dismissed. If there is no response, the Conditional Order is the final notice to the claimant/appellant. The DAL will notify the MCE of all decisions regarding these matters.

PART 4: SALESFORCE SITE

SALESFORCE DOCUMENT UPLOADS

MCEs shall upload documents to LDH's Salesforce site as an ad hoc report in PDF format. Refer to the [Salesforce MCE User Guide](#) for in-depth instructions. Use the appropriate "Category" (State Fair Hearing) and "Name" (DAL Documents), and provide additional key information under "Notes" (e.g., "Docket 2022-1234"). In the "Notes" box, enter key information, including the name of the intended recipient.

DECISIONS

After the hearing is held and the DAL makes a decision, the DAL uploads the decisions to the MCE's Final Decision folder in its SharePoint site. LDH retrieves the decisions and emails the MCE with the final decision.

APPENDIX A – Request for State Fair Hearing Form

**LOUISIANA DEPARTMENT OF HEALTH
REQUEST FOR STATE FAIR HEARING FORM**

[Health Plan to INSERT Recipient Name]

[Health Plan to INSERT Street Address]

[Health Plan to INSERT City, State & Zip Code]

I want to appeal the decision [INSERT Health Plan Name] made on my case because:

Signature: _____ Date: _____

Recipient/Representative: _____

Your address if different from the address shown above: _____

Telephone Number: _____

Social Security Number: _____

Email address: _____

Name, Address and Phone number of your Authorized Representative at the Hearing, if any:

**MAIL THIS COMPLETED FORM TO:
DIVISION OF ADMINISTRATIVE LAW
LOUISIANA DEPARTMENT OF HEALTH SECTION
P.O. BOX 4189
BATON ROUGE, LA 70821-4189**

The postmark showing the date you mailed your appeal will be the date of your appeal request.

You may fax the completed form to (225)219-9823 or complete the form online at:

<https://www.adminlaw.la.gov/HH.htm>

After you ask for a State Fair Hearing, the Division of Administrative Law will send you a Notice by mail of the date, time and location of your State Fair Hearing. If you are unable to mail or fax the attached form, you may phone (225)342-1800 to give the information for your appeal.

APPENDIX B – Notice of Disposition

Health Plan Name/Logo

Notice of Disposition

Member's Name:

Member's ID#:

Member's Address:

Date:

Dear Member,

Thank you for allowing us time to review our previous decision regarding {service\procedure}, which was (denied, reduced, suspended or terminated). We received your request on DATE, we completed the appeal on DATE.

We have reviewed all of the information provided and our decision is:

- ☐ To keep the previous decision for the requested service\procedure. This means that we will not provide the requested service.
- ☐ To provide the service\ procedure. This means that your provider may provide the requested service. We are also sending a copy of this approval to your provider so please feel free to contact them to schedule your appointment.

If you disagree with our decision, you may ask for a State Fair Hearing. If you want to request a State Fair Hearing, you **must** do so by _____ (120 days from the date of this notice). The ***Request for a State Fair Hearing*** form is attached to this letter. If you request a State Fair Hearing, please include **a copy of this letter along with the form** and mail to the address on the form.

If you ask for a State Fair Hearing, you will have the right to:

- ☐ Review your case and/or any information (you, the Health Plan or the provider) plan to use before the hearing;
- ☐ Appear at the hearing;
- ☐ Represent yourself or have anyone else you choose to represent you. You may be able to get free legal help by calling the nearest legal assistance office at (800) 310-7029;
- ☐ Present your own evidence or witnesses; and
- ☐ Question any person who testifies against you.

If you have any questions that we may help you with please feel free to call us at:

_____.

***** DON'T FORGET TO INCLUDE THE NOTICE OF BENEFIT ADVERSE DETERMINATION LETTER WITH THIS FORM*****

State Fair Hearing Cover Memorandum

Name of Submitter:

Date Request submitted:

Contact Phone Number:

Entity Submitting Summary of Evidence: (Check one) ☒ Enrollment Broker ☐ Health Plan
☐ Medicaid Fiscal Intermediary ☐ LDH

Is Copy of denial notice included: ☐ No ☐ Yes **If yes, specify the date the denial was issued:**

Entity Filing Request*: SPECIFY IF EXPEDITED HEARING IS BEING REQUESTED ☐ No ☐ Yes

If request is filed by the:

Provider on the Recipient/Member's behalf: The filing of this request requires written consent from the Health Plan's member for the provider to file on their behalf. Is the written consent form included with the appeal request? Yes No ☐ ☐

The filing of this request requires a copy of the appropriate denial notice (*Notice of Adverse Action or Notice of Disposition*) to be included with the appeal request. Is the Notice enclosed? Yes No ☐ ☐

If request is filed for a Provider: (FFS or Bayou Health-Shared Only)

The filing of this request requires a copy of the appropriate denied Medicaid claim. Is the Claim enclosed? ☐ Yes ☐ No

*This state fair hearing request may be rejected if complete documentation is not submitted.

** When the request is received by mail, the original envelope* must be routed to the Division of Administrative Law with the request.

Recipient/Member's Identification information:

(First Name) _____ Last Name) _____ Recipient/Member's

Medicaid ID#: _____

DAL Docket #: _____

Check all that apply ☐ Health Plan Reversal ☐ Untimely State Fair Hearing Request ☐ Premature State Fair Hearing Request
☐ Withdrawal by Appellant

Provide the Benefit/Service(s) that was denied/terminated/reduced/suspended: _____ Have the benefits continued at the

level prior to the request for State Fair Hearing? Yes No N/A ☐ ☐ ☐

The recipient is a member of: (Check which Bayou Health Plan **OR** if in Fee-for-Service Program)

Managed Care Entity:

☐ Aetna ☐ AmeriHealth Caritas ☐ DentaQuest
☐ Healthy Blue ☐ Humana ☐ Louisiana Healthcare Connection
☐ MCNA ☐ United Health Care

*if the member participates in one of the Managed Care Entity above;

Has the Member exhausted Managed Care Entity Internal Appeals Process? Yes ☐ No ☐

☐ Fee-For- Service Program

If recipient is in a Health Plan, provide the Health Plan's ID#: _____

If the recipient is represented by legal representation the following information must be provided for the representative:

Name: _____ Telephone number: _____

Address _____

Other: (Please provide any additional comments you deem essential:

Attestation and Signature: The undersigned attests the above information is accurate and complete. I understand that providing false or inaccurate information may result in administrative actions to the entity as deemed appropriate by DHH.

 Authorized Signature

 Date

SUMMARY OF EVIDENCE

I. IDENTIFYING INFORMATION

Claimant/Appellant's Name

Medicaid ID Number

SSN: xxx-xx-1234

Docket # (*leave blank if one is not available*)

II. ACTION CLAIMANT IS APPEALING

In this section explain who is appealing and what action caused the person to appeal. Example: Jane/John Deaux is appealing the pre-authorization denial of her request for weight loss surgery.

III. EXPLANATION OF ACTION

In this section explain what transpired from the beginning up to the actual request for appeal. Date of action, what type of action and supporting documentation should all be described. The supporting documentation will need to be included in the packet and listed as "exhibits". The exhibits will need to be listed in Section IV (below) in the order in which it is referenced in this section (III).

Example: On February 14, 2011, an appeal was received from Jane/John Deaux for reconsideration of pre-certification denial for weight loss surgery. Jane/John Deaux's request included a letter describing the hardships she faced dealing with obesity (Exhibit A), progress notes from a visit with the XXXX Clinic (Exhibit B), and a radiology report from the American Legion Hospital (Exhibit C).

After review of the prior authorization information (Exhibit D), it was determined that prior authorization for Jane/John Deaux's procedure was denied for failure to submit the medical reason/reasons and documented proof of these reasons for gastric bypass surgery and failure to submit documentation that the patient's medical problems would be alleviated by the requested device/services (Exhibits E and F).

According to policy published in the 2007 Louisiana Medicaid Professional Services Provider Training Manual, "A letter documenting recipient qualifications and medical necessity from the physician must be submitted with the prior authorization request, and must include confirmatory evidence of co-morbid condition(s). The manual notes that in order for a recipient to qualify for a gastric restrictive surgery or gastric bypass, a recipient must:

1. Be a minimal of 16 years of age;
2. Have a documented weight that falls in the morbidly obese range, as defined by a body mass index of greater than 40;
3. Have at least three failed efforts at non-surgical methods of weight reduction;
4. Have a current obesity-related medical conditions(s) which is/are classified as being high risk for morbidity and mortality;
5. Not have a current/recent history of alcohol abuse or abuse of other substance(s);
6. Be capable of complying with the modified food intake regimen and prescribed program which will follow surgery (Exhibit G)

In order for Jane/John Deaux's request for prior authorization to be considered, it is necessary for her medical provider to provide a written statement that details that she meets the aforementioned qualifications. This letter was not provided to the MCE Prior-Authorization Unit, and thus, the prior authorization request was denied appropriately.

I. RELATED DOCUMENTS

Exhibit A: Jane/John Deaux's letter (2 pages)

Exhibit B: Progress notes from XXXX Clinic (20 pages)

Exhibit C: Radiology report from American Legion Hospital (7 pages)

Exhibit D: Prior Authorization information (2 pages)
Exhibit E: etc.
Exhibit F: etc.
Exhibit G: etc.