Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3701. Introduction

A. An MCO must have a grievance system for Medicaid enrollees that complies with federal regulations. The MCO shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws and as specified in the contract and all department issued guides.

B. The MCO's grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation and must include, at a minimum, the requirements set forth herein.

1. The MCO shall refer all members who are dissatisfied, in any respect, with the MCO or its subcontractor to the MCO's designee who is authorized to review and respond to grievances and to require corrective action.

2. The member must exhaust the MCO's internal grievance/appeal process prior to accessing the state fair hearing process.

C. The MCO shall not create barriers to timely due process. If the number of appeals reversed by the state fair hearing process exceeds 10 percent of appeals received within a 12 month period, the MCO may be subject to sanctions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1589 (June 2011), amended LR 41:938 (May 2015).

§3703. Definitions

Action—the denial or limited authorization of a requested service, including:

1. the type or level of service;

2. reduction, suspension, or termination of a previously authorized service;

3. denial, in whole or in part, of payment for a service for any reason other than administrative denial;

4. failure to provide services in a timely manner as specified in the contract; or

5. failure of the MCO to act within the timeframes provided in this Subchapter.

Appeal—a request for review of an action as defined in this Section.

Grievance—an expression of dissatisfaction about any matter other than an action as that term is defined in this Section. The term is also used to refer to the overall system that includes MCO level grievances and access to a fair hearing. Possible subjects for grievances include, but are not limited to:

1. the quality of care or services provided;

2. aspects of interpersonal relationships, such as rudeness of a provider or employee; or

3. failure to respect the member's rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1589 (June 2011), amended LR 41:939 (May 2015).

§3705. General Provisions

A. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the state fair hearing process once the MCO's appeal process has been exhausted.

B. Filing Requirements

1. Authority to File. A member, or a representative of his/her choice, including a network provider acting on behalf of the member and with the member's consent, may file a grievance and an MCO level appeal. Once the MCO's appeals process has been exhausted, a member or his/her representative, with the member's written consent, may request a state fair hearing.

a. An MCO's provider, acting on behalf of the member and with his/her written consent, may file a grievance, appeal, or request a state fair hearing on behalf of a member.

2. Filing Timeframes. The member, or a representative or provider acting on the member's behalf and with his/her written consent, may file an appeal within 30 calendar days from the date on the MCO's notice of action.

3. Filing Procedures

a. The member may file a grievance either orally or in writing with the MCO.

b. The member, or a representative or provider acting on the member's behalf and with the member's written consent, may file an appeal either orally or in writing

C. Grievance Notice and Appeal Procedures

1. The MCO shall ensure that all members are informed of the state fair hearing process and of the MCO's grievance and appeal procedures.

a. The MCO shall provide a member handbook to each member that shall include descriptions of the MCO's grievance and appeal procedures.

b. Forms to file grievances, appeals, concerns, or recommendations to the MCO shall be available through the MCO, and must be provided to the member upon request. The MCO shall make all forms easily available on its website.

D. Grievance and Appeal Records

1. The MCO must maintain records of grievances and appeals. A copy of the grievance logs and records of the disposition of appeals shall be retained for six years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six-year period, whichever is later.

E. Grievance Reports

1. The MCO shall provide an electronic report of the grievances and appeals it has received on a monthly basis in accordance with the requirements specified by the department, which will include, but is not limited to:

a. the member's name and Medicaid identification number;

b. summary of grievances and appeals;

c. date of filing;

d. current status;

e. resolutions; and

f. resulting corrective action.

F. All state fair hearing requests shall be sent directly to the state designated entity.

G. The MCO will be responsible for promptly forwarding any adverse decisions to the department for further review and/or action upon request by the department or the MCO member.

H. The department may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance or appeal.

I. Information to Providers and Subcontractors. The MCO must provide the information about the grievance system as specified in federal regulations to all providers and subcontractors at the time they enter into a contract.

J. Recordkeeping and Reporting Requirements. Reports of grievances and resolutions shall be submitted to the department as specified in the contract. The MCO shall not modify the grievance system without the prior written approval of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1590 (June 2011), amended LR 41:939 (May 2015), LR 41:2368 (November 2015).

§3707. Handling of Member Grievances and Appeals

A. In handling grievances and appeals, the MCO must meet the following requirements:

1. give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free telephone numbers that have adequate TTY/TTD and interpreter capability;

2. acknowledge receipt of each grievance and appeal;

3. ensure that the individuals who make decisions on grievances and appeals are individuals who:

a. were not involved in any previous level of review or decision-making; and

b. if deciding on any of the following issues, are health care professionals who have the appropriate clinical expertise, as determined by the department, in treating the member's condition or disease:

i. an appeal of a denial that is based on lack of medical necessity;

ii. a grievance regarding denial of expedited resolution of an appeal; or

iii. a grievance or appeal that involves clinical issues.

B. Special Requirements for Appeals

1. The process for appeals must:

a. provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal);

b. provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The MCO must inform the member of the limited time available for this in the case of expedited resolution;

c. provide the member and his/her representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents and records considered during the appeals process; and

d. include, as parties to the appeal:

i. the member and his/her representative; or

ii. the legal representative of a deceased member's estate.

2. The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

3. The appropriate individual or body within the MCO having decision making authority as part of the grievance and appeal procedures shall be identified.

4. Failure to Make a Timely Decision

a. Appeals shall be resolved no later than the stated time frames and all parties shall be informed of the MCO's decision.

b. 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.

5. The MCO shall inform the member that he/she may seek a state fair hearing if the member is not satisfied with the MCO's decision in response to an appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1590 (June 2011), amended LR 41:940 (May 2015).

§3709. Notice of Action

A. Language and Format Requirements. The notice must be in writing and must meet the language and format requirements of federal regulations in order to ensure ease of understanding. Notices must also comply with the standards set by the department relative to language, content, and format.

B. Content of Notice. The notice must explain the following:

1. the action the MCO or its subcontractor has taken or intends to take;

2. the reasons for the action;

3. the member's right to file an appeal with the MCO;

4. the member's right to request a state fair hearing after the MCO's appeal process has been exhausted;

5. the procedures for exercising the rights specified in this Section;

6. the circumstances under which expedited resolution is available and the procedure to request it; and

7. the member's right to have previously authorized services continue pending resolution of the appeal, the procedure to make such a request, and the circumstances under which the member may be required to pay the costs of these services.

C. Notice Timeframes. The MCO must mail the notice within the following timeframes:

1. for termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except as permitted under federal regulations;

2. for denial of payment, at the time of any action taken that affects the claim; or

3. for standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service. A possible extension of up to 14 additional calendar days may be granted under the following circumstances:

a. the member, or his/her representative or a provider acting on the member's behalf, requests an extension; or

b. the MCO justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

D. If the MCO extends the timeframe in accordance with this Section, it must:

1. give the member written notice of the reason for the decision to extend the timeframe;

2. inform the member of the right to file a grievance if he/she disagrees with that decision; and

3. issue and carry out its determination as expeditiously as the member's health condition requires, but no later than the date that the extension expires.

E. For service authorization decisions not reached within the timeframes specified in this Section, this constitutes a denial and is thus an adverse action on the date that the timeframes expire.

F. For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision.

1. A notice must be furnished as expeditiously as the member's health condition requires, but no later than 72 hours or as expeditiously as the member's health requires, after receipt of the request for service.

2. The MCO may extend the 72 hour time period by up to 14 calendar days if the member or provider acting on behalf of the member requests an extension, or if the MCO justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

G. The department shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1591 (June 2011), amended LR 41:940 (May 2015).

§3711. Resolution and Notification

A. The MCO must dispose of a grievance, resolve each appeal, and provide notice as expeditiously as the member's health condition requires, within the timeframes established in this Section.

B. Specific Timeframes

1. For standard disposition of a grievance and notice to the affected parties, the timeframe is established as 90 days from the day the MCO receives the grievance.

2. For standard resolution of an appeal and notice to the affected parties, the timeframe is established as 30 calendar days from the day the MCO receives the appeal.

3. For expedited resolution of an appeal and notice to affected parties, the timeframe is established as 72 hours or as expeditiously as the member's health requires after the MCO receives the appeal.

C. Extension of Timeframes

1. The MCO may extend the timeframes by up to 14 calendar days under the following circumstances:

a. the member requests the extension; or

b. the MCO shows to the satisfaction of the department, upon its request, that there is need for additional information and that the delay is in the member's interest.

D. If the MCO extends the timeframes for any extension not requested by the member, it must give the member written notice of the reason for the delay.

E. Format of Notice

1. The MCO shall follow the method specified in the department issued guide to notify a member of the disposition of a grievance.

2. For all appeals, the MCO must provide written notice of disposition.

3. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

F. Content of Notice of Appeal Resolution. The written notice of the resolution must include, at a minimum, the following information:

1. the results of the resolution process and the date it was completed;

2. for appeals not resolved wholly in favor of the members:

a. the right to request a state fair hearing and the procedure to make the request;

b. the right to request to receive previously authorized services during the hearing process and the procedure to make such a request; and

c. that the member may be held liable for the cost of those services if the hearing decision upholds the MCO's action.

G. Requirements for State Fair Hearings

1. The department shall comply with the federal regulations governing fair hearings. The MCO shall comply with all of the requirements as outlined in the contract and department issued guides.

2. If the member has exhausted the MCO level appeal procedures, the member may request a state fair hearing within 30 days from the date of the MCO's notice of appeal resolution.

3. The parties to the state fair hearing include the MCO as well as the member and his/her representative or the representative of a deceased member's estate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:941 (May 2015).

§3713. Expedited Resolution of Appeals

A. The MCO must establish and maintain an expedited review process for appeals when the MCO determines (either from a member's request or indication from the provider making the request on the member's behalf or in support of 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.

B. If the MCO denies a request for expedited resolution of an appeal, it must:

1. transfer the appeal to the timeframe for standard resolution in accordance with the provisions of this Subchapter; and

2. make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

C. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an action or require a notice of action. The member may file a grievance in response to this decision.

D. Failure to Make a Timely Decision. Appeals shall be resolved no later than the established timeframes and all parties shall be informed of the MCO's decision. If a determination is not made by the established timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

E. The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution.

1. The member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required.

2. The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:941 (May 2015).

§3715. Continuation of Services during the Pending MCO Appeal or State Fair Hearing [Formerly LAC 50:I.3711]

A. *Timely Filing*—filing on or before the later of the following, but no greater than 30 days:

1. within 10 calendar days of the MCO's mailing of the notice of action; or

2. the intended effective date of the MCO's proposed action.

B. Continuation of Benefits. The MCO must continue the member's benefits if the:

1. member or the provider, with the member's written consent, files the appeal timely;

2. appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. services were ordered by an authorized provider;

4. original period covered by the original authorization has not expired; and

5. member requests continuation of benefits.

C. Duration of Continued or Reinstated Benefits

1. If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

a. the member withdraws the appeal;

b. 10 calendar days pass after the MCO mails the notice providing the resolution of the appeal against the member, unless the member has requested a state fair hearing with continuation of benefits, within the 10-day timeframe, until a state fair hearing decision is reached;

c. a state fair hearing entity issues a hearing decision adverse to the member; or

d. the time period or service limits of a previously authorized service has been met.

D. Member Liability for Services. If the final resolution of the appeal is adverse to the member, the MCO may recover from the member the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with federal regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1591 (June 2011), amended LR 41:942 (May 2015).

§3717. Effectuation of Reversed Appeal Resolutions [Formerly LAC 50:I.3713]

A. Provision of Services during the Appeal Process

1. If the MCO or the state fair hearing entity reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

B. If the MCO or the state fair hearing entity reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services in accordance with the contract.

C. At the discretion of the secretary, the department may overrule a decision made by the Division of Administration, Division of Administrative Law (the state fair hearing entity).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1592 (June 2011), amended LR 41:942 (May 2015).

Subchapter B. Provider Grievance and Appeal Process

§3721. General Provisions

A. If the provider is filing a grievance or appeal on behalf of the member, the provider shall adhere to the provisions outlined in Subchapter A of this Chapter.

B. The MCO must have a grievance and appeals process for claims, medical necessity, and contract disputes for providers in accordance with the contract and department issued guides.

1. The MCO shall establish and maintain a procedure for the receipt and prompt internal resolution of all provider initiated grievances and appeals as specified in the contract and all department issued guides.

2. The MCO's grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation.

3. Notwithstanding any MCO or department grievance and appeal process, nothing contained in any document, including, but not limited to Rule or contract, shall preclude an MCO provider's right to pursue relief through a court of appropriate jurisdiction.

4. The MCO shall report on a monthly basis all grievance and appeals filed and resolutions in accordance with the terms of the contract and department issued guide.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1592 (June 2011), amended LR 41:942 (May 2015).