Government Business Division
Policies and Procedures

Section (Primary Department)	**SUBJECT (Document Title)**
Health Plan Operations	**Member Appeals – Core Process - LA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
June 19, 2015	August 31, 2020	~~August 31, 2020~~January ~~8,~~ March 10~~9~~, 2021	~~August 31, 2020~~March 10, 2021

Department Approval/Signature

Policy applies to applicable plans operating in the following State(s). Applicable products noted below.

Products	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☒ **Medicaid/CHIP**	☐ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **Medicare/SNP**	☐ Colorado	☒ Louisiana	☐ New York – Empire	☐ Virginia
☐ **MMP/Duals**	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Missouri	☐ South Carolina	☐ West Virginia
	☐ Indiana	☐ Nebraska		

POLICY:

To comply with general requirements of 42 Code of Federal Regulations Part 43 – Managed Care Rule Subpart F – Grievance and Appeal System Section §438.400 - §438.424 and with other state, federal and accreditation standards, The Health Plan will ensure that members, and authorized representatives acting on behalf of the member, have a full and fair process for resolving requests to reconsider a decision that they find unacceptable regarding denial of coverage of, or payment for their request for service(s).

The health plan will ensure that members, and authorized representatives acting on behalf of the member, have a full and fair process for addressing the outcome of an appeal, as appropriate.

The health plan will ensure inclusion as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate.

The health plan will provide the member a reasonable opportunity to present evidence, submit written comments, documents, records, other information relevant to the appeal along with allegations of fact or law, orally, in person or in writing (the MCO must inform the member of the limited time available for this sufficiently in advance of the date by which the MCO shall resolve the appeal in the case of the expedited resolution). The organization documents when members fail to submit relevant information by the specified deadline.

The health plan will ensure that the member and his or her representative are provided the opportunity, before and during the appeal process to request copies and/or examine the member's case file, including medical records, and any other documents and records considered during the appeal process, and any evidence considered, relied upon, or generated by the MCO in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the date by which the MCO shall resolve the appeal. The Contractor shall provide such records free of charge and within seven (7) calendar days of request.

The health plan will establish and maintain an expedited review process for appeals, when the health plan determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

~~The health plan will ensure that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) unless the member or the provider requests an expedited appeal resolution. The oral appeal shall be followed by a written, signed appeal unless the member requests and expedited resolution. The enrollee has fifteen (15) calendar days from the date of the notice to send their written confirmation.~~
~~If written confirmation is not received within the fifteen (15) day timeframe:~~

- ~~The Contractor shall close the appeal as incomplete for non-receipt of written confirmation.~~
- ~~The Contractor shall send a notification to the enrollee of the appeal closure. This notice shall consist of the reason for the incomplete appeal and inform the enrollee that they may submit a new appeal if they are within the original sixty (60) calendar days of the adverse action. This closure does not escalate the appeal to a state fair hearing since the initial appeal process was not completed.~~

~~Once a request for an oral appeal has been closed for non-receipt of a written confirmation, a new appeal date can be established with an oral or written appeal request if it is within the original sixty (60) calendar days of the adverse action.~~

The health plan will inform the member of limited time if the expedited process is used.

The health plan is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing.

No additional follow-up may be required and in accordance with 42 CFR§438.410 no punitive action will be taken against a provider who requests an expedited resolution or supports a member's appeal.

~~The[kls1] health plan will ensure that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) unless the member or the provider requests an expedited appeal resolution. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution. The enrollee has fifteen (15) calendar days from the date of the notice to send their written confirmation.~~

~~If written confirmation is not received within the fifteen (15) day timeframe:~~

- ~~The Contractor shall close the appeal as incomplete for non-receipt of written confirmation.~~
- ~~The Contractor shall send a notification to the enrollee of the appeal closure. This notice shall consist of the reason for the incomplete appeal and inform the enrollee that they may submit a new appeal if they are within the original sixty (60) calendar days of the adverse action. This closure does not escalate the appeal to a state fair hearing since the initial appeal process was not completed.~~

~~Once a request for an oral appeal has been closed for non-receipt of a written confirmation, a new appeal date can be established with an oral or written appeal request if it is within the original sixty (60) calendar days of the adverse action~~[DC2]~~.~~

The health plan will ensure that the appeal process and all member services and interactions are communicated and administered in a culturally and linguistically competent manner, including to individuals with limited English proficiency, and accommodate those individuals with disabilities consistent with the requirements of the American Disabilities Act (ADA) of 1990.

The health plan will ensure it maintains an electronic documentation system for monitoring timeliness of appeals whether initiated orally or in writing to the health plan or a regulatory agency.

The health plan will monitor member satisfaction with services and identify areas for improvement.

The health plan will have a system in place for members that includes an appeal process, and access to the State's fair hearing system.

The Board of Directors for The Health Plan has delegated oversight of the member appeals process to the Quality Improvement Committee (QIC)/Quality Management Committee (QMC).

The health plan will provide an appeal and acknowledges the member's right to request a State Fair Hearing or external appeal (as applicable).

The health plan shall not create barriers to timely due process and shall be subject to sanctions if it is determined by LDH that the health plan has created barriers to timely due process, and / or, if ten (10) percent or higher of appeal decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to:

- Including binding arbitration clauses in the health plan member choice forms;
- Labeling complaints as inquiries and funneled into an informal review;
- Failing to inform members of their due process rights;
- Failing to log and process grievance and appeals;
- Failure to issue a proper notice including vague or illegible notices;

- Failure to inform of continuation of benefits; and
- Failure to inform of right to a State Fair Hearing.

The health plan's members and authorized representatives have sixty (60) calendar days to file an oral, fax or written appeal from the date on The Health Plan Louisiana adverse benefit determination / notice of action or inaction (plus 7 additional days to allow for mailing).

The health plan makes provisions for informing members of their right to have a representative act on their behalf at all levels of appeal when it notifies them of a denial decision[kls3]. ~~Additionally, the member and his or her representative have the opportunity, before and during the appeals process, to examine the members' case file, including medical records, and any other documents and records considered during the appeals process. The Contractor shall provide such records free of charge and within seven (7) calendar days of request.~~ A provider may file an appeal or request a state fair hearing on behalf of the enrollee with the enrollee's written consent. The enrollee's consent shall not be required for provider appeals of claim denials. If you are requied to obtain prior authorization on a concurrent or post-service basis, the consent of the Member who received the services will not tbe required in order to dispute the denied authorization for service.

Time Frames

Appeal decisions must be resolved within the following timeframes:

1) Pre service Appeals: Within thirty (30) calendar days of receipt of the appeal.

2) Expedited Appeals: As expeditiously as the medical condition requires, but no later than seventy-two (72) hours of receipt of the appeal request.
    - An expedited request begins when a member, the member's authorized representative or a practitioner acting on behalf of the member, requests an expedited appeal.
    - The organization will grant expedited review for all 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.

3) Oral Appeals: Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow–up is required.

4) Post-service Appeals: Within thirty (30) calendar days of receipt of the appeal request.

5) The health plan may extend the timeframes by up to fourteen (14) calendar days if:
    - The member requests the extension; or

- The health plan shows, to the satisfaction of the LDH, upon its request, that there is a need for additional information and how the delay is in the members' interest; or
- If the health plan extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

6) Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the health plans decision in writing. If a determination is not made by the above timeframes, the member's request will be deemed to have been exhausted the MCO's appeal process as of the date upon which a final determination should have been made. The member may then initiate a State Fair Hearing.

7) The health plan must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

8) If the health plan denies a request for expedited resolution of an appeal, in accordance with 42 CFR §438.408 (b)(2) Standard resolution of appeals & (c)(2) Action following denial of a requested expedited resolution it must:
    a. Transfer the appeal to the timeframe for standard resolution;
    b. Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.
    c. The decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute and Action or require a Notice of Action. The member may file a grievance in response to this decision.

9) The health plan complies with the National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), State and Federal standards. State-specific standards regarding appeals are included in health plan-specific policies.

10) The health plan acknowledges appeals within five (5) business days unless the state mandated time frame is shorter.

DEFINITIONS:

Adverse benefit determination: Means in the case of a health plan any of the following:
1) Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
2) Reduction, suspension, or termination of a previously authorized service;

3) Denial, in whole or in part, of payment for a service;
4) Failure to provide services in a timely manner, as defined by the State;
5) Failure of to act within the timeframes provided in 42 CFR§438.408(b)(1) and (2) regarding standard resolution of appeals; or
6) For a resident of a rural area with only one MCO, the denial of a Medicaid member's request to exercise his or her right, under 42 CFR§438.52(b) (2) (ii), to obtain services outside the network;
7) Denial of a Medicaid members request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal (NCQA definition): ~~A formal request to an organization by a practitioner or member for reconsideration of a decision (e.g. utilization review recommendation, benefit payment, administrative action, quality of care or service issue) with the goal of finding a mutually acceptable solution.~~
A[kls4] request to change an adverse decision made by the organization. A member or authorized representative of a member may appeal any adverse decision.

Appeal (Louisiana Contract Language): An oral, written or fax request for a review of an action.

Appeal (42 Code of Federal Regulations with § 438.400 statutory basis, definitions, and applicability): Means a review by an MCO of an adverse benefit determination.

Appeals Mechanism/Procedure: The formal process whereby a member or provider, acting on behalf of the member, has the right to contest an adverse determination/action rendered by the health plan, which results, in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Additionally, if a member contacts the Louisiana health plan telephonically and/or in writing expressing dissatisfaction with an adverse determination, reduction, suspension, termination, delay and or denial of a health care benefit/services these member contacts will be considered appeals and not a complaints or member grievances and reported as such.

Complaint/Grievance (NCQA definition): An[kls5] expression of dissatisfaction with an aspect of the organization's operations or activities, including the actions of network providers and practitioners.
Note: *NCQA's definition of complaint is inclusive of the CMS definition of "grievance."*
~~An oral or written expression of dissatisfaction. The expression of dissatisfaction can be with any aspect of the health plan or the provider's operation, provision of health care services, activities, or behaviors, other than an "action". Possible sources of complaints and grievances include, but are not limited to: quality of care,~~
~~access, attitude and service, billing and financial issues, and quality of practitioner office site or~~

~~failure to respect member's rights.~~

Designated Representative: Any person or entity acting on behalf of the member and with the member's written consent.

Grievance (Louisiana Contract Language): An expression of member/ provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness or a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Emergency Services: Policies and procedures require coverage of emergency services in the following situations:

1) To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
2) If an authorized representative, acting for the organization, authorized the provision of emergency services.

Expedited appeal: A request to change an adverse determination for urgent care.

External quality review (EQR): The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that the health plan or its contractors furnish to Medicaid members.

External quality review organization (EQRO): An organization that meets the competence and independent requirements set forth in 42 CFR§438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR§438.358, or both.

Grievance Process (Louisiana Contract Language): The process for addressing enrollee's grievances.

Grievance System (Louisiana Contract Language): A grievance process, an appeal process, and access to the state's fair hearing system. Any grievance system requirements apply to all three components of the grievances system not just to the grievance process.

Independent Review Organization/agent (IRO): External review by an independent utilization review organization which/who will provide same-or-similar specialists as consultants during the internal appeal process and is subject to State laws and regulations. An appeals review that is conducted by a third party that is not affiliated with the health plan or a providers' association and has no conflict of interest or stake in the outcome of the review.

Medical Necessity Appeal: Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

Member: A covered enrollee to which benefits are available including the right to appeal and grieve and to designate a representative or advocate to assist or have the provider act on their behalf (with member's consent) in the appeal process. Member designee also includes representation of a deceased covered member's estate.

Post service Appeal: A request to change an adverse determination for care or service that has already been received by the member.

Practitioner: A professional who provides health care services. Practitioners are usually licensed as required by law.

Pre service Appeal: A request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining medical care or services.

Provider: An institution or organization that provides services for health plan members. Examples of providers include hospitals and home health agencies. NCQA uses the term practitioner to refer to the professionals who provide health care services, but recognizes that a provider directory generally includes both providers and practitioners and the inclusive definition is the more common use of the word.

Provider Payment Dispute: A health care provider payment disagreement for services already provided, for lost or incomplete claim forms or electronic submissions, requests for additional explanation for services or treatment rendered by a health care provider, inappropriate or unapproved referrals initiated by the providers or any other reason for billing disputes. No action is required of the member for provider payment disputes.

Prudent Layperson: A person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

Request for A Hearing: 42 CFR§431.201 A clear expression by the applicant or recipient, or his

authorized representative, that he wants the opportunity to present his case to a reviewing authority.

Same/Similar Specialists: To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:

- Includes treating the condition.
- Includes treating complications that may result from the service or procedure.
- Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.

"Training and experience" refers to the practitioner's clinical training and experience.

~~A health care practitioner who has appropriate training and experience in the field of medicine involved in a UM appeal case. The same specialty refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A similar specialty refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems~~.

UM Personnel Decision Making: UM decisions that require clinical judgment (e.g., assessing if a member reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care) must be licensed health care professionals. Licensed health care professionals may include appropriately qualified practitioners in accordance with state laws.

The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: education, training or professional experience in medical or clinical practice; a current license to practice without restriction.

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 result in the following circumstances:

1) Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
2) In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

PROCEDURE:

The internal appeal process includes collaboration between departments: Corporate Clinical Quality Management (CCQM), National Customer Care Center (NCC), Enterprise Services Document Control Center (DCC), Claims, as well as the Quality Management, Plan Operations and

Healthcare Management Services departments at the health plan level. Each area has defined responsibilities within the process for the progression and resolution of the appeal.

1) A member or a person designated by the member to act on their behalf, may file an appeal and may request a State Fair Hearing after receiving notice under 42 CFR § 438.408 that the adverse benefit determination is upheld. If the member has exhausted the MCO-level appeal procedures, the member can request a State Fair Hearing within one hundred twenty
   (120) days from the date of the MCO's notice of resolution. Parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.
2) In Louisiana, in the case of an MCO that fails to adhere to the notice and timing requirements as outlined in 42 CFR §438.408, the member is deemed to have exhausted the MCO's appeal process, the member, or authorized representative acting on the member's behalf, may request a State Fair Hearing.
3) In accordance with 42 CFR§438.414, the health plan must provide appeal process information to practitioners, providers and subcontractors at the time they enter the network contract. The appeal process is contained in the member handbook, the provider manual and via the website.
4) NCC [kls6][DC7]or Health Plan Representatives, in accordance with 42 CFR§438.406 will give the member any reasonable assistance and/or member representatives in understanding the appeal process, and providing next steps in the appeal process to the member. This assistance will include but is not limited to, auxiliary aids and services upon request, such as providing interpreter services, help completing forms and toll-free numbers with adequate TTY/TTD and interpreter capability.
5) Appeal requests received either orally or in writing from the member or the member's authorized representative will be processed by Central Appeal Processing. Oral filings will be treated as appeals to establish the earliest possible filing date. Appeal requests received by fax are processed at the health plan.
6) Enterprise Services Document Control Center (DCC), will receive written appeal requests, scan the appeal and any attachments, into Macess Kofax electronic scan batch for appeal correspondence.
7) The health plan may also receive appeal requests at their physical location. In this instance the health plan scans the appeal and any attachments and places it into the electronic tracking system for the appropriate queue documentation and tracking.
8) The date of any oral filing is considered the filing date of the appeal. NCC documents appeals in contact logs and routes appeals to the health plan. See exceptions section for any exclusions
9) The health plan is notified of appeal request via the electronic tracking system (queue content).

10) The health plan will mail acknowledgement letters to the member or the member's authorized representative within five (5) business days of receipt of an appeal.
11) The health plan will investigate, review and resolve appeals within regulatory and/or State specific established timeframes and provide the member with notification of the outcome.

12) The health plan will provide, free of charge, the clinical criteria utilized to make the determination upon request from the member or provider.
13) Oral notification may be provided initially, within 72 hours of an expedited appeal request. The health plan may notify the hospital/ facility Utilization Review department staff of its decision, with the understanding that staff will inform the attending/treating practitioner.
14) ~~14~~All appeal documents are treated as confidential, placed in a secure location, within the health plans electronic documentation system and retained in accordance with the Records and Information Management (RIM) policy. Additionally, in accordance with 42 CFR §438.416, Louisiana requires the health plan to maintain appeal records per the state's minimum retention periods (10 years) and in a manner accessible to the state and available upon request to CMS. Files may be reviewed as part of the state quality strategy. The Contractor shall report on grievances and appeals to LDH in a manner and format determined by LDH.

Quality Monitoring and Reporting

1. The health plan tracks, trends, and analyzes appeal data. Data is gathered and categorized by type, originator, decision and external review in compliance with regulatory and/or State requirements.
2. On a monthly basis, the health plan evaluates appeal data to identify trends that impact member care. Electronic documentation system tracks and categorizes at a minimum:
    i. Date of receipt
    ii. Individual requesting appeal
    iii. Type of appeal
    iv. Reason for appeal
    v. Date of appeal decision
    vi. Appeal decision-maker
    vii. Nature of appeal determination
    viii. Date the notification letter was sent
4. Information is reported to the Plan Quality Management Committee. Action plans are developed and followed as appropriate.
5. On an annual basis, the health plan analyzes and trends appeal data and provide a report to the Plan Quality Improvement Council and will include action plans

and statuses of quality initiatives, where appropriate.

Adverse Determination/ Actions:

1) The MCO's Medical Director has ultimate responsibility and accountability for member medical necessity appeals.
2) The Medical Director or physician designee evaluates and discusses the care with the attending provider by telephone. The attending physician will be expected to respond within a reasonable time frame with additional information before completing the review.
3) The Medical Director/designee shall have a documented proactive process that may be accomplished by fax, paging, calling the office of the provider or hospital and leaving messages with a call back request to ensure at least one (1) documented attempt for peer review.
4) The Medical Director and any designee must maintain licensure as a physician practicing within the State if applicable under regulatory requirements.
5) The Medical Director or designee will make all decisions concerning adverse actions. The reviewer must have appropriate clinical expertise in treating the member's condition or disease.

Appeal Documentation

The health plan will document all information related to the appeal within the electronic documentation system/ database:

1) Document the substance of the appeal, including the member's reason for appealing the previous decision. Also document actions taken, including but not limited to; previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
2) Investigate and document the substance of the appeal, including any aspects of clinical care involved, provided with the appeal file. A full review and investigation of the appeal will be conducted. The reviews will not give deference to the original denial decision.
3) Provide the member or the member's representative every opportunity to submit written comments, documents, records and other information relevant to the appeal. The health plan staff will document, in the system, when members/ authorized representatives, fail to submit relevant information by the specified deadline.
4) Appoint a new person to review the appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial However, the practitioner who made the initial decision, may review the case and overturn the initial decision.

Appoint at least one (1) health care practitioner to review the appeal who has appropriate clinical knowledge, sufficient training and experience in:

- Treating the same medical condition, service or procedure as those in question in the appeal and treating similar complications of those medical conditions, service or procedure in a clinical setting.

- ~~2.~~ Determining if the service or procedure meets medical criteria for medically necessary and
- ~~3~~. Pharmacists are not considered same-or-similar specialists for appeal decisions. Depending on the type of case, a same or similar specialist may be a physician, behavioral healthcare practitioner, chiropractor, dentist, physical therapist or other type of practitioner as appropriate.

The health plan's written adverse determination notification will describe:

1) The procedure and the process to request documents free of charge;

2) Provide a Member services 1-800 number to request help with forms;

3) Notify the member in writing about further appeal rights in a culturally and linguistically appropriate manner including instructions on how to pursue and use of an authorized representative;

4) Provide the specific reasons for the appeal decision in easy to understand language. An appropriately written notification includes a complete explanation of the grounds for the decision written in plain language that a layperson could understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. Abbreviations/acronyms that are clearly explained in lay language e.g. DNA, are not required to be spelled out.

5) Reference the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision is based in easy to understand language (plain language) and within a culturally and linguistically appropriate manner in order to meet the members'/authorized representatives needs instructions

6) Upon request, provide members access to and copies of all documents relevant to the appeal, free of charge and supplying members with forms and on how to designate an authorized representative to act on his/her behalf;

7) Inform members how to request an expedited appeal;

8) Include a list of titles and qualifications, including specialties, of all individuals participating in a medical necessity appeal review; benefit appeals only require the Reviewer's Title.

9) Describe the possibility of continued coverage pending the outcome of the appeal;

Continuation of Benefits in accordance with 42 CFR§438.420 and the Louisiana State Contract, the health plan must continue benefits if all of the following occur:

- The member or provider, acting on behalf of the member and with the member's written consent, seeking to have benefits continue pending the appeal process files timely on or before ten (10) days of the health plan's mailing the adverse benefit determination / notice of action or the intended effective date of the health plans proposed action;
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- Services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The member requests extension of benefits.

If, at the member's or the provider acting on behalf of the member, and with the member's written consent request, the health plan continue or reinstate the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of the following occurs:

- The member or provider acting on behalf of the member withdraws the appeal.
- The member or provider acting on the member's behalf, fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the health plan mails the notice of an adverse resolution to the member's appeal in accordance with 42 CFR §438.408(d)(2);
- The State Fair hearing office issues a hearing decision adverse to the enrollee;
- The time period or service limits of a previously authorized service has been met;
- If the final resolution of the appeal is adverse to the member, that is, the decision is upheld, the health plan may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR §431.230(b);
- In accordance with §438.424, where the health plan, or the State Fair hearing officer, reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the health plan must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires; but no later than 72 hours from the date it receives notice reversing the decision.
- When the health plan, or the State Fair hearing officer, reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan ~~or the State~~ must pay

for those services in accordance with the contract.

Extending the decision timeframe:

For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:

- The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or
- The MCO justifies (to LDH upon request) a need for additional information and how the extension is in the member's best interest.

If the Health Plan extends the timeframes without the request of the member, the Health Plan must notify the member/representative through written notice of the extension and reason for the delay and must complete all of the following:

1) Make reasonable efforts to give the member prompt oral notice of the delay.
2) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires

The extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for appeal, without the informed written consent of the enrollee. In all circumstances the appeal determination must not be extended beyond forty-five (45) calendar days from the day the Health plan receives the appeal request.

State Fair Hearings:

1) The health plan must permit the member to request a State Fair hearing within the time period specified by the State and once the health plan's internal appeal process has been exhausted.
2) The parties to the State Fair Hearing will include the health plan as well as the member and his or her representative or the representative of a deceased member's estate.
3) Eligible members may request a Fair Hearing if the decision was not wholly resolved in the member's favor. The notice of appeal determination will include information on the right to request a State Fair Hearing and the process of how to appeal.
4) To request a review, the member may submit the request orally, written, via fax or online within the timeframe and to the appropriate State entity.
5) If a member or his designee requests a Fair Hearing, the health plan will promptly

provide documentation about the appeal investigation and findings to the appropriate State entity.

6) The health plan will continue the member's benefits currently being received, including the benefit that is the subject of the appeal if all of the following criteria are met:
   - The member or his authorized representative files the appeal timely (timeframes may differ by market);
   - The appeal involves the termination, suspension or reduction of coverage of a previously authorized course of treatment;
   - The services were ordered by an authorized provider;
   - The original period covered by the original authorization has not expired and,
   - The member requests an extension of the benefits.
7) Benefits shall be continue until one of the following occurs:
   - The member withdraws the appeal;
   - Ten (10) [or other state required time frame] calendar days pass after the health plan mails the notice providing the appeal resolution and a request has not been received;
   - The State's Fair Hearing office issues a hearing decision adverse to the member and;
   - The time period or service limits of a previously authorized service has been met.

~~8) If the hearing decision reverses a decision that was adverse to the member, and services were not provided while the appeal was pending the health plan will authorize or arrange to provide the disputed services promptly and as expeditiously as the member's health condition requires.~~

8) If the Health Plan, or the State Fair Hearing officer, reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Health Plan must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

9) If the hearing decision reverses a decision that was adverse to the member and services were provided while the appeal was pending, the health plan is responsible for payment of the services.

REFERENCES:

- Federal Register / Vol. 81, No. 88 / Friday, May 6, 2016 / Rules and Regulations. 42 CFR 438 – Managed Care Subpart F Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302). Effective May 6, 2016, § 438.370 Grievance and Appeal System. Sections § 438.400 – §438.424
- Louisiana State Contract

- NCQA Accreditation Standards and Guidelines

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Plan Operations

Secondary Department(s):
Claims
Document Control Center (DCC)
Enterprise Services
Health Care Management
National Customer Care
Quality
Regulatory

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
06/19/2015	• New. Plan-specific version created from corporate version. Revised to exclude other plans information and designed policy to be LA specific and align with 2/1/2015 new contract language
02/29/2016	• Off cycle review • Updated to conform to NCQA standards and update turnaround time for appeal acknowledgement.
07/13/2016	• For annual review • Definitions placed in alphabetical order • Secondary department name updated from DCC to Enterprise Services Document Control Center (DCC) • The term Bayou Health removed from State Department's title
07/17/2017	• For annual review • Revised for inclusion of LA Contract and Amendment 9 • Inclusion of Annual External Review Organization (IPRO) recommendations • Revised for updated 42 CFR Mega Regulation Rule

	• Primary department changed from QM to OPS • Amerigroup references updated to The Health Plan
08/07/2018	• For annual review • Policy section updated with current contract language • Minor update to definitions section • Update to procedure section with current contract language
03/08/2019	• Off cycle review • Edits to procedure section with current NCQA language
07/10/2019	• Annual Review • Updated Policy Section • Updated Procedure Section • Updated Secondary Departments in alphabetical order
08/31/2020	• Annual Review • Updated policy, procedure, and references
03~~1~~/10~~08~~/2021	• Off-Cycle Review • Updated the policy, definitions, and procedure per Contract Amendment 3 changes and NCQA standards