# POLICY AND PROCEDURE

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| **POLICY NAME:** Adverse Determination (Denial) Notices | **POLICY ID:** LA.UM.07 |
| **BUSINESS UNIT:** ~~LHCC~~Louisiana Healthcare Connections | **FUNCTIONAL AREA:** ~~PHCO~~Utilization Management |
| **EFFECTIVE DATE:** 09/01/2011 | **PRODUCT(S):** Medicaid |
| **REVIEWED/REVISED DATE:** 10/13, 7/14, 11/14, 2/15, 9/15, 9/16, 9/17, 9/18, 8/19, 6/20, 5/21, 11/21, 12/22, 09/2023 | |
| **REGULATOR MOST RECENT APPROVAL DATE(S):** ~~n/a~~Refer to system of record - Archer | |

**POLICY STATEMENT:**

All areas and departments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

~~This policy outlines adverse determination notices.~~

**PURPOSE:**

The purpose of ~~T~~this policy ~~outlines~~ is to outline the denial types and identify~~ies~~ how enrollees and practitioners are to be notified of adverse benefit determinations. ~~To~~ This policy also ensures enrollees and practitioners receive sufficient information to understand and decide whether to appeal an adverse determination to deny care or coverage.

**SCOPE:**

This policy applies to employees of the Utilization Management (UM) Department. This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

~~Louisiana Healthcare Connections (Plan) Population Health and Clinical Operations Department~~

**DEFINITIONS:**

**Action**: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner (as defined by Louisiana Department of Health (LDH)~~LDH~~); or the failure to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR 438.400(b); and in the rural area with only one Managed Care Organization (MCO), the denial of a enrollee's right to obtain services outside the provider network as described in 438.52(b)(2)(ii).

**Adverse Benefit Determination:** Includes any of the following:

- The denial or limited authorization of a requested service, including 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 the Plan to act within State specific contractual timeframes from the date the Plan receives a grievance, or from the date the Plan receives an appeal.
- For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.
- The denial of an enrollee's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

**Appeal:** A request to change an adverse decision made by the Plan. A enrollee or the enrollee's authorized representative may appeal an adverse decision.

**Appropriate Practitioner:** An organization representative who makes UM denial decisions. Depending on the type of case, the reviewer may be a physician, pharmacist, chiropractor, dentist, or other practitioner type, as appropriate.

**Business Day**: Monday, Tuesday, Wednesday, Thursday, and Friday, excluding s~~S~~tate-designated holidays. In

computing a period of time prescribed in bBusiness dDays, the date of the triggering act or event is not to be included. The last day of the period is to be included, unless it is a Saturday, a Sunday, or a State-designated holiday, in which event the period shall run until the end of the next day that falls on a bBusiness bDay.

**Concurrent Request**: A request for coverage of medical care or services made while an enrollee is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. This includes any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments and requests for initial authorizations, which are requested after care has been initiated but not completed. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

**Insufficient Clinical Information:** Lack of any clinical information, even a diagnosis, required to determine medical necessity of a covered service.

**Level I Review:** First level of medical necessity review performed by clinical UM staff using applicable criteria.

**Level II Review:** Second level of medical necessity review. Performed by Plan medical director or another designated qualified practitioner. See associated policy for further description.

**Medical Necessity:** Services or supplies for diagnosing, evaluating, treating, or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria.

**Non-urgent request:** A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function and would not subject the enrollee to severe pain.

**Notice of Adverse Benefit Determination**: A written notice of any decision by the Plan regarding an adverse benefit determination as for Medicaid enrollees.

**Post Service Request/Retrospective Review**: A request for coverage of medical care or services that have been received.

**Provider:** Attending Physician, ordering provider, or facility

**Service Authorization Request**: A request by a enrollee, or a provider on the enrollee's behalf, to the Plan for the provision of a service, including a request for a referral or for a non-covered service.

**Urgent Request:** A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:

- Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment, or
- Could seriously jeopardize the life, health or safety of the enrollee or others, due to the enrollee's psychological state, or
- In the opinion of a practitioner with knowledge of the enrollee's medical or behavioral condition, would subject the enrollee to adverse health consequences without the care or treatment that is the subject of the request.

~~**Appropriate practitioner**: An organization representative who makes UM denial decisions. Depending on the type of case, the reviewer may be a physician, chiropractor, or other practitioner type, as appropriate.~~

~~**Level II Review**: Second level of medical necessity review. Performed by Plan medical director or other designated qualified practitioner.~~

**POLICY:**

Upon any adverse benefit determination (denial) made in a Leve II Review by the medical director, or other appropriately licensed health care professional ~~Upon any adverse determination for standard or pre-authorized medical services made by the Plan medical director or other appropriately licensed health care professional (~~as indicated by case type), a written notification, at a minimum, ~~will be~~is communicated to the enrollee and treating/attending provider. ~~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. No written notification is required~~[KF1][CF2] ~~to the enrollee for concurrent inpatient adverse determinations. All notifications will be provided within the timeframes as noted in~~ Adverse determinations include both medical necessity and benefit denials. All notifications are provided within the timeframes as noted in *LA.UM.05 Timeliness*

*of UM Decisions and Notifications* policy. The Plan ~~shall~~ notifies ~~y~~ the enrollee ~~and provider~~[AB3], in writing using language that is easily understood by the enrollee, of ~~decisions~~ determinations to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, (Model Contract 2.12.6.4.2.1). and include the specific reason/rationale for the determination, as well as the availability, process, and timeframes ~~for~~ to appeal of the decision. ~~(Model Contract 2.12.6.4.2.1).~~ The letter to the provider ~~will~~ also includes a copy of the criteria used to make the decision. (LARS §46:460.74.(B)~~HB 424/Act 330, Model Contract 2.12.5.2.1~~[AB4]).

The Plan ~~will~~ provides ~~availability of~~ an appropriate practitioner reviewer to discuss any ~~Utilization Management (~~UM~~)~~ adverse determination decisions with the treating or attending physician.

The Plan gives enrollees and providers timely and adequate notice of an adverse benefit determination in writing consistent with 42 CFR § 438.404 and § 438.10.

It is the Plan's policy to make determinations on service authorization requests as expeditiously as possible, and within the federal and state-specified timeframes, and to notify the enrollee, enrollee's designee and/or an enrollee's health care provider of adverse benefit determinations as promptly as possible.

~~Availability of such Peer-to-Peer discussion and how to initiate such communications may be conveyed to providers through various avenues including, but not limited to, the provider handbook, provider newsletter, verbal denial notification, and/or within the written adverse determination letter. (Refer to Informal Reconsideration in *LA.UM.05 Timeliness of Decisions and Notifications* policy).~~

Upon request[KF5] ~~by Louisiana Department of Health (~~LDH~~)~~ or the enrollee, the Plan ~~will be~~is responsible for promptly forwarding any adverse decisions to LDH for further review/action. LDH may submit recommendations to the Plan regarding the merits or suggested resolution of any grievance/appeal.[CF6]

**PROCEDURE:**

**Level I Review**

**Administrative Denials**

A requested service may be denied during a level I review for non-clinical reasons, such as enrollee ineligibility, failure to obtain prior authorization, failure to provide timely notification (for a post service request), or failure to receive any clinical information (note: diagnosis alone is considered sufficient clinical information).

Requests based on benefits are not considered to be administrative denials and follow the process outlined in this policy and associated policies.

**Benefit Denials**

Determination by a medical director is not required for requests for services that are specifically excluded from enrollees' Plan or that exceed limits or restrictions noted in the Plan and may be denied during a level 1 review.

Note: Benefit restrictions are specific to the Plan package.

Examples of benefit determinations include, but are not limited to:

- Requests for additional physical therapy visits when the Plan clearly states a specified amount are covered.
- Authorization for eyeglasses when vision care is specifically excluded from the Plan.
- Requests for abortion services when such services are specifically excluded from the Plan.
- Medical equipment or supplies for which the codes are specifically listed as excluded from coverage.

Medical director review is required if clinical judgment is needed to determine if a service may be covered, depending on the circumstances. Such requests follow the level II review process outlined below. Examples of such requests, which are considered medical necessity decisions, include but are not limited to:

- Breast reduction surgery for back pain, versus cosmetic reasons.
- Use of an out-of-network provider if no in-network provider has the appropriate clinical experience.
- Experimental procedure unless the requested service is specifically listed as excluded from the enrollee's Plan.

**Insufficient Information**

For requests when there is insufficient information to determine services requested and conditions to be treated, the clinical reviewer makes at least three (3) outreach attempts via phone or fax to the requesting provider to attempt to gather needed information.

- The clinical reviewer clearly specifies what information is needed and a deadline for information to be provided in order to make a determination based on medical necessity.
- Clinical reviewers make outreach attempts allowing as much time as possible for the provider to respond depending on the contractually defined turnaround time for the authorization decision.
- Clinical reviewers document outreach attempts in the clinical documentation system.

For services that require prior authorization, if the Plan receives any clinical information, including only a diagnosis, the request must be reviewed by an appropriate professional and sent for level II review if unable to approve.

~~**Administrative Denials**~~

~~An adverse benefit determination that is not based on medical necessity but rather based on specific contractual requirements related to authorization rules, such as covered benefits and prior authorization notification requirements. A requested service may be denied during a Level I review for non-clinical reasons, such as enrollee ineligibility, failure to obtain prior authorization, failure to provide timely notification, or failure to receive any clinical information (note: diagnosis alone is considered sufficient clinical information).~~

~~Requests based on benefits are not considered to be administrative denials and follow the process outlined in this policy and associated policies.~~

~~**Administrative Non-medical Necessity/ Contractual Adverse Benefit Denials**~~

~~An adverse benefit determination that is not based on medical necessity but rather based on specific contractual requirements related to authorization rules, such as covered benefits and prior authorization notification requirements. Determination by a medical director or appropriate practitioner reviewer is not required for requests for services that~~

~~are specifically excluded from enrollees' benefit plan or that exceed limits or restrictions noted in the benefit plan and may be denied during a Level 1 review. Note: benefit restrictions are specific to the Plan and product.~~

~~Examples of benefit determinations include, but are not limited to:~~

- ~~Requests for additional physical therapy visits when the benefit plan clearly states a specified amount are covered.~~
- ~~Medical equipment or supplies for which the codes are specifically listed as excluded from coverage.~~

~~Secondary Advisor Review is required if clinical judgment is needed to determine if a service may be covered, depending on the circumstances. Such requests follow the Level II review process outlined below. Examples of such requests, which are considered medical necessity decisions, include but are not limited to:~~

- ~~Breast reduction surgery for back pain, versus cosmetic reasons.~~
- ~~Use of an out-of-network provider if no in-network provider has the appropriate clinical experience.~~
- ~~Experimental procedure unless the requested service is specifically listed as excluded from the enrollee's benefit plan.~~

**~~Insufficient Information~~**

~~When insufficient clinical information is received to determine medical necessity for requested service(s), attempts to obtain additional information are made and are documented in the clinical documentation system. If the Plan receives any clinical information, including only a diagnosis, the request must be reviewed by an appropriate professional and sent for Level II review if unable to approve.~~

**Level~~ II~~ Review**

During~~ a~~ level~~ II~~ ~~medical necessity~~ review,~~ the~~ medical~~ director~~ or~~ appropriate~~ practitioner~~ reviewer~~ may~~ make an~~ adverse~~ determination~~ to~~ deny,~~ terminate,~~ or~~ reduce~~ services.~~ The Plan ensures that only licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease and training in the use of any required assessments determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. (Model Contract 2.12.5.2)~~The Plan shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee'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.~~ The Plan notifies the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Plan provides written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) business days of making the determination. (Model Contract 2.12.6.4.2.2) ~~The Plan shall notify the requesting provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Plan shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the enrollee's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial determination. (Model Contract 2.12.6.4.2)~~

It is Plan policy to not to suspend, terminate, or reduce previously authorized services, honoring authorizations through the end of the authorization period. However, in the event of termination, suspension, or reduction of previously authorized covered services, the Plan mails the Adverse Benefit Determination at least ten (10) calendar days before the date of the Adverse Benefit Determination is to start OR not later than the date of the Adverse Benefit Determination in the event of one of the following exceptions:

- The Plan has factual information confirming the death of an enrollee.
- The Plan receives a clear statement signed by the enrollee that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
- The enrollee has been admitted to an institution and becomes ineligible under the Plan for further services.
- The enrollee's whereabouts are unknown, and the post office returns Plan mail directed to the enrollee indicating no forwarding address (refer to 42 CFR 431.231(d) for procedures if the enrollee's address becomes known.)
- The Plan establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the recipient's physician.
- The notice involves an adverse benefit determination made regarding the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or
- The date of action occurs in less than ten (10) days, in accordance with 42 CFR 483, which provides exceptions to the 30-day notice requirements of 42 CFR 483.12(a). This exception is related to the admission, transfer, and discharge rights, in which before a facility transfer or discharges a resident the facility must notify the enrollee, the family enrollee or legal representative at least 30 days before the transfer or discharge.
- The Plan may shorten the period of advance notice to five (5) calendar days before date of action if the Plan has facts indicating that action should be taken because of probable enrollee fraud and the facts have been verified, if possible, though secondary sources.

An appeal may be filed orally or in writing within 60 days from the date on the Notice of Adverse Benefit Determination and, except when expedited resolution is required, must be followed with a written notice within ten (10) days of oral filing. The date of the oral filling constitutes the date of receipt.

~~The Plan must mail the Adverse Notice of Action within the following timeframes:~~

- ~~For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action.~~
- ~~In cases of verified enrollee fraud, or when LDH has facts indicating that action should be taken because of probable enrollee fraud, at least five (5) days before the date of action.~~
- ~~By the date of action for the following:~~
    - ~~in the death of an enrollee~~
    - ~~if the enrollee submits a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);~~
    - ~~the enrollee's admission to an institution where he/she is eligible for further services;~~
    - ~~the enrollee's address is unknown, and mail directed to him/her has no forwarding address;~~
    - ~~the enrollee has been accepted for Medicaid services by another local jurisdiction; or~~
    - ~~the enrollee's physician prescribes the change in the level of medical care; or~~
    - ~~as otherwise permitted under 42 CFR §431.213.~~
- ~~For denial of payment, at the time of any action affecting the claim.~~

The adverse decision and rationale for the determination ~~will be~~is documented in the clinical documentation system notes.

**Notification of Reviewer Availability:**

- The Plan medical director or appropriate practitioner reviewer serves as the point of contact for treating practitioners calling in with questions about the UM process and/or case determinations.

- Treating practitioners are notified of availability of an appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Handbook (available in hard copy and on plan provider website), new provider orientation, and/or the provider newsletter.

- The Plan medical director or appropriate practitioner reviewer may be contacted by calling the Plan's main toll-free phone number and asking for the Plan medical director. A Plan clinical reviewer may also coordinate communication between the Plan medical director and treating practitioner.

Treating practitioners are provided with the opportunity to discuss any ~~medical or behavioral health~~ UM denial decisions with a physician or other appropriate reviewer. Only the treating physician/provider may participate in this peer-to-peer discussion.

- At the time of verbal notification to the requesting practitioner/facility of an adverse determination, the reviewer or designee ~~correspondence nurse will~~ notifies~~y~~ the requester of the opportunity for the treating physician to discuss the case directly with the Plan medical director or applicable practitioner reviewer making the determination.
    - The time and date of both the denial notification and the offer of physician reviewer availability is documented in the system notes.
- Practitioner/facility notification that a physician or other appropriate reviewer is available to discuss the denial decision is also included in the written denial notification.

Both the enrollee and requesting provider ~~shall~~ receive a written Notice of Action (denial of medical coverage) regarding any denial, reduction, or termination of service.e ~~with the exception of concurrent inpatient services. OnlyThe provider/facility will receive written notification for denied concurrent inpatient services.~~[KF7][CF8]

**Written Notification for Medical Necessity Adverse Determination:**

The written notice to enrollees and their treating practitioners must explain the following:

- The adverse benefit determination the Plan has made or intends to make.
- The enrollee specific reasons for the adverse benefit determination in easily understandable language, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.
- The Plan gives practitioners the opportunity to discuss healthcare UM denial decisions with a physician or other appropriate reviewer.
- An explanation of the appeal process, including the enrollee's right to representation by anyone (including an attorney), contact information for the state Office of Health Insurance Consumer Assistance or ombudsman (if applicable), the time frames for filing and deciding appeals, exhausting the internal appeal process and the circumstances under which additional external appeal rights are available and how to request them, including State fair hearings where applicable.
- The enrollee's right to request an appeal of the Plan's adverse benefit determination, based on product line, as information on exhausting the Plan's one level of appeal described at § 438.402(b) and the right to request a State fair hearing consistent with § 438.402(c).
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.
- ~~The Notice of Action letter will be sent from the clinical documentation system and includes:~~
    - ~~The enrollee specific action and reason for the denial, in easily understood language.~~
    - ~~Notification that oral interpretation is available for all languages at no cost and how to access it.~~
    - ~~A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.~~
    - ~~The medical necessity criteria used in the denial by providing one of the following:~~

- Providing instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline OR
- A copy of the applicable law, regulation, policy, procedure, or medical criteria or guideline

- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.
- An explanation of the appeal process, including the enrollee's right for representation by anyone including an attorney and time frames for deciding appeals and the circumstances under which a State Fair Hearing is available, after the appeal process has been exhausted, and how to request one.
- A description of the expedited appeal process including under what circumstances an expedited appeal can be requested, how to request an expedited appeal, and the time frames for resolution of an expedited appeal.
- The enrollee's right to have benefits continue pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to repay the costs of these services. (Model Contract 2.12.6.4.2.1[AB9])

- The medical director or appropriate practitioner reviewer may work with the correspondence nurse[CF10] to draft the denial letter.
- The letter must have the signature of the Plan medical director or appropriate practitioner reviewer making the adverse determination.

The adverse determination letter will be mailed within the timeframes as indicated in *LA.UM.05 Timeliness of UM Decisions and Notifications policy*.

- The Plan will assist any enrollee requesting assistance in understanding an adverse determination notice, including any enrollee with special communication needs such as large print, Braille, audio CD, in a different language (each prevalent non-English language in the service area), or another format.

**Informal Reconsideration / Peer to Peer**[AB11][KF12]

As part of the Plan's appeal procedures, the Plan includes an informal reconsideration process that allows the enrollee (or provider/agent on behalf of an enrollee) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing. In accordance with Model Contract Section 2.12.6.4.3.1 and Title 37, Part XIII, §6219, the Plan will provide the enrollee and the provider the opportunity to request an informal reconsideration process that allows the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person, as well as in writing(Model Contract Section 2.12.6.4.3.1). In a case involving an initial determination or a concurrent review determination, the Plan provides the enrollee or a provider acting on behalf of the enrollee and with the enrollee's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [KF13](Model Contract Section 2.12.6.4.3.2).Plan should provide the enrollee, or a provider acting on behalf of the enrollee and with the enrollee's written consent, an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination.

- For all medical necessity adverse determinations, the plan will give the enrollee and provider rendering the service an opportunity to request, on behalf of the enrollee, an informal reconsideration of an adverse determination by the physician or clinical reviewer making the adverse determination. [AB14]
- The enrollee and provider will beare allowed a ten (10) day period following the date of the adverse determination to request such.[KF15]
- The informal reconsideration occurs within one (1) business day of the receipt of the request and is conducted between the provider rendering the service and the Contractor's Plan'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) business day (Model Contract 2.12.6.4.3.3). The reconsideration shall occur within one (1) working day of the receipt of the request, at the convenience of the requesting provider, and shall be conducted between the enrollee and provider rendering the service and the Plan's Medical Director 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.
    - The Grievance[KF16] and Appeals Coordinator scheduler willPlan makes three attempts by phone to reach the provider to schedule an appointment with one of LHCC's the Plan's medical directors. Should all three attempts fail, the request for an informal reconsideration will beis closed at 5:00

p.m. on the ~~working~~ business day following the date of receipt of the request and the adverse determination may be appealed by the enrollee or the provider on behalf of the enrollee.

- A request for consideration ~~will be~~is considered invalid in instances when the provider ~~has~~ fail~~sed~~ to include clinical documentation in their request for prior authorization or in the case of a provider representing an enrollee the provider fail~~sed~~ to provide the enrollee's written consent. The request for an informal reconsideration ~~will be~~is closed and the adverse determination may be appealed by the enrollee or the provider on behalf of the enrollee.
- In an instance where a provider fails to call-in or calls in later than 15 minutes after their scheduled review time the denial decision ~~will be~~is upheld. The request for an informal reconsideration ~~will be~~is closed and the adverse determination may be appealed by the enrollee or the provider on behalf of the enrollee.

- The peer-to-peer discussion (which could include the enrollee's input) and outcome ~~will be~~are documented in the clinical documentation system by the medical director or the clinical peer as appropriate.
- If the informal reconsideration process does not resolve the differences of opinion, the adverse determination may be appealed by the enrollee or the provider on behalf of the enrollee. Informal reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.
- ~~The~~ informal reconsideration will in no way extend the thirty (30) Calendar day required timeframe for a Notice of Appeal Resolution (Model Contract 2.12.6.4.3.4).
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**REFERENCES:**
LA MCO Model Contract:
2.12.5.2
2.12.6.4.2.1-2
2.12.6.4.3.1-4
42 CFR § 431.231(d) Reinstating Services
42 CFR § 438.10 Information requirements
42 CFR § 483.12(a) Freedom from abuse, neglect, and exploitation
42 CFR § 438.400(b) Grievance and Appeal System
42 CFR § 438.402(b-c) Grievance and Appeal System
42 CFR § 438.404 Grievance and Appeal System
42 CFR § 438.52(b)(2)(ii) State Responsibilities
NCQA Health Plan Standards and Guidelines UM7(Elements A-C)
Louisiana Revised Statue (LARS) §46:460.74.(B)~~House Bill 424- Act 330~~
Louisiana Revised Statue (LARS) §46:460.54
LA.UM.05 Timeliness of UM Decisions and Notifications~~LA MCO Model Contract~~
~~Health Plan Advisory 12-9 April 25, 2013: Clarification of Provider Disputes Relative to Denied Claims and Services~~[KF17][KF18]
~~Title 37, Part XIII, §6217- §6219~~ [KF19]
~~Code of Federal Regulation: 42 CFR 422; 438.400~~
~~Current NCQA Health Plan Standards and Guidelines~~
~~LA.UM.05 Timeliness of UM Decisions and Notifications~~
~~House Bill 424- Acct 330~~
~~LA.UM.01 Utilization Management Program Description~~
~~LA.UM.04 Appropriate UM Processionals~~

**ATTACHMENTS:** N/A

**ROLES & RESPONSIBILITIES:** N/A

**REGULATORY REPORTING REQUIREMENTS:** LARS §46:460.54 applies to material changes for this policy.
~~Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.~~

## REVISION LOG

| REVISION TYPE | REVISION SUMMARY | DATE APPROVED & PUBLISHED |
|---|---|---|
| Ad Hoc Review | Reviewed without change. | 10/2013 |
| Ad Hoc Review | Clarification of written notification to members | 07/24/14 |
| Ad Hoc Review | LA Procurement 2015 Policy Update | 11/19/14 |
| Ad Hoc Review | Per IPRO readiness review, added C1 – services provided at no cost and that state fair hearings are available after the appeal process has been exhausted | 02/23/15 |

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| | C5 - such as large print, Braille, audio CD, in a different language (each prevalent non-English language in the service area), or another format | |
| Ad Hoc Review | Added CCL.230 in references<br>Updated NCQA date reference<br>Added Behavioral Health Services to scope | 09/29/15 |
| Ad Hoc Review | Changed DHH to LDH, adjusted verbiage to comply with NCQA time criteria. Changed Care to Case. Changed Case manager to Correspondence nurse. | 09/26/16 |
| Ad Hoc Review | Grammatical changes<br>Additions to Section D. Informal Reconsiderations / Peer to Peer to include "Peer to Peer" and clarification of timeframe for reconsideration within one working day if requested by Provider | 09/25/17 |
| Ad Hoc Review | Grammatical changes<br>Provider Adverse Determination Notification updated to reflect LA MCO RFP Amendment 11 - Section 8 Utilization Management (8.5.4.1.2.2) change from one (1) calendar day of the initial request to "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 written notification to the provider within two (2) business days of making the initial determination."<br>Informal Reconsideration / Peer to Peer, Section D., updated to reflect LA MCO RFP Amendment 11 – Section 8 Utilization Management (8.5.4.1.3.1) and LA.UM.05 Timeliness of UM Decisions and Notifications.<br><br>Informal Reconsideration / Peer to Peer, Section D.5 removed.<br>Removed CCL.230 Adverse Determination Process and Notifications from References | 09/25/18 |
| Ad Hoc Review | Added new process for inclusion of copy of criteria with denial notices per new House Bill 424 - Act 330 requirement<br>Added references to House Bill 424 | 08/26/19 |
| Ad Hoc Review | Added references to LA.UM.01 and LA.UM.04<br>Changed RFP to Emergency Contract<br>Added Emergency contract sections 8.1.15, 8.1.17 and 8.4.2.3 | 06/25/20 |
| Ad Hoc Review | Changed MM to PHCO | 05/27/21 |
| Ad Hoc Review | Added Administrative Denial, non-medical necessity/benefit denials, and insufficient information section<br>Changed recipient to member<br>Changed care manager to Clinical Reviewer | 11/19/21 |
| Ad Hoc Review | Changed department from MM to PHCO<br>Updated the purpose<br>Updated administrative denials<br>Added Administrative/Contractual denial information<br>Added Medical Necessity to Level II review<br>Updated Peer to Peer language to include procedural steps 3i through 3iii and step 6<br>Added member to receive denial letter<br>Changed Member to Enrollee<br>Updated contract references including adding RFP Model Contract to references<br>Reformatted to new policy template | 12/07/22 |
| Annual Review | Updated policy statement and scope, several definitions. Style guide and grammar corrections. Updated to current contract language, corrected contract references, removed inaccurate references, added appropriate references. Updated Level II review process. Updated what is included in the Notice of Action letter. Replaced working day with business day. Replaced House bill 424/Act 330 with Louisiana | 09/2023 |

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| | Revised Statue (LARS) §46:460.74.(B), Replaced Act 319 with Louisiana Revised Statue (LARS) §46:460.54<br>**Added following sections:** Written Notification for Medical Necessity Adverse Determination, Administrative/Contractual Adverse Benefit Determination, Medical Necessity Adverse Benefit Determinations<br>**Replaced above sections with the following sections:** Administrative Denials, Administrative Non-medical Necessity/Contractual Adverse Benefit Denials. | |

**POLICY AND PROCEDURE APPROVAL**

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

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