POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Adverse Determination (Denial) Notices
PAGE: 1 of 10	**REPLACES DOCUMENT:**
APPROVED DATE: Sept 2011	**RETIRED:**
Effective DATE: Jan 2012, 2/1/15, 12/1/15	**REVIEWED/REVISED:** 10/13, 7/14, 11/14, 2/15, 9/15, 9/16. 9/17, 9/18, 8/19, 6/20, 5/21, 11/21
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.07

SCOPE:
Louisiana Healthcare Connections (Plan) ~~Medical Management~~Population Health and Clinical Operations Department.

PURPOSE:
To ensure members and practitioners receive sufficient information to understand and decide whether to appeal an adverse determination to deny care or coverage.

POLICY:
Upon any adverse determination for standard or pre-authorized medical services made by the Plan Medical Director or other appropriately licensed health care professional (as indicated by case type), a written notification, at a minimum, will be communicated to the member and treating/attending provider. The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise. No written notification is required to the member for concurrent inpatient adverse determinations. All notifications will be provided within the timeframes as noted in LA.UM.05 Timeliness of UM Decisions and Notifications policy. The Plan shall notify the member and provider, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and include the specific reason/rationale for the determination, as well as the availability, process and timeframes for appeal of the decision. (RFP 8.5.4.1.2.1). The letter to the provider will also include a copy of the criteria used to make the decision. (HB 424/Act 330, Emergency Contract 8.1.17).

The Plan will provide availability of an appropriate practitioner reviewer to discuss any Utilization Management (UM) adverse determination decisions with the treating or attending physician. Availability of such Peer to Peer discussion and how to initiate such communications may be conveyed to providers through various avenues including, but not limited to, the provider handbook, provider newsletter, verbal denial notification, and/or within the written adverse determination letter. (Refer to Informal Reconsideration in LA.UM.05 Timeliness of Decisions and Notifications policy).
Upon request by Louisiana Department of Health (LDH) or the member, the Plan will be responsible for promptly forwarding any adverse decisions to LDH for further

review/action. LDH may submit recommendations to the Plan regarding the merits or suggested resolution of any grievance/appeal.

PROCEDURE:

I. Administrative Denials

A requested service may be denied during a Level I review for non-clinical reasons, such as member ineligibility, failure to obtain prior authorization, failure to provide timely notification, or failure to receive any clinical information (note: diagnosis alone is considered sufficient clinical information).

Requests based on benefits are not considered to be administrative denials and follow the process outlined in this policy and associated policies.

II. Non-medical Necessity/Benefit Denials

A. Determination by a Medical Director or appropriate practitioner reviewer is not required for requests for services that are specifically excluded from members' benefit plan or that exceed limits or restrictions noted in the benefit plan, and may be denied during a Level 1 review. Note: benefit restrictions are specific to the Plan and product.

Examples of benefit determinations include, but are not limited to:

1. Requests for additional physical therapy visits when the benefit plan clearly states a specified amount are covered.
2. Medical equipment or supplies for which the codes are specifically listed as excluded from coverage.

B. Secondary Advisor Review is required if clinical judgment is needed to determine if a service may be covered, depending on the circumstances. Such requests follow the Level II review process outlined below. Examples of such requests, which are considered medical necessity decisions, include but are not limited to:

1. Breast reduction surgery for back pain, versus cosmetic reasons.
2. Use of an out-of-network provider if no in-network provider has the appropriate clinical experience.
3. Experimental procedure, unless the requested service is specifically listed as

excluded from the member's benefit plan.

III. Insufficient Information

When insufficient clinical information is received to determine medical necessity for requested service(s), attempts to obtain additional information are made and are documented in the clinical documentation system. If the Plan receives any clinical information, including only a diagnosis, the request must be reviewed by an appropriate professional and sent for Level II review if unable to approve[CF1].

IV. Level II Review

During a Level II review, the Medical Director or appropriate practitioner reviewer may make an adverse determination to deny, terminate, or reduce services. The Plan shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. The Plan shall notify the requesting provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Plan shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial determination. (Emergency Contract 8.1.15, 8.4.2.3 & 8.5.4.1.2.2)

The Plan must mail the Adverse Notice of Action within the following timeframes:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action.
- In cases of verified member fraud, or when LDH has facts indicating that action should be taken because of probable member fraud, at least five (5) days before the date of action.
- By the date of action for the following:
  - in the death of a ~~recipient~~ member[CF2]

- if the member submits a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);
- the ~~recipient's~~ member's admission to an institution where he/she is eligible for further services;
- the ~~recipient~~member's address is unknown and mail directed to him/her has no forwarding address;
- the ~~recipient~~ member has been accepted for Medicaid services by another local jurisdiction; or
- the ~~recipient's~~ member's physician prescribes the change in the level of medical care; or
- as otherwise permitted under 42 CFR §431.213.

• For denial of payment, at the time of any action affecting the claim.

The adverse decision and rationale for the determination will be documented in the clinical documentation system notes.

A. Notification of Reviewer Availability
1. The Plan Medical Director or appropriate practitioner reviewer serves as the point of contact for treating practitioners calling in with questions about the UM process and/or case determinations.
2. Treating practitioners are notified of availability of an appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Handbook (available in hard copy and on plan provider website), New Provider Orientation, and/or the Provider Newsletter.
3. The Plan Medical Director or appropriate practitioner reviewer may be contacted by calling the Plan's main toll-free phone number[CF3] and asking for the Plan Medical Director. A Plan ~~Care Manager~~Clinical Reviewer [CF4]may also coordinate communication between the Plan Medical Director and treating practitioner.

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B. Treating practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. Only the treating physician/provider may participate in this peer-to-peer discussion.
    1. At the time of verbal notification to the requesting practitioner/facility of an adverse determination, the Correspondence Nurse will notify the requester of the opportunity for the treating physician to discuss the case directly with the Plan Medical Director or applicable practitioner reviewer making the determination.
        i. The time and date of both the denial notification and the offer of physician reviewer availability is documented in the system notes.
    2. Practitioner/facility notification that a physician or other appropriate reviewer is available to discuss the denial decision is also included in the written denial notification.

C. Both the Member and requesting Provider shall receive a written Notice of Action (denial of medical coverage) regarding any denial, reduction or termination of service with the exception of concurrent inpatient services. Only the Provider/facility will receive written notification for denied concurrent inpatient services.
    1. The Notice of Action letter will be sent from the clinical documentation system and includes:
        - The member specific action and reason for the denial, in easily understood language.
        - Notification that oral interpretation is available for all languages at no cost and how to access it.
        - A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.
        - The medical necessity criteria used in the denial by providing one of the following:
            - Providing instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline OR
            - A copy of the applicable law, regulation, policy, procedure, or medical criteria or guideline
        - A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.

- An explanation of the appeal process, including the member's right for representation by anyone including an attorney and time frames for deciding appeals and the circumstances under which a State Fair Hearing is available, after the appeal process has been exhausted, and how to request one.
- A description of the expedited appeal process including under what circumstances an expedited appeal can be requested, how to request an expedited appeal, and the time frames for resolution of an expedited appeal.
- The member's right to have benefits continue pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.

2. The Medical Director or appropriate practitioner reviewer may work with the Correspondence Nurse to draft the denial letter.
3. The letter must have the signature of the Plan Medical Director or appropriate practitioner reviewer making the adverse determination.
4. The adverse determination letter will be mailed within the timeframes as indicated in LA.UM.05 Timeliness of UM Decisions and Notifications policy.
5. The Plan will assist any member requesting assistance in understanding an adverse determination notice, including any member with special communication needs such as large print, Braille, audio CD, in a different language (each prevalent non-English language in the service area), or another format.

D. Informal Reconsideration / Peer to Peer

In accordance with Contract Section 8.5.4.1.3.1 and Title 37, Part XIII, §6219, the Plan will provide the member and the provider the opportunity to request an informal reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person, as well as in writing. Plan should provide the member, or a provider acting on behalf of the member and with the member's written consent, an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination.

1. For all medical necessity adverse determinations, the plan will give the member and provider rendering the service an opportunity to request, on

behalf of the member, an informal reconsideration of an adverse determination by the physician or clinical reviewer making the adverse determination.

2. The member and Provider will be allowed a ten (10) day period following the date of the adverse determination to request such.
3. The reconsideration shall occur within one (1) working day of the receipt of the request, at the convenience of the requesting provider, and shall be conducted between the member and provider rendering the service and the Plan's Medical Director or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.
4. The peer to peer discussion (which could include the member's input) and outcome will be documented in the clinical documentation system by the Medical Director or the clinical peer as appropriate.

~~6.~~5. If the informal reconsideration process does not resolve the differences of opinion, the adverse determination may be appealed by the member or the provider on behalf of the member. Informal reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

REFERENCES:

LA MCO RFP Amendment 11– Section 8 Utilization Management
LA MCO RFP Amendment 11– Section 12 Marketing and Member Education
LA MCO RFP Amendment 11- Section 13 Member Grievance and Appeals Procedures
Health Plan Advisory 12-9 April 25, 2013: Clarification of Provider Disputes Relative to Denied Claims and Services
Title 37, Part XIII, §6217- §6219
Code of Federal Regulation: 42 CFR 422; 438.400
Current NCQA Health Plan Standards and Guidelines
LA.UM.05 Timeliness of UM Decisions and Notifications
House Bill 424- Acct 330
LA.UM.01 Utilization Management Program Description

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LA.UM.04 Appropriate UM Processionals

ATTACHMENTS:

DEFINITIONS:

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 part of payment for a service; the failure to provide services in a timely manner (as defined by LDH); or the failure to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR 438.400(b); and in the rural area with only one MCO, the denial of a member's right to obtain services outside the provider network as described in 438.52(b)(2)(ii).

Appropriate practitioner: An organization representative who makes UM denial decisions. Depending on the type of case, the reviewer may be a physician, chiropractor or other practitioner type, as appropriate.

Level II Review: Second level of medical necessity review. Performed by Plan Medical Director or other designated qualified practitioner.

REVISION LOG	**DATE**
Reviewed without change.	10/13
Clarification of written notification to members	7/14
LA Procurement 2015 Policy Update	11/2014
Per IPRO readiness review, added C1 – services provided at no cost and that state fair hearings are available after the appeal process has been exhausted C5 - such as large print, Braille, audio CD, in a different language (each prevalent non-English language in the service area), or another format	2/15
Added CCL.230 in references Updated NCQA date reference Added Behavioral Health Services to scope	9/15

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Changed DHH to LDH, adjusted verbiage to comply with NCQA time criteria. Changed Care to Case. Changed Case manager to Correspondence nurse.	9/16
Grammatical changes Additions to Section D. Informal Reconsiderations / Peer to Peer to include "Peer to Peer" and clarification of timeframe for reconsideration within one working day if requested by Provider	9/17
Grammatical changes Provider Adverse Determination Notification updated to reflect LA MCO RFP Amendment 11- Section 8 Utilization Management (8.5.4.1.2.2) change from one (1) calendar day of the initial request to "verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial determination." Informal Reconsideration / Peer to Peer, Section D., updated to reflect LA MCO RFP Amendment 11 – Section 8 Utilization Management (8.5.4.1.3.1) and LA.UM.05 Timeliness of UM Decisions and Notifications. Informal Reconsideration / Peer to Peer, Section D.5 removed. Removed CCL.230 Adverse Determination Process and Notifications from References	9/18
Added new process for inclusion of copy of criteria with denial notices per new House Bill 424- Act 330 requirement Added references to House Bill 424	8/19
Added references to LA.UM.01 and LA.UM.04 Changed RFP to Emergency Contract Added Emergency contract sections 8.1.15, 8.1.17 and 8.4.2.3	6/20
Changed MM to PHCO	5/21
Added Administrative Denial, non-medical necessity/benefit denials, and insufficient information section	11/21

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Changed recipient to member Changed care manager to Clinical Reviewer	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.

Sr. VP Population Health: _____Electronic Signature on File_____
Chief Medical Officer: _____Electronic Signature on File_____