POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Appeals Process
PAGE: 1 of 18	**REPLACES DOCUMENT:**
APPROVED DATE: 9/2015	**RETIRED:**
EFFECTIVE DATE: 2/2015	**REVIEWED/REVISED:** 9/16, 10/16, 11/16, 12/16, 7/17, 8/17, 6/18 10/18, 8/19, **6/20**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.QI.11.03

SCOPE:
Louisiana Healthcare Connections (Plan) Quality Improvement, Medical Management and Customer Service Departments

PURPOSE:
To ensure that the plan has an effective and consistent process for acknowledging, investigating, resolving and making notification of appeals in a timely manner. The plan has written policies and procedures for thorough, appropriate and timely resolution of member appeals. The plan shall have a thorough and consistent process for addressing member appeals.

POLICY:
The Chief Medical Director is significantly involved in the Quality Improvement program including grievance and appeals **(G&A)**. The day to day responsibility for the coordination of the Appeals Process resides with the Clinical Appeals Coordinator (CAC). One of the responsibilities of the CAC is to ensure that the various deadlines are adhered to in accordance with state and federal laws.
The plan has policies and procedures for registering and responding to oral and written appeals that include:

- Documentation of the substance of appeals and actions taken
- Investigation of the substance of the appeals, including any aspect of clinical care involved.
- Notification to members of the disposition of appeals and the right to further appeal, as appropriate.
- Standards of timeliness, including standards for clinically urgent situations
- Provision of language services for the appeals process

The appeals procedures shall ensure that Louisiana HealthCare Connections (LHCC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex in accordance with Section 1557 (the nondiscrimination provision) of the Affordable Care Act (ACA). LHCC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
LHCC:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters

- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

PROCEDURE:

A. General Requirements

1. Members are notified upon enrollment of the procedure for requesting, processing and resolving member grievances, appeals and SFH. The notification explains specific instructions about how to contact the Plan's Customer Service Department and identifies the G & A Coordinator, GAC or C & A Coordinator, CAC, or the designated staff, who process grievances, appeals and SFH.
2. A member, or authorized representative acting on the member's behalf or a provider, acting on behalf of the member and with the member's written consent, may file a grievance or appeal, and may request a SFH.
3. A member, or member authorized representative, may file a grievance or appeal verbally or in writing. The Plan gives members reasonable assistance in completing forms and taking other procedural steps of the member grievance system, including, but not limited to, auxiliary aides and services, such as providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability.
4. The Plan gives the member written notice of any action (not just service authorization actions) within the timeframes for each type of action and will not create barriers to timely due process.
5. The Plan's Customer Service Department documents the grievance or appeal and completes a task in the member relations documentation system. If the grievance is resolved by the Customer Service Department at the time of submission (first call resolution), the Customer Service Department will document the resolved case in member relations documentation system and mark the call complete as appropriate.

6. If the grievance is not resolved at the time of the call, the Customer Service Department will save the call and the case will be sent to the G&A Coordinator for review, investigation, and resolution.
7. The Plan takes into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination, if applicable.
8. The Plan provides the member a reasonable opportunity, verbally and in writing, to present evidence, testimony, and make legal and factual arguments. The Plan informs the member of the limited time available in advance of the resolution timeframe for grievance and appeals and in the case of expedited resolution.
9. The Plan provides the member and his or her representative, free of charge and in advance of the resolution timeframe for grievance and/or appeals: the member's case file, medical records involved, other documents and records, and any new or additional evidence used in the case. The Plan includes information (including all related policies, procedures and timeframes) regarding grievances and appeals in the Plan's Provider Manual and Member Handbook.
    a. The Plan provides a copy of the Provider Manual to all providers/ subcontractors at the time the Plan enters into agreements with said providers/subcontractors.
    b. A Member Handbook is distributed to all members upon enrollment.
    c. The information is also posted on the Plan's web site and communicated annually through the Member and Provider Newsletters/Manuals.
10. The Plan maintains a record/log of all grievances, appeals and requests for SFH that will be available to the State agency in electronic format upon request. The log will be specific to the Plan members; entries in the log will not be intermingled with entries of members from the Plan's other lines of business. At a minimum, the log will include:
    a. The member's name and member ID number;
    b. The name of the grievant or appellant if not the member;
    c. The date of filing and description of the issue;
    d. The date and description of the resolution;
    e. Whether the grievance was determined valid; and
    f. The date of the member notification.

11. As part of the QI/QM process, the Plan tracks the grievances and appeals to identify trends. The trends are reviewed by the Grievance & Appeals Committee or Performance Improvement Team for identification of appropriate interventions and recommendations submitted to the Quality Committee. An analysis of the grievance system is included in the annual QI/QM Program Evaluation.
12. The Plan electronically provides the State agency with a monthly report of the grievances and appeals in accordance with the requirements outlined in the Contract, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action.
13. The Plan assures that no punitive action is taken against a provider or member who files a grievance, an appeal, requests an expedited appeal on behalf of a member, or supports a member's grievance, appeal or request for an expedited appeal.
14. All subcontractors, including those delegated for services, will meet the member grievance and appeal system requirements for problems related to delegated services.
15. The Plan maintains records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals will be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.

B. Appeal Process

1. **Filing an Appeal**
   a. The appeal process is the Plan's procedure for addressing member appeals, which are requests for review of a previous decision by the Plan. Appeal rights may not be applicable for some grievances (i.e. member grievances about Emergency Room wait times, staff conduct or physician conduct, where there is no adverse decision to appeal).

b. The member, member's authorized representative with the member's written consent, or provider acting on behalf of the member, with the member's written consent, may file an appeal. An appeal must be filed within 60 calendar days from date on the adverse benefit determination notice or within 10 calendar days if the member is requesting to continue benefits during the appeal investigation.

c. An appeal request may be submitted several ways:
   (1) The member may call in to the Member Services Department through the Plan's toll-free customer service line. All inquiries received by Customer Service Department are probed to validate the possibility of any inquiry actually being a grievance or appeal. The **G&A** Coordinator is notified of the appeal and obtains the information from the member relations documentation system and/or documents the information in the clinical documentation system **(Attachment A – Grievance or Appeal Form)**.
   (2) The member may submit the appeal by mail, fax or email or by oral request for an appeal. (See RFP Final: 13.2.4.2 pg. 240) If the member chooses to submit an oral standard appeal request, the member's request must be followed by a written follow up request within 15 calendar days **(Attachment B - Oral Appeal & Written Notifications Guidelines)**.
   (3) If a member would like an authorized representative working on the member's behalf, the member must complete the form designating the person **(Attachment C – Personal Appeal Representative Form)**.
   (4) The Plan gives members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aides and services, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability and providing the option for the member to utilize 711.

d. The resolution timeframe depends on the type of Appeals:
   (1) Standard Appeal Pre-service-requires resolution in 30 calendar days
   (2) Standard Appeal Post-service –requires resolution in 30 calendar days

(3) Expedited Appeal-requires resolution within 72 hours of receipt of the submission of the appeal. Plan maintains an expedited review process for appeals when the Plan determines the member request 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, health or ability to attain, maintain, or regain maximum function. Expedited appeals are not available for post service requests.

e. The Plan acknowledges all oral and written Standard Appeals in writing within 5 business days of the receipt of a request for an appeal. Expedited Appeals acknowledgement occurs at the same time the resolution is determined (with 72 hours) (See RFP Final: 13.4.1.1 pg. 241).
f. The member and his or her representative has the right to examine the case file and receive free of charge the medical records, and any other documents and records, including any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan considered in connection with the appeal of the adverse benefit determination before and during the appeals process.
g. The Plan ensures that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making nor a subordinate of any such individual, and who, if deciding any clinical decisions, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease.
h. Form and/or letter templates that are in the Plan's clinical documentation system are utilized to communicate with the member. If the State has specific form and/or template requirements, those will be utilized in lieu of Plan specific developed forms and/or templates.
i. Communication to the member identifies circumstances under which a member may continue to receive benefits pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

2. **Standard Appeal Process**

a. The Clinical Appeals Coordinator is responsible for managing standard appeals from when the appeal request is received and through to resolution.
b. Acknowledgement of the Standard Appeal
   (1) The Appeal Acknowledgement Letter for a Standard Appeal is sent within 5 business days of the receipt of the appeal request.
   (2) The member Appeal Acknowledgement Letter for a Standard Appeal is attached in the clinical documentation system (TruCare) utilized at the Plan.
      - The acknowledgement letter includes notification of member rights and appeal processes in a culturally and linguistically appropriate manner:
      - The member's right to choose additional representation by anyone, including an attorney, physician, advocate, friend or family member to represent him or her during the appeal process. The designation of their authorized representative must be submitted to the Plan in writing.
      - The member's right to submit comments, documents or other information relevant to the appeal.
      - The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired
      - The timeframe for resolution of the appeal.
      - The member'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 member may be required to pay for the cost of those services.
      - Need for missing information, such as a signed authorized representative form, if applicable or written follow up from the member's initial verbal request (See RFP Final: 13.2.4.2 pg. 240 and Attachment B - Oral Appeal and Written Notification Guidelines).
c. The Clinical Appeals Coordinator creates an appeal in the Plan's clinical documentation system; requests additional information as applicable and submits to Medical Director for review.
d. Resolution of the Standard Appeal

(1) The Resolution of the Standard Appeal must be completed within 30 calendar days of receipt of the Standard Appeal request.
(2) An Appeal Resolution Letter for a Standard Appeal is sent out as soon as possible after the resolution determination, the appeal resolution should not exceed thirty (30) calendar days from the appeal receipt (See RFP Final: 13.6.1.2). The notice of resolution (or disposition) includes the results of the resolution process, the date it was completed and further appeal rights, if any.
(3) The member–specific Appeal Resolution Letter for a Standard Appeal is attached in the member's clinical documentation system utilized at the Plan. Based on the outcome of the resolution, a member-specific resolution letter will be sent.
(4) The Clinical Appeals Coordinator is responsible for updating/closing the case in the member relations documentation system. Letters will only be attached in the clinical documentation system.
(5) Appeals shall be resolved no later than the above stated timeframes and all parties shall be informed of the MCO's decision in writing. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved.

d. Extension of Standard Appeal
(1) If the Plan determines that the extension may produce information in the member's favor, the Clinical Appeals Coordinator may request a 14 calendar day extension. The member may also request a 14 calendar day extension (See RFP Final: 13.6.2.1 pg. 246).
(2) The Plan must obtain State approval and member consent for the extension.

e. If the member or member representative is not satisfied with the resolution, the member may file for a State Fair Hearing (SFH)

3. **Expedited Appeal Process**
a. The Clinical Appeals Coordinator is responsible for managing Expedited Appeals from the date of appeal request through to resolution.

b. Acknowledgement of the Expedited Appeal
   (1) The Clinical Appeals Coordinator calls the member acknowledging the Expedited Appeal.
   (2) If the Expedited Appeal request is determined not to meet criteria, the Standard Appeal process will be followed.
   (3) The Clinical Appeals Coordinator creates an appeal in the Plan's clinical documentation system; requests additional information as applicable and submits to Medical Director for review.

c. An expedited appeal request must be granted to 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 the facility. The Plan must provide an expedited appeal if a physician demonstrates that the standard timeframe for an appeal decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

d. State contracts may dictate other situations where expedited appeals are allowed.

e. If the Plan denies a request for an expedited appeal, the appeal must automatically be transferred to the standard timeframe. A reasonable attempt must be made to provide oral notification of the expedited request denial and followed up with written notice within 2 calendar days (CFR 438.410), or per state contract requirements if more stringent.

f. Resolution of the Expedited Appeal
   (1) The resolution of the Expedited Appeal must be completed within 72 hours of receipt of the Expedited Appeal request.
   (2) Once a resolution is made, the member is called to discuss the resolution decision, an Appeal Resolution Letter for an Expedited Appeal (which also documents the acknowledgement) is sent out after calling, or making a reasonable attempt to call the member to confirm the conversation of the resolution decision.
   (3) The member-specific Appeal Resolution Letter for the Expedited Appeal is attached in the member's clinical documentation system (TruCare) utilized at the Plan. Based on the outcome of the resolution, a member-specific resolution will be sent. The notice of resolution (disposition) includes the results of the resolution process, the date it was completed and further appeal rights, if any. When the adverse decision is upheld in whole or part, the

written appeal decision notification must include the following elements when applicable:

- Specific reasons for the appeal decision, in easily understood language. Easily understandable notification includes a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
- Notification that the member can obtain, upon request and free of charge, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based with any new or additional evidence.
- Notification that the member is entitled to receive, upon request and at no cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
- For medical necessity appeals, a list of titles (e.g. Medical Director, external physician reviewer), and qualifications (e.g. MD, DO), including specialty (e.g. predications, neurology, etc.) 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 benefit appeals, only the reviewer's/reviewer's title is required.
- A description of the next level of appeal, either within the organization or to an external organization (i.e. second level internal appeal, State Fair Hearing, Independent Review Organization (IRO), etc.) as applicable, along with any relevant written procedures and contact information (appeal rights are required whenever the organization

makes a decision that is adverse to the member) (See RFP Final: 17.6.5 pg. 306. This IRO process is managed by the Provider Solutions Department).

(4) The Clinical Appeals Coordinator is responsible for updating/closing the case in the member's clinical documentation system (TruCare). Letters will only be attached in the clinical documentation system.

g. Extension of Expedited Appeal

(1) If Plan determines that the extension may produce information in the member's favor, the Clinical Appeals Coordinator may request a 14 calendar day extension. The member may also request a 14 calendar day extension.

(2) The Plan must obtain State and member consent for the extension. Written member consent is not required for expedited appeals requested by the provider. If the member does not consent to the extension, the appeal will be decided with the information available before the timeframe expires. An appeal may be withdrawn by written request from the person who filed the appeal.

h. If the member or member representative is not satisfied with the resolution, the member may file for a SFH.

C. State Fair Hearing

3. **Receiving a Hearing Request**
   a. The member, member's authorized representative or provider with the member's written consent, may request a SFH after the Plan's internal grievance or appeal process has been exhausted, as applicable, and defined by the State regulations. The request may be concurrent in the case of expedited appeals.
   b. The parties to a State Fair Hearing (SFH) include the Plan, as well as the member, and his/her representative.
   c. Independent External Review (IER) may be requested simultaneously with the SFH, when directed by the State. (See RFP Final: 17.6.5 pg. 306. The IER or the Independent Review Organization (IRO) is managed by the Provider Solutions Department).

4. **Timeframe for Hearing Request**

a. A State Fair Hearing (SFH) must be requested no later than 120 calendar days from the date of final appeal adverse benefit determination notice (See RFP Final 13.6.6.1 pg. 247).
b. The request must be submitted within ten (10) calendar days of the date of the final appeal adverse benefit determination notice, if the member wishes to have continuation of benefits during the SFH (See RFP Final: 13.8.3.2).

c. The member's right to request a State Fair Hearing, after the MCO's one level appeal process has been exhausted.

5. **Plan Follow-Up for State Fair Hearing (SFH)**
   a. The Plan will cooperate with the State agency, Division of Administrative Law (DAL) in the hearing process and submit a copy of the member's appeal of the Plan's action; the contents of the appeal file including research, medical records and other documents used to make their decision and a summary of the member's appeal ; the evidence used by the Plan to make its decision (SOE); and a copy of the notice of resolution provided to the member and to the State agency within the required timeframe (La: 7 days; Bayou Health State Fair Hearing Companion pg. 38).
   b. The State (Division of Administrative Law (DAL) and/ or Louisiana Department of Health (LDH) will contact the Plan with the decision.
   c. The Clinical Appeals Coordinator is responsible for management and organization of documentation related to SFH process. Letters will be attached in the clinical documentation system (TruCare).

D. Continuation of Benefits

3. Plan will continue the member's benefits if all of the following are true:
   a. The member files the appeal in a timely manner, meaning on or before the later of the following:
      (1) Within ten (10) calendar days of the date on the Plan's adverse benefit determination notice or
      (2) The intended effective date of the Plan's intended action.
   b. The action involves the termination, suspension or reduction of a previously authorized course of treatment;
   c. The services were ordered by an authorized provider;
   d. The authorized period has not expired; and
   e. The member requests extension of benefits.

4. If the Plan continues or reinstates the member's benefits while the appeal is pending, the Plan will continue providing the benefits until one of the following occurs:
   a. The member withdraws the request for an appeal or SFH;
   b. Ten (10) calendar days pass after the Plan mails the notice providing the resolution of the appeal against the member, unless the member, within the ten (10) calendar day timeframe, has requested a SFH with continuation of benefits until a SFH decision is reached;
   c. The SFH officer renders a decision that is adverse to the member; and/or
   d. The member's authorization expires or the member reaches his/her authorized service limits.

5. If the final resolution of the SFH is adverse to the member, the Plan may recover the costs of the services furnished while the SFH was pending to the extent that the services were furnished solely because of the requirement to continue benefits during the appeal.

6. If services were not furnished while the SFH was pending, and the SFH resolution reverses Plan's decision to deny, limit or delay services, Plan must authorize or provide the disputed services as quickly as the member's health condition requires (See RFP Final: 13.11.1 pg. 250).

7. If services were furnished while the SFH was pending, and the SFH resolution reverses the Plan's decision to deny, limit or delay services, Plan will pay for disputed services in accordance with State policy and regulations (See RFP Final: 13.11.2 pg.250).

E. Investigating an Appeal

1. The Plan will fully investigate and document the content of the appeal including all aspects of clinical care involved, without giving deference to the denial decision. All information will be taken into account regardless of whether the information was submitted or considered in the initial determination. Any additional information required to review the appeal request should be requested at this time and that request documented in the clinical documentation system. If no additional information is

available, per the provider and/or member, this should also be documented.

2. The appeal will be reviewed by a person or people who were not involved in the prior adverse decision. The appointed person will neither be the individual who made the adverse determination nor a subordinate of such individual; however, if additional clinical information is received and meets criteria for coverage, the practitioner who made the initial adverse determination may review the case and overturn the previous decision. A nurse, pharmacist, or other appropriate qualified licensed health professional may also overturn the prior adverse decision if additional clinical information is received with the appeal request and the additional information meets criteria for coverage.

3. Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate will be reviewed by a clinical peer who holds an active, unrestricted license to practice medicine, or a health professional who is board-certified, if applicable, and who is of the same-or-similar health care profession and 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.

REFERENCES:

MCO-2014 RFP - Section 13
Current NCQA standards & guidelines
Oral Appeals & Written Notification Guidelines
Bayou Health State Fair Hearing Companion
Medicaid Federal Register 42 CFR 422.564-Grievance Procedures
Medicaid Federal Register 42 CFR 431.200-Fair Hearing
Medicaid Federal Register 42 CFR 438, Subpart F, Grievance and Appeals System

ATTACHMENTS:

A – Grievance or Appeal Form
B – Oral Appeal & Written Notification Guidelines
C – Personal Appeal Representative Form

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Standard Appeal Flow Process
Expedited Appeal Flow Process

DEFINITIONS:

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

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 in part, of payment for a service, the failure to provide services in a timely manner as defined by Sections 7.3 and 7.5 of this RFP; or the failure of the Plan to act within the timeframes provided in Section 13.7.1 of this RFP.

Adverse Action – Any decision by the Plan to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. 42 CFR §438.210(c)

Adverse Determination - An admission, availability of care, continued stay or other health care service that has been reviewed by the Plan and based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed or terminated.

Appeal – A request for a review of an action pursuant to 42 CFR §438.400(b).

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

Benefits or Covered Services - Those health care services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.

Business Day -Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m.

Calendar Days - All seven (7) days of the week. Unless otherwise specified, the term "days" in the Contract (RFP) refers to calendar days.

External Quality Review Organization (EQRO) — an organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR and other related activities for states with Medicaid managed care programs.

Grievance – 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 of 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.

Grievance Process – The procedure for addressing enrollee's grievances.

Grievance System – 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 grievance system.

Medically Necessary Services - Health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must(1) be deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering; or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The LDH-OBH Assistant Secretary and/or The LDH-OBH Assistant Secretary and/or Medical Director, in consultation with the Medicaid Director and/or Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.

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Non-Covered Services - Services not covered under the Title XIX Louisiana State Medicaid Plan.

REVISION LOG	**DATE**
LDH requested a separate Grievance policy and Appeal Policy therefore we will be retiring LA.QI.11 (the combined document) and this policy and LA.QI.11.02 will replace it.	9/15
Changed DHH to LDH due to state name change	9/16
Revised Purpose to include current NCQA standards & guidelines	9/16
Added current NCQA standards & guidelines to the policy	9/16
Revised definitions to be consistent with the current RFP	9/16
Changed MCO to plan	9/16
Added current NCQA language to the following sections 13.6.3 Format of Notice of Disposition paragraph 1 regarding receipt acknowledgment and resolution notification timelines **Removed following sections specific to the grievance process** 13.2.4.2 #3-5, Investigation/Research #1-5, 13.6.1.1, 13.6.3.1 Changed Department of Health and Hospitals (DHH) to Louisiana Department of Health (LDH)	10/16
Removed last two paragraphs of the policy 13.6 and 13.6.3 as they were already present on page 9 of 17 in this policy	11/16
Added nondiscrimination language of the Affordable Care Act (ACA) in last paragraphs of the policy section	12/16
Added Medicaid and CHIP Managed Care Proposed Rule/ 438.402 effective 7.1.2017 in these sections: **13.2.3, 13.2.4.1**	7/17
Reversed changes made July 2017 as a mandate came from the State of LA stating that the mega rule changes will not go into effect until extension or renewal of contract 2/1/18.	8/17
Changed the format of the appeals policy to be comparable to the format of the current Centene Corporate Policy, noting the requirements that are specific to Louisiana, and compliant with the RFP extension requirements, NCQA, and the new Oral Appeals & Written Notifications.	6/18

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Added reference to RFP(MCO Contract) effective 2/1/2018, regarding 13.5.2.4 indicating that the MCO has only one level appeal process	10/18
Added reference to RFP section 13.7.3 indicating that a member's request for an appeal will be deemed approved should a determination not be made within the allocated timeframe.	8/19
Changed "Clinical Appeals" Coordinator to "G&A" Coordinator	6/20

POLICY AND PROCEDURE APPROVAL

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

VP, Quality: _____Electronic Signature on File_____
~~**Sr. VP,**~~**Chief Medical Officer**~~**Affairs**~~:___ Electronic Signature on File_____