Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy / Procedure / Document Section(s) / Number(s)	MCO Page Number(s)
8.1	**General Requirements**				
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	Met Addressed in Document Oversight and Adherence policy.	01.11 Document Oversight and Adherence See under 8.1	Policy - Statement Addenda	Pg. 1 Pg. 4
8.1.2 8.1.2.1 8.1.2.2 8.1.2.3 8.1.2.4	The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that: 8.1.2.1. Are adopted in consultation with a contracting health care professionals; 8.1.2.2. Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 8.1.2.3. Are consider the needs of the members; and 8.1.2.4. Are reviewed annually and updated periodically as appropriate.	Met Addressed in Document Oversight and Adherence and Clinical Review Criteria policies and screenshot of website containing CPGs.	01.11 Document Oversight and Adherence See under 8.1	Whole Policy Addenda	Whole Policy Pgs. 4-5
8.1.3	The policies and procedures shall included, but not be limited to:				
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	Met Addressed in Clinical Review Criteria policy.	Clinical Review Criteria See under 8.1	Whole Policy	Whole Policy
8.1.3.2	The data sources and clinical review criteria used in decision making;	Met Criteria addressed in Clinical Review Criteria policy. Data sources addressed in Information Based Clinical Review policy.	06.10 Clinical Review Criteria See under 8.1	Whole Policy	Whole Policy
8.1.3.3	The appropriateness of clinical review shall be fully documented;	Met Addressed in Initial Adverse Determination Notice and Peer Clinical Review policies.	06.18 Initial Adverse Determination Notice See under 8.1	Provisions, Section B2	Pg. 2
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	Met Addressed in Peer Clinical Review policy.	06.15 Peer Clinical Review See under 8.1	Addenda	Pg. 10
8.1.3.5	Mechanisms to ensure consistent application of review	Met	06.10 Clinical Review Criteria	Policy - Statement	Pg. 1

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	criteria and compatible decisions;	Addressed in Clinical Review Criteria policy (including training, auditing, corrective action plans).	See under 8.1		
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services; and	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Policy - Statement and Provisions Addenda	Pgs. 1-2 Pg. 4
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information.	Met Addressed in Consumer Rights policy.	04.10 Consumer Safety See under 8.1	Whole Policy	Whole Policy
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	Met Addressed in Quality Management Program Description (nationally recognized guidelines are used), Provider Manual and screenshot of website containing CPGs.	QM program description (see 14.1) Clinical Screen shot of CPG Provider Manual (see 10.4)	 Clinical Practice Guidelines	Page 23 Page 97
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	Met Providers: Addressed in Quality Management Program Description, Provider Manual and screenshot of provider website. Members: Addressed in Clinical Review Criteria and Initial Adverse Determination Notice policies.	QM program description (see 14.1) Clinical Screen shot of CPG Provider Manual (see 10.4)		Page 23 Page 97
8.1.6	The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	Met Addressed in Clinical Review Criteria policy.	06.10 Clinical Review Criteria See under 8.1	Policy - Provisions A1-3	Pg. 1
8.1.6.1	The vendor must be identified if the criteria was purchased;	Met Addressed in Clinical Review Criteria policy (criteria are developed by organization physicians).	06.10 Clinical Review Criteria See under 8.1	Policy - Provisions A1-3	Pg. 1
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state	Met Addressed in Clinical Review	06.10 Clinical Review Criteria See under 8.1	Policy - Provisions A1-3	Pg. 1

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	health care provider association or society;	Criteria policy (internal and external criteria are used. "External clinical review criteria are based on applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines such as MCG Care Guidelines or InterQual)." Addressed in Utilization Management Program Description Louisiana Addendum Draft (the following nationally published criteria are used: Milliman Care Guidelines – Inpatient and Surgical Care, General Recovery, Ambulatory Care, Recovery Facility Care).			
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Met Addressed in Clinical Review Criteria policy.	06.10 Clinical Review Criteria See under 8.1	Policy - Provisions A1-3	Pg. 1
8.1.6.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.	Met Addressed in Initial Clinical Review and Peer Clinical Review policies.	06 14 Initial Clinical Review See under 8.1	Policy - Statement	Pg. 1
8.1.7	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	Met Addressed in Clinical Review Criteria policy.	06.10 Clinical Review Criteria See under 8.1	Policy - Provisions C Addenda	Pg. 2 Pg. 6
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the	Met Addressed in Information Based Clinical Review policy.	06.19 Information Based Clinical Review See under 8.1	Whole Policy Addenda	Whole Policy Pg. 5

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	process to be followed in the event the MCO determines the need for additional information not initially requested.				
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.	Met Addressed in Information Based Clinical Review policy.	06.19 – Information Based Clinical Review See under 8.1	Addenda	Pg. 5
8.1.10	The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.	Met Initial Clinical Review addresses the qualifications of staff. Staffing addressed in organizational chart.	06 14 Initial Clinical Review See under 8.1 8.0 Staffing Plan	Policy – Statement and Purpose UnitedHealthcare Community Plan of Louisiana Staffing Plan	Pg. 1 Entire document
8.1.11	The MCO shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.	Met The Initial Clinical Review addendum contains the exact contract language of 8.1.11 (although the definition is not stated).	06.14 Initial Clinical Review See under 8.1	Addenda	Pg. 10
8.1.12 8.1.12.1 8.1.12.2 8.1.12.3	The MCO shall submit written policies and procedures for DHH approval, within thirty (30) days of the contract being signed by the MCO, addressing how the core benefits and services ensure: 8.1.12.1. The prevention, diagnosis, and treatment of health impairments. 8.1.12.2. The ability to achieve age-appropriate growth and development and 8.1.12.3. The ability to attain, maintain, or regain functional capacity.	Met The Document Oversight and Adherence addendum addresses submission within 30 days. The addendum contains the exact contract language of 8.1.12.1, 2 and 3. However, the addendum should clearly state how core benefits will address these requirements . Addressed in Quality Management Program Description, Section Preventive Care Program, Page 30.	01.11 Document Oversight and Adherence See under 8.1 14.0- Quality Mgmt Program Description	Addenda Preventive Care Program	Pg. 6 Pg. 30
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	Met Addressed in Staff Qualifications and Credentials	02 10 Staff Qualifications and Credentials See under 8.1	Whole Policy	Entire Policy

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		policy.			
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Met Addressed in Regulatory Compliance policy.	03.12 Regulatory Compliance See under 8.1	Addenda	Pg. 3
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	Met Addressed in Peer Clinical Review policy.	06 15 Peer Clinical Review See under 8.1	Whole Policy	Whole Policy
8.1.16	The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.	Met Addressed in Peer Clinical Review policy addendum.	06 15 Peer Clinical Review See under 8.1	Addenda	Pg. 11
8.1.17	The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.	Met Addressed in Peer Clinical Review policy addendum.	06 15 Peer Clinical Review See under 8.1	Policy - Purpose	Pg. 1
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.	Met Addressed in Initial Clinical Review policy addendum.	06 14 Initial Clinical Review See under 8.1	Addenda	Pg. 10
8.1.19	The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.	Met Addressed in Performance Assessment and Incentives policy.	02.12 Performance Assessment and Incentives See under 8.1	Whole Policy	Whole Policy

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8.1.20	The MCO shall report fraud and abuse information identified through the UM program to DHH in accordance with 42 CFR §455.1(a)(1).	Met Addressed in Regulatory Compliance policy.	03.12 Regulatory Compliance See under 8.1	Addenda	Pg. 3
8.1.21	In accordance with 42 CFR §§456.111 and 456.211, the MCO Utilization Review (UR) plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Policy – Statement Addenda	Pg. 1 Pg. 5
8.1.21.1	Identification of the enrollee;	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Addenda	Pg. 5
8.1.21.2	The name of the enrollee's physician;	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Addenda	Pg. 5
8.1.21.3	Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Addenda	Pg. 6
8.1.21.4	The plan of care required under 42 CFR §456.80 and §456.180;	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Addenda	Pg. 6
8.1.21.5	Initial and subsequent continued stay review dates described under 42 CFR §§456.128, 456.133; 456.233 and 456.234;	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Addenda	Pg. 6
8.1.21.6	Date of operating room reservation, if applicable;	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Addenda	Pg. 6
8.1.21.7	Justification of emergency admission, if applicable.	Met Addressed in Information Based Clinical Review addendum.	06.19 Information Based Clinical Review See under 8.1	Addenda	Pg. 6
8.2					
8.2.1	The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the	Met Addressed in Utilization	Louisiana Addendum: Utilization Management Program Description	SCOPE	Pg. 2

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	MCO as appropriate and supports the QAPI Program (refer to the Quality Management subsection for details regarding the QAPI Program).	Management Program Description Louisiana Addendum Draft.	See 8.2		
8.2.2	The UM Committee shall provide utilization review and monitoring of UM activities of both the MCO and its providers and is directed by the MCO Medical Director. The UM Committee shall convene no less than quarterly and shall make meeting minutes available to DHH upon request. UM Committee responsibilities include:	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2	SCOPE	Pg. 2
8.2.2.1	Monitoring providers' requests for rendering healthcare services to its members;	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2	ROLES AND RESPONSIBILITIES	Pg. 3
8.2.2.2	Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2	ROLES AND RESPONSIBILITIES	Pg. 3
8.2.2.3	Reviewing the effectiveness of the utilization review process and making changes to the process as needed;	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2	ROLES AND RESPONSIBILITIES	Pg. 3
8.2.2.4	Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2	ROLES AND RESPONSIBILITIES	Pg. 3
8.2.2.5	Monitoring consistent application of "medical necessity" criteria;	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2	ROLES AND RESPONSIBILITIES	Pg. 3
8.2.2.6	Application of clinical practice guidelines;	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2	ROLES AND RESPONSIBILITIES	Pg. 3
8.2.2.7	Monitoring over- and under-utilization;	Met Addressed in Utilization	Louisiana Addendum: Utilization Management Program Description	ROLES AND RESPONSIBILITIES	Pg. 3

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		Management Program Description Louisiana Addendum Draft.	See 8.2 Ambulatory Medical Record Policy Medical Record Review Audit Tool QM Program Description (see 14.1)		Entire document Entire document Pg. 23
8.2.2.8	Review of outliers, and	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2 Ambulatory Medical Record Policy Medical Record Review Audit Tool QM Program Description (see 14.1)	ROLES AND RESPONSIBILITIES	Pg. 3 Entire document Entire document Pg. 23
8.2.2.9	**Medical Record Reviews -** reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards. **Medical Record Review Strategy** The MCO shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided within thirty (30) days from the date the Contract is signed and annually thereafter. The strategy shall include, at a minimum, the following: Designated staff to perform this duty; The method of case selection; The anticipated number of reviews by practice site; The tool the MCO shall use to review each site; and How the MCO shall link the information compiled during the review to other MCO functions (e.g. QI, credentialing, peer review, etc.) The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.	Met 14.5_Att_7G_-_NQM-025_Ambulatory_Medical_Record_Review_PD0913 and 14.5_Copy_of_AUDIT_TOOL_MASTER were found in 14.5 Credentialing and Re-credentialing of Provider and Clinical Staff. All requirements are addressed in the above two documents and the Quality Management Program Description, Ambulatory Medical Record Review section.	8.2.2.9 now contains all previous subsections Ambulatory Medical Record Policy Medical Record Review Audit Tool QM Program Description(14.1)		Entire document Entire document Entire document Pg. 23
8.2.3	The MCO shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The MCO shall review each site at least one (1) time during each two (2) year period.	Met High volume providers are those whose panel sizes fall within the top 50% of a Plan's total panel sizes (Not 50 or more as stated in the	Ambulatory Medical Record Policy Medical Record Review Audit Tool QM Program Description (see 14.1) 12/24 QM program		Entire document Entire document Pg. 24 12/24 page 24

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		contract). The plan may review a sample of medical records from 30 randomly selected high volume primary care sites on an annual basis. Providers who successfully pass Medical Record Review will not be re-audited any earlier than three years. Addressed in updated QM Program Description, Section Ambulatory Medical Record Review, Page 24.			
8.2.4	The MCO shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target. For large group practices (six or more providers in the group), three record reviews per provider shall be required.	Met The nurse will review three charts. In the event that a practitioner scores below 85% on the Medical Record Review Tool, an additional five charts will be reviewed. The nurse will review those data elements which were substandard in the first three charts. The 5-10 chart per site contracted requirement is addressed in updated QM Program Description, Section Ambulatory Medical Record Review, Page 24.	Ambulatory Medical Record Policy Medical Record Review Audit Tool QM Program Description (see 14.1) 12.24 QM program		Entire document Entire document *Pg.* 23 12/24-page 24
8.2.5	The MCO shall report the results of all medical record reviews to DHH quarterly with an annual summary.	Met Addressed in Quality Management Program Description (“audits are completed in compliance with	Ambulatory Medical Record Policy Medical Record Review Audit Tool QM Program Description (see 14.1)		Entire document Entire document Pg. 23

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		… state regulatory requirements).”			
8.4	**Service Authorization**				
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft and Initial Review Timeframes policy.	06.16 Initial Review Timeframes See under 8.1	Whole Policy	Whole Policy
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:	Met Addressed in Regulatory Compliance policy addendum.	03.12 Regulatory Compliance See under 8.1	Addenda	Pg. 3
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;	Met The Initial Clinical Review addendum contains the contract language of 8.4.2.1	06.14 Initial Clinical Review See under 8.1 The process in this policy applies to any request where there is lack of clinical information. Process applies if provider does not give timely information and/or refuses to give any information.	Addenda	Pg. 11
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Met Addressed in Clinical Review Criteria and Peer Clinical Review policies.	06.15 Peer Clinical Review See under 8.1UHC UMPD	Provisions B2-3 Addenda	Pg. 2 Pg. 11
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	Met Addressed in Clinical Review Criteria policy.	06.15 Per Clinical Review See under 8.1	Policy – Purpose Addenda	Pg. 1 Pg. 11
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	Met Addressed in Non-Clinical Intake and Initial Screening policy. The Member Manual Draft (found in 12.2) addresses	06.13 Non-Clinical Intake and Initial Screening See under 8.4	Policy - Provisions Section B1	Pg. 2

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		member non-clinical service requests (e.g., transportation, p. 23), clinical service requests which do not require provider pre-authorization (women's health, pregnancy care, p. 22), and expedited review requests, p. 59. A comment in the Member Manual Draft (p. 56) notes a bullet on Member Request for Organizational Determination may be added. Reasons a member may file a grievance are contained in the Member Manual Draft on p. 57 (although in response to a member service request outcome is not explicitly stated).			
8.4.2.5	The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	Met Addressed in Approval and Certification Notices policy (found in 8.5).	06.13 Non-Clinical Intake and Initial Screening See under 8.4	Addenda	Pg. 4
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	Met Addressed in Approval and Certification Notices policy (found in 8.5).	06.13 Non-Clinical Intake and Initial Screening See under 8.4	Policy – Provisions B2; Addenda	Pg. 1; Pg. 4
8.4.3	The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.	Met Addressed in Peer Clinical Review policy addendum.	06.15 Peer Clinical review See under 8.1	Addenda	Pg. 11
8.5	**Timing of Service Authorization Decisions**				
8.5.1.	**Standard Service Authorization**				
8.5.1.1.	The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business	Met Addressed in Review	06.16 Review Timeframes See under 8.1	Addenda	Pg. 8

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	days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	Timeframes policy addendum.			
8.5.1.2	The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	Met Addressed in Review Timeframes policy addendum.	06.16 Review Timeframes See under 8.1	Addenda	Pg. 9
8.5.2	**Expedited Service Authorization**				
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	Met Addressed in Review Timeframes policy addendum.	06.16 Review Timeframes See under 8.1	Addenda	Pg. 9
8.5.2.2	The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to DHH a need for additional information and how the extension is in the member's best interest.	Met Addressed in Review Timeframes policy addendum.	06.16 Review Timeframes See under 8.1	Addenda	Pg. 9
8.5.3	**Post Authorization**				
8.5.3.1	The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	Met Addressed in Review Timeframes policy addendum.	06.16 Review Timeframes See under 8.1	Addenda	Pg. 9
8.5.3.2	The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	Met Addressed in Review Timeframes policy addendum.	06.16 Review Timeframes See under 8.1	Addenda	Pg. 9
8.5.4	**Timing of Notice**				
8.5.4.1	**Notice of Action**				
8.5.4.1.1	**Approval [Notice of Action]**				
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the	Met Addressed in Approval and	06.17 Approval and Certification Notices	Addenda	Pg. 4

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	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 shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	Certification Notices addendum.	See under 8.5		
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	Met Addressed in Approval and Certification Notices addendum.	06.17 Approval and Certification Notices See under 8.5	Addenda	Pg. 4
8.5..4.1.2	**Adverse [Notice of Action]**				
8.5.4.1.2.1	The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section § 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404(a) and (c) and 42 CFR §438.210(b)(c)(d) and Section § 12 of this RFP for member written materials.	Met Addressed in Initial Adverse Determination policy and addendum.	06.18 Initial Adverse Determination Notice See under 8.1	Policy – Provisions B4iv Addenda	Pg. 2 Pgs. 8-9
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a healthcare professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	Met Addressed in Initial Adverse Determination addendum.	06.18 Initial Adverse Determination Notice See under 8.1	Addenda	Pg. 9
8.5.4.1.3	**Informal Reconsideration**				
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	Met Addressed in Peer Clinical Review addendum.	06.15 Peer Clinical Review See under 8.1	Addenda	Pg. 12
8.5.4.1.3.2	In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or	Met Addressed in Peer Clinical	06.15 Peer Clinical Review See under 8.1	Policy – Provisions C1 Addenda	Pg. 2 Pg. 12

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	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 (§438.402(b)(ii).	Review addendum.			
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO'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) working day.	Met Addressed in Peer Clinical Review policy and addendum.	06.15 Peer Clinical Review See under 8.1	Policy - Statement Addenda	Pg. 1 Pg. 12
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.	Met Addressed in Peer Clinical Review addendum.	06.15 Peer Clinical Review See under 8.1	Addenda	Pg. 12
8.5.4.2	**Exceptions to Requirements**				
8.5.4.2	The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft and Consumer Safety policy and addendum.	Louisiana Utilization Management Program Description 2015 See 8.2 04.11 Consumer Safety See under 8.5	Emergency Admissions Section UM Program Description Addendum Policy – Statement Addenda	Pg. 5 Pg. 1 Pg. 6
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	Met Addressed in Consumer Safety policy addendum.	04.11 Consumer Safety See under 8.5	Addenda	Pg. 6
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	Met Addressed in Consumer Safety policy addendum.	04.11 Consumer Safety See under 8.5	Addenda	Pg. 6
8.5.4.2	The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.	Met Addressed in Out of Network Requests and Continuing Care addendum.	06.21 Out of Network Requests and Continuing Care See under 8.5	Addenda	Pg. 13
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled members linkage to the plan.	Met Addressed in Out of Network Requests and Continuing Care addendum.	06.21 Out of Network Requests and Continuing Care See under 8.5	Addenda	Pg. 13
8.5.4.2	The MCO shall not require a PCP referral (if the PCP is not a	Met	Louisiana Addendum: Utilization	Prospective/Pre-service Review	Pg. 4

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	women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.	Addressed in Utilization Management Program Description Louisiana Addendum Draft and Provider Manual.	Management Program Description See 8.2 Provider Manual (see 10.4)	Direct Access to Women's Health Care	Pg. 46 Column 1
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2	Prospective/Pre-service Review	Pg. 4
8.5.4.2	The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft.	Louisiana Addendum: Utilization Management Program Description See 8.2 Provider Manual (See 10.4)	Obstetrical/Maternity Care/Family Planning Obstetrical Admissions	Pg. 5 Page 56, Column 2
8.5.4.2	The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft and Provider Manual.	03.12 Regulatory Compliance See under 8.1 Louisiana Addendum: Utilization Management Program Description See 8.2 Provider Manual (See 10.4)	Addenda Obstetrical/Maternity Care/Family Planning Obstetrical Admissions	Pg. 3 Pg. 5 Page 56, Column 2
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	Met Addressed in Utilization Management Program Description Louisiana Addendum Draft and Consumer Safety policy addendum.	04.11 Consumer Safety See under 8.5 Louisiana Addendum: Utilization Management Program Description See 8.2	Addenda Emergency Admissions	Pg. 6 Pg 5
8.6	**Service Authorization Pharmacy Services**				
8.6.1	Prior authorization may be used for drug products under the following conditions: • When prescribing medically necessary non-Formulary or non-preferred (non-PDL) drugs. • When prescribing drugs inconsistent with FDA approved labeling, including behavioral health drugs. When prescribing is inconsistent with	Met Pharmacy Coverage Reviews and Generic Substitution policies address most requirements; however, FDA off-label use and exceptions related to maintenance drug	P/P for UM	Rx-012 Pharmacy Coverage Reviews Rx-026 Generic Substitution Policy	Policy overview Procedure E

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	nationally accepted guidelines. • When prescribing brand name medications which have A-rated generic equivalents. • To minimize potential drug over-utilization. • To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.	therapy are not explicitly noted. Addressed in updated policy LA Pharmacy Benefit.			
8.6.2	DHH may prohibit prior authorization for selected drug products or devices at its discretion.				
8.6.3	Any prior approval issued by the MCO shall take into consideration prescription refills related to the original pharmacy service. The MCO must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber.	Met Case closure within 24 hours addressed in Service Standards for PNS policy (although no Procedure IV as noted by the plan could be found). Notification of provider is addressed throughout Pharmacy Coverage Reviews policy.	P/P for UM	Rx-007 Service Standards for PNS	Procedure IV
8.6.4	The MCO must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone, fax or automated process. If the MCO or its pharmacy benefit manager operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in Section 10.	Met Addressed in Pharmacy Coverage Reviews and LA Rx 001 policies.	P/P for UM	Rx-012 Pharmacy Coverage Reviews LA Rx 001	Procedure, B, I Procedure 1, a PG. 1
8.6.5	The MCO shall not penalize the prescriber or enrollee, financially or otherwise, for such requests and approvals.	Met Addressed in LA Rx 001 policy.	LA Rx 001	Procedure, I, b	Page 1
8.6.6	Details of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and/or member in writing.	Met Addressed in Pharmacy Coverage Reviews policy.	Rx-012 Pharmacy Coverage Reviews	Procedure for policy compliance	Page 3
8.6.7	An enrollee receiving a prescription drug that was on the MCO's Formulary or PDL, and subsequently removed or changed, shall be permitted to continue to receive that prescription drug if determined to be medically necessary for at least sixty (60) days. The MCO must make that	Met Addressed by Preferred Drug List Change Notice policy. Note the requirement is met by	RX 033 Preferred Drug List Change Notice	Procedure B	Page 2-3

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	determination in consultation with the prescriber.	notifying practitioners and enrollees 60 days before the change will be put into effect.			
8.6.8	If a prescription for a medication is not filled when the prescription is presented to the pharmacy due to a prior authorization requirement, the MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO is only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.	Met Addressed in LA Rx 001 policy.	LA Rx 001	Procedure, I, c	Page 1 and 2
8.6.9	A member, or a provider on Member's behalf, may appeal prior authorization denials in accordance with Section 13 (Grievances and Appeals).	Met Addressed in Pharmacy Coverage Reviews policy. (Appeal Process and Requirements policy as described not found).	Appeal Process and Requirements	UHL_12_Appeal Process and Requirments_v1_112514/Section 2/Number 1 a & b	Page 4
8.7	**Step Therapy and/or Fail First Protocols**				
8.7.0	MCO are allowed to implement step therapy or fail first protocols to first drive utilization toward the most cost-effective and safest drug therapy. These protocols may be applied to either individual drugs or classes of drugs. However, the MCO must provide a clear process for a provider to request an override of such restrictions. At a minimum, the MCO should grant the override when the prescribing physician provides evidence that the preferred treatment method has been ineffective in the treatment of the patient's medical condition in the past or will cause or will likely cause an adverse reaction or other physical harm to the patient	Met Addressed in Pharmacy Coverage Reviews and LA Rx 001 policies, and PDL example.	Rx-012 Pharmacy Coverage Reviews LA Rx 001 PDL (MS example)	Procedure for policy compliance Procedure I, d Preface	Page 3 Page 3 Page iv
8.11	**Medical History Information**				
8.11.1	The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations.	Met Addressed in Information Based Clinical Review policy.	06.19 Information Based Clinical Review See under 8.1	Policy – Provisions A1 Addenda	Pg. 1 Pg. 5
8.11.2	The MCO shall take appropriate action when a treating health	Met	06.19 Information Based Clinical Review	Policy - Provisions D3	Pg. 2

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	care provider does not cooperate with providing complete medical history information within the requested timeframe.	Addressed in Information Based Clinical Review policy.	See under 8.1	Addenda	Pg. 5
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	Met Addressed in the Provider Manual.	Provider Manual See 10.4	Referral Process	Pg 29
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by DHH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	Met Addressed in the Provider Manual.	Provider Manual See 10.4	Section 12: Claims	Pg. 71 Colum e 1