Wells Settlement

Companion Guide for Contractors and Louisiana Department of Health Staff

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Previous versions obsolete

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INTRODUCTION

The Wells Companion Guide is a dynamic document created for use by Louisiana Department of Health (LDH) staff involved in compliance reviews and the contractors and the LDH program offices that must comply with the Wells Settlement.

GENERAL INFORMATION

The Wells Settlement was signed by the judge on October 23, 2014. That signature officially started the clock for compliance with deadlines outlined in the settlement.

Services and Contractors Monitored

All LDH contractors and LDH program offices that produce denial and partial denial notices for prior authorized services must comply with the Wells settlement. The Wells settlement only covers specific services including the following:

PA Service Type Name	Abbreviation	Code
Rehabilitation Services	Rehab	05
Home Health Care	HomeHealth	06
Durable Medical Equipment	DME	09
Pharmacy	Pharm	12
Personal Care Services	PCS	16
Medical – procedures and diagnostics tests	Medical	17
Transportation	Trans	18
Dental	Dental	19
Imaging	Imaging	40
Long Term Personal Care Services	LTPCS	50
Long Term Care	LTC	70
Pediatric Day Health Care	PDHC	71
Hospice	Hospice	88
Specialized Behavioral Health	Behavioral	90
Other	Other	99

The following contractors/LDH program offices must comply with Wells:

- Aetna Better Health of Louisiana
- Amerigroup Real Solutions
- Amerihealth Caritas Louisiana
- Community Health Solutions – *Discontinued as contractor on Jan. 31, 2015*
- Louisiana Healthcare Connections
- Magellan – *Coordinated System of Care (CSoC) denials only beginning December 1, 2015 when specialized behavioral health was integrated into the Medicaid managed care organizations.*
- MCNA (dental)
- Molina
- Conduent (formerly Xerox)
- UnitedHealthcare Community Plan
- University of Louisiana at Monroe
- LDH: Office of Aging and Adult Services, Office of Behavioral Health and Office for Citizens with Developmental Disabilities

Wells Timelines and Processes

Implementation

- All denial/partial denial notices issued to Medicaid recipients must be Wells compliant by **December 22, 2014** except for LTPCS and fee for service pharmacy.
- All denials/partial denial notices issued to Medicaid recipient for LTPCS and fee for service pharmacy must be Wells compliant by **February 20, 2015**.
- No later than **January 21, 2015** for all denials/partial denials, except LTPCS and fee for service pharmacy, LDH will begin to accept the weekly prior authorization and denial transaction file that will include a record of all prior authorization requests and denials covered by Wells from all contractors.
- No later than **March 22, 2015**, for all denials/partial denials for LTPCS and fee for service pharmacy, LDH will begin to accept the weekly prior authorization and denial transaction file that will include a record of all prior authorization requests and denials covered by Wells from applicable contractors.

Reporting and Sampling

The Wells Settlement requires monitoring of a random sample of 3 percent of all denials from each contractor/LDH program office by major service type, or a minimum of one sample case. The sample is pulled based on an algorithm developed by LDH.

Timeline

- Upon notification of the sample cases designated, the contractors will have three business days to provide copies of the actual notice and the documentation used to make the decision.
- LDH will prepare a summary of findings and any notices of corrective action within 14 business days after receipt of the sample cases, which will be contemporaneously copied to Plaintiff's counsel.

- LDH initially conducted the sample verification weekly for one calendar month and then moved to monthly after that point. The monthly review continues until LDH has determined that the contractor has demonstrated compliance for two consecutive months.
- Once a contractor has demonstrated compliance for two consecutive months, the sample verification will be performed quarterly.

Process

- LDH generates the prior authorization sampling file list, using the approved algorithm.
- The list is posted to each contractor's inbox on the FTP (the MCO inbox).
- LDH compliance staff notifies all applicable contractors (based on the calendar) via e-mail that the sampling file is in their respective inboxes and that they have three business days to upload the requested prior authorization notices and the supporting documentation, using the following protocol:
    - All notices should be combined into a single PDF file for each service type. An exception is to be made for exceptionally large files. In this case, files should be broken down into files no greater than 5 MB.
    - All supporting documentation should be combined into a single PDF for each service type, separate from the notices.
    - Each PDF should be identified by contractor's name, submission week, whether it is the notice submission or the support submission and service type (example: ABC_DME_Support_Week1 or ABC_DME_Notices_Week1).
    - Both notification letters and supporting documentation should be posted to the FTP.
- Compliance staff uses the sampling file to create a tracking report to be used in monitoring.
- On day four, LDH compliance staff will access each contractor's folder on the FTP in the "LDH inbox" and move the notices to a monitoring Sharepoint.
- Compliance staff will update the tracking report to indicate if a notice was supplied or not and may request additional notices to replace those missing.
- Review begins.

Sample Review

From receipt of notices to delivery to the Advocacy Center, LDH has 14 business days for review and assessment of compliance. LDH review is a multi-layered process that includes compliance staff and LDH legal staff.

- **Days 1 – 7** – The Compliance Unit conducts a two-tier review of all notices. Staff dedicated to a specific contractor reviews their contractor's notices, then compliance management provides a second-level review. Compliance completes review of both levels of review within **five to seven (5-7) business days**, making comments on actual notices to provide guidance to contractors and updating the tracking report to denote compliance or noncompliance.
- **Days 8 – 12** – LDH Legal conducts a complete review of all notices. Legal has **five (5) business days** to complete review and check for any additional edits or modifications beyond what the Compliance Unit provided. If Legal disagrees with the Compliance Unit assessment, Compliance management and the initial Compliance Unit reviewer will re-evaluate the item and determine if changes are necessary.

- **Day 14** – The Compliance Unit posts the reviewed notices and the completed tracking report back to the contractor's FTP in box. All reviewed notices for all contractors and all completed tracking reports are posted to the Advocacy Center folder on the FTP. Contractors are notified of the posting by the Compliance Unit and the Advocacy Center is notified by LDH Legal.

How to Review Notices

The following guidance is provided for LDH staff for the review of Wells compliance. This information can be applied in the drafting of notices for all contractors/LDH program offices. Guidance is based on the Wells settlement, LDH legal guidance and feedback from the Advocacy Center.

Style and Language Guidance

- Use 12 point or greater type.
- Do not use all capital letters.
- Avoid repetition of information, unless it is necessary to clarify a point.
- Write in plain language.
- Where clinical terminology is required, provide some explanation. For additional guidance, see the list of acceptable terms and acronyms that do not require explanation. If a term is not included on the list or there is any doubt, explain or define.
- Keep verb tense consistent.
- Utilize grade-level assessment tools to ensure the language is not too complicated for the audience.

General Content Guidance

- Include a header that indicates if the services are denied or partially denied (should also do the same for approved services, but Wells does not require monitoring of approval notices).
- Use the term "denied" or "denial" or "partial denial" or "partially denied" in the introductory paragraph.
- Include dates of service.
- For partial denials, the notice should clearly specify the services and amounts that are denied and the services and amounts approved, in plain language.
- Include internal appeal language in the denial/partial denial, if applicable (all Healthy Louisiana Managed Care Organizations).
- If a subcontractor is referenced in the notice, be certain to explain their role to the member in the introductory paragraph or the first page.
- Use the state fair hearing and emergency language provided by LDH in the template, if applicable (all Healthy Louisiana Managed Care Organizations).

LDH Staff Checklist

The Compliance Unit utilizes a checklist of notice elements to assist with the determination of compliance. This checklist is not the full sum of Wells Settlement review, but breaks down the simpler elements to ensure an expeditious review, allowing staff to focus more time on the complex elements that cannot be reduced to a check list of items that are or are not included (such as the "reasons for denial" section).

This list includes both those items mandated by the settlement (included in the signed settlement) and additional guidance for template use, provided to the contractors through directives from LDH, including Wells Bulletins and template revisions.

Description/Notes
DENIAL NOTICE HEADER • Located on first page of notice • "Denial" or "Partial Denial" must appear in a conspicuous location on page 1. • If "partial denial", the services approved and denied must be clearly identified.
ENROLLEE CONTACT INFORMATION • Located on first page of notice • Not in all caps • Includes name, address, city, state and zip
DATE • Located on first page of notice • Date of notice
SALUTATION • Located on first page of notice • Dear member or parent or guardian of member • Related – including a closing signature at the end of the letter.
INTRODUCTORY PARAGRAPH • Located on first page of notice • Introductory paragraph must use the term "denied", "denial", "partial denial" or "partially denied". • Must be specific as to the service being denied and date(s) of service.
APPEAL LANGUAGE • Located on first page of notice • For MCOs only, must include internal appeal rights (just a reference to the option, details provided later in the letter). • State Fair Hearing language should be included in an appeal denial letter
APPROVED CARE • Located on first page of notice

- Only applicable if partial denial
- If service is provided in increments (hours per week/day, milligrams for pharmacy, etc.) that needs to be included.

CONTACT INFORMATION

- Located on first page of notice
- Contractor must include its toll free number and TTY user toll free number in all notices.
- Formatting should be consistent for all contact numbers throughout the letter.

REASON FOR DENIAL

- Section should include a comprehensive explanation in plain language for why the request does not meet the guidelines for care.
- It should include ALL criteria and reasons for the denial. Do not limit to just one reason if there are multiple, but do not cloud the notice with criteria that were not a reason for the denial. However, when the denial is based on lack of information, do not include an exhaustive list of criteria and information needed and do not list what the contractor already has in its possession. Just list the missing items needed to process an approval.
- Notices should explain how many of the factors listed, or what combination of those listed factors, must be present in order to establish medical necessity.
- If denied due to lack of information, the explanation must note the specific information needed to be considered for approval. Do not list information that you already have.
- Provide adequate information to assist in preparing an appeal.
- If regulations are cited, the regulation must be explained and the notice must include language that relates how the facts of the recipient's situation compare/apply to the regulation cited.

CONTINUATION OF BENEFITS LANGUAGE

- MCOs must comply with contractual guidance on continuation of services pending resolution as per Section 13.5.2.7 of their contract. This language is not prescribed in the template, but must be included as applicable. Insert where appropriate.

CONTACT FOR DOCTOR – MEDICAL NECESSITY DENIALS ONLY

- Include contact for doctor or reviewer/decisions maker to follow up with questions.

APPEAL AND STATE FAIR HEARING LANGUAGE

- Organizations with internal appeals processes (Managed Care Organizations) must include details for appeal. Entities without internal appeals must direct to State Fair Hearing process.
- Include requirement to take action within 30 calendar days from the date of the notice.

FAST DECISION

- Replaces original “emergency” language.
- Contractor must use language provided by LDH.

Reason for Denial – Explanation

The area of the notice that causes the most non-compliance is the free-form language supplied by the contractor/LDH program office in the paragraph or paragraphs used to explain exactly why the service was denied/partially denied. These are primarily divided into two categories – administrative denials and medical necessity denials.

Administrative Denials

There is a finite list of reasons a benefit or service can be denied on an administrative basis. The list below includes all of those reasons identified so far through Wells review. LDH, in coordination with all contractors/LDH program offices, is working to standardize the notice language for the following.

- *Provider out of network*
- *Provider cancels request before request is processed*
- *Duplicate requests*
- *Member not enrolled with Health Plan*
- *Member not enrolled in Medicaid*
- *Member not enrolled at time of service*
- *Member has Medicare coverage and Medicare should be billed first*
- *Member does not meet age range requirements*
- *Request for non-covered benefit*
- *Authorization request or notification not submitted within required timeframe (late filing)*
- *Benefit limitation denial guidance.*

Guidance for Administrative Denials

Provider Out of Network

- The notice must identify the specific service requested and denied.
- The notice must identify the out-of-network provider.
- The notice should specify that the request will be reviewed if made through an in-network provider.
- The notice must specify the circumstances under which an out-of-network provider can be used and discuss any documentation submitted related to these - such as 42 CFR 438.206(b)(4).

Provider Cancels Request before Request is Processed

- Language TBD

Duplicate Requests

- Language TBD

Member Not Enrolled with a Health Plan

- Notice should be clear that denial only means the health plan cannot approve or pay for the service, since the finding is that the recipient is not a member of the plan.
- Notice must make it clear that, if a recipient is enrolled in Medicaid, the service may be covered by Medicaid through their current health plan.

Member Not Enrolled in Medicaid

- Language TBD

Member Not Enrolled at Time of Service

- Language TBD

Member has Medicare Coverage and Medicare Should be Billed First

- Language TBD

Member Does Not Meet Age Range Requirements

- Notice must provide the age range for which the item or service will be approved.

Request for Non-Covered Benefit

- Language TBD

Authorization Request or Notification not Submitted within Required Timeframe (late filing)

- Language TBD

Benefit Limitation Denial Guidance

- Benefit limitation denials must include the last known date of service when the service/item was last used.

Medical Necessity Denials

The medical necessity denials/partial denials are more complex and are not easily defined. Contractors/LDH program offices must follow basic guidance provided by Wells and LDH to draft

language that will be considered compliant. General guidance for all notices as well as specific guidance based on service type is provided below.

General Guidance

- Guidelines for denial/partial denial must be explained in plain language and applied to the specific case.
- Follow the requirements of the template provided by LDH. This should include, at a minimum:
    - What criteria the contractor used to make the determination (requests made, medical records reviewed, etc.).
    - References to rules, regulations and guidance (federal and state) used to make the decision. Include numbers for reference of rules and a clear explanation of how the guidance relates to this particular case.
    - What guidelines the member does not meet, including a plain language explanation of medical necessity, as applicable.
    - A summary of the activity that helped to make the decision about their care. This should only be included if it provides specific information. If it refers to records, the records should be clearly identified. If it refers to a physician or provider who was contacted, the identity of the provider and the date of the contact should be given.
- Do not reference the contract with LDH or the "Healthy Louisiana Program" as a reason for denial. In such cases, health plan policy or a provider handbook could be reference.
- There is no need to use Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) codes in the letter.
- Include somewhere in the explanation that, because of the reasons included in the letter, the contractor/LDH program office does not find the service medically necessary.
- When citing criteria, ensure the reason for denial/partial denial explains the number of factors or the combination of factors listed in the notice that led to the denial and are needed to establish medical necessity. Simply citing the name of the policy/guideline/regulation is not sufficient.
- When enumerating reasons for denial/partial denial, do not include any information in the explanation that is not a reason for denial.
    - *Example*: "Why Won't XYZ Health Plan pay for X service? We cannot approve your request. The test is medically necessary when there are suspected complications with this disease." Instead, remove the sentence "We cannot approve your request." It is redundant and not applicable to the explanation of why the service is not approved.

Additional Information Needed

When a service is denied due to lack of information, the contractor/LDH program office must clarify what guidelines are used and what is still needed.

- Ensure it is clear what was NOT provided and that is still needed to make a determination. Only list what is still missing/needs to be submitted. Include in the notice the specific information to be supplied by the provider.
- Be sure to indicate whether one or more – or all – of the items listed are required for review for approval.
    - *Example*: "Based on the XYZ Health Plan medical necessity criteria, you must show the following: Difficulty breathing. Decreased appetite. Weight loss." Instead, "Based on the

XYZ Health Plan medical necessity criteria, you must show at least one of the following: Difficulty breathing. Decreased appetite. Weight loss."

- Always tie a request for additional information back to the guidelines. Do not state "we" need something.
    - *Example*: Do not say "We need chart notes with details of leg numbness." Instead, say "The guidelines require chart notes that detail leg numbness."

Durable Medical Equipment Denial Guidance

- Name the specific DME being denied/partially denied (i.e., prosthetic knee). It is not sufficient to simply state that the member's request for DME is denied. The same applies to outpatient rehabilitation services (i.e., occupational therapy).

Pharmacy Denial Guidance

- Point of sale pharmacy is excluded from the Wells Stipulation and is not subject to this guidance.
- When referencing dosages and the denial/partial denial is based on going over the max dosage, make sure to indicate how often in that day the dosage must be used:
    - *Example*: If the notice states "Tramadol at 50 mg is denied." based on the fact that the FDA does not approve Tramadol over 400 mg per day, there must be an explanation of how much per day the provider is requesting
- Do not switch up drug/medication names throughout the denial without explanation. Be consistent.
- When a drug not on the formulary is requested and denied/partially denied, if the contractor provides alternates that are formulary drugs, they must be clear on how many the member must try before requesting a non-formulary.
    - *Example*: "To meet the criteria, you must first try our formulary drugs used to treat your condition, such as drug a, drug b, drug c, drug d, drug e and drug f." It is unclear if the member needs to try one or more – or all – of these drugs.
- Pharmacy requests DO NOT include dates of service.
- When a denial/partial denial is made for an age restriction, include the required age in the notice. Including the age of the member in the denial notice is NOT necessary.
- When a denial/partial denial is for a medical condition, include the member's actual condition.
- Off-label use drug denials/partial denials must state the specific information needed to support the request. Requesting that the provider submit "clinical supporting evidence" will not suffice.

Remediation Plans

Contractors and LDH program offices with notices found out of compliance in any monitoring period must provide a Remediation Plan to LDH.

- Remediation Plans must accompany a signed attestation from the contractor's executive officer.
- Remediation plans must address all non-compliant issues identified and be specific as to how the problems will be addressed.
- At a minimum, Remediation Plans must address how the entity intends to accomplish these tasks:

- Specification of members whose sampled notices were denoted as non-compliant by LDH, and plans for reissuance of a corrected notice. Services for these individuals must be continued (This does not apply to requests for new services). ***Note***: Corrected letters must include the reissuance date and an explanation that the letter is being reissued to make sure the member understands the reasons their request for service was denied. It must also include a term in front of the denial header that distinguishes the notice as a reissued version. The term "Reissue" is acceptable.
- Efforts to determine if there were any similarly denied member notices and plans to correct those as well. If no similarly denied member notices were found, provide an explanation of why, which LDH will review and forward to Plaintiff's counsel.
- Submission with the remediation plan of two corrected notices for each service type for those notices found deficient in the sample. Submit both the original and the corrected notices.

Web Site

LDH has established a Wells Compliance web site to serve as a repository for Wells guidance and a resource for contactors in their compliance efforts. The web site includes the actual settlement, the latest template and compliance guide and any bulletins released by LDH with Wells guidance. The web site is located here: http://new.dhh.louisiana.gov/index.cfm/page/2460.

Common Terms and Acronyms

Does Not Need Explanation and/or Definition

Certain common terms and acronyms can stand alone in a notice without definition or explanation. Those are listed below:

- ADD – Attention Deficit Disorder
- ADHD
- CAT Scan
- CT Scan as in Chest CT Scan, Abdomen CT Scan, etc.
- EKG
- Generic
- MRI
- PET Scan

Needs Explanation and/or Definition

The following acronyms must be spelled out on first reference. Terms listed below need some explanation included in their first reference.

- COPD - Chronic Obstructive Pulmonary Disease
- CPAP – Continuous Positive Airway Pressure
- CPST – Community Psychiatric Supportive Treatment (face-to-face psychiatric visits)
- DME – Durable Medical Equipment
- FDA – Food and Drug Administration
- Formulary – a formulary is a list of covered drugs

- PDL- preferred drug list (this term should also be explained as a list of drugs that are ordinarily approved)
- Placebo
- PSR – Psychosocial Rehabilitation Services (services to help a person cope with society and within their community)
- OTC - over the counter