**Government Business Division**
**Policies and Procedures**

| **Section (Primary Department)** | **SUBJECT (Document Title)** |
|---|---|
| **Health Care Management – Utilization Management** | **Informal Reconsideration ~~and Peer-to-Peer~~ – LA** |

| **Effective Date** | **Date of Last Review** | **Date of Last Revision** | **Dept. Approval Date** |
|---|---|---|---|
| March 1, 2013 | ~~October 3, 2018~~November 13, 2019 | ~~March 4, 2019~~November 13, 2019 | ~~March 4, 2019~~November 13, 2019 |

**Department Approval/Signature :**

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

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

**POLICY:**

As part of appeal procedures, Healthy Blue shall include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

In a case involving an initial determination or a concurrent review determination, Healthy Blue shall provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [42 CFR §438.402(b)(ii)].

The informal reconsideration must occur within one (1) working day of the receipt of the request and ~~should be~~ conducted between the provider rendering the service and the Healthy Blue~~'s~~ physician authorized to make adverse determinations or a clinical peer designated by the ~~m~~Medical ~~d~~Director if the physician who made the adverse determination cannot be available within one (1) working day.

The Informal Reconsideration will in no way extend the thirty (30) calendar day required timeframe for a Notice of Appeal Resolution.

**DEFINITIONS:**

** Denotes terms for which Healthy Blue must use the State-developed definition.*

**Adverse Benefit Determination** – ~~Means a~~Any of the following:

- The denial or limited authorization of a requested service, including but limited to determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of Healthy Blue~~an MCO~~ to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

**Appeal*** – A ~~formal~~ request for review of an ~~action, whereby a member has the right to contest an~~ adverse benefit determination~~./action rendered by Healthy Blue, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by federal and state laws and regulations and any and all applicable court orders and consent decrees.~~

**Appeal Procedure** – The formal process whereby an enrollee can contest an adverse determination rendered by Healthy Blue, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by federal and state laws and regulations and all applicable court orders and consent decrees.

**Authorized Representative** – Any person who has been delegated the authority to obligate or act on behalf of another.

**Informal Reconsideration** – ~~P~~Appeal process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

**Medical Denial** – An admission, continued stay, availability of care, or other healthcare service that has been reviewed by Healthy Blue and based upon the clinical information provided, does not meet the requirements for medical necessity, level of care, healthcare setting, appropriateness, or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed, or terminated.

**Medically Necessary Services*** – Those 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 the community of their




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respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) ~~D~~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.~~ those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. 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. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

**PROCEDURE:**

1) The informal reconsideration or peer-to-peer (P2P) process allows the member (or provider/agent on behalf of a member) an opportunity to address a medical necessity denial in real time.

~~1)~~2) Within one (1) business day of a medical necessity denial determination, the provider is notified of the adverse decision and applicable ~~P2P and~~ appeal rights. Notification to members and providers provide clear documentation and communication of the reason for denial of service and informs member and providers that a Healthy Blue Medical Director is available to discuss the decision.

~~2)~~3) The member (or provider/agent on behalf of a member) may request a P2P discussion within ten (10) business days from the notification of denial.

~~3)~~4) The member may designate a representative to act on his/her behalf. This may be a provider, legal agent, or other individual delegated by the member. The member's written consent is required in certain circumstances:

a) A provider acting on behalf of a member concerning a denial reconsideration of a pre-service procedure, (~~proposed admission, procedure,~~ or other service not yet rendered,) ~~denial reconsideration~~ is required to provide the member's written consent upon request for a P2P discussion.

i) A member's verbal request for representation to act on his/her behalf must be followed with written consent.

~~ii)~~ Written consent must be completed and dated after the denial was issued.

~~iii)~~ii) Blanket representation forms completed prior to a denial determination will not be accepted.

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~~iv)~~iii) A completed *Healthy Blue Reconsideration and Appeal Representative Form* may be submitted, but this form is not mandatory.

~~b)a) The member's written consent is **not** required for a provider to act regarding concurrent or post-service denial reconsiderations. Consent of the member who received the service shall not be required in order for the provider to dispute the denial.~~

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b) Other agents or representatives must provide the member's written consent in all circumstances, subject to the details ~~i – iv~~ above.

The member's written consent is **not** required for a provider to act regarding concurrent or post-service denial reconsiderations. Consent of the member who received the service shall not be required in order for the provider to dispute the denial.

c)

~~4)~~5) The designated health plan HCM representative ~~will~~ reviews the P2P request to~~and~~ determine if the reconsideration is appropriate (i.e., the request for the informal reconsideration or P2P is for an eligible medical necessity denial, within the allotted timeframe, and/or submitted with the member's written consent, ~~if~~when required).

~~5)~~6) If the P2P request is ineligible (i.e., outside of the designated timeframe or without required written consent), the requestor is notified of the reason the request cannot be accommodated, provided process education, and informed of applicable appeal rights. The formal appeal process is specified within the written notice of action.

~~6)~~7) If the P2P request is eligible, the reconsideration occurs within one (1) working day of the receipt of the request. The HCM designee works with the requestor to accommodate and schedule the P2P.

a) The P2P is scheduled based on the requestor's availability to ensure ample opportunity to exercise the informal reconsideration/P2P option, but will not be scheduled to occur more than one (1) business day following receipt of request.

If the requestor is unable to accept or schedule a discussion within the allotted~~is~~ timeframe the reconsideration request is closed. The next course of action will be to follow the formal appeal process.

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~~a)~~i)

b) Attempt is made to schedule the discussion with the Healthy Blue Medical Director who rendered the original denial decision, however if this is not possible, the Medical Director's designated clinical peer may complete the reconsideration request.

c) The Medical Director is notified of scheduled discussions and provided any requested records for review prior to the P2P.

~~7)1)~~ ~~If the requestor is unable to accept or schedule a discussion within this timeframe the reconsideration request is closed. The next course of action will be to follow the formal appeal process.~~

8) The Medical Director shall make two (2) documented attempts to connect with the requestor through either paging, calling, and/or leaving messages for a call back. If the

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requestor fails to return contact within the specified timeframe, the request is closed and the next course of action will be to follow the formal appeal process.

9) If the Medical Director determines to uphold the original denial decision, the requestor is notified verbally of the decision by the Medical Director during the P2P discussion, and the next course of action will be to follow the formal appeal process. The determination is documented in the claims payment system and routed to the UM Reviewer to complete the denial uphold notification process.
10) If the Medical Director overturns the original denial decision, the requestor is notified verbally of the decision by the Medical Director during the P2P discussion. The decision is documented in the claims payment system and routed to the UM Reviewer to update the authorization status and complete the denial overturn notification process.
11) The informal reconsideration ~~or P2P~~ process will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.

**REFERENCES:**

Behavioral Health Member Appeals – Core Process
CFR Title 42
Administrative Denial Appeal Process – LA
Clinical Criteria for Utilization Management Decisions – Core Process
Clinical Information for Utilization ~~Management~~ Review~~s Core Process~~ – LA
Concurrent Review (Telephonic and On-Site) ~~and On-Site Review Protocol Process~~ – LA
Federal Medicaid Managed Care Rule – 42 CFR
Healthcare Management Denial ~~Core Process~~ – LA
Health Plan Advisory 12-9
Health Plan Advisory 13-4
Louisiana State Contract
Member Appeals – Core Process – LA
NCQA Accreditation Standards and Guidelines
Pre-Certification of Requested Services – LA
Updating and Auditing Notice of Proposed Action Letters and Appeals Review Forms

**RESPONSIBLE DEPARTMENTS:**

**Primary Department:**
Health Care Management – Utilization Management

**Secondary Department:**
Behavioral Health
Quality Management – Appeals

| **Section (Primary Department)** | **SUBJECT (Document Title)** |
|---|---|
| **Health Care Management – Utilization Management** | **Informal Reconsideration ~~and Peer-to-Peer~~ – LA** |

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**EXCEPTIONS:**

Behavioral Health operates in compliance with contractual requirements, but follows separate informal reconsideration procedures.~~None~~

**REVISION HISTORY:**

| Review Date | Changes |
|---|---|
| 11/11/2014 | • 2015 LA contract language added<br>• Placed on generic template |
| 10/01/2015 | • Template revised |
| 11/10/2016 | • Annual review<br>• Minor edits to definitions section |
| 10/05/2017 | • For annual review |
| 10/03/2018 | • For annual review<br>• No changes |
| 01/10/2019 | • Off cycle review<br>• Procedure updated with current contract language |
| 03/04/2019 | • Off cycle edits<br>• Edits to procedure section with current contract language |
| 11/13/2019 | • ~~Off cycle~~Annual review<br>• ~~;n~~New LA – Emergency Contract language added<br>• Policy title change from "Informal Reconsideration and Peer-to-Peer-LA" to "Informal Reconsideration-LA"<br>• Edits within policy, definitions, procedure, and references<br>• Behavioral Health added as a secondary department<br>• New exception language added |

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