

# GRIEVANCES, APPEALS, AND STATE FAIR HEARINGS

## Grievance, Appeal, and State Fair Hearing Reporting

The MCO shall document and report to LDH all enrollee grievances, appeals, and State fair hearing requests received by or on behalf of the enrollee, including those processed by the MCO's subcontractor(s), on its behalf, according to the established manner and format determined by LDH and containing, at minimum, the information specified in 42 CFR §438.416(b).

NOTE: Grievances do not typically include customer service inquiries, such as a request for assistance finding a provider or inquiring about a covered service, unless during that request the enrollee or their representative also expresses dissatisfaction.

With the written consent of the enrollee, a provider or an authorized representative may request an appeal, file a grievance, or request a State fair hearing, on behalf of an enrollee, according to 42 CFR 438.402(c)(1)(ii) and LAC 50:I-3705.B.

The MCO shall comply with the following reporting requirements for standard grievances, appeals, or State fair hearing requests received from an entity other than the enrollee, without the required written consent:

- ❖ The MCO shall report the unauthorized grievance, appeal, and State fair hearing as concurrently received, resolved, and closed for the reporting month received, per the established reporting template and associated requirements.
- ❖ The MCO shall follow its established policies and procedures to request the required, written enrollee consent.
- ❖ If and when the enrollee's required, written consent is received, the MCO shall report the grievances, appeals, and State fair hearings as new requests for the reporting months in which they are received, using the date on which the written consent was received and newly assigned tracking numbers. The MCO must comply with the required documentation and status required by LDH's established reporting template and associated requirements.

NOTE: To ensure clean data and records, the MCO shall not use the original tracking number nor revise the receipt date for unauthorized grievances, appeals, and State fair hearings, in subsequent reports. Both the original unauthorized request and the newly authorized request must be reported and documented separately, according to their receipt dates.

## Continuation of Benefits

The MCO shall continue an enrollee's benefits pending resolution of an appeal or State fair hearing when the following occur:

- ❖ The enrollee files the request for an appeal timely in accordance with § 438.402(c)(1)(ii) and (c)(2)(ii);
- ❖ The appeal involves the termination, suspension, or reduction of previously authorized services;

- ❖ The services were ordered by an authorized provider;
- ❖ The period covered by the original authorization has not expired; and
- ❖ The enrollee timely files for continuation of benefits

Expiration of an approved number of visits does not constitute a termination for purposes of notice and continuation of benefits. The expiration of authorized services is not a cause to continue benefits. The enrollee should not expect services to continue beyond the “previously authorized” quantity, period, or duration.

When an enrollee’s prescription, including refills, runs out and the enrollee submits a request for another prescription, this is considered a new request, not a termination of benefits. In this instance, the MCO is not required to send a notice of Adverse Benefit Determination or continue benefits pending the outcome of an appeal or State fair hearing. If the enrollee requests a reauthorization that the MCO denies, the MCO shall treat this request as a new request for service authorization and provide notice of the denial or limitation.

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