



Fair Notice Companion Guide

Companion Guide for Contractors and Louisiana Department of Health Staff

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INTRODUCTION

The Fair Notice Companion Guide is a dynamic document created for use by the Louisiana Department of Health (LDH) staff involved in compliance reviews, the managed care entities (MCE), and the LDH program offices that must comply with the Fair Notice Review requirements. The requirement of “fair notice” ensures Medicaid members are provided timely, clear and understandable information that is vital to ensuring access to necessary healthcare services.

GENERAL INFORMATION

These guidelines reflect a continuation of the principles originally established with the Wells Settlement, which ended in October 2019. LDH will continue to ensure compliance with Title 42 of the Code of Federal Regulations relative to timely and adequate notices of benefit determinations for prior authorized services. LDH will continue its process of monitoring of the contracted managed care entities (MCE).

CONTRACTORS AND SERVICES MONITORED

All contractors who authorize services must comply with all Fair Notice Review rules and regulations, as well as the Code of Federal Regulations (42 CFR). The following entities are subjected to the Fair Notice Review and the Title 42, Chapter IV, Subchapter C, Part 438 (Managed Care) - § 438.404:

<u>Acronym</u>	<u>Contractor/MCE</u>
<i>AET</i>	Aetna Better Health of Louisiana
<i>ACLA</i>	AmeriHealth Caritas of Louisiana
<i>DQ</i>	DentaQuest
<i>GT</i>	Gainwell Technologies
<i>HB</i>	Healthy Blue
<i>HUM</i>	Humana Healthy Horizons in Louisiana
<i>LHCC</i>	Louisiana Healthcare Connections
<i>MCNA</i>	Managed Care of North America

The Fair Notice Review only covers applicable prior authorized services. These service types include the following:

<u>Service Type/Code</u>	<u>Service/Acronym</u>
05	Rehabilitation Services (REHAB)
06	Home Health (HH)
09	Durable Medical Equipment & Supplies (DME)
12	Pharmacy (excl. injectable/physician administered) (PHARM)
16	Personal Care Services (PCS)
31	Psychosocial Rehabilitation Services (PSR)
32	Community Psychiatric Supportive Treatment (CPST)
40	Imaging
49	Other Behavioral Health Services (OP/Prof) (BHS)
71	Pediatric Day Health Care (PDHC)
A1	Dental Early Periodic Screening and Diagnostic Testing (EPSDT)
A2	Adult Denture
B1	Applied Behavior Analysis (ABA)

STYLE AND LANGUAGE GUIDANCE

The style and language of each prior authorized denial and/or partial denial notice must be written in a language that the intended audience, including individuals with limited English proficiency, can easily understand. The notice shall be written in a style that is concise and well organized.

- Write in plain language.
- Use 12 point or greater font.
- Do not use all capital letters.
- Keep verb tense consistent.
- Acronyms must be spelled out at first use, unless they are approved by LDH to be used without definition. See chart.
- Avoid repetition of information, unless it is necessary to clarify a point.
- Where clinical terminology is required, provide some explanation.
- Utilize grade-level assessment tools to ensure the language meets contractual requirements, using any one of the indices listed in the contract, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to ensure accuracy.

GENERAL NOTICE CONTENT

The notice must contain the following components:

- Include a header that indicates if the services are denied or partially denied .
- Use the term “approved,” “denied,” “denial,” “partial denial” or “partially denied” in the introductory paragraph.
- Include dates of service.
- For partial denials, the notice should clearly specify the services and amounts that are denied and the services and amounts approved, in plain language. Include internal appeal language in the denial/partial denial, if applicable.
- If a subcontractor is referenced in the notice, be certain to explain their role to the member in the introductory paragraph or the first page.
- Use of appeals and state fair hearing language is required.

DENIAL REASONS

The area of the notice that causes the most non-compliance is the free-form language supplied by the MCEs in the paragraph or paragraphs used to explain exactly why the service was denied/partially denied. These are primarily divided into two categories – administrative denials and medical necessity denials.

Administrative denials

There is a finite list of reasons a benefit or service can be denied on an administrative basis. The list below includes all of those reasons identified through Fair Notice reviews.

- Provider out of network
- Provider cancels request before request is processed
- Duplicate requests
- Member not enrolled with MCE
- Member not enrolled in Medicaid
- Member not enrolled at time of service
- Member does not meet age range requirements
- Request for non-covered benefit
- Authorization request or notification not submitted within required timeframe (late filing)
- Benefit limitation denial guidance
- Untimely decision

Medical Necessity Denials

The medical necessity denials/partial denials are more complex and are harder to define. MCEs must follow general guidance provided by LDH to draft language that will be considered compliant.

GENERAL DENIAL GUIDANCE

Guidelines for prior authorization denial and partial denial notices must be explained in plain language and applied to the specific case. This should include, at a minimum:

- What criteria the contractor used to make the determination (requests made, medical records reviewed, etc.).
- References to rules, regulations and guidance (federal and state) used to make the decision. Include numbers for reference of rules and a clear explanation of how the guidance relates to this particular case.
- What guidelines the member does not meet, including a plain language explanation of medical necessity, as applicable.
- A summary of the activity that helped to make the decision about their care. This should only be included if it provides specific information. If it refers to records, the records should be clearly identified. If it refers to a physician or provider who was contacted, the identity of the provider and the date of the contact should be given.
- Include specific language in the explanation that, because of the reasons included in the letter, the contractor does not find the service medically necessary.
- When citing criteria, ensure the reason for denial/partial denial explains the number of factors or the combination of factors listed in the notice that led to the denial and are needed to establish medical necessity. Simply citing the name of the policy/guideline/regulation is not sufficient.
- When enumerating reasons for denial/partial denial, do not include any information in the explanation that is not a reason for denial.

Notices **should not** include the following:

- Any reference to the contract with LDH or the “Healthy Louisiana Program” as a reason for denial. In such cases, MCE policy or a provider handbook could be referenced.
- Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) codes.

ADDITIONAL INFORMATION NEEDED

When a service is denied due to lack of information, the MCEs must clarify what guidelines are used and what is still needed.

Ensure it is clear what was not provided and that it is still needed to make a determination. Include in the notice the specific information to be supplied by the provider. Be sure to indicate whether one or more – or all – of the items listed are required for review for approval.

ADMINISTRATIVE DENIAL GUIDANCE

This is a list of the requirements for each administrative denial, as well as an example of denial verbiage for each basis. The example does not need to be used verbatim, as long as the context of the verbiage is similar. In the examples below, language that is customizable by the MCE is shown in brackets.

Provider out of network

- The notice must identify the specific service requested and denied.
- The notice must identify the out-of-network provider.
- The notice should specify that the request will be reviewed if made through an in-network provider.
- The notice must specify the circumstances under which an out-of-network provider can be used and discuss any documentation submitted related to these - such as 42 CFR 438.206(b)(4).
- *Example:* “To meet the guidelines for approval, the requested (service) needs to be from a participating provider with [Contractor Name]. This request is from [Name of Out-of-Network Provider], a non-participating provider, and this service can be provided by a participating provider in your area. Therefore, this request is denied.”

Provider cancels request

- The notice must identify the name of the service requested and amount of service being requested.
- The notice must identify the name of the provider and the date the provider canceled the request.
- Include language about finding a new provider, if applicable.
- *Example:* ““Your provider, [Provider Name], asked your health plan to cover [Name of Service]. However, your provider decided to cancel this request before we could make a determination. Therefore, this request is denied. If you need to find a new provider, you can search our directory of providers at [Website].”

Duplicate requests

- The notice must identify the name of provider with approved requested, name of service, amount of service, and dates of service.
- *Example:* “Your doctor ordered a [Service, Test or Prescription]. We reviewed the notes we have. The notes show that this is a duplicate request. The same or similar [Service, Test or Prescription] was approved for you in the past. The notes do not show why you need another [Service, Test or Prescription]. Based on the information we have, this second request is denied.”

Member not enrolled with MCE

- The notice should be clear that denial only means the MCE cannot approve or pay for the service, since the finding is that the member is not a member of the MCE.
- The notice must make it clear that, if a member is enrolled in Medicaid, the service may be covered by Medicaid through their current MCE.
- *Example:* “Your provider asked your health plan to cover [Name of Service]. We cannot approve this. Our records indicate that you are not currently enrolled in a Louisiana Medicaid health plan. We cannot cover this service. Therefore, [Name of Service] for [Month Day, Year] through [Month Day, Year] has been denied.”

Member not enrolled in Medicaid

- The notice must state that the member is not currently enrolled in a Louisiana Medicaid health plan.
- *Example:* “Your provider asked your health plan to cover [Name of Service]. We cannot approve this. Our records indicate that you are not currently enrolled in a Louisiana Medicaid health plan. We cannot cover this service. Therefore, [Name of Service] for [Month Day, Year] through [Month Day, Year] has been denied.”

Member not enrolled at time of service

- The notice must include the date the member became ineligible for benefit coverage.
- *Example:* “To meet the guidelines for approval, you must be eligible for benefit coverage with [Contractor Name] at the time of the requested service. You became ineligible for benefit coverage with [Contractor Name] on [Month Day, Year], therefore this request is denied.”

Member does not meet age range requirements

- The notice must provide the age range for which the item or service will be approved.
- *Example:* “[Service] is a covered service for members under the age of 21. You are [Age] years old. Please speak to your provider about your options. This request is denied.”

Request for non-covered benefit

- The notice must state that the services being requested are a non-covered benefit with the member's plan.
- *Example:* "To meet the guidelines of consideration for approval, the services requested must be a covered benefit with [Contractor Name]. This request is for a non-covered benefit with your plan. This request is denied."

Authorization request or notification not submitted within required timeframe (late filing)

- Prior authorization services will be denied if the provider fails to submit the request to the contractor before the service is performed.
- *Example:* "Your provider asked your health plan to cover [Name of Service]. We cannot approve this. Your provider did not get the permission needed before performing the services. This request was made on [Month Day, Year]. Therefore, [Name of Service] for [Month Day, Year] through [Month Day, Year] has been denied."

Benefit limitation

- The notice must state that the services being requested are a non-covered benefit with the member's plan.
- The notice must state which services are covered with the member's health plan.
- *Example:* "To meet the guidelines for approval, the service requested must be covered under your [Contractor Name] plan benefits. Your [Contractor Name] plan benefits only cover [Name of service] only. This request is for [Name of service], which is not covered under your [Contractor's Name] plan. Therefore, this request is denied."

Untimely Decision

- Per the MCE contracts with the Louisiana Department of Health and federal regulations ([42 CFR 438.404](#) and [438.210](#)), requests for prior authorizations must be denied if a decision is not made within the standard timeframe of 14 calendar days.
- *Example:* "The prior authorization request for [Name of Service] was received on [Month Day, Year] and the decision was due on [Month Day, Year 14 calendar days OR 72 hours after receipt of the request for service]. [Contractor Name] was unable to make a decision within the required timeframe. Therefore, the request for [Name of Service] is denied. If you believe you were eligible to receive this service, you may present evidence at an appeal that you met the medical criteria to get the service."

APPEAL RIGHTS

Notices of adverse benefit determinations must inform the member of their right to appeal, and provide them with enough information to assist them in preparing a defense for the appeal. The following are appeal requirements that must be included in prior authorization denial and partial denial notices.

Standard Appeal Language

For all contractors that are required to have an internal appeals process, all prior authorization denial and partial denial notices must inform the member of their right to appeal the contractor's decision. The required timeframe to request an appeal is 60 calendar days.

Ways to Appeal

Contractors are required to establish an appeal system in place for their members. Methods used to receive appeals are typically by phone, mail or fax.

Oral appeals do not require a written, signed appeal after an oral request.

Expedited Appeal

Expedited resolution of appeals is used when the condition of the member is considered urgent. The provider must agree that the need is urgent. Expedited appeals are required to be resolved within 72 hours of receipt of the appeal by the contractor.

State Fair Hearing

For all contractors that are required to have an internal appeals process, the denial notice must advise the member that they may request a State Fair Hearing after exhausting the contractor's internal appeals process, if they still disagree. A State Fair Hearing must be requested within 120 calendar days from the date of the contractor's notice of appeal resolution.

Continuation of Benefits

Notices of adverse benefit determinations must include the member's right to request continuation of benefits if the member filed a timely appeal. The notice must also provide the member with instructions on how to request continuation of services during an appeal or request for a state fair hearing. The notice must also inform the member that they may be held liable for the cost of those services/benefits if the hearing decision upholds the contractor's adverse benefit determination. The required timeframe to request continuation of benefits is 10 calendar days from the date of the denial notice.

REISSUANCE OF NOTICES

Notices that are found non-compliant must be reissued to the member if deemed necessary. Some examples of non-compliance that may be considered for reissuance, triggering new appeal rights, include:

- Large blocks of text in all caps.
- A mislabeled notice, such as a full denial that should have been a partial denial.
- Truncated or missing text.
- Missing appeals language.
- Missing guidelines or criteria used to make the determination.
- Unclear reasons for medical necessity denial.

ACRONYMS

Certain acronyms can stand alone in a notice without a definition or explanation. Those are listed below:

<u>Acronym</u>	<u>Definition</u>
<i>ADD</i>	Attention Deficit Disorder
<i>ADHD</i>	Attention Deficit\Hyperactivity Disorder
<i>CAT Scan</i>	Computed Axial Tomography
<i>CT Scan</i>	Computed Tomography
<i>EKG</i>	Electrocardiogram
<i>MRI</i>	Magnetic Resonance Imaging
<i>PET Scan</i>	Positron Emission Tomography

TEMPLATES AND EXAMPLES:

LDH has developed multiple templates and template examples to help MCEs with Fair Notice review compliance. LDH strongly encourages use of these templates as a resource tool to assist with compliance.

The following service types are required to use service specific templates: Community Psychiatric Supportive Treatment (CPST)/Psychosocial Rehabilitation Service (PSR), Pediatric Day Health Care (PDHC), and dental. These templates and template examples, along with other guidance can be found on the Legal Compliance webpage at: <https://ldh.la.gov/page/2855>.

To ensure continued compliance with LDH, it is required that any new MCE templates used for prior authorization denial and partial denial notices be reviewed and approved by LDH prior to implementation.