Document ID:	Title: National Clinical Services (NCS) 506 Peer to Peer Review Policy & Procedure – Louisiana Medicaid	
Parent Documents: AETCSPS-074201		
Effective Date: See Document Information Page	Last Review Date: See Review and Revision History Section	Business Process Owner (BPO): Sr. Principal Clinical Ldr, CS AMA UM Leadership
Exhibit(s): N/A		
Document Type: Tool		

PURPOSE

This Amendment is written to meet regulatory and legislative requirements under Louisiana law/regulation that impact NCS 506 Peer to Peer Review policy. This amendment will be used in conjunction with NCS 506 to comply with Louisiana requirements.

SCOPE

Applies to Department:	☐ Care Management	☐ Precertification (including NME, SCPU, Specialty Medical Precert)	☐ NME Case Management	☐ Aetna Maternity Program
	☐ SCPU Case Management	☐ 24-Hour Nurse Line	☐ DM	☐ BH
	☐ Medical Management – Concurrent Review	☐ Medical Management – Prior Authorization	■ Medical Management – Utilization Management	☐ Medical Management

Product:	☐ HMO	☐ EPO	☐ PPO	☐ MC/POS	☐ TC	☐ JV
	■ Medicaid					

These requirements apply when the Controlling State is Louisiana.

POLICY

Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization, Attachment A: Model Contract, Section 2.12.6.4.3.1 As part of the Managed Care Organization (MCO) appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and	Informal Reconsideration The health plan includes an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

allegations of fact or law, in person as well as in writing.	

PROCEDURE
N/A

Concurrent Review:

Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization, Attachment A: Model Contract, Section 2.12.6.4.3.2 **In a case involving an initial determination or a concurrent review determination, the MCO 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 [42 CFR§438.402(b)(ii)]**	**In a case involving an initial determination or a concurrent review determination, the health plan will 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.**
2023 Louisiana Medicaid Managed Care Organization, Attachment A: Model Contract, Section 2.12.6.4.3.3 **The informal reconsideration shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse Attachment A, Model Contract Page 173 of 390 determination cannot be available within one (1) Business Day.**	**The informal reconsideration will occur within one (1) business day of the receipt of the request and will be conducted between the provider rendering the service and the health plan's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) business day.**
2023 Louisiana Medicaid Managed Care Organization, Attachment A: Model Contract, Section 2.12.6.4.3.4 **The Informal Reconsideration does not extend the thirty (30) Calendar Day required timeframe for a Notice of Appeal Resolution.**	**The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.**
2023 Louisiana Medicaid Managed Care Organization, Attachment A: Model Contract, Section 2.12.6.4.1.1 **For Service Authorization approval for a nonemergency admission, procedure or service, the**	**For Service Authorization approval for a nonemergency admission, procedure or service, the health plan shall notify the provider 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 provide**

Contractor shall notify the provider verbally or as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Day of making the initial determination and provide written notification to the provider within two (2) Business Days of making the determination.	**written notification to the provider within two (2) Business Days of making the determination.**
2023 Louisiana Regular Session Act Number 312, Page 9, Section (C) (1) **If a health insurance issuer denies a request for utilization review and the healthcare provider requests a peer review of the determination to deny, the health insurance issuer must appoint a licensed healthcare practitioner similar in education and background or a same-or-similar specialist to conduct** **the peer review with the requesting provider. To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:** **(a) Treating the condition.** **(b) Treating complications that may result from the service or procedure.** **2023 Louisiana Regular Session Act Number 312, Page 9, Section (C)** **(2) The criteria set forth in Paragraph (1) of this Subsection are sufficient for the specialist to determine if the service or procedure is medically necessary** **or clinically appropriate. For the purpose of this Subsection, "training and experience" refers to the practitioner's clinical training and experience.** **2023 Louisiana Regular Session Act Number 312, Page 9, Section (C)** **(3) When the peer review is requested by a physician, the health insurance issuer must appoint a physician to conduct the review.** **The health insurance issuer must notify the physician of its peer review determination within two business days of the date of the peer review.**	**If a health insurance issuer denies a request for utilization review and the healthcare provider requests a peer review of the determination to deny, the health insurance issuer must appoint a licensed healthcare practitioner similar in education and background or a same-or-similar specialist to conduct** **the peer review with the requesting provider. To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:** **(a) Treating the condition.** **(b) Treating complications that may result from the service or procedure.** **2) The criteria set forth in Paragraph (1) of this Subsection are sufficient for the specialist to determine if the service or procedure is medically necessary** **or clinically appropriate. For the purpose of this Subsection, "training and experience" refers to the practitioner's clinical training and experience.** **(3) When the peer review is requested by a physician, the health insurance issuer must appoint a physician to conduct the review.** **The health insurance issuer must notify the physician of its peer review determination within two business days of the date of the peer review.**

REVIEW AND APPROVALS

Jess R Hall, Chief Executive Officer **Date**

Antoinette K Logarbo, MD Chief Medical Officer **Date**

EXHIBIT(S): N/A