POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Appeal of UM Decisions
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REVISED EFFECTIVE DATE: 2/1/15	
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.08

SCOPE:
Louisiana Healthcare Connections (Plan) Compliance, Quality, Provider, Medical Management, Member Services, and Behavioral Health Management. The scope of services includes both medical and behavioral health services.

PURPOSE:
To offer a full and fair process for resolving members' disputes and responding to members' requests to reconsider a decision they find unacceptable regarding care and service.

POLICY:
The Plan will not use the time frames or procedures of the appeals process to avoid the medical decision process or to discourage or prevent the member from receiving medically necessary care in a timely manner.

A member or their authorized representative who may be a family member, friend, lay advocate or attorney, with the written consent of the member, may file an appeal orally or in writing with the Plan. A health care practitioner with knowledge of the member's medical condition, acting on behalf of the member (with the written consent from the member) may also file an appeal regarding adverse action/determination about care or service. Punitive action will not be taken against a provider who requests an expedited resolution or supports a member's appeal. The member may file an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution. Per the "***Oral Appeals & Written Notifications***" protocol, as outlined by LDH in coordination with CMS and initiated on 025/01/2018, for Louisiana Medicaid. The MCO will provide a form for the enrollee to sign and send back, as well as the options available for receipt of written confirmation (fax, email, regular postal mail). The enrollee has 15 days from the date of the notice to send their written confirmation.

Members will be provided a reasonable timeframe to file an appeal. Appeals may be requested in writing, or by phone, by the member or the member's representative within 60 days of the date of the Plan's notice of

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adverse action or as described in the notice of action if the continuation of benefits is requested. An expedited appeal is available under certain circumstances, including urgent care requests. The Plan will establish and maintain an expedited review process for appeals, when the Plan determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and may be confirmed in writing, unless the member or the provider requests expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required. Also please note that provider appeals, or post service appeals, would not require the signed consent of the member.

The content of an appeal, including all clinical care aspects involved, will be fully investigated and documented. Documentation includes the substance of the appeal and the actions taken. Members will have the right to review their case file and submit comments, documentation, records and other information relevant to the appeal in person or in writing. In the case of expedited appeal requests, the member will be informed of the limited time available to provide the information for this sufficiently in advance of the date by which the MCO shall resolve the appeal in the case of expedited resolution. A physician or other appropriate clinical peer of a same-or-similar specialty, not supervised by the individual nor involved in the initial adverse decision, must evaluate medical necessity decisions for adverse appeal decisions.

Appeal decisions will be made as expeditiously as the member's condition warrants, but no later than 30 days for a standard appeal (44 days if an extension is taken as described below) and no later than 72 hours for an expedited appeal with a possible extension of 14 days if approved by the Louisiana Department of Health (LDH). Post-service or provider appeals

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will be resolved within 30 calendar days of receipt of the request. If the appeal request is expedited, a written notification of the appeal decision (resolution) will be made within 72 hours, or if the Medical Director denies the expedited appeal status request, the written notification shall be made within two (2) calendar days of appeal status determination, which is outlined in the timeframes designated by the LDH.

An appeal may be withdrawn by written request from the person who filed the appeal at any time during the appeal process.

PROCEDURE:

I. Filing an Appeal

A. An appeal may be filed orally or in writing, and received via mail, telephone, facsimile, electronic mail, or in person. . The member's oral appeal request shall be followed by a written, signed appeal unless the member requests an expedited resolution.
B. Members must file an appeal request within 60 calendar days of the date on the Plan Notice of Action unless requesting continuation of benefits, then the appeal request must be filed in ten (10) calendar days.
C. Plan will assist any member requesting assistance in understanding a Notice of Action and in filing an appeal, including any member with special communication needs. This includes, but is not limited to, providing a toll-free telephone number, translation services, and a toll-free number, 711, which is in compliance with FCC standardized services, and interpreter capability.
D. Members appealing urgent care services/ life threatening situations may request an expedited appeal. A practitioner with knowledge of the member's condition may request an expedited appeal on a member's behalf; written member consent is required for expedited appeals requested by the provider.
E. The Plan shall ensure that all Plan members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The Plan shall provide to each member a member handbook that shall include descriptions of the Plans grievance

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and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the Plan shall be available through the Plan, and paper copies must be provided by the Plan upon request of the member. The Plan shall make all forms easily available on the Plan's website.

~~F. Who take 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 action.~~

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II. Acknowledging an Appeal

A. The member appeal is acknowledged in writing within five (5) business days of the receipt of a request for appeal. The acknowledgement includes notification of member rights and appeal processes:
   - The member's right to choose an authorized representative to act on their behalf (with written consent from the member as dictated by state contract) or the legal representative of a deceased member's estate.
   - 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, in writing or in person.
   - 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 (an explanation that if the Plans action is upheld in an appeal or a hearing, the member may be liable for the cost of any continued benefits).

III. Investigating an Appeal

A. 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. The Plan will provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, any other documents and records considered during the appeals process, and any evidence considered, relied upon, or generated by the Plan in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the date by which the Plan shall resolve the appeal.

B. The appeal review will be scheduled during regular business hours and within a reasonable distance so that the member can appear in person if desired. If face-to-face is not practical for geographic reasons, the Plan will offer the member the opportunity to communicate with the review panel at the Plan's expense by conference call, video conferencing or other appropriate technology.

C. The appeal will be reviewed by a person or people who were not involved in the prior adverse decision, nor a subordinate of any such individual who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was ~~C.~~ submitted or considered in the initial action. ~~.~~Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate service will be reviewed by a clinical peer who holds an active, unrestricted license to practice medicine or a health profession, who is board-certified *if applicable*, and who is of the same-or-similar health care professional, 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. The appointed person will neither be the individual who made the initial adverse decision nor a subordinate of such individual; however, the practitioner who made the initial adverse decision may review the case and overturn the previous adverse decision based on additional information received.

IV. Standard Appeal Resolution

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A. Plan must resolve a **standard appeal** and provide the member and the provider with written or electronic notification as expeditiously as the member's health condition requires, but no later than 30 calendar days after receipt of the appeal request.
B. Plan may extend the resolution notification timeframe, for standard appeals, for up to 14 calendar days to obtain additional information only if:
    - The member requests an extension or
    - The member voluntarily agrees to extend the appeal time frame.

    Written notification of the reason for the delay is provided to the member, if the member has not requested the extension, and the member's consent for the extension is obtained.

    If the member does not consent to the extension, the appeal will be decided with the information available before the timeframe expires.
C. If the appeal resolution completely overturns the denial, the resolution notice will state the decision, the resolution date and all necessary authorization detail.
D. When the adverse decision is upheld in whole or part, the written appeal decision notification must include the following elements when applicable:
    - Date of appeal resolution
    - Specific reasons for the appeal decision, in easily understood language.
    - A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
    - Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
    - Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. 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.

- A list of titles and qualifications, including specialty 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).
- A description of the next level of appeal (i.e. State Fair Hearing, as described further in section VI below), along with any relevant written procedures and contact information (appeal rights are required whenever Plan makes a decision that is adverse to the member).
- The right to continue to receive benefits pending a hearing (as applicable), how to request the continuation of benefits, and an explanation that if the Plans action is upheld in a hearing, the member may be liable for the cost of any continued benefits.
- Notification is given to the member, provider, and facility (if applicable).

V. Expedited Appeal Resolution

A. In an expedited appeal, all necessary information, including the Plan's decision will be transmitted between the Plan and the covered person, or his authorized representative, or the provider acting on behalf of the covered person, by telephone, facsimile, or any other available expeditious method.

B. For expedited appeals initial notification of the appeal decision may be provided orally to the party requesting the appeal and must be provided within 72 hours of receipt of the appeal request. Attempts will be made to provide prompt verbal notice to the member and/or provider. If initial notification is oral, written notification must be sent to the member, provider, and facility (if applicable) no later than two (2) calendar days after the initial oral notification
Plan may extend the resolution notification timeframe, for up to 14 calendar days to obtain additional information only if:

- The member requests an extension or

- The member voluntarily agrees to extend the appeal time frame.
- Written notification of the reason for the delay is provided to the member, if the member has not requested the extension, and the member's consent for the extension is obtained.

If the member does not consent to the extension, the appeal will be decided with the information available before the timeframe expires.

C. 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 two (2) calendar days.

D. Appeals shall be resolved no later than stated time frames and all parties shall be informed of the Plan's decision. If a determination is not made by the above time frames, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

VI. Appeal Notification Letter

A. The appeal resolution letter must contain, at a minimum, the following elements:

- The title, qualifying credentials and specialty of the physician affirming the adverse determination;
- A statement of the reason for the covered person's request for an appeal;
- An explanation of the reviewer's decision in clear, easily understood terms and the date the decision was made.
- The medical rationale in sufficient detail for the covered person to respond further to the Plan's position (including reference to the specific criteria);
- Notification that the member can obtain, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based; Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits

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- Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal, free of charge. Relevant documents include documents or records relied upon and document and records submitted in the course of making the appeal decision;
- A description of the process to obtain a State Fair Hearing of a decision and the procedures and timeframes for requesting such Hearing.

B. If Plan completely overturns the denial, the appeal notice must state the decision and the decision date.

C. In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a state fair hearing

VII. Reversed Appeal Resolutions

A. If Plan or the State Fair Hearing decision reverses a decision to deny, limit, or delay services, where the services were not furnished while the appeal was pending, Plan will authorize the disputed services promptly and as expeditiously as the Member's health condition requires.

B. In the event that the services were continued while the appeal was pending, Plan will provide reimbursement for those services in accordance with the terms of the final decision rendered by the Plan or the Division and with the terms of the contract and applicable regulations.

VIII. Continuation of Benefits:

A. Plan will continue the member's benefits (as applicable) until issuance of the final appeal decision or the State fair hearing decision, if all of the following occurs:

- The member or their authorized representative files an appeal on or before the later of the following:
  - Ten (10) days from the *Notice of Action* or
    The intended effective date of Plan's action

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- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The appeal involves a denial and the physician asserts the requested service treatment is a necessary continuation of a previous authorized service;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The member requests a continuation of benefits

B. If Plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
- The member withdraws the appeal.
- The member does not request a fair hearing within 10 days from when Plan mails an adverse decision.
- A State Fair Hearing decision adverse to the member is made.
- The authorization expires or authorization service limits are met.

IX. State Fair Hearing

The member has the right to a State Fair Hearing after he/she has exhausted his/her appeal rights with the Plan. Plan will follow all procedures associated with a State Fair Hearing per contract requirements and as described below.

A. The member's right to request a State Fair Hearing, after the MCO's one level appeal process has been exhausted which will be included in the appeal resolution letter.

B. The member or their representative shall submit a request for a state fair hearing to the Division of Administration (DOA) – Administrative Law Judge Division (ALJ) within 120) calendar days from the date of the notice of resolution regarding their standard appeal. The request shall be submitted within ten (10) calendar days of the date of the notice of resolution, if the member wishes to have continuation of benefits during the state fair hearing.

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C. Upon receipt of the member's request for a state fair hearing, LDH shall fax or via secure email, a copy of the request to the Plan's Grievance and Appeals Manager, or designee. The Plan will be responsible for promptly forwarding any adverse decisions to LDH for further review/action upon request by LDH or the Plan member. LDH may submit recommendations to the Plan regarding the merits or suggested resolution of any grievance/appeal. Within seven (7) calendar days of receipt of the request from the Department, the Plan will send a copy of the member's standard appeal of the Plan's action; the contents of the standard 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; and a copy of the notice of resolution provided to the member and to the Department. For further clarification, appeals filed with the DAL (Division of Administrative Law), the Plan must provide the State Fair Hearing Packet within seven (7) calendar days of receipt of request for Summary of Evidence from the DAL. All information shall be uploaded to the LDH State Fair Hearing SharePoint Site in the Health Plan's folder. The complete packet, including the Summary of Evidence shall be uploaded to the LDH State Fair Hearing SharePoint Collaboration Site. The HP must also send a copy of the State Fair Hearing Packet to the appellant (member). If the appellant (member) has retained legal representation, the HP shall mail a copy of the State Fair Hearing packet to that individual as well. If the HP is notified of legal representation at a later date, provide the State Fair Hearing packet promptly to that individual.

D. The parties to the state fair hearing shall include the Plan, the member, their representative or the representative of a deceased member's estate.

E. An administrative law judge (ALJ) at DOA shall conduct the state fair hearing. Upon the completion of the hearing, the Director of DOA shall notify the Plan, member and LDH of the hearing decision.

F. The Plan shall continue the member's benefits as noted above.

G. If the decision overturns the Plan's denial or adverse resolution, and the service was not furnished while the appeal was pending,

the Plan is required to commence services as quickly as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision. The Plan shall pay for the disputed services, in accordance with the Department's policy and regulations.

H. If the Plan or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Plan must pay for those services, in accordance with the Department's policy and regulations.

I. If the decision upholds the Plan's denial or adverse resolution and the benefits were continued pending the decision, the Plan may recover from the member the costs of the services furnished to the member while the decision was pending, to the extent that the services were furnished solely because of the requirement to do so as outlined above.

XI. Documentation of Appeals

All appeals requests will be documented and kept on file in a secure, centralized location for a period of no less than seven years. Appeal files will contain at a minimum:

- Documentation of the substance of the appeal and actions taken, including name of the member and associated provider and/or facility
- Investigation of the appeal, including any aspect of clinical care involved
- Date of appeal reviews and the name and credentials of the reviewer(s) who made the appeal decision
- Notifications, include documentation of verbal and written notifications of acknowledgement, resolution, etc. of the appeal
- All other correspondence and records associated with the appeal
- Minutes or transcripts of appeal proceedings, if any

XII. Reporting

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A. The Plan shall electronically provide LDH with a monthly report of the appeals in accordance with the requirements outlined, to include, but not be limited to:
   - Member's name
   - Medicaid number,
   - Summary of appeals;
   - Date of filing;
   - Current status; and
   - Resolutions and resulting corrective action.

B. The Plan will be responsible for promptly forwarding any adverse decisions to LDH for further review/action upon request by LDH or the Plan member. The LDH may submit recommendations to the Plan regarding the merits or suggested resolution of any appeal.

REFERENCES:

MCO Contract– Section 8: Utilization Management
MCO Contract - Section 13: Member Grievance and Appeals
Health Plan Advisory 12-9 April 25, 2013 – Clarification of Provider Disputes Relative to Denied Claims and Services
Louisiana Administrative Code Title 37 Part XIII
Revised Statute R.S 22:1130
Code of Federal Regulations: 42 CFR 438
Current NCQA Health Plan Standards and Guidelines

ATTACHMENTS: Expedited Appeal Flow
Standard Appeal Flow
Oral Appeal Process
Personal Appeal Representative Form

DEFINITIONS:

Action: The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). 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 as defined by §7.3 an § 7.5 of the RFP; or The failure of the Plan to act within the timeframes provided in §13.7.1 of the RFP

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Appeal: A formal request from a member to seek a review of an action taken by the Plan pursuant to 42 CFR 438.400(b) and Section §13.1.1 of the RFP.
Authorized Representative: a person to whom a covered person has given written consent to represent the covered person in an internal or external review of an adverse determination of medical necessity. Authorized representative may include the covered person's treating provider, if the covered person appoints the provider as his authorized representative and the provider agrees and waives in writing, any right to payment from the covered person other than any applicable copayment or coinsurance amount. In the event that the service is determined not to be medically necessary by the MNRO/IRO, and the covered person or his authorized representative thereafter requests the services, nothing shall prohibit the provider from charging the provider's usual and customary charges for all MNRO/IRO determined non-medically necessary services provided when such requests are in writing. (Louisiana Administrative Code Title 37-Insurance Chapter 67 Medical Necessity Review Organizations)
Clinical Peer: A physician or other health care professional who holds an unrestricted license in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. Non-physician practitioners, including but not limited to nurses, speech and language therapists, occupational therapists, physical therapists, and clinical social workers, are not considered to be clinical peers and may not make adverse determinations of proposed actions of physicians (medical doctors shall be clinical peers of medical doctors, etc.) (Louisiana Administrative Code Title 37 Part XIII).
Expedited appeal: a request to change an adverse determination regarding urgent care as defined below. Additionally, requests for an expedited appeal review must be granted to any request concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.
Final Adverse Determination: an adverse determination that has been upheld by a reviewer at the completion of the medical necessity review organization's internal review process (Louisiana Administrative Code Title 37-Insurance Chapter 67 Medical Necessity Review Organizations).
Pre-service appeal: regarding a request for provision of service; a request to change an adverse decision for care or service that the Plan must approve, in whole or in part, in advance of the member obtaining care or services.

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Post-service appeal: a request to change an adverse decision for care or services that have already been received by the member; regarding a request for reimbursement of services received.
Same-or-similar specialist: practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal or who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.
Urgent care: any request for medical care or treatment, with respect to which the application of the time period for making non-urgent care determinations, could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on the prudent layperson's judgment or, in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

REVISION LOG:	**DATE**
VII. **Appeal Notification Letter** A. Added date of decision to notification of decision letter	10/12
Policy: First paragraph, last sentence – replace "medical necessary care" with "medically necessary care".	10/12
Language added to meet Louisiana contractual requirements, "legal" representative	11/8/13
Clarified timeliness of post service appeals and clarified that member may request reasonable access to all documents relevant to appeal free of charge.	11/13
Changed NCQA date to 2013 Added pharmacy information to Policy section. Added approval verbiage by DHH. Section XC added Clinical Appeal Coordinator. Changed from 14 to 7 days. Added clarification section on DAL.	6/2014
Change business days to calendar days per RFP 13.7.2.2 Updated attachment flows NCQA reference changed to current	11/15

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Changed Department of Health and Hospitals (DHH) to Louisiana Department of Health (LDH) NCQA reference changed to current	11/16
Changed the reference to the TTY/TDD system for interpretation to the appropriate standardized services in compliance with FCC standards under 711 2015, the FCC standardized these services under 711 http://transition.fcc.gov/cgb/consumerfacts/711.pdf https://www.fcc.gov/consumers/guides/telecommunications-relay-service-trs	10/17
Changed time frame for submission of appeal requests (to 60 days) and time frame for State Fair Hearing request (to 120 days) as indicated by the MCO contract initiated on 2/1/2018, Section 13	10/18
Changes made to the requirements for the member oral request for appeal as outlined by LDH (and CMS) in "Oral Appeals & Written Notifications" effective 05/01/2018	10/18
Changes made to requirements for the Plan related to reversal of a decision at the State Fair Hearing Level r/t the authorization and provision of the services to the member if the services were not furnished while the appeal (SFH) was pending.	10/18
Changes made to the policy in regard to changes or clarifications contained in the MCO Contract initiated on 02/01/2018.	10/18
Fragmented statement moved from section I F. to fit into Investigating an Appeal procedure section III C. Typographical errors concerning date of "Oral Appeals & Written Notifications" and spelling "Hearing" corrected.	910/19

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Appeal of UM Decisions
PAGE: 17 of 18	**REPLACES DOCUMENT:**
APPROVED DATE: 9/11	**RETIRED:**
INITIAL EFFECTIVE DATE: 1/12	**REVIEWED/REVISED:** 11/13; 6/14; 11/14, 11/15, 11/16, 10/17 10/18, 910/19
REVISED EFFECTIVE DATE: 2/1/15	
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.08

POLICY AND PROCEDURE APPROVAL

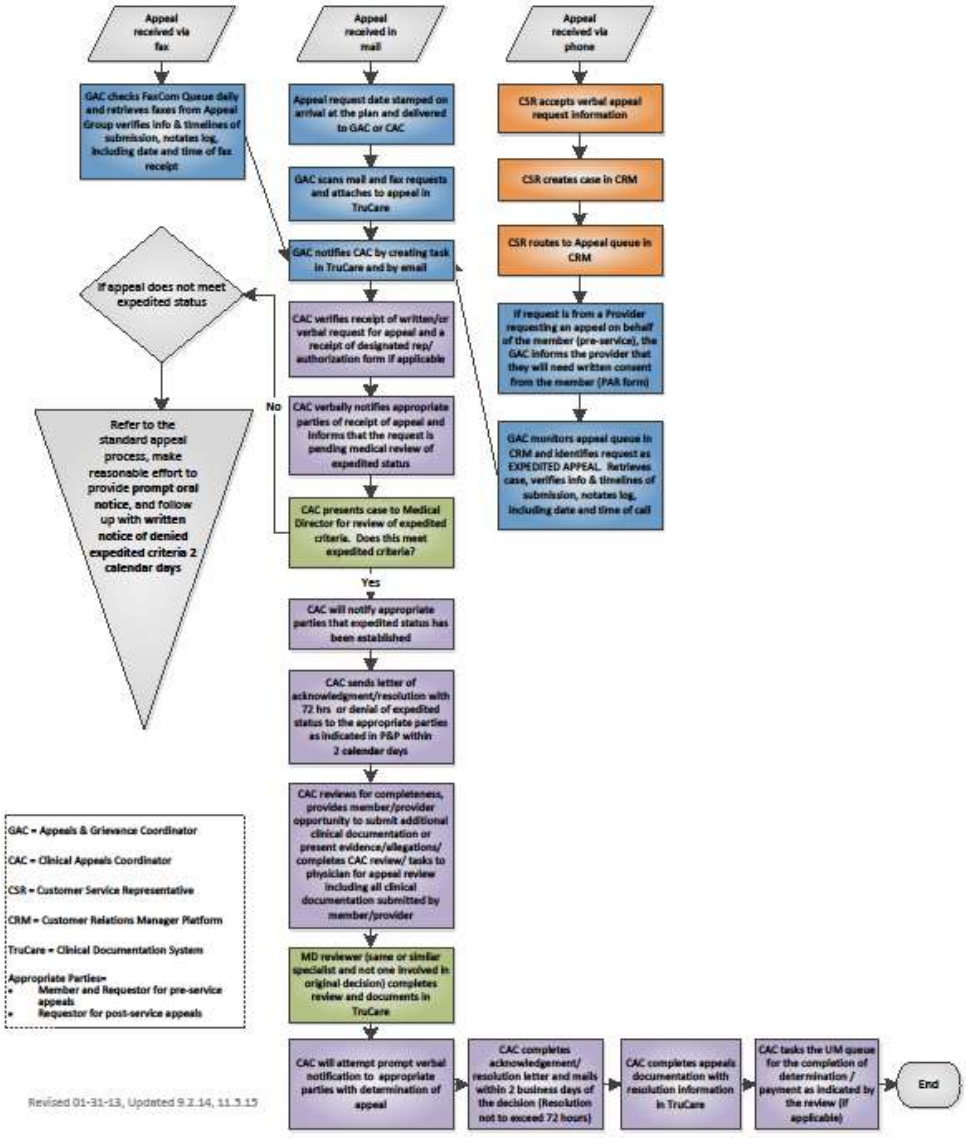
The electronic approval retained in Archer GRC, Centene's P&P management software, is considered equivalent to a physical signature.

V.P. Medical Management: __Approval on file_____
Sr. VP of Medical Affairs: _____Approval on file_____

CHART C3: EXPEDITED APPEALS PROCESS

louisiana healthcare connections

Louisiana HealthCare Connections Expedited Appeal Process Flow



Revised 01-31-13, Updated 9.2.14, 11.3.15