

## POLICY AND PROCEDURE

<b>POLICY NAME:</b> -Appeal of Utilization Management Decisions	<b>POLICY ID:</b> -LA.UM.08
<b>BUSINESS UNIT:</b> -Louisiana Healthcare Connections	<b>FUNCTIONAL AREA:</b> Utilization Management
<b>EFFECTIVE DATE:</b> 1/2012	<b>PRODUCT(S):</b> Medicaid
<b>REVIEWED/REVISED DATE:</b> 11/13, 6/14, 11/14, 11/15, 11/16, 10/17, 10/18, 9/19, 6/20, 7/21, 12/22,-11/23, 10/24, 8/25,-11/25	
<b>REGULATOR MOST RECENT APPROVAL DATE(S):</b> Please refer to system of record – Archer	

### POLICY STATEMENT:

All Areas and Departments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

### PURPOSE:

The purpose of this policy is to offer a full and fair process for resolving enrollee disputes and responding to enrollee requests to reconsider a decision they find unacceptable regarding care and service.

### SCOPE:

This policy applies to employees of the Utilization Management (UM) Department. This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

### DEFINITIONS:

**Action:** The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension, or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure of an MCO to act within the timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

**Adverse Benefit Determination** – Any of the following:

- The denial or limited authorization of a requested service, including, but not limited to, determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- 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 the State.
- The failure of the Contractor to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
- The denial of an Enrollee's request to dispute a financial liability, including Cost Sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

**Appeal:** A request for a review of an Adverse Benefit Determination.

**Authorized Representative:** An individual or organization designated by a Beneficiary, or authorized under State law, including, but not limited to, a court order establishing legal guardianship or a power of attorney, to act responsibly on their behalf, in accordance with 42 C.F.R. §435.923.

**Clinical Peer:** A physician or other health care professional who holds an unrestricted license in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. Non-physician practitioners, including but not limited to nurses, speech and language therapists, occupational therapists, physical therapists, and clinical social workers, are not considered to be clinical peers, and may not make adverse determinations of proposed actions of physicians (medical doctors shall be clinical peers of medical doctors, etc.).

**Expedited Appeal:** A request to change an adverse determination regarding urgent care as defined below. Additionally, requests for an expedited appeal review must be granted to any request concerning admissions, continued stay or other health care services for an enrollee who has received emergency services but has not been discharged from a facility.

**Final Adverse Determination:** An adverse determination that has been upheld by a reviewer at the completion of the medical necessity review organization's internal review process.

**Post-service Appeal:** A request to change an adverse decision for care or services that have already been received by the enrollee; regarding a request for reimbursement of services received.

**Pre-service Appeal:** A request to change an adverse decision for care or service that the Plan must approve, in whole or in part, in advance of the enrollee obtaining care or services.

**Same-or-Similar Specialist:** Practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal or who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

**Urgent Care:** Any request for medical care or treatment, with respect to which the application of the time period for making non-urgent care determinations, could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on the prudent layperson's judgment or, in the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

**POLICY:**

The Plan does not use the time frames or procedures of the appeals process to avoid the medical decision process or to discourage or prevent the enrollee from receiving medically necessary care in a timely manner.

An enrollee or their authorized representative who may be a family member, friend, lay advocate, or attorney, with the written consent of the enrollee, may file an appeal orally or in writing with the Plan. A health care practitioner with knowledge of the enrollee's medical condition, acting on behalf of the enrollee (with the written consent from the enrollee) may also file an appeal regarding adverse action/determination about care or service. The Plan does not take punitive action against a provider who either requests an expedited resolution on behalf of an enrollee or supports an enrollee's appeal.

An enrollee, authorized representative, or legal representative may file an appeal with the Plan, orally or in writing, within sixty (60) calendar days from the date on the notice of Adverse Benefit Determination. An expedited appeal is available under certain circumstances, including urgent care requests. The Plan establishes and maintains an expedited review process for appeals, when the Plan determines (for a request from the enrollee) or the provider, acting on behalf of the enrollee and with the enrollee's written consent, indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The enrollee, enrollee's authorized representative or provider, acting on behalf of the enrollee and with the enrollee's written consent, may file a request for an expedited appeal either orally or in writing. Once an oral appeal is received, the Plan informs the enrollee they shall receive a notice or written confirmation of the appeal. The date of the oral filing shall constitute date of receipt. No additional enrollee follow-up is required. Provider appeals or post-service appeals, do not require the signed consent of the enrollee.

The content of an appeal, including all clinical care aspects involved, are fully investigated, and documented. Documentation includes the substance of the appeal and the actions taken. Enrollees have the right to review their case file and submit comments, documentation, records, and other information relevant to the appeal in person or in writing. The organization documents when members fail to submit relevant information by the specified timeline. In the case of expedited appeal requests, the enrollee is informed of the limited time available to present evidence and allegations of fact or law, in person and in writing and ensure that the enrollee understands any time limits that apply. A physician or other appropriate clinical peer of a same-or-similar specialty, not supervised by the individual nor involved in the initial adverse decision, evaluates medical necessity decisions for adverse appeal decisions.

Appeal decisions are made as expeditiously as the enrollee's condition warrants, but no later than 30 days for a standard appeal (44 days if an extension is taken as described below) and no later than 72 hours for an expedited appeal with a possible extension of 14 days if approved by the Louisiana Department of Health (LDH). Post-service or provider appeals are resolved within 30 calendar days of receipt of the request. If the appeal request is expedited, a written notification of the appeal decision (resolution) will be made within 72 hours, or if the Medical Director denies the expedited appeal request, the written notification is made within two (2) calendar days of the appeal status determination, which is outlined in the timeframes designated by the LDH.

An appeal may be withdrawn by written request from the person who filed the appeal at any time during the appeal process.

The Plan does not create barriers to Timely due process. The Plan recognizes barriers are subject to penalties if it is determined by LDH that the Plan has created barriers to Timely due process, and/or, if ten percent (10%) or higher of denied appeals are reversed or otherwise resolved in favor of the enrollee following a State Fair Hearing within a calendar year. Examples of creating barriers includes, but are not limited to:

- Failure to inform enrollees of their rights to file grievances, appeals, and State Fair Hearings;
- Failure to log and process grievances and appeals;
- Failure to issue a proper notice including vague or illegible notices; and
- Failure to inform of continuation of benefits
- Labeling Grievances as inquiries and funneling them into an informal review;

## **PROCEDURE:**

### **Filing an Appeal**

- An appeal may be filed orally or in writing, and received via mail, or telephone, facsimile, electronic mail, or in person.
- The Plan includes as parties to the appeal: The enrollee, the enrollee's authorized representative, and/or the enrollee's legal representative; or the legal representative of a deceased enrollee's estate. An enrollee, authorized representative, or legal representative may file an appeal with the Plan, orally or in writing, within sixty (60) calendar days from the date on the notice of Adverse Benefit Determination.
- The Plan assists any enrollee requesting assistance in understanding a Notice of Action, completing forms, in filing an appeal or requesting a State Fair Hearing, including any enrollee with special communication needs. This includes, but is not limited to, providing a toll-free telephone number, translation services, and a toll-free number, 711, which is in compliance with Federal Communications Commission standardized services, and interpreter capability.
- Enrollees appealing urgent care services/ life threatening situations may request an expedited appeal. The enrollee, enrollee's authorized representative or provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an expedited appeal either orally or in writing. The organization grants an expedited review for all the requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.
- The Plan ensures that all Plan enrollees are informed of the State Fair Hearing process and of the Plan's grievance and appeal procedures. The Plan provides an enrollee handbook to each enrollee that includes descriptions of the Plans grievance and appeal procedures. Forms on which enrollees may file grievances, appeals, concerns or recommendations to the Plan are available through the Plan, and paper copies are provided by the Plan upon request of the enrollee. The Plan makes all forms easily available on the Plan's website.

### **Acknowledging an Appeal**

Once an oral appeal is received, the Plan informs the enrollee they shall receive a notice or written confirmation of the appeal. The date of the oral filing constitutes date of receipt. The Plan acknowledges each appeal in writing within five (5) business days of receipt of each appeal unless the enrollee requests an expedited resolution. The acknowledgement includes notification of enrollee rights and appeal processes:

- The enrollee's right to choose an authorized representative to act on their behalf (with written consent from the enrollee as dictated by state contract) or the legal representative of a deceased enrollee's estate.
- The enrollee's right to submit comments, documents, or other information relevant to the appeal.
- The enrollee's right to present information relevant to the appeal, in writing or in person.
- The timeframe for resolution of the appeal
- The enrollee's right to have the specified benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay for the cost of those services (an explanation that if the Plans action is upheld in an appeal or a hearing, the enrollee may be liable for the cost of any continued benefits).

### **Investigating an Appeal**

The Plan fully investigates and documents the content of the appeal, including all aspects of clinical care involved, without giving deference to the denial decision. All information is taken into account regardless of whether the information was submitted or considered in the initial determination. The Plan provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Plan provides the enrollee, his or her authorized or legal representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, any other documents and records considered during the appeals process, and any evidence considered, relied upon, or generated by the Plan in connection with the appeal. This information is provided free of charge and sufficiently in advance of the date by which the Plan shall resolve the appeal.

The appeal review is scheduled during regular business hours and within a reasonable distance so that the enrollee can appear in person if desired. If face-to-face is not practical for geographic reasons, the Plan offers the enrollee the opportunity to communicate with the review panel at the Plan's expense by conference call, video conferencing or other appropriate technology.

The appeal is reviewed by a person or people who were not involved in the prior adverse decision, nor a subordinate of such individual. However, the practitioner who made the initial adverse decision may review the case and overturn the previous adverse decision based on additional information received. The individual considers all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial action. Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate service are reviewed by a clinical peer who holds an active, unrestricted license to practice medicine or a health profession, who is board-certified *if applicable*, and who is of the same-or-similar health care professional, has similar credentials and licensure, and appropriate training and experience as those who typically treat the condition or health problem in question in the appeal.

### **Standard Appeal Resolution (Pre-Service and Post-Service Appeals)**

- For resolution, an appeal is heard and notice of appeal resolution is sent to the enrollee and all parties no later than thirty (30) calendar days from the date the Plan receives the appeal.
- The Plan may extend the resolution notification timeframe, for standard appeals, for up to 14 calendar days to obtain additional information only if:
  - The enrollee requests an extension or
  - The enrollee voluntarily agrees to extend the appeal timeframe.
    - Written notification of the reason for the delay is provided to the enrollee, if the enrollee has not requested the extension, and the enrollee's consent for the extension is obtained.
- If the enrollee does not consent to the extension, the appeal will be decided with the information available before the timeframe expires.

### **Expedited Appeal Resolution**

- For an expedited appeal, all necessary information, including the Plan's decision is transmitted between the Plan and the covered person, or their authorized representative, or the provider acting on behalf of the covered person, by telephone, facsimile, or any other available expeditious method.
- The Plan resolves each expedited appeal and provides notice to the enrollee, as quickly as the enrollee's health condition requires, within established timeframes not to exceed 72 hours after the Plan receives the appeal request, whether the appeal was made orally or in writing. The Plan may extend the resolution notification timeframe, for up to 14 calendar days to obtain additional information only if:
  - The enrollee requests an extension or
  - The enrollee voluntarily agrees to extend the appeal time frame.
  - Written notification of the reason for the delay is provided to the enrollee, if the enrollee has not requested the extension, and the enrollee's consent for the extension is obtained.
  - If an enrollee asks for an extension, the Plan treats the request as a denial for expedited appeal, immediately transfers the appeal to the timeframe for standard resolution and shall so notify the enrollee. Nothing in this section relieves the Plan of its obligation to resolve the enrollee's appeal as expeditiously as the enrollee's health condition requires, in accordance with Federal and State laws, regulations, rules, policies, procedures, and manuals.
- If the enrollee does not consent to the extension, the appeal will be decided with the information available before the timeframe expires.
- In the case of an expedited appeal denial, the Plan provides oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two (2) calendar days of the disposition. Appeals are resolved no later than the stated time frames and all parties are informed of the Plan's decision.

### **Appeal Notification Letter**

- The Plan provides the enrollee with a written notice of appeal resolution using a template approved by LDH in writing. The Plan includes on the notice a unique identifying number, corresponding to the number on the notice of Adverse Benefit Determination that gave rise to the appeal.
- The appeal resolution letter must contain, at a minimum, the following elements:
  - [For a benefit appeal: The title \(position or role in the organization\).](#)
  - [For a medical necessity appeal: The title \(position or role in the organization\), qualifications \(clinical credentials such as MD, DO, PhD, physician\) and specialty \(e.g., pediatrician, general surgeon, neurologist,](#)

~~clinical psychologist)The title, qualifying credentials and specialty of the physician affirming the adverse determination.~~

- A statement of the reason for the covered person's request for an appeal.
  - An explanation of the reviewer's decision in clear, easily understood terms and the date the decision was made.
  - The medical rationale in sufficient detail for the covered person to respond further to the Plan's position including reference to the specific criteria.
  - Notification that the enrollee can obtain, upon request, a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
  - Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
  - Notification that the enrollee is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal or State Fair Hearing, free of charge. Relevant documents include documents or records relied upon and document and records submitted in the course of making the appeal decision.
  - A description of the process to obtain a State Fair Hearing of a decision and the procedures and timeframes for requesting such Hearing.
  - The written notification is based on the enrollee's cultural and linguistic needs.
- If the appeal resolution completely overturns the denial, the resolution notice will state the decision, the resolution date, and all necessary authorization detail.
  - When the adverse decision is upheld in whole or part, the written appeal decision notification must include the following elements when applicable:
    - Date of appeal resolution.
    - Specific reasons for the appeal decision, in easily understood language.
    - A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
    - Notification that the enrollee, upon request, can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
  - A list of titles and qualifications, including specialty of the individual(s) conducting the medical necessity review, of individuals participating in the appeal review. (Participant names do not need to be included in the written notification to members but must be provided to members upon request).
  - For appeals not resolved wholly in favor of the member, the notice includes all information required under 42 C.F.R. 438.408, including, but not limited to, informing the member of their right to seek a State Fair Hearing if the member is not satisfied with the Plan's decision in response to an Appeal, and the process for doing so. The right to continue to receive benefits pending a hearing (as applicable), how to request the continuation of benefits, and an explanation that if the Plans action is upheld in a hearing, the member may be liable for the cost of any continued benefits.
  - Notification is given to the member, provider, and facility (if applicable).
  - In the case that the Plan fails to adhere to the notice and timing requirements as required per contract, the enrollee is deemed to have exhausted the Plan's appeal process and may initiate a State Fair Hearing.

### **Reversed Appeal Resolutions**

If Plan or the State Fair Hearing decision reverses a decision to deny, limit, or delay services, where the services were not furnished while the appeal was pending, Plan will authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires.

In the event that the services were continued while the appeal was pending, Plan will provide reimbursement for those services in accordance with the terms of the final decision rendered by the Plan or the Division and with the terms of the contract and applicable regulations.

### **Continuation of Benefits:**

The Plan will continue the enrollee's benefits (as applicable) until issuance of the final appeal decision or the State Fair Hearing decision, if all of the following occurs:

- An appeal is filed timely as defined in the Plan in accordance with applicable Federal and State laws, regulations, rules, policies, procedures, and manual. As used in this section, "timely" filing means filing on or before the later of the following: Ten (10) calendar days from the Notice of Action or the intended effective date of Plan's proposed action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

- The appeal involves a denial, and the physician asserts the requested service treatment is a necessary continuation of a previous authorized service.
- The services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- The enrollee timely files for continuation of benefits.

If Plan continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The enrollee withdraws the appeal.
- Ten (10) calendar days pass after the Plan mails the notice providing the resolution of the appeal adverse to the enrollee, unless the enrollee, within the ten (10) calendar day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; following a State Fair Hearing, the administrative law judge issues a hearing decision adverse to the enrollee; or the time period or service limits of a previously authorized service has been met.

### **State Fair Hearing**

The enrollee has the right to a State Fair Hearing after they have exhausted their appeal rights with the Plan. The Plan will follow all procedures associated with a State Fair Hearing per contract requirements and as described below.

- If a determination is not made in accordance with the timeframe specified, the enrollee's request shall be deemed to have exhausted the Plan's appeal procedure as of the date upon which a final determination should have been made. The enrollee may then initiate a State Fair Hearing. The enrollee or their authorized representative shall submit a request for a State Fair Hearing to the Division of Administration Law (DAL) Administrative Law Judge Division (ALJ) within 120 calendar days from the date of the notice of resolution regarding their standard appeal. The request shall be submitted within ten (10) calendar days of the date of the notice of resolution if the enrollee wishes to have continuation of benefits during the State Fair Hearing.
- Upon receipt of the enrollee's request for a State Fair Hearing, LDH faxes or emails (via secure email), a copy of the request to the Plan's Grievance and Appeals Manager, or designee. The Plan is responsible for promptly forwarding any adverse decisions to LDH for further review/action upon request by LDH or the Plan enrollee. LDH may submit recommendations to the Plan regarding the merits or suggested resolution of any grievance/appeal. Within seven (7) business days of receipt of the request from the Department, the Plan sends a copy of the enrollee's standard appeal of the Plan's action; the contents of the standard appeal file including research, medical records and other documents used to make their decision and a summary of the enrollee's appeal; the evidence used by the Plan to make its decision; and a copy of the notice of resolution provided to the enrollee and to the Department. For further clarification regarding appeals filed with the DAL (Division of Administrative Law), the Plan must provide the State Fair Hearing Packet within seven (7) business days of receipt of request for the Summary of Evidence from the DAL. All information is uploaded to the LDH State Fair Hearing SharePoint Site in the Health Plan's folder. The complete packet, including the Summary of Evidence is uploaded to the LDH State Fair Hearing SharePoint Collaboration Site. The Plan also sends a copy of the State Fair Hearing Packet to the appellant (enrollee). If the appellant (enrollee) has retained legal representation, the Plan mails a copy of the State Fair Hearing packet to that individual as well. If the Plan is notified of legal representation at a later date, the Plan provides the State Fair Hearing packet promptly to that individual.
- Within two (2) Business Days of notification of the State Fair Hearing request, LHCC shall provide the corresponding Notice of Adverse Benefit Determination and the Notice of Appeal Resolution that relate to the State Fair Hearing request to LDH.
- The Plan attends State Fair Hearings and supplies the necessary witnesses and evidentiary materials.
- The parties to the State Fair Hearing include the Plan, the enrollee, their representative, or the representative of a deceased enrollee's estate.
- An administrative law judge (ALJ) at DAL conducts the State Fair Hearing. Upon the completion of the hearing, the Director of DAL notifies the Plan, enrollee and LDH of the hearing decision.
- The Plan continues the enrollee's benefits as noted above.
- If the Plan's action is reversed by the administrative law judge and the services were not furnished while the appeal was pending, the Plan authorizes or provides the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date the Plan receives the notice reversing the determination. The Plan pays for the disputed services, in accordance with the Department's policy and regulations.

- If the Plan or the State Fair Hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Plan must pay for those services, in accordance with the Department’s policy and regulations.
- If the decision upholds the Plan’s denial or adverse resolution and the benefits were continued pending the decision, the Plan may recover from the enrollee the costs of the services furnished to the enrollee while the decision was pending, to the extent that the services were furnished solely because of the requirement to do so as outlined above.

**Documentation of Appeals**

All appeals requests are documented and kept on file in a secure, centralized location for a period of no less than ten years. Appeal files contain at a minimum:

- Documentation of the substance of the appeal and actions taken that includes but is not limited to:
  - The enrollee’s reason for appealing the previous decision.
  - Additional clinical or other information provided with the appeal request.
  - Previous denial or appeal history.
  - Follow up activities associated with the denial and conducted before the current appeal.
  - Name of the enrollee and associated provider and/or facility.
  - The enrollee’s failure to submit relevant information by the specified deadline.
- Investigation of the appeal, including any aspect of clinical care involved.
- Date of appeal reviews and the name and credentials of the reviewer(s) who made the appeal decision.
- Notifications, including documentation of verbal and written notifications of acknowledgement and resolution of the appeal.
- All other correspondence and records associated with the appeal.
- Minutes or transcripts of appeal proceedings if any.

**Reporting**

The Plan electronically provides LDH with a monthly report of the appeals in accordance with the requirements outlined, to include, but not be limited to:

- Enrollee’s name
- Medicaid number
- Summary of appeals
- Date of filing
- Current status
- Resolutions and resulting corrective action

**REFERENCES:**

MCO Model Contract: Section 2.12 Utilization Management  
 MCO Model Contract: Section 2.15 Member Grievance and Appeals  
 Louisiana Administrative Code Title 37 Part XIII  
 LA Revised Statute § 22:1130 Appeals of adverse determinations; standard appeals  
 Code of Federal Regulations: 42 CFR §435.923 and 438  
 NCQA Health Plan Standards and Guidelines UM8: Policies for Appeals, UM9: Appropriate Handling of Appeals

**ATTACHMENTS:**

**ROLES & RESPONSIBILITIES:** N/A

**REGULATORY REPORTING REQUIREMENTS:**

Louisiana Revised Statute §46:460.54 applies to material changes for this policy.

**REVISION LOG**

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	VII. Appeal Notification Letter Added date of decision to notification of decision letter Policy: First paragraph, last sentence – replace “medical necessary care” with “medically necessary care”.	10/2012

Ad Hoc Review	Language added to meet Louisiana contractual requirements, "legal" representative Clarified timeliness of post service appeals and clarified that member may request reasonable access to all documents relevant to appeal free of charge.	11/08/13
Ad Hoc Review	Changed NCQA date to 2013 Added pharmacy information to Policy section. Added approval verbiage by DHH. Section XC added Clinical Appeal Coordinator. Changed from 14 to 7 days. Added clarification section on DAL.	06/27/14
Ad Hoc Review	Change business days to calendar days per RFP 13.7.2.2 Updated attachment flows NCQA reference changed to current	11/2015
Ad Hoc Review	Changed Department of Health and Hospitals (DHH) to Louisiana Department of Health (LDH) NCQA reference changed to current	11/14/16
Ad Hoc Review	Changed the reference to the TTY/TDD system for interpretation to the appropriate standardized services in compliance with FCC standards under 711 2015, the FCC standardized these services under 711 <a href="http://transition.fcc.gov/cgb/consumerfacts/711.pdf">http://transition.fcc.gov/cgb/consumerfacts/711.pdf</a> <a href="https://www.fcc.gov/consumers/guides/telecommunications-relay-service-trs">https://www.fcc.gov/consumers/guides/telecommunications-relay-service-trs</a>	10/24/17
Ad Hoc Review	Changed time frame for submission of appeal requests (to 60 days) and time frame for State Fair Hearing request (to 120 days) as indicated by the MCO contract initiated on 2/1/2018, Section 13 Changes made to the requirements for the member oral request for appeal as outlined by LDH (and CMS) in "Oral Appeals & Written Notifications" effective 05/01/2018 Changes made to requirements for the Plan related to reversal of a decision at the State Fair Hearing Level r/t the authorization and provision of the services to the member if the services were not furnished while the appeal (SFH) was pending. Changes made to the policy in regard to changes or clarifications contained in the MCO Contract initiated on 02/01/2018.	10/24/18
Ad Hoc Review	Fragmented statement moved from section I F. to fit into Investigating an Appeal procedure section III C. Typographical errors concerning date of "Oral Appeals & Written Notifications" and spelling "Hearing" corrected.	09/24/19
Ad Hoc Review	Changed Department of Administration or Department of Administration Law and changed the acronym accordingly.	06/25/20
Ad Hoc Review	Updated Policy section and Procedure section language to align with language in Emergency Contract	06/30/21
Annual Review	No Revisions	07/28/22
Ad Hoc Review	Changes made to language in the following sections to align the policy and procedure with the language in the Model Contract: "Policy", "Filing an Appeal", "Acknowledging an Appeal", "Investigating an Appeal" "Standard Appeal Resolution", "Expedited Appeal Resolution", "Appeal Notification Letter", "Continuation of Benefits", "State Fair Hearing", "Documentation of Appeals", and "Reporting". Added to bullet one of section XI, "The member's failure to submit relevant information by the specified deadline." Changed 7 calendar days to 7 business days for IX. State Fair Hearing, section B (2.15.4.4 of Model Contract) Reformatted to latest Policy Template	12/22/22
Annual Review	Updated references. Formatting and grammatical edits. Changed instances of "member" to "enrollee." Added adverse benefit determination definition Revised language in last bullet point in "filing and appeal" Repositioned language in Standard Appeal Resolution to Appeal Notification Letter section	11/14/23

	Added contract element to State Fair Hearing section Removed Attachments	
Annual Review	Added language in the following sections to align the policy and procedure with NCQA standards: "Policy", "Filing an Appeal", "Standard Appeal Resolution", and "Appeal Notification Letter".	10/11/224
Annual Review	No Changes	08/12/25
<a href="#">Ad Hoc Review</a>	<a href="#">Updated language to the Appeal Notification Language to comply to NCQA standards</a>	<a href="#">11/12/2025</a>

**POLICY AND PROCEDURE APPROVAL**

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

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