STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS (OGB)

NOTICE OF INTENT TO CONTRACT (NIC)

FOR

MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE (MHSA) PROGRAM

Issued
November 6, 2009

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SECTION I

GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT

A. Introduction

The State of Louisiana, Office of Group Benefits (hereinafter called "OGB" or the "Program") gives notices of its intent to contract with a qualified firm/organization (hereinafter called "Proposer") to develop, implement, and administer an effective Managed Mental Health and Substance Abuse (MHSA) Program and solicits proposals from any qualified firm/organization to provide such services on the terms and conditions specified below.

B. Background

The State of Louisiana through OGB is authorized by statute to provide health and accident benefits and life insurance to state employees, retirees and their dependents. Plan member eligibility includes employees of state agencies, institutions of higher education, local school boards that elect to participate and certain political subdivisions. Eligibility does not include local government entities, parishes, or municipalities.

OGB provides self-insured health and accident benefit plans for approximately 148,000 covered contracts. The self-insured benefit plans available to plan participants, effective July 1, 2009 are: Preferred Provider Option (PPO); Exclusive Provider Option (EPO); and Health Maintenance Organization (HMO). The services pursuant to this NIC will include all of these benefit plans. In addition, OGB provides services for all participants in the LaCHIP Affordable plan, an expansion of the children's health insurance program available to uninsured Louisiana children up to the age of 19 whose families have an annual income up to 250 percent of the Federal Poverty Level (FPL), for which OGB provides administrative services pursuant to an interagency agreement with the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing.

Since 1993, MHSA benefits have been carved out of the OGB's self-funded benefit plans and OGB has contracted with a managed behavioral care firm to provide a gatekeeper/managed care network and all related administrative services for MHSA on a capitated (PEPM) basis.

Basic and supplemental life insurance is provided through Prudential Insurance Company. The OGB also administers an IRS qualified cafeteria plan offering optional benefits such as dental, eye care, cancer and catastrophic illness coverage, long term disability, and child care flexible spending accounts.

C. GB Information Technology

Desktop: Dell 450 Workstations running Windows XP
LAN: 10/100/1000 Ethernet using Cisco switches
Servers: Windows servers, AIX UNIX servers, and LINUX servers
WAN: Frame Relay using Cisco routers, switches, and firewalls. In addition, Fujitsu

scanners, and various laser printers are used

OGB computer applications include: Impact (claims adjudication, customer services, provider contracting and eligibility processes), Discoverer (Oracle report writer), MS Office, MS Exchange, FileNet (Oracle based imaging and document management system). OGB uses Oracle databases as its standard.

OGB uses ONESIGN – Biologin and e-Trust, a single-sign-on and centralized security system.

D. Scope of Services

Contractor will provide a Managed Mental Health and Substance Abuse Program for OGB plan members that participate in its PPO, EPO, HMO and LaCHIP Affordable Plan plan of benefits.

Contractor will be responsible for providing and managing MHSA benefits through a network of providers and services to provide effective treatment and outcomes. In order for a plan member to receive full benefits, he or she must utilize the network for initial assessment and counseling as well as for ongoing MHSA treatment, both inpatient and outpatient. Contractor will provide all professional, technical, and administrative services in connection with the MHSA benefits, including, but not limited to, medical management, medical necessity reviews required under applicable laws and regulations, care management, claims adjudication and payment, customer services, and provider relations.

Option 1: Fully Insured (at risk)

Option 2: Self Insured (administrative services)

E. Standard Contract Provisions

It is expected that a 3-year contract will be awarded with the contract terms provided in Exhibit 1. Any deviation sought by a Proposer from these contract terms should be included in the Proposal. The provisions of the NIC and the winning proposal will be incorporated by reference into the contract. Any additional clauses or provisions, required by the Federal or State law or regulation in effect at the time of execution of the contract, will be included.

F. Miscellaneous

1. Member I.D. Cards: The MHSA firm will not be required to produce member I.D. cards. OGB utilizes a single member I.D. card for medical, prescription drug, utilization management services and MHSA benefits combined. The MHSA firm will be required to provide the party responsible for card printing with the appropriate information to be included on the member I.D. card according to an OGB mandated deadline.

2. Insurance Requirement: The MHSA firm shall procure and maintain for the duration of any contract, as a result of this NIC, liability insurance with a combined single limit liability

of not less than Ten Million ($10,000,000.00) Dollars.

3. The MHSA firm shall on request furnish OGB with certificate(s) of insurance affecting the required coverage. The certificate for each insurance policy is to be signed by a person authorized by that insurer to bind coverage on its behalf. OGB reserves the right to require complete, certified copies of all required insurance policies, at any time.

4. Performance Bond: The MHSA firm shall furnish a performance bond in the amount of three (3) months payments to assure performance under the Contract. The amount of the performance bond shall be determined using the number of enrolled employees and retirees on July 1, 2010, multiplied by the monthly payment, multiplied by three.

G. Fee Quotation

Option 1 - Fully Insured

MHSA Benefits

All-inclusive per employee/retiree/LACHIP monthly (PEPM) cost to provide MHSA benefits as described in the NIC on a capitated (at risk) basis. The cost must include the cost of the benefits, the payment of claims, all required utilization and management reports (including any special ad hoc reports requested by OGB), member services and communications, postage, etc. In short, the monthly cost must include all services required under the contract.

Option 2 – Self Insured

MHSA Benefits

All-inclusive per employee/retiree/LACHIP monthly (PEPM) premium to administer MHSA benefits as described in the NIC. The cost must include payment of claims, all required medical management, utilization and management reports (including any special ad hoc reports requested by OGB), member services and communications, postage, etc. In short, the monthly premium must include all services required under the contract. OGB will be "at risk" for all claims payments and will promptly reimburse MHSA firm for all claim payments.

The basis of your fees should be as follows:

1. Fees must be quoted on a single composite basis for all benefit plan types per contract for actives and retirees without Medicare, retirees with Medicare and LaCHIP. The term "covered contract" as used throughout this NIC is defined as any class of coverage in which a plan member is enrolled, whether employee only, employee and spouse, employee and children or family; therefore, a contract includes the employee or retiree and all dependents or LaCHIP enrollee.

2. Fees must include cost to develop, print and disseminate to all employees, retirees and providers communication materials necessary to effectively implement and manage the MHSA program for the OGB. This communication material shall be subject to OGB's advance approval.

3. Fees must include all services described in this NIC, including all necessary reports and any start-up fees. Furthermore, fees must take into account your expenses associated with attendance at meetings in Baton Rouge with OGB staff and actuarial consultant and with the OGB Policy and Planning Board or its committees, as requested. No pass-through of costs will be permitted.

4. The monthly cost may be quoted as a level per month fee for the entire three-year contract and may contain a flat, pre-determined dollar escalator for years two and three. In no event, will add-ons or changes be permitted during the term of the contract, except in the event of benefit modifications which would materially affect the contractor's responsibilities.

5. Fees must be guaranteed for the three (3) year period of the contract.

6. Commissions or finders fees will <u>not</u> be payable under the contract.

H. Instructions on Proposal Format

Proposers should respond thoroughly, clearly and concisely to all of the points and questions set forth in the Notice of Intent to Contract (NIC). Answers should specifically address current capabilities separately from anticipated capabilities.

1. Submit an original (clearly marked "original") and (8) copies of a completed, numbered proposal placing each in a three-ring binder along with (2) electronic copies.

2. Use tabs to divide each section and each attachment. The tabs should extend beyond the right margin of the paper so that they can be read from the side and are not buried within the document.

3. Order of presentation:
   - ❑ Cover letter (Optional)
   - ❑ Tab 1 (See Section V) - Proposers Requirements
   - ❑ Tab 2 (See Section VI) – Questionnaire
   - ❑ Tab 3 (See Section VII) - Attachments to Proposal Response
   - ❑ Tab 4 (See Section VIII) - MHSA Firm Information and Mandatory Signature

4. Submit a original and eight (8) numbered copies of the Fee Proposal Form, in a separate, <u>sealed</u> envelope clearly marked, "MHSA NIC Fee Proposals" on the outside of such envelope.

   Proposers must complete the Fee Quotation Forms and Total Cost Worksheets provided in Section IX of the NIC.

5. Answer questions <u>directly</u>. Where you can not provide an answer, indicate not applicable or no response.

6. Do not answer a question by referring to the answer of a previous question; restate the answer or recopy the answer under the new question. If however, the question asks you

to provide a copy of something; you may indicate where this copy can be found by an attachment/exhibit number, letter or heading. You are to state the question, then answer the question. Do not number answers without providing the question.

I. Ownership, Public Release and Costs of Proposals.

1. All bids submitted in response to this NIC become the property of the OGB and will not be returned to the bidders.

2. After award of the Contract, all bids will be considered public record and will be available for public inspection during regular working hours.

   If a proposal contains trade secrets and/or privileged or confidential commercial or financial information which the Proposer (or his SubContractor) does not want used or disclosed for any purpose other than evaluation of the proposal. The use and disclosure of such data may be restricted, provided the Proposer marks the cover sheet of the proposal with the following legend, specifying the pages of the proposal which are to be restricted in accordance with the conditions of the legend:

   "*The data contained in Pages ___ of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions."*

   Further, to protect such data, each page containing such data shall be specifically identified and marked **"CONFIDENTIAL".**

   It should be noted, however, that data bearing the aforementioned legend shall be subject to release under the provision of the Louisiana Public Records Law, L.R.S. 44.1 et. seq. The State of Louisiana/OGB assumes no liability for disclosure or use of unmarked data and may use or disclose such data for any purpose. It should be noted that any resultant contract will become a matter of public record.

   OGB reserves the right to make any proposal, including proprietary information contained therein, available to the Office of the Governor, Division of Administration, Office of Contractual Review, or other state agencies or organizations for the purpose of assisting the OGB in its evaluation of the Proposal. OGB will require such individuals to protect the confidentiality of any specifically identified proprietary information or privileged business information obtained as a result of their participation.

In addition, you are to provide a redacted version of your proposal, omitting those responses and attachments (or portions thereof) that you determine are within the scope of the exception to the Louisiana Public Records Law. In a separate document, you must provide the justification for each omission.

OGB will make the edited proposal available for inspection and/or copying upon the request of any individual pursuant to the Louisiana Public Records Law without notice to you.

SECTION II

MHSA PROGRAM REQUIREMENTS

A. Proposer Requirements

1. Your firm must have a minimum of five (5) years experience in providing MHSA services.

2. Your firm must currently provide MHSA services to at least two (2) groups each with a minimum size of 25,000 covered employees and/or retirees (not counting dependents) of which at least one of these groups is a single employer (corporate or government).

3. Your firm must be licensed as required by the Louisiana Commissioner of Insurance in order to provide the coverage requested in this NIC. You must provide evidence that your firm is so licensed or, if not currently licensed, a detailed description of the procedures, including a time line, you would follow in order to insure compliance.

4. Your firm must meet the following minimum network access standard as of the date your proposal is submitted:

   - 70% of plan members within 10 miles of one professional providers (Urban)
   - 70% of plan members within 20 miles of one professional provider (Suburban)
   - 70% of plan members within 45 miles of one professional providers (rural)
   - 70% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban)
   - 70% of plan members within 60 miles of one inpatient acute inpatient facility (rural)

5. Your firm must commit to the following minimum network access standard as of July 1, 2010 effective date:

   - 90% of plan members within 10 miles of two (2) professional providers (Urban)
   - 90% of plan members within 20 miles of two (2) professional provider (Suburban)
   - 90% of plan members within 45 miles of two (2)professional providers (rural)
   - 90% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban)
   - 90% of plan members within 60 miles of one inpatient acute inpatient facility (rural)

6. Your firm must have the capability to transmit and receive electronic claims in the HIPAA Standard formats (837P and 837I).

B. MHSA Benefit Structure

The MHSA schedule of benefits is as follows:

- Inpatient – No plan deductible; $100 per day; maximum of $300 per admission; Authorization required.
- ER – Paid by medical plan

- Outpatient - $25 co-pay; Authorization required.
- Out-of-Network
    - No plan deductible
    - Member resides In-state: Member pays 30 percent of fee schedule and subject to balance billing.
    - Member resides Out-of-state: Member pays 10 percent of fee schedule and subject to balance billing.

Lifetime Maximum Benefit will be combined with OGB self-funded medical plans.

There are no pre-existing condition (PEC) exclusions or active at work limitations imposed on current plan members unless a plan member is in the process of satisfying a new employee or late applicant PEC limitation. The MHSA firm is required to duplicate the OGB eligibility rules in all respects. For more information regarding the plan's eligibility rules, including PEC exclusions, refer to the plan document on the OGB website, www.groupbenefits.org.

The MHSA firm will not be required to cover outpatient prescription drugs under the terms of this contract. The cost of outpatient prescription drugs related to the treatment of MHSA disorders are covered under a separate prescription drug carve-out program administered by OGB's contracted pharmacy benefits manager (PBM).

C. OGB Plan Documents

Copies of the OGB's plan documents for the PPO, EPO and HMO plan can be obtained from the OGB website, www.groupbenefits.org. The plan documents list numerous exclusions and limitations relative to treatment and expenses considered ineligible under the PPO, EPO and HMO plan. Although it is the intent of the OGB to maintain these exclusions in principle, there will be situations in which the MHSA firm will be required to provide treatment. Examples might include psychiatric treatment following a suicide attempt; even though intentionally self-inflicted injuries are excluded, psychiatric treatment, psychological counseling and family counseling which may be appropriate treatment for certain diagnoses.

D. Diagnoses Covered Under MHSA Contract

The MHSA firm shall cover expenses in connection with conditions classified in the Diagnosis and Statistical Manual of Mental Disorders (most recent edition) of the American Psychiatric Association, subject to the exclusions set forth in the self-funded medical plan document. In addition, the following DSM IV-R codes are specifically excluded under the MHSA contract: 307.81 (tension headaches), 310.0 (frontal lobe syndrome) and 310.2 (post-concussion syndrome).

E. Incurred Claims and Extension of Coverage for Hospital Confined Patients

The MHSA firm shall indemnify and administer all MHSA claims which are incurred during the length of its contract. No additional fees may be charged to the OGB by the MHSA firm to administer the run-out of any claims incurred while the contract was in effect but paid after the termination of the MHSA contract.

Any inpatient hospital admissions and associated professional fees in progress on the effective date of the MHSA contract are the responsibility of the incumbent MHSA firm until date of discharge. The MHSA firm shall be liable for any inpatient hospital admissions and associated professional fees in progress on the termination date of its contract with the OGB, until the date that the patient is discharged from the hospital.

F. Initial Visit to Primary Care Physician or Other Non-MHSA Provider

The OGB self-funded medical plan reimburses the cost of one office visit to a primary care physician or other non-mental health provider related to the initial diagnosis of a MHSA disorder. Thereafter, the patient is to be referred to the MHSA plan and any subsequent visits to non-MHSA network providers are excluded under the OGB self-funded medical plan.

G. Coordination of Benefits (COB) with Other Plans

The MHSA firm will be required to coordinate benefits with other plans when OGB is secondary payor, as well as with Medicare for those retirees who are enrolled for the coverage. For Medicare retirees, benefits must be coordinated on a Medicare carve-out basis. Whatever benefits remain after Medicare has paid its benefits are subject to the plan's deductible and coinsurance provisions or on a full COB basis, depending if the retiree has chosen full COB under the optional Retiree 100 rider. Full coordination of benefits applies to active employees and to retirees without Medicare and their dependents.

H. Administrative Requirements

1. File Transfer

Proposer must possess the capability to submit and transmit data via a secured file transfer process (FTP).

2. Maximum Accumulators

The MHSA benefits are subject to and applied towards the aggregate lifetime maximum benefit available under the OGB self-funded medical plan.

The OGB will transfer current participant lifetime maximum accumulation data to the MHSA firm upon inception of the contract. Thereafter, the MHSA firm shall be responsible for updating its lifetime maximum accumulators to ensure that benefits for MHSA are not authorized or paid above the plan members maximum. In addition, the MHSA firm shall furnish benefit accumulation data to the OGB for each plan member monthly.

3. Plan Member Communication Materials

The MHSA firm shall submit copies of all plan member communication materials and promotional materials to the OGB. All such materials shall be approved in writing by OGB prior to their use in communicating the features of the MHSA plan to eligible enrollees. Liquidated damages of $5000 per occurrence may be assessed for failure to obtain OGB

approval.

The cost of preparation and distribution of any plan member communication materials, including provider directories, must be included in the MHSA firm's quoted fees.

4. Grievance Procedures

If Option 1 is selected, the MHSA firm will be at full risk for providing MHSA coverage to plan members and the contractor's determination is final. If Option 2 is selected, the Contractor shall maintain appeal, grievance and review procedures in compliance with Louisiana law and provide same to OGB upon request. A plan member whose appeal, grievance or request for review is not satisfactorily resolved by Contractor's final determination may request further review through OGB's administrative review process.

5. Telephone Service Requirement

The MHSA firm must maintain a sufficient number of toll-free lines which may be accessed by plan members on a 24-hour basis for emergency crisis intervention. A sufficient number of toll-free lines must also be maintained to provide access during regular business hours (8:00 AM – 5:00 PM, Central Time) for routine assessment and referral for general questions.

Members/providers calls should be answered within 30 seconds by a person. The maximum period of time a call may be placed on hold may not exceed three (3) minutes. The average abandonment rate must be no greater than 3%. If the telephone access standards are not met, the MHSA will be required to add additional phone lines and personnel as necessary to meet the required standards. An electronic phone system capable of tracking call volume and abandonment rates is required.

Staff responding to incoming calls must have on-line computer terminals available for instant access to member eligibility.

6. Account Executive Requirement

The MHSA firm shall provide a designated, experienced Account Executive and at least one back-up staff member to handle the overall responsibility of the OGB program. The individual who serves as Account Executive must be experienced in working with large accounts (20,000 employees plus). Additionally, this representative must be responsible for assistance with program implementation and ongoing account support.

7. Meeting Requirement

The Account Executive for the MHSA firm shall be available for monthly management meetings with OGB staff and/or meetings of the OGB Policy and Planning Board or its committees, as requested. At these meetings, the MHSA firm should be prepared to discuss any aspect of its program. Discussions may include an in-depth review of management reports and any suggestions for program changes. The cost of all travel expense associated with attendance at these meetings are to be included in the fee

quotation in Section IX of this NIC.

8. Data Elements

The MHSA contractor should maintain a minimum of data elements for each claim transaction as specified in Exhibit 4.

I. Reporting Requirements

1. Monthly Reports (Must be received within 30 days following the end of the month), Monthly reports must contain an Executive Summary.

a. Enrollment -- Number enrolled sorted by active, retiree, (Medicare and non-Medicare), dependent, LACHIP by age and sex. Average age of plan members to be included, sorted by active, retiree, dependents and LACHIP.

b. Authorization – Admission and units of service authorized by level of care and network status (participating vs. out of network) and reported separately for MH, SA and Total combined MH and SA; displayed by number and per 1000 members annualized.

c. Financial -- Provider charges and paid claims amounts for current month and cumulative year-to-date broken into categories by actives, retirees (Medicare and non-Medicare), dependents, LACHIP and level of care.

d. Claims Processing -- Number of claims received, paid, pended and denied by type of service; dollar amount of claims paid and denied; number and percent processed within 14 days and within 30 days.

e. Appeals and Denials by level of care and level of appeal Report should include break-out by clinical (medical necessity) and administrative denials reason type, providing data on number of denials, number/percent that are appealed at each level; resolution of appeal and % resolved within timeframe standards.

f. Member and Provider Complaints

g. Telephone Service – To include number of calls received (by type and combined), average speed of answer, percent answered within 30%, average hold time, number of calls placed on hold that exceeded three (3) minutes, average abandonment rate and number of calls actually abandoned.

2. Quarterly Reports (Must be received within 45 days following the end of the each quarter). Quarterly reports must contain an Executive Summary.

a. Roll-up of monthly reports and year to date

b. Cost and Utilization of Care:
   - total charges and total paid (incurred during qtr and YTD and paid though run date of report) claims by level of care and broken out for MH and SA;
   - penetration rate, PMPM expense, PEPM expense, utilizers per 1000;members per 1000 by level of care;
   - paid (incurred during qtr and YTD and paid though run date of report) admits per 1000 and days/visits per 1000 by level of care;
   - average cost (amount claims paid) per day/visit, per admission by level of care and total;
   - Charges and paid by level of care and member category (active, dependents, retirees (with Medicare, retirees without Medicare), LACHIP;
   - Top 15 diagnosis report with claims paid, unique member count, utilizer per 1000 for quarter and YTD; Report should detail top 15 for Inpatient (total days and average length of stay, average amount paid per day and per admission); top 15 for outpatient (ambulatory) and combined.
   -

c. Care Management:
   - High cost report – number of members accumulating > $10,000 in paid claims during period and > $25,000 YTD with number of patients, average paid per patient, total paid amount, percent of total paid claims, distribution by diagnosis and member category (active, dependents, retirees with Medicare, retirees without Medicare).
   - Number screened for Intensive management programs (case management, disease management, etc); number admitted to intensive management programs
   - In-patient Follow-Up Program Metrics – number of discharges, number members with attempted calls, number members with calls completed; number and percent of discharged with ambulatory follow-up appointment within 7 days of discharge and 30 days of discharge.
   - Readmissions within 30 day, 90 days and 365 days; should include comparison across quarters/years
   - number of IP admission reviews, and number of concurrent reviews;

d. Network:
   - Claim charges and paid for participating versus non-participating providers by level of care and broken out for MH and SA
   - Total claim charges submitted, amount paid, member responsibility, disallowment amount and net paid
   - Number of providers and facilities in network by type (MD, Psychologist, Masters level, Intensive Outpatient, Partial Hospital, Acute Hospital, CD Rehab, Residential);
   - Number provider and facility terminations by type during report period;
   - Number of new and re-contracted contracted providers and facilities by type during report period.

e. Claims Quality Report – number of claims reviewed/audited, dollar amount of claims reviewed; percent financial payment accuracy and percent claims processing accuracy.

f. COB/Subrogation - Report by active, retiree with Medicare and retiree without Medicare, type of service, amount of claim and amount recovered;

g. Quality Report – Report of status and/or progress on performance standards and quality improvement projects

h. “ALERT" Report – Over-utilization or abuse by plan member or provider, fraud, etc. with number of cases identified and disposition, number of cases under review.

i. Fraud and Abuse Report

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3. Semi-Annual Reports (Must be received 30 days following the end of every 6 months) Semi-Annual Reports must contain an Executive Summary).

   a. Geo Access Report for rural and urban, displayed for inpatient facility, partial, hospital, outpatient provider and MD

4. Annual Reports (Must be received within 60 days following the end of the fiscal year) Annual reports must contain an Executive Summary. and cumulative monthly and quarterly reports.

   a. Financial – Charges billed and paid claims amounts for each metropolitan area for current month and cumulative year-to-date broken into categories by:
      - level of care, service type (MH, SA, Combined MHSA)
      - employee category (actives, dependents, retirees (Medicare and non-Medicare), LACHIP
      - age group.

   b. Claims -- Lag report showing month of service and month of payment.

   c. Clinical Trend Report-- List of 25 most common inpatient diagnoses, (charges and paid) and list of outpatient diagnosis with paid charges and paid (include cost/member, sorted by geographic location and in the aggregate.

   d. Clinical Quality Metrics
      - Follow-up care for children prescribed ADHD medication (can be submitted for last calendar year ending within the contract year)
      - Follow-up after hospitalization for mental illness – 7 days, 30 days.
      - Antidepressant Medication Management (can be submitted for last calendar year ending within the contract year)
      - Results of selected performance improvement projects

   e. Network:
      - List of 50 most utilized network providers in Louisiana by geographic region, by average number of visits

- List of top 25 most utilized facilities by number of admissions, average length of stay, 30 and 90 day readmission rate and 30 day ambulatory follow-up rate.
- In-network versus out-of network analysis for each level of care.

f. Geo Access for inpatient, outpatient and MD (based on performance standards)

g. Patient Satisfaction Survey Results

h. Provider Satisfaction Survey Results

i. Savings – Savings summary by COB, subrogation, other.

In general, periodic reports must contain sufficient data to allow the reader to quickly analyze current period utilization as compared to previous periods and comparative benchmarks. The reports should contain a one-page overview of the period's activity noting the following key elements for mental health care alone, substance abuse alone, and mental health/substance abuse combined:

Inpatient (by facility type and combined)

1. Number of admissions
2. Number of total beds in acute facility
3. Average length of stay in acute facility
4. Average cost/day
5. Average cost per inpatient case
6. Total inpatient claim cost
7. Number of readmits within 30 days, 90 days and 365 days
8. Percentage of readmits with 30 days, 90 days and 365 days
9. Number of treatments within 30 days, 90 days and 365 days
10. Percentage of readmits with 30 days, 90 days and 365 days

Outpatient (by service type and combined)

11. Total number of patients receiving outpatient sessions
12. Total number of outpatient sessions
13. Average number sessions/patients
14. Average cost/session
15. Average cost per outpatient episode/case
16. Number of outpatient visits/1000 plan participants

A sample report layout which would include this information plus a trend of activity might look like:

Key	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			Year-to-Date		
Elements	P	S	C	P	S	C	P	S	C	P	S	C	P	S	C
# of admissions															

P=psychiatric S=substance abuse C=combined

Included with your quarterly reports should be information as suggested by the following formats:

Utilization	Benchmark (using your firm's goal data)	Quarter beginning _____ and ending _____
Acute Inpatient Admissions		Combined Mental Health Substance Abuse
IP Average Length of Stay		Combined Mental Health Substance Abuse
IP Days/1000 lives		Combined Mental Health Substance Abuse
Residential Admissions		
Residential Average Length of Stay		
Residential Days/1000 lives		
Partial Hospital (PH) Admissions		
PH Average Length of Stay		
PH Days/1000 lives		
Intensive Outpatient (IOP) Admissions		
IOP Average Length of Stay		
IOP sessions/1000 lives		
Outpatient visits/patient		Combined Mental Health Substance Abuse
Outpatient visits/1000 lives		Combined Mental Health Substance Abuse

Paid Claims

Claim Type	Requested Amount	Allowed Amount	Provider Discount	COB	Copay	Deductible	Amount Paid
Inpatient							
CD Rehab							
Residential							
Partial Hospital							
Intensive Outpatient							
Outpatient							
Other							
Totals							

j. Other

1. Ad hoc reports other than those listed above may be required by OGB from time to time.

   In preparing your response, bear in mind that this section is intended to illustrate the types of reports that might be required on a periodic basis. You should consider this the minimum data that you will be required to collect and maintain. The final report formats will be determined based upon mutual discussion and agreement among OGB staff, its consulting firm and the successful proposer prior to contract implementation.

k. Performance Standards and Guarantees.

Each MHSA firm must agree to abide by the performance standards and guarantees specified on the following tables.

OGB reserves the right to reduce or waive any performance penalties if, in OGB's sole discretion, the failure of the MHSA firm to meet a performance standard was due to extraordinary circumstances.

See Tables on Pages 19 - 21.

PERFORMANCE STANDARD TOPIC	DESCRIPTION OF STANDARD	STANDARD EVIDENCED BY	TARGET	PENALTY (Fees At Risk)
Appointment Access	Appointment available for elective requests within 72 hours.	Report to OGB based on audit of valid sample of cases using methodology approved by OGB.	≥ 90 %	1.5%
	Urgent/emergency requests receive immediate telephone contact by an appropriate counselor and appointment available within 24 hours.	Audit of valid sample of cases using methodology approved by OGB.	≥ 95%	1.5%
Customer Service	Telephones answered 24 hours a day/7 days a week with average speed of answer of 30 seconds	Call system reports submitted to OGB calculated from time member selects a prompt to the time answered by a live voice. Includes intake and member service lines	≤ 30 seconds	1.0%
	Less than 3% abandonment rate for all intake and member service calls.	Call system reports submitted to OGB showing percent of calls that are placed in queue but not answered before caller hangs up. Includes intake and member service lines	≤ 3%	0.5%
Network	Maintain network with adequate providers to meet the following standards: 90% of plan members within 10 miles of two professional providers (Urban/Suburban) 90% of plan members within 45 miles of two professional providers (rural) 90% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban) 90% of plan members within 60 miles of one inpatient acute care facility provider (rural)	Geographic network accessibility reports produced by MHSA firm and submitted to OGB. Urban and rural standards must be met for both OP and IP standards to meet performance standard.	 ≥ 90% ≥ 90% ≥ 90% ≥ 90%	3.0%

PERFORMANCE STANDARD TOPIC	DESCRIPTION OF STANDARD	STANDARD EVIDENCED BY	TARGET	PENALTY (Fees At Risk)
Satisfaction Surveys	Member Satisfaction Survey Scores	Report to OGB. Member satisfaction survey administered at least annually with survey tool, methodology and sampling approved by OGB. Scores calculated by adding positive rating.	≥ 90%	1.5%
	Provider Satisfaction Survey Scores	Report to OGB. Provider satisfaction survey administered at least annually with survey tool, methodology and sampling approved by OGB. Scores calculated by adding positive rating.	≥ 85%	1.5%
Complaints	Complaints acknowledged within one business day following receipt of complaint.	Report to OGB, tracking time complaint is received verbally or in writing to time of acknowledgement, documented in writing to client.	≥ 95%	0.5%
	Complaints researched and resolved within 30 calendar days	Report to OGB, tacking time complaint is received verbally or in writing to time of resolution with client, documented in writing to client.	≥ 95%	1.5%
	Appeals resolved within time frame per MNRO standards	Report to OGB from Appeal log tracking receipt date, acknowledgement date, and resolution date for each level of appeal	100%	1.5%
Reporting Requirements	As specified in Section I(Y)	Receipt date of reports.	≥ 99%	1.5%
Claims Processing Accuracy	Percent of claims paid within 30 days	Monthly reports to OGB showing percentage of clean claims processed within 30 calendar days from receipt of claim (Subject to independent third party audit at discretion of OGB)	≥ 99%	1.5%
	Financial Payment (dollar) accuracy	Monthly report to OGB showing percentage of audited claims dollars paid accurately. (Subject to independent third party audit at discretion of OGB)	≥ 99%	1.0%

PERFORMANCE STANDARD TOPIC	DESCRIPTION OF STANDARD	STANDARD EVIDENCED BY	TARGET	PENALTY (Fees At Risk)
	Claim processing accuracy	Monthly report to OGB showing percentage of audited claims processed accurately (Subject to independent third party audit at discretion of OGB)	≥ 97%	1.0%
Clinical Standards	Ambulatory follow-up after acute hospitalization within 30 days after discharge	Ambulatory follow-up within 7 days of discharge from 24 hour acute facility using HEDIS specifications or modified HEDIS specification as approved by OGB	≥ 80%	1.5%
	Medical integration for members identified with major depressive, bipolar and psychotic disorders.	Percent of members identified with major depressive disorder, bipolar disorder, or psychotic disorders with annual medical visit with a primary care provider during the reporting year, using reporting specifications to be agreed upon during contract implementation	10% annual improvement from baseline	1.5%
	Readmission Rate with 30 days	Reported to OGB as measured through reporting based on discharge within the measurement period with readmission to an inpatient level of care within 30 days	≤ 8%	3.0%

SECTION III

SCHEDULE OF EVENTS

A. Time Line

Public notice by advertising in the official journal of the State	November 6, 2009
NIC mailed or available to prospective Proposers Posted to OGB Website; Posted to LAPAC	November 6, 2009
Deadline to notify OGB of interest to submit a Proposal **(MANDATORY)**	November 16, 2009
Deadline to receive written questions	November 16, 2009
Electronic data sent to interested proposers	November 18, 2009
Issue answers to written questions	November 23, 2009
Proposer's Conference – Attendance in Person **(MANDATORY)**	December 1, 2009
Proposals due	December 11, 2009
Finalist's interviews/site visits	TBD
Probable selection and notification of award	TBD
Contract effective date	July 1, 2010

NOTE: The OGB reserves the right to deviate from this schedule.

B. Mandatory – Notification to OGB of Interest to Submit a Proposal

All interested Proposers shall notify OGB of its interest in submitting a proposal on or before date listed in the Schedule of Events. Notification should be sent to:

Tommy D. Teague
Chief Executive Officer
Office of Group Benefits

Delivery:
7389 Florida Blvd., Ste 400
Baton Rouge, LA 70806

Mail:
Post Office Box 44036
Baton Rouge, LA 70804

Fax: (225) 922-0282

E-Mail: prahl@ogb.state.la.us

NOTE: Proposals will only be accepted from Proposers that have met this requirement of notification to OGB of their interest to submit a proposal.

C. Written Questions

Written questions regarding the NIC are to be submitted to and received on or before 4:00 p.m. Central Standard Time (CST) on the date listed in the Schedule of Events. Written questions should be directed to the address listed in subsection B of Section III.

D. Mandatory – Proposers Conference (In Person)

The Proposer's Conference will be held in the conference room at 10:00 a.m. Central Standard Time (CST) on the date listed in the Schedule of Events at the following location:

Office of Group Benefits
7389 Florida Blvd., Ste. 400
Baton Rouge, LA 70806

A representative of your organization must participate in person at the Mandatory Proposers Conference. OGB staff will be available to discuss the proposal specifications with you and answer any questions you may have in regards to submitted questions. If participation will be by telephone Proposer shall advise OGB of such when notifying OGB of their interest to submit a proposal.

Proposals will only be accepted from Proposers that have met this mandatory requirement. Attendance by a subcontractor is welcome, but will not be an acceptable substitute for a representative of the primary proposing firm/organization.

E. Proposal Due Date

The original proposal must be signed by an authorized representative of your firm/organization and delivered, together with eight (8) numbered copies, between the hours of 8:00 a.m. and 4:00 p.m. Central Standard Time (CST) on or before the date listed in the Schedule of Events at the address listed in subsection B of Section III.

SECTION IV

PROPOSAL EVALUATION

A. Proposal Evaluation

Proposals will be evaluated by a Selection Committee. Each proposal will be evaluated to insure all requirements and criteria set forth in the NIC have been met. Failure to meet all of the Proposer Requirements will result in rejection of the proposal.

After initial review and evaluation the, Selection Committee may invite those Proposers whose proposals are deemed reasonably susceptible of being selected for award for interviews and discussions at the OGB's offices in Baton Rouge, Louisiana, or the Committee may make site visits to the Proposers' offices and conduct interviews and discussions on site. The interviews and/or site visits will allow the Committee to substantiate and clarify representations contained in the Proposers written proposals, evaluate the capabilities of each Proposer and discuss each Proposers' understanding of the OGB's needs. The results of the interviews and/or site visits, if held, will be incorporated into the final scoring for the top scored proposals.

Following interviews and discussions, scoring will be finalized in accordance with the evaluation criteria below. The proposal receiving the highest total score will be recommended for contract award.

B. Evaluation Criteria

After determining that a proposal satisfies the Proposer Requirements stated in the NIC, an assessment of the relative benefits and deficiencies of each proposal, including information obtained from references, interviews and discussions and/or site visits, if held, shall be made using the following criteria:

Category	Maximum Points	Major Areas to be Addressed
1. Financial	500	Cost of Services
2. Network and Member Access	200	Plan Member Disruption/Continuity of Care, Providers by Discipline and Other Access Criteria (Office Hours, Average Wait Times for Appointments, provider issues, provider rate schedule)
3. Clinical Quality	150	Care management program, and clinical quality management program and results.

4. Administrative Member Services	100	Service capabilities, Claim paying Services and Guarantees (Non-Financial), Responsiveness to OGB issues
5. Organizational	50	Experience, References and Stability Financial Solvency
Maximum Points	1,000	

C. Cost Evaluation

Option 1 – Fully-Insured

The Proposer that provides the lowest fee per employee per month will be awarded the full points for cost of services.

All expenses (personnel compensation, travel, office supplies, copies, communications and etc.) should be included in the proposed rate. In addition, any projected increases for delivery of services for the entire contract period should be anticipated and included in the proposed rate.

Option 2 – Self-Insured

Points will be based on expected claims cost **(actuarially determined)** and administrative services fee averaged over a maximum three year term. The cost proposal determined to be most beneficial to the state will be awarded the full points for cost of services.

Each proposer will receive a CD containing claims actually incurred by OGB members. The claims on this CD must be readjudicated by each proposer utilizing the OGB MHSA Plan of Benefits detailed in Section II, Item B, reflecting which of the identified providers are in network and the discounts currently provided by your existing MHSA contracted providers. These readjudicated claims must be submitted with your proposal.

All expenses (personnel compensation, travel, office supplies, copies, communications and etc.) should be included in the proposed rate. In addition, any projected increases for delivery of services for the entire contract period should be anticipated and included in the proposed rate.

NOTE: OGB reserves the right to award a contract for Option 1 or Option 2.

Evaluation of Cost:

The total contract charge shall be quoted on the Fee Proposal Form of this NIC.

A maximum of 400 points shall be given to the proposal with the lowest total cost.

Points for the other proposals shall be awarded using the following formula for each category:

$$\frac{(X)}{N} \quad X \quad 400 \quad = Z$$

Where:

X = lowest computed cost for any proposal
N = actual computed cost awarded to the proposal
Z = awarded points

This formula will be used for all options.

SECTION V

PROPOSERS REQUIREMENTS

Requirements Checklist

Instructions for Completion of the Proposers Requirements Checklist:

Please proof your answers before submitting your response to ensure completeness.

The MHSA firm will be held accountable for the accuracy/validity of all answers. You may also be asked to substantiate any response during the interview, on-site visit or through a formal audit process.

Please note that your proposal will become part of the contract between OGB and the MHSA firm, if and when the proposal is accepted and accompanied by a separate formal written contract document.

Name of MHSA firm:

Minimum Requirements Checklist	Indicate "Yes" or "No"
1. Does your firm have a minimum of five (5) years experience in providing MHSA services?	
2. Are you currently providing MHSA services to at least two (2) groups with a minimum size of 25,000 covered employees and/or retirees (not counting dependents) of which at least one of these groups is a single employer (corporate or government)?	
3. Is your firm licensed as required by the Louisiana Commissioner of Insurance in order to provide the coverage requested in this NIC? Please attach your response to this Section evidence that your firm is so licensed or, if not currently licensed, a detailed description of the procedures, including a time line, you would follow in order to insure compliance by July 1, 2010?	
4. Do you meet the following minimum network access standard as of the date your proposal is submitted? 70% of plan members within 10 miles of one professional providers (Urban) 70% of plan members within 20 miles of one professional provider (Suburban)	

Minimum Requirements Checklist	Indicate "Yes" or "No"
70% of plan members within 45 miles of one professional providers (rural) 70% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban) 70% of plan members within 60 miles of one inpatient acute inpatient facility (rural)	
5. Are you willing to commit to the following minimum network access standard as of July 1, 2010 effective date? 90% of plan members within 10 miles of two (2) professional providers (urban) 90% of plan members within 20 miles of two (2) professional provider (suburban) 90% of plan members within 45 miles of two (2) professional providers (rural) 90% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban) 90% of plan members within 60 miles of one inpatient acute inpatient facility (rural)	

SECTION VI

QUESTIONNAIRE

A. General Information

1. Provide a brief history of and an organizational table for your company. Include any name changes, mergers and reorganizations. Include the names and titles of all senior officers.

2. Name all organizations which have a financial interest in your company. Describe their relationship to your company in terms of percentage of stock held or amount of venture capital invested.

3. List the names, addresses and professional affiliations of members of your Board of Directors.

4. a. Provide the names and resumes for each of your staff who will provide services to OGB and their function with respect to this contract.

   b. Provide a team organization chart, indicating the senior officer in charge of the team and the specific liaison(s) with OGB.

5. If you are the successful proposer, what percentage of your business would this contract represent in terms of:

   a. Membership _____% (number of employees)

   b. Dollar volume _____% (% of total revenue)

   c. Claims paid _____% (% of number of claims)

6. What is the total dollar volume of MHSA business written by your company during the most recent fiscal year?

7. What was the total volume, in terms of numbers of claims and benefits paid by your company during the most recent fiscal year?

8. Please list the locations of your

   a. Main office
   b. Claims office
   c. Service office(s)
   d. Service locations for after hours

9. Do you have an office in Louisiana? If so, note location and describe its function.

10. For how many years has your company been providing capitated full-risk MHSA network services?

11. Please list any accreditations (e.g. URAC, NCQA, etc) your company has for the proposed service center that will serve OGB employees.

12. Within the last 3 years has your organization, any affiliate of the company, any senior officers or board members been a party to a lawsuit or governmental investigation? If so, provide a brief description of each incident. What was disposition?

13. List any ownership interest your company has in any MHSA facility or provider. Describe the relationship and attach the organizations' audited financial statements for the most recent two fiscal years. Please include all financial statements and any notes that relate to those statements.

14. Do you now subcontract with any other organization(s) for services (such as claims processing, utilization review, data processing or any other professional services)? If so, provide a description of your subcontracting arrangements.

15. If your firm is the successful proposer, will the services required under this contract require you to enter into new or substantially modified subcontracting arrangements? If so, describe the reasons and a description of the new or modified arrangements.

16. Please explain the measures you take to protect patient and organizational confidentiality. Specifically, what measures do you take to protect your current clients' confidentiality?

17. Describe the internal quality control audits performed by your firm by type and frequency during a given year.

18. Pursuant to Section II of this NIC, is your firm currently licensed as required by the Louisiana Commissioner of Insurance? If not, provide a detailed description, including a time line, that you would follow to ensure that your firm is properly licensed before the effective date of the contract with the OGB.

19. Disclose any financial or claims paying ability ratings issued to your firm by any of the following rating agencies: A.M. Best, Moody's, Standard & Poor's and Duff and Phelps. Provide the same information on ratings issued to your parent company, if any.

20. Identify the full name of the insurance company underwriting the proposed MHSA benefits and disclose any financial or claims paying ability ratings issued to the carrier by the following agencies: A.M. Best, Moody's, Standard & Poor's and Duff and Phelps.

21. Do you agree to provide liability coverage, including malpractice and insolvency

protection, with a combined single liability of not less than $10 million?

22. Do you agree to a performance bond in an amount equal to three (3) months' aggregate per-contract cost based on enrollment as of July 1, 2010, to insure performance under the contract?

23. Do you agree to provide MHSA services, as specified in this NIC, recognizing the unique benefit plan designs of OGB?

24. Do you agree to assume liability for all MHSA services rendered from July 1, 2010 through the date of termination of the contract, with the exception of inpatient admissions in progress on July 1, 2010, which are the responsibility of the incumbent MHSA firm until date of discharge, thereafter, such patients will be covered by your contract?

25. Do you agree to assume liability for inpatient admissions in progress on termination date of the new contract until date of discharge?

26. Do you agree to the Performance Standard and Guarantees? (See Section II)

27. For each of the past two fiscal years, please provide the following information by class of employee, e.g. physicians, RNs, LPNs, member services staff, provider relations staff, claims processing staff, etc. a. number of staff, b. employee turnover, average tenure with company.

B. Communications

1. How do you propose to educate plan members and their dependents about the plan and your services? Describe the approach you would use for initial and ongoing communication.

2. a. What communications materials do you propose to provide to plan members and OGB staff?

   b. Keeping in mind that OGB will have final approval, please provide samples of initial and ongoing communication materials you would suggest.

3. You must agree to make appropriate members of your organization available to meet with OGB staff, employee groups, etc. as needed and agree to attend meetings of the OGB Policy and Planning Board and its committees, as requested.

4. What website capability is available to members? Please provide information necessary to access a demonstration website (i.e. URL, logon ID, password)

C. Intake and Member Services

1. For the following services, list the days and hours of accessibility as well as staffing information, i.e. who answers the phone and their qualifications.

   a. Intake and Referral/crisis line

   b. Provider relations

   c. Member service

   d. Utilization review

2. Do you use an automated attendant to route callers? If yes, how many choices is the caller offered (i.e. buttons to press) before speaking with a live staff member? Can you customize the auto-attendant message for OGB?

3. How do you handle after-hours and weekend emergency calls? Who handles the calls and what are their qualifications?

4. Describe the screening and referral process starting from the moment the patient contacts you. Provide a flow chart.

5. For a typical, non-emergency assessment/referral call, what information is taken over the toll-free line and by whom?

6. When calls to member service require transfer to a licensee clinician, do you transfer callers to voicemail or to the clinical queue – If to the clinical queue, what is the average wait time in queue to access a licensed clinician?

7. a. Provide a description of your telephone system and a sample of your standard call report.

   b. How do you track the number of calls received, speed of answer, hold time (time in queue) abandoned calls, etc.?

8. Please provide actual average performance results based on your book of business for the most recent 12 month period of time (include intake and member service calls).

	ACTUAL	GOAL
a. Percent Abandoned calls	%	%
b. Average speed of answer	Seconds	Seconds
c. After-hours average speed of answer	Seconds	Seconds
d. Average percent of calls answered within 30 seconds	%	%

	ACTUAL	GOAL
e. Average time in queue for transfer from member service to any other department	Seconds	Seconds
f. Percent calls receiving busy signal	%	%
g. Percent abandonment rate	%	%

9. Initial calls from plan members can be expected to be answered within how many seconds or rings?

10. a. Indicate your standard business hours and days:
DAYS:
HOURS:

b. Indicate your "after" hours and days:
DAYS:
HOURS:

11. Provide the average time from a call being answered to a referral being given for both emergency and non-emergency assessment calls.

12. You must agree to maintain a sufficient number of toll-free lines which may be accessed by plan members on a 24-hour basis for emergency crisis intervention. A sufficient number of toll-free lines must be maintained to provide access during regular business hours for routine assessment and referral and for general questions. Describe how you plan to accomplish this for OGB.

13. Describe how you would handle urgent, emergent and calls requiring crisis intervention such as a threat of suicide or violence.

a. How call will be triaged to an appropriate clinician and then to an appropriate network resource?
b. List of risk screening questions that staff is required to ask?
c. Follow-up to assure member reaches and is seen by network resources to resolve crisis and appropriate intervention.
d. Indicate the qualifications of the person managing this call.

14. What are your current average waiting times and what are your goals for participant secure appointments for the following types of conditions:

	Current	Goal
a. Emergency b. Urgent c. Routine		

15. Describe any automated patient registration and referral technologies that your organization has available for members which will enhance access to services.

16. Discuss your method of measuring patient satisfaction including scoring, sampling, administration and follow-up for improvement. You must evaluate satisfaction for a statistically valid sample of members receiving treatment each year. Provide the complete results of your most recent patient survey and the time frame covered. Include a copy of the questionnaire/survey.

17. Discuss the process you follow to address complaints from participants dissatisfied with member services. Include a definition of "complaint" and "grievance" and how you train staff on documenting and resolving complaints and grievances.

18. Describe specifically your appeals process to which plan members and their dependents would have access in the event of a disputed claim or referral procedure. Indicate the maximum turnaround time at each stage of the process and provide a flow chart describing the appeals procedure.

D. Claims Administration/Data Reports

1. Describe your claims turnaround goal vs. actual turnaround time with respect to contracted providers, non-contracted providers and COB claims.

2. Describe your claim processing quality review procedures. What type of internal and external audits are done, how often and by whom?

3. Explain how you would propose to handle COB for OGB. What percentage of COB savings do you now realize on average? How do you achieve this?

4. Provide a description of your claims processing system, including hardware and software.

5. How would you design safeguards against an ineligible plan member attempting to or actually using the network? Would your procedure attempt to identify the ineligible member at the point of interface with the referral counselor or would it be an after the fact benefits denial?

6. As a continuation of (5) above, describe your computer capability for data analysis and reporting, including model, capacity, redundancy, access protocols, ability to recognize duplicate claims, interface with UR firm decisions, etc.

7. List a representative sample of your explanation of benefit messages and furnish a sample of the EOB your company will be using. Also provide a representative sample of all claim-related form letters sent to participants including denial notices and describe how forms and letters will be customized for the purposes of OGB.

8. Please confirm your ability to accept and integrate into your system eligibility information furnished by OGB, both initially and for monthly updates. Are there any specific requirements that your system cannot accommodate?

9. Who owns the claim system and/or facility?

10. How much longitudinal data (in months) is maintained in your working data set? Archived? At any point in time, how much is accessible for analytical purposes?

11. If original claims fields are not preserved in detail, which are summarized and which are excluded?

12. Please confirm that your system is capable of processing paperless (electronic) and paper claims.

13. Please describe your procedures for processing and documenting adverse claims decisions (complete and partial). The successful proposer must retain this documentation during the term of this contract and for a period of time thereafter as determined by OGB.

14. Discuss the flexibility of your data structure. Can it be reorganized, expanded or otherwise modified to accommodate OGB's reporting requirements? If so, what is the time frame needed for such modification?

15. Is your computer system owned by your firm? If not, who owns the system?

16. Are system programmers comprised of in-house staff or contracted professionals? In either case, please discuss staffing adequacy.

17. What experience do you have exporting MHSA data to another vendor for the purpose of implementing integration initiatives? Describe the nature and size of the data sent and frequency of data feed.

18. What experience do you have for accepting medical, pharmacy, health risk assessment or other patient data form other vendor partners for the purpose of implementing integration initiatives? Describe the nature and size of the data set and what you did with the data once received, including use by care managers in the management of care.

19. Describe your reporting system and its purpose, including report parameters.

20. Your system must provide the flexibility to accommodate OGB needs which may include, but may not be limited to reports showing utilization by provider, geographic area, type and duration of treatment, diagnosis, classification and age of the plan member, normative comparisons, etc. Please confirm your understanding of and ability to conform to this requirement.

21. Describe the time frame needed to produce any ad hoc reports over and above OGB-specific periodic reports which will be decided upon prior to July 1, 2010.

22. What is the average length of time from a network provider submitting its charges to date of payment by your firm?

Cases in Progress

1. There will be MHSA cases in progress at the time of implementation of the next MHSA contract. How would you handle existing inpatient and outpatient cases in progress during the transition? Specifically address the potential problems of non-matches of providers between your network and the incumbent MHSA firm's network.

Provider Network

1. Describe the process and specific criteria your firm uses to:

   a. Develop a network

   b. Select network providers, both facilities and professionals.

   Be certain to include the specific qualifications you require and credentialing criteria you apply in the selection of network hospitals, residential treatment centers, partial day facilities and half-way homes, as well as those for individual practitioners. In your response, discuss the extent to which your credentialing process is automated.

2. Address each of the following issues separately:

   a. **Guidelines and software used for determining a cost-efficient provider**

   b. Minimum requirements for practitioner and facility malpractice and liability insurance

   c. Methods for evaluating quality of care

   d. Profiling or metrics reported to network providers and facilities to provide feedback on performance.

   e. Any initiation, processing, or ongoing fees paid to you by providers in order to

participate in the network.

f. Any Pay for Performance incentives in place.

3. Describe any difficulties you may have experienced in the past in identifying or developing network providers in various areas throughout Louisiana.

4. Do you interview the potential provider face-to-face?

5. Do you visit provider offices A) prior to credentialing or as part of re-credentialing? B) If yes, a) what percentage of network providers in Louisiana had a provider office visit, b) what are the criteria for deciding who will receive an office visit c) what are criteria reviewed when the office visit is made?

6. Do you require that physicians be Board Certified in psychiatry? What percentage of your physicians are Board Certified?

7. a. How are credentials verified?

   b. How often do you re-credential providers?

   c. What standards must be met for re-credentialing?

8. Describe how provider data is used for contract negotiation and renewal.

9. a. How many providers did you recruit during the past two years?

   b. What is the average length of time from receipt of application to join your network and official contract effective date as a network provider?

   c. What is the average length of time from receipt of application to join the network and official credentialing date as a network provider?

10. How many providers were involuntarily terminated during the past two years? Provide this information for both facilities and practitioners, indicate the percentage of network providers terminated and the reasons for termination.

11. How many providers resigned during the past two years? Provide this information for both facilities and practitioners, indicate the percentage of network providers who resigned and the reasons for resignation, if available.

12. Describe specifically your process for removing, penalizing, or warning/counseling providers who do not meet performance and/or quality standards.

13. Provide a description of the following financial and contractual provider arrangements for

network providers:

a. Hospital and other in- and out-patient facilities

b. Physician and other practitioner arrangements, including:
   - Any Capitation arrangements
   - Fee schedules
   - Withholds, bonuses, incentives
   - Per case rates

14. a. What type of case(s) or specialized treatment conditions cannot be provided by any of the professional providers in your network?

    b. How can members access these services? Where?

15. Does your provider contract contain language which requires the provider to comply with Utilization management and quality management protocol/procedures?

16. For your existing provider network, describe the number and nature of any malpractice suits incurred during the past two years, including the following information:

    a. Number and nature
    b. Disposition of each and the amount of judgment
    c. Pending suits and anticipated outcome
    d. Preventive steps against future actions

17. Address any areas of Louisiana where you feel you should expand or add providers to your network. Discuss your approach and time frame for recruiting the number of providers where needed in order to insure that plan members in all areas of the State are afforded access to your network as of July 1, 2010, which meet the minimum access standards set forth in this NIC.

18. Provide your firm's benchmark guidelines relative to the ratio of each type of MHSA provider per 1,000 members and accessibility in terms of mileage and driving time.

19. Explain how you will handle the provision of services to plan members who are located out-of-state and out of the country.

20. Please describe your medical director's credentials and responsibilities. If your medical director is not full-time, describe the time commitment to your firm.

21. What qualifications are required of your in-house professional staff? Describe by practice and provide information on required continuing education.

22. Please describe your standards and protocols for monitoring provider practice patterns,

treatment outcomes and telephone responsiveness. Is there a profiling system for MHSA practitioners? If yes, briefly describe. Is profile data available to members? Indicate how profiling information is used in monitoring and improve quality

23. With respect to your current book of business, describe current utilization in terms of:

A. Capitated, Full-Risk Book of Business

	MH	SA	Combined
a. IP Admits/1,000 members			
b. Inpatient days/1,000 members			
c. Residential admits/1000 members			
d. Res days/1000 members			
e. Partial Hosp admits/1000 members			
f. Partial Hosp days/1000			
g. IOP admits/1000			
h. IOP visits/1000			
i. Outpatient encounters/1,000 members			
j. Emergency Visits/1,000 members			
k. Avg paid claim rate per IP acute care day			
l. Avg paid claim rate per 90801 procedure			
m. Avg paid claim rate per 90806 procedure			
n. Av paid claim rate per 90862 procedure			

B. Administrative Services Only Book of Business

	MH	SA	Combined
a. IP Admits/1,000 members			
b. Inpatient days/1,000 members			
c. Residential admits/1000 members			
d. Res days/1000 members			
e. Partial Hosp admits/1000 members			
f. Partial Hosp days/1000			
g. IOP admits/1000			
h. IOP visits/1000			
i. Outpatient encounters/1,000 members			
j. Emergency Visits/1,000 members			
k. Avg paid claim rate per IP acute care day			
l. Avg paid claim rate per 90801 procedure			

m. Avg paid claim rate per 90806 procedure			
n. Av paid claim rate per 90862 procedure			

24. For OGB, using the experience data provided in the Exhibits to this NIC, please provide your projected utilization statistics for the first 18 months and the final 12 months of the contract using the above format.

G. Clinical Treatment Protocols

1. Describe in detail your systems and procedures for admission authorization of hospital admissions. If these are different for psychiatric, substance abuse and detoxification admissions, present the information for each separately.

2. How does your firm conduct admission authorization? How is it initiated? It is carried out by telephone, forms, electronic submission, etc.? What is the average length of time from request to completion of the authorization process?

3. Describe the screening and referral process starting from the moment the patient contacts you. Provide a flow chart.

4. Do you require an authorization for outpatient services. Describe your processes for outpatient review, including:
   a. How many sessions (visits are ordinarily covered by the initial authorization?
   b. In-network outpatient concurrent review
   c. Out-of-network outpatient concurrent review

5. a. Do you send authorization letters for inpatient and outpatient cases?

   b. If so, to whom with copies to whom?

   c. Provide a sample authorization letter for acute hospital and outpatient visits.

   d. Provide a sample denial letter. Include a sample when there is a partial denial of services (number of day/sessions authorized are less than requested) for acute hospital and outpatient visits.

6. Describe any automated member registration and referral technologies that your organization has available and propose for OGB.

7. What percentage of proposed service requests are referred by the intake reviewers to physician advisors?

   a. What are the types of cases (in addition to denial) that are sent for review by physician advisors?

b. How do physician advisors interact with providers to address quality of care issues identified?

8. How do you identify alcohol and substance abuse cases that are admitted through the emergency room on a secondary medical diagnosis? What outreach or other intervention is initiated for those cases that are identified?

9. a. What is your procedure when a dual diagnosis (both psychiatric/medical and substance abuse) is apparent?

   b. Is this handled differently from when only one diagnosis is assigned?

   c. Please describe what criteria you use to determine medical necessity and appropriateness of care for dual diagnosis cases for each level of care.

10. Provide the criteria used to determine whether a patient should be treated for substance abuse on an inpatient basis or an outpatient basis.

11. What is the source for medical criteria used for MHSA admissions and continued stay reviews for each level of care?

12. List the clinical practice guidelines or evidence based practices adopted by your organization. Provide the name and source from which the guidelines/practices were developed.

13. How do you manage requests for alternative treatment and programs not specifically excluded or included in the benefit design, i.e. wilderness therapy, equestrian therapy, etc?

14. Describe any tele-psychiatry or tele-therapy services you have utilized with other customers and your approach for utilization of these and other technology products.

15. How does your organization track a patient's treatment and changes in the patient's condition during a hospital stay? Please be specific as to the responsibilities of the patient, hospital, physician and review organization.

16. a. What is reviewed during the concurrent review process: i.e. diagnosis, length of hospitalization, expected length of continued hospitalization, resources of the facility, alternative outpatient opportunities? Others?

   b. From whom do you receive the information?

   c. Is the review performed on-site at the facility or over the telephone or via secure web transmission or other?

17. a. How often are higher level of care concurrent reviews scheduled?

    b. When are high frequency reviews scheduled to focus on ongoing dynamic changes in the patient's status?

    c. What factors related to the patient's condition would increase this frequency of reviews, i.e., an unclear diagnosis?

18. a. What criteria are used to screen cases for potential problems with discharge planning?

    b. At what point is discharge planning initiated?

    c. When does the process end?

    d. Describe your interaction with facilities, providers and patients in the discharge planning process.

    e. What data is collected during the discharge planning process and how is it used to prevent readmissions?

    f. What care management processes are in place after the discharge occurs?

19. What patient information is provided to the outpatient provider regarding the hospitalization and treatment plan to address ongoing treatment needs and facilitate continuity of care?

20. How are follow-up appointments made after discharge form an acute inpatient hospital? What strategies are employed by your organization to facilitate and encourage the client to keep appointments made after discharge? How are ambulatory follow-up appointments tracked to measure if appointments were kept within 7 days and 30 days after discharge?

21. When is a case considered closed?

22. How does coordination of services involving referrals between multiple providers and/or facilities occur? Who is responsible?

23. Describe your methodology for tracking a patient at 30, 90 and 365 days following inpatient care discharge.

24. Describe care management processes and programs for clients who are readmitted to acute inpatient care and other complex cases.

25. Do you utilize any type of data mining or predictive models to identify high risk clients

for more intensive care management?

26. Describe your intensive care management program capability.

27. Describe your experience implementing integration initiatives with medical providers.

28. Describe your system for monitoring quality of care and intervening with providers. Please be specific, using hypothetical examples as may be appropriate.

29. Under what circumstances may patients use a non-network provider? How does care management differ when the provider is out of network?

30. Describe your denial and appeal process for adverse UR decisions.

    a. What are the qualifications of person(s) who can make an adverse decision (denial)?

31. How do physician advisors obtain clinical information to make adverse decisions?

    a. What is the protocol for denial when clinical information is insufficient to make an adverse decision?

32. Do your denial letters stipulate the right to and method of appeal?

33. If acute care facility treatment is deemed inappropriate, what alternatives are presented and how are they communicated to the client?

34. For your last fiscal year (or other most recent 12-month reporting period), indicate:

    a. the number of appeals handled and closed
    b. the number of appeals resolved in favor of the patient
    c. the number of appeals resolved in favor of the company
    d. the number of open appeals
    e. the average length of time from filing an appeal to final resolution.

35. Describe your' firm's protocols for financial and clinical management responsibility and claims/services for covered plan members for each of the following:

    a. Tourette's
    b. ADD/ADHD
    c. Autism spectrum disorders

36. What methods do you use to monitor intake and care management staff performance and quality? What is the frequently of the monitoring? How is feedback given to staff?

37. Describe an example of a QI project that resulted in improved quality of care.

H. MHSA Network Within the State of Louisiana Exhibit

1. For purposes of this NIC, OGB has established nine major service areas which are defined by the first three digits of the zip codes. The nine major service areas are as follows:

Region	Zip Code	Fee Schedule Area
1	70000-70199	New Orleans
2	70300-70399	Houma Thibodaux
3	70400-70499	Slidell Hammond Covington
4	70500-70531 70533-70545 70550-70580 70582-70590 70592-70599	Lafayette
5	70600-70699 70532 70546 70549 70581 70591	Lake Charles
6	70700-70899	Baton Rouge
7	71300-71499	Alexandria
8	71000-71199	Shreveport
9	71200-71299	Monroe

Based upon these nine service areas, complete Table 1 and Table 2 on the following pages with regard to your current MHSA provider network within the State of Louisiana. Do not include providers you may anticipate recruiting pending contract award.

Table–1 - MHSA Provider Network within the State of Louisiana

Complete Table 1 based on your current MHSA provider network.

Major Service Areas	Total Number of Available MHSA Network Professional Providers	Total Number of MHSA Network Professional Providers	Total Number of Available MHSA Network Facility Providers	Total Number of MHSA Network Facility Providers	Total EAP Providers
1. New Orleans					
2. Houma/Thibodaux					
3. Hammond					
4. Lafayette					
5. Lake Charles					
6. Baton Rouge					
7. Alexandria					
8. Shreveport					
9. Monroe					
Total State of Louisiana					

Table–2 - MHSA Provider Network within the State of Louisiana

Complete Table 1 based on your current MHSA provider network.

Major Service Areas	Psychiatrists	Child Psychiatrists	Psy.D	PhD	Ed.D	LPC	BCIA	LMSW	ARNP	DO	CEAP
1. New Orleans											
2. Houma/Thibodaux											
3. Hammond											
4. Lafayette											
5. Lake Charles											
6. Baton Rouge											
7. Alexandria											
8. Shreveport											
9. Monroe											
Total State of Louisiana											

SECTION VII

ATTACHMENTS TO PROPOSAL RESPONSE

Please provide the following:

1. Audited financial statements for the most recent two fiscal years.

2. Information documenting the current access of the covered employee/retiree to your existing provider network.

   Enclosed with the NIC is a compact disk/diskette containing a listing of covered plan members (employees and retirees) by five digit zip code of their home residence. The zip code census information is provided separately for active employees and retirees, please note that the data represents the current OGB member data and does not constitute a guarantee that all members will be available at July 1, 2010 for this MHSA enrollment. The MHSA firm should combine the active employee and retiree zip code information and conduct an analysis of the match between total covered plan members and your current MHSA provider network. The exact parameters for the information requested is identified below:

   a. Network Accessibility Summary Reports based on the following specifications:

      - Plan Member Groups
        - Employees, retirees and LACHIP with zip codes within the State of Louisiana;
        - Employees and retirees with zip codes outside of the State of Louisiana; and
        - All employees zip codes

      - Access Standard (for each of the above groups)
        -One (1) professional provider within ten (10) miles for urban, twenty (20) miles for suburban and forty-five (45) miles for rural areas; and
        -One (1) facility provider within thirty (30) miles for urban and suburban and sixty (60) miles for rural

   b. Generate a report identifying any of the nine designated service areas within Louisiana, as defined in Section VII(H)(1) for which your current MHSA network does not meet the minimum access standards as defined in the Minimum Requirement Checklist, Section VI (A). For each service area not meeting the minimum access standard, the MHSA firm should indicate the total number of employees, number of employees without desired access and average distance to one (1) professional and one (1) facility provider.

      Note: The report names and terminology utilized above are representative of the GeoAccess program. If you utilize a program other than GeoAccess, your response must identify the number and percentage of employees meeting and not meeting the

desired access standard.

3. Provide a proposed implementation plan and timetable, beginning with the award of business to effective date of coverage, include:

    a. Steps required to implement the program
    b. Role played by the plan sponsor/MHSA firm's
    c. Transfer of eligibility and lifetime maximum accumulators
    d. Production and distribution of directories and other employee materials
    e. Contacts and personnel assigned to each step of the implementation process

4. Résumés of your firm's key management staff and account management team which would be responsible for servicing the OGB.

5. Sample of educational material provided to plan members and participating providers.

6. Sample of communications material available to plan sponsors and plan participants with regard to network enrollment, network utilization, etc.

7. Directory of your MHSA provider network for the State of Louisiana.

8. Samples of all forms that would be used in the administration of this plan that are included in your quoted fees.

9. Sample of monthly, quarterly and annual reports.

10. Your firm's protocols for financial and clinical management responsibility and claims/services for covered plan members involving mixed diagnoses which are related to both medical and MHSA disorders.

11. Proposed changes/modifications to the terms of the Standard Contract attached as an Exhibit to the NIC.

12. Additional provisions, terms, and conditions that your firm wishes to include in any contract resulting from this NIC.

SECTION VIII

MHSA FIRM INFORMATION
AND
MANDATORY SIGNATURE PAGE

A. MHSA FIRM INFORMATION

Organization Name _____

Date Founded _____

Contact Person's Name _____

Title _____

Address _____

City/State _____

Telephone Number
(with extension) _____

Fax Number _____

A MHSA firm must provide the name, key contact, phone number, number of covered employees and retirees (not including dependents) for its three largest existing clients and two recently terminated clients. At least two (2) of the current references must be for clients with at least 25,000 or more covered employees and retirees (not including dependents), of which one must be a single employer client (corporate or government).

Current Client References				
Company Name	Name of Contact and Title	Phone Number and City Location	Number of Employees/ Retirees	Contract Start Date
1.				
2.				
3.				

Recently Terminated Client Information				
Company Name	Name of Contact and Title	Phone Number	Termination Reason*	Term. Date
1.				
2.				

**Please provide details of the reason for termination, please elaborate in the space below. Be brief.*

B. Mandatory Signature Page

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

MHSA PROGRAM

This proposal complies with all mandatory requirements of the NIC. In the event of any ambiguity or unclarity, the response is intended to be in compliance.

_____ certifies that this proposal was not prepared or developed using assistance or information illegally obtained.

_____ is solely responsible for this proposal meeting the requirements of the NIC. (Exceptions are not allowed.)

_____ is solely responsible for its compliance with all applicable laws and regulations to the preparation, submission and contents of this proposal.

_____
Date

_____
Signature

_____
Printed Name

_____
Title

SECTION IX
FEE QUOTATION

A. Option 1: Fully Insured

The MHSA firm is required to quote an all-inclusive monthly premium non-refundable cost per employee **per month.**

1.1 MHSA Benefits

Annual Rate – Premium

July 1, 2010 – June 30, 2011 $_____per employee/retiree per month
July 1, 2011 – June 30, 2012 $_____per employee/retiree per month
July 1, 2012 – June 30, 2013 $_____per employee/retiree per month

B. Option 2: Self Insured

The MHSA firm is required to quote an all-inclusive monthly capitated non-refundable cost per employee **per month.** OGB will assume risk for all claims payments and will promptly reimburse MHSA firm for all claim payments.

2.1 MHSA Benefits

Annual Rate – Fee

July 1, 2010 June 30, 2011 $_____ per employee/retiree per month
July 1, 2011 - June 30, 2012 $_____ per employee/retiree per month
July 1, 2012 - June 30, 2013 $_____ per employee/retiree per month

MHSA firm:_____

By: _____

Title:_____

Signature_____

SECTION X

EXHIBITS

EXHIBIT 1 **OGB Standard Contract**
Business Associate Addendum
Attachment A – Financial Agreement

EXHIBIT 2 **Medical Necessity Review Organization Act**

EXHIBIT 3 **Census Data**

EXHIBIT 4 **Data File Layout and Requirements**

EXHIBIT 1

CONTRACT FOR MANAGED MENTAL HEALTH AND SUBSTANCES ABUSE PROGRAM

BY AND BETWEEN

THE STATE OF LOUISIANA OFFICE OF GROUP BENEFITS

AND

(CONTRACTOR)

The STATE OF LOUISIANA, DIVISION OF ADMINISTRATION, OFFICE OF GROUP BENEFITS (hereinafter sometimes referred to as the State or OGB) located at 7389 Florida Blvd., Suite 400, Baton Rouge, LA 70806 and ("CONTRACTOR"), located at (Contractor Address) do hereby enter into a contract under the following terms and conditions:

1.0 SCOPE OF SERVICES

1.01 CONTRACTOR agrees to provide for OGB managed mental health and substance abuse (MHSA) treatment services, administration and payment of claims for such services, and all related services, utilization and management reports, all in accordance with the terms, conditions, requirements, specifications, and representations set forth in the following documents, attached hereto and incorporated herein by reference:

Attachment A – The Request for Proposal (NIC) issued by OGB on _____.

Attachment B – The proposal submitted by CONTRACTOR in response to the NIC, dated _____, including the cost proposal.

Attachment C – Group insurance policy issued by TBD covering the MHSA benefits provided by CONTRACTOR pursuant to this contract. (Applies to fully-insured option only).

1.02 CONTRACTOR shall provide medically necessary managed mental health and substance abuse treatment services up to the benefits provided in OGB's plan documents, subject to the deductibles, copayments, limitations, and exclusions set forth therein. CONTRACTOR shall be financially responsible for the provision of managed mental health and substance abuse treatment services that are authorized by CONTRACTOR and received by a covered employee, retiree, or dependent during the term of this contract. In the event that OGB materially alters the benefit levels of the Plan Document, the parties shall negotiate in good faith an adjustment to the compensation hereunder that fairly and adequately compensates

CONTRACTOR in light of such alteration of benefits.

2.0 OGB FURNISHED INFORMATION

OGB will promptly furnish to CONTRACTOR, in a format agreed upon by the parties, all information necessary for CONTRACTOR to render services set forth herein, including, but not limited to:

2.01 A list of all eligible persons, and subsequent timely additions to and deletions from such list as changes occur; and

2.02 Copies of OGB's Plan Documents, in effect on the date of this Contract, pursuant to which it provides health and accident benefits for eligible persons. Thereafter, OGB shall provide CONTRACTOR with copies of all Plan Document amendments at least thirty (30) days prior to the effective date of such amendment, unless such amendments are implemented pursuant to a declaration of emergency, in which case notice shall be given within five (5) days after such declaration of emergency.

3.0 CONTRACT TERM; TERMINATION

3.01 This Contract is effective TBD, for a term of three years, through TBD, unless earlier terminated as set forth herein.

3.02 The foregoing notwithstanding, this Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana regarding agreements with an agency of the State.

3.03 Termination for Cause. State may terminate this Contract for cause based upon the failure of CONTRACTOR to comply with the material terms and/or conditions of the Contract; provided that the State shall give CONTRACTOR written notice specifying CONTRACTOR's failure. If within thirty (30) days after receipt of such notice, CONTRACTOR shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the State may, at its option, place CONTRACTOR in default and this Contract shall terminate on the date specified in such notice.

CONTRACTOR may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the State to comply with the terms and conditions of this Contract; provided that CONTRACTOR shall give the State written notice specifying the State's failure. Furthermore, CONTRACTOR shall be entitled to suspend any and all services until such time as when the State is not in default of its obligations under this contract.

3.04 Termination for Convenience. The State may terminate the contract at any time without penalty by giving thirty (30) days written notice to CONTRACTOR. Upon

any termination of this contract CONTRACTOR shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

3.05 Availability of Funding. The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract. If the legislative fails to appropriate sufficient monies to provide for the continuation of the Contract, or if such appropriation is reduced by veto of the Governor or by any means provided in the appropriation act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reductions to provide insufficient monies for the continuation of the Contract, the Contract shall terminate on the date of the beginning of the first fiscal year for which funds have not been appropriated. Such termination shall be without penalty or expense to the State except for payments which have been earned prior to the termination.

4.0 PAYMENT TO CONTRACTOR

4.01 For services provided pursuant to this Contract, OGB will pay CONTRACTOR as follows:

4.01.1 TBD Dollars per enrolled employee and retiree (exclusive of dependents), per month.

4.01.2 The amount of each monthly payment will be based upon the number of employees and retirees (exclusive of dependents) enrolled on the first day of the month in OGB's self-insured health and accident benefit plans for which CONTRACTOR provides services as described in this Contract. Adjustments to the fees based upon retroactive enrollments or disenrollments or lags in eligibility updates shall be made on the payment date next following the eligibility update.

4.01.3 OGB will remit each monthly payment to CONTRACTOR not later than 20 days after the end of the month in which the services are rendered.

4.02 Based upon the anticipated enrollment in OGB's plans at the time of execution of this contract, the total payment by OGB to CONTRACTOR is not estimated to exceed TBD over the three-year term of the contract. The parties agree that the maximum payment amount will be appropriately increased by amendment of this contract, in light of changes in enrollment, if and when the total amount paid reaches within twenty (20%) of the maximum.

5.0 TAXES

The Contractor hereby agrees that the responsibility for payment of taxes from the administrative fees received under this Contract and/or legislative appropriation shall be the Contractor's obligation and identified under Federal Tax Identification Number _____.

OGB shall reimburse the Contractor for any taxes, charge of fees which may be assessed against the Contractor by any governmental entity for providing any service or Benefits to OGB, as set forth under the Plan or this Contract, with the exception of income taxes owed by the Contractor. In the event that the reimbursement of any Benefits of Plan Participants in connection with this Contract is subject to tax reporting requirements, OGB is responsible for complying with these requirements.

6.0 CONTRACT MANAGMENT

6.01 CONTRACTOR agrees to provide the following contract related resources:

6.01.1 Account Manager: CONTRACTOR shall provide an account manager to provide day-to-day coordination of CONTRACTOR's support and administrative activities, and for supervision of CONTRACTOR employees. The account manager shall possess the functional skills and knowledge to direct all aspects of the project.

6.01.2 Key Personnel: CONTRACTOR shall assign staff who possesses the knowledge, skills, and abilities to successfully perform assigned tasks.

6.02 OGB shall appoint a Contract Manager for this contract that will provide oversight of the activities conducted hereunder. The assigned OGB Contract Manager shall be the principal point of contact on behalf of the State and will be the principal point of contact for CONTRACTOR concerning CONTRACTOR'S performance under this contract.

7.0 MONITORING PLAN; PERFORMANCE MEASURES

7.01.1 Reporting Requirements. CONTRACTOR will provide to OGB's Contract Manager, and to others designated by the Contract Manager, the monthly, quarterly, and annual reports as specified in the NIC.

7.01.2 Performance Standards and Guarantees. CONTRACTOR will abide by the performance standards and guarantees specified in the NIC.

8.0 GOVERNING LAW, VENUE

The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties hereunder, shall be construed pursuant to, and in accordance with, the laws of the State of Louisiana, and venue of any action brought under this contract shall be the Nineteenth (19th) Judicial District Court for the parish of East Baton Rouge, Louisiana.

9.0 INSURANCE CERTIFICATE

a. The Contractor shall procure and maintain for the duration of the Contract liability insurance, including coverage for but not limited to: claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, employees or sub-contractors; liability and insolvency protection, with a combined single limit liability of not less than Ten Million ($10,000,000.00) Dollars. The State of Louisiana, Office of OGB Benefits must be named as a loss payee.

b. The Contractor shall on request furnish OGB with certificate(s) of insurance effecting coverage required by this Contract. The certificate(s) for each insurance policy is to be signed by a person authorized by that insurer to bind coverage on its behalf. OGB reserves the right to require complete, certified copies of all required insurance policies, at any time required by this contract.

10.0 LIABILITY FOR DAMAGES BY THE CONTRACTOR

a. OGB shall not be held liable for claims for damages relating to any services rendered or arranged for by the Contractor.

b. The Contractor agrees to hold OGB harmless from all claims for damages relating to the Contractor negligence, including any claims relating to failure of the Contractor to provide services as specified in this Contract due to financial hardship or insolvency.

11.0 PERFORMANCE BOND

The Contractor shall furnish a performance bond in the amount of $1,000,000 (One Million) dollars.

12.0 RESPONSIBILITIES AND OTHER RIGHTS; THIRD PARTY LIABILITY

a. Both parties will use their best effort to advise the other party of matters regarding potential legal actions involving the Plan or this Contract and shall promptly advise the other party of such legal actions instituted against either party which come to its attention.

b. The Contractor shall make diligent but reasonable efforts to recover any erroneous payment of claims and any payment of claims for which an individual or entity other than the parties is primarily responsible. The Contractor shall not be required to institute legal proceedings or to provide legal representation to OGB to force its rights of subrogation and/or reimbursement, or coordination of Benefits, but may secure such representation for OGB at OGB's expense in those instances where

institution of legal proceedings is warranted, if authorized by OGB.

1. Each of the parties hereto shall use reasonable efforts to identify these claims and shall notify the other party of any such claims which come to its attention.

2. The Contractor shall not be required to join as a party litigant in any such action, except as required by law, but shall cooperate fully in all such recovery efforts. However, the Contractor, in its discretion and at its sole option, may join in any such action in which it has a justifiable interest.

3. The Contractor shall monitor any legal proceedings for the recovery of said payments on behalf of OGB and shall advise and consult with OGB during the course of litigation.

4. OGB shall be responsible for all attorney fees, court costs and other expenses associated with such recovery efforts unless the need for such efforts resulted from the grossly negligent, dishonest, fraudulent or criminal conduct of the Contractor.

13.0 REMEDIES FOR DEFAULT

Any claims or controversy arising out of this contract shall be resolved in accordance with the provisions of La R.S. 39:1524 – 1526.

14.0 SECURITY

CONTRACTOR's personnel will always comply with all security regulations in effect at the OGB's premises, and externally for materials belonging to the State or to the project. CONTRACTOR is responsible for promptly reporting any breach of security to the State.

15.0 CONFIDENTIALITY

The parties, their agents, staff members and employees agree to maintain as confidential all individually identifiable information regarding Louisiana Office of Group Benefits plan members, including but not limited to patient records, demographic information and claims history. All information obtained by CONTRACTOR from the Office of Group Benefits shall be maintained in accordance with state and federal law, specifically including but not limited to the Health Insurance Portability and Accountability Act of 1996, and any regulations promulgated thereunder (collectively, "HIPAA"). To that end, the parties have executed and hereby make a part of this Agreement a Protected Health Information (Business Associate) Addendum to be in full compliance with all relevant provisions of HIPAA, including but not limited to all provisions relating to Business Associates.

Further, the parties agree that all financial, statistical, personal, technical and other data and information relating to either party's operations which are designated confidential by such party and made available to the other party in carrying out this contract, shall be

protected by the receiving party from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the OGB and/or Contractor. Neither party shall be required to keep confidential any data or information which is or becomes publicly available, is already rightfully in the party's possession, is independently developed by the party outside the scope of this contract, or is rightfully obtained from third parties.

16.0 REPRODUCTION, PUBLICATION AND USE OF MATERIAL

Subject to the confidentiality obligations as set forth above, OGB shall have authority to reproduce, publish, distribute, and otherwise use, in whole or in part, any reports, data, studies, or surveys prepared by the Contractor for OGB in connection with this Contract or in the performance hereof which are not designated as proprietary by the Contractor.

17.0 ACKNOWLEDGEMENT OF PRIORITY POSITION

The Contractor acknowledges that OGB is a primary responsibility of the organization, and that such acknowledgement places performance of its Contractual duties for the State of Louisiana, Office of OGB Benefits in a high priority position relative to other clients of the organization

18.0 MOST FAVORED CUSTOMER GUARANTEE

The Contractor certifies and guarantees that the retention or other administrative charges to OGB, as forth in this Contract, are comparable to or better than the equivalent fees or charges being offered by the Contractor to any present or future customer or group of customers having a similar product design and of a comparable or lesser size. If the Contractor shall, during the term of this Contract, enter into an administrative services only agreement with any other customer or group customers having a similar product design to administer a comparable plan for a similar or lesser number of Participants in the Contractor's service area which provides for a lower retention or other administrative charges, this Contract shall be deemed thereupon amended to provide the same to OGB, with a retroactive finance adjusted to OGB dating back to the effective date of such lower retention or other administrative charge. An officer of the Contractor shall certify annually that, to the best of his or her knowledge, information, and belief, and predicated on his or her familiarity with the billing practices of the Contractor, the fees being charged to OGB by the Contractor are in full and complete compliance, in all respects, with the provisions of this Section. The Contractor shall provide such annual notice during the first quarter of each calendar year.

The Contractor certifies and guarantees that its medical reimbursement fee schedule is, in all respects, at least as low as any other medical reimbursement fee schedule presently in effect, or which shall be in effect, at any time during the term of this Agreement. If, at any time during the term of this Agreement, the Contractor offers a lower medical reimbursement fee schedule to any customer in the State of Louisiana it shall immediately

notify OGB to this effect in writing and all medical reimbursement fee schedules shall be immediately reduces to such lower amounts with a retroactive financial adjustment to OGB dating back to the effective date of the lower medical reimbursement fee schedule.

19.0 INDEMNIFICATION

19.01 CONTRACTOR agrees to protect, defend, indemnify and hold harmless OGB, the State of Louisiana, all State Departments, Agencies, Boards and Commissions, their respective officers, directors, agents, servants and employees, including volunteers (each a State Affiliated Indemnified Party), from and against any and all claims, demands, expense and liability arising out of or in any way growing out of any act or omission of CONTRACTOR, its agents, servants, and employees, together with any and all costs, expenses and/or attorney fees reasonably incurred as a result of any such claim, demands, and/or causes of action **except** those claims, demands and/or causes of action arising out of the act or omission of OGB, the State of Louisiana, State Departments, Agencies, Boards, Commission, their officers, directors, agents, servants and/or employees. CONTRACTOR agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at its sole expense, even if it (claims, etc.) is groundless, false or fraudulent, provided that (a) the State Affiliated Indemnified Party has given reasonable notice to CONTRACTOR of the claim or cause of action, and (b) no State Affiliated Indemnified Party has, by act or failure to act, compromised CONTRACTOR's position with respect to the resolution or defense of the claim or cause of action.

19.02 OGB agrees to protect, defend, indemnify and hold harmless CONTRACTOR, its officers, directors, agents, servants and employees, including volunteers (each an CONTRACTOR Indemnified Party), from and against any and all claims, demands, expense and liability arising out of or in any way growing out of any act or omission of OGB, its agents, servants, and employees, together with any and all costs, expenses and/or attorney fees reasonably incurred as a result of any such claim, demands, and/or causes of action **except** those claims, demands and/or causes of action arising out of the act or omission of CONTRACTOR, its officers, directors, agents, servants and/or employees. OGB agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at its sole expense, even if it (claims, etc.) is groundless, false or fraudulent, provided that (a) the CONTRACTOR Indemnified Party has given reasonable notice to OGB of the claim or cause of action, and (b) no CONTRACTOR Indemnified Party has, by act or failure to act, compromised OGB's position with respect to the resolution or defense of the claim or cause of action.

20.0 PATENT, COPYRIGHT, AND TRADE SECRET INDEMNITY

CONTRACTOR warrants that all materials and/or products affiliated by or produced by CONTRACTOR hereunder will not infringe upon or violate any patent, copyright, or trade secret right of any third party. In the event of any such claim by any third party against OGB, OGB shall promptly notify CONTRACTOR, and CONTRACTOR shall defend such claim, in OGB's name, but at CONTRACTOR's expense, and shall indemnify OGB against any loss, expense, or liability arising out of such claim, whether or not such claim is successful. Notwithstanding this paragraph, CONTRACTOR may delegate some responsibilities under this Contract to one or more affiliates of CONTRACTOR.

21.0 OWNERSHIP OF PRODUCT

All records, reports, documents and other material delivered or transmitted to CONTRACTOR by State shall remain the property of State, and shall be returned by CONTRACTOR to State, at CONTRACTOR's expense, at termination or expiration of this contract. CONTRACTOR may retain one copy of such records, documents or materials for archival purposes and to defend its work product. All records, reports, documents, or other material related to this contract and/or obtained or prepared by CONTRACTOR specifically and exclusively for State in connection with the performance of the services contracted for herein shall become the property of State, and shall, upon request, be returned by CONTRACTOR to State, at CONTRACTOR's expense, at termination or expiration of this contract.

22.0 ASSIGNMENT

CONTRACTOR shall not assign any interest in this contract and shall not transfer any interest in same (whether by assignment or novation), without prior written consent of the State, provided however, that claims for money due or to become due to CONTRACTOR from the State may be assigned to a bank, trust company, or other financial institution without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to the State and to the Office of Contractual Review, Division of Administration.

23.0 RIGHT TO AUDIT

CONTRACTOR hereby grants to the Legislative Auditor of the State of Louisiana and/or the Office of the Governor, Division of Administration Auditors, and/or OGB's Internal Audit Division, or any third party designated by OGB, the option of auditing all records of CONTRACTOR pertinent to the contract. Such audit or audits shall be performed in a manner so as not to interfere unreasonably with CONTRACTOR's obligations and shall be performed at OGB's expense upon adequate prior written notice, at reasonable intervals, and during regular business hours.

24.0 RECORD RETENTION

CONTRACTOR agrees to retain all books, records, and other documents relevant to this contract and the funds expended hereunder for at least three years after project completion of contract, or as required by applicable Federal law, whichever is longer.

25.0 AMENDMENTS IN WRITING

Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when it has been reduced to writing and duly signed. No amendment shall be valid until it has been executed by all parties and approved by the Director of the Office of Contractual Review, Division of Administration.

26.0 FUND USE

CONTRACTOR agrees not to use funds received for services rendered under this contract to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition on any election ballot or a proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority.

27.0 NON-DISCRIMINATION

CONTRACTOR agrees to abide by the requirements of the following as applicable: Title VI and VII of the Civil Rights Act of 1964, as amended by the Equal Opportunity Act of 1972, Federal Executive Order 11246, the Federal Rehabilitation Act of 1973, as amended, the Vietnam Era Veteran's Readjustment Assistance Act of 1974, Title IX of the Education Amendments of 1972, the Age Act of 1972, and CONTRACTOR agrees to abide by the requirements of the Americans with Disabilities Act of 1990. CONTRACTOR agrees not to discriminate in its employment practices, and will render services under this contract without regard to race, color, religion, sex, national origin, veteran status, political affiliation, disabilities, or because of an individual's sexual orientation. Any act of discrimination committed by CONTRACTOR, or failure to comply with these obligations when applicable shall be grounds for termination of this contract.

28.0 CAUSES BEYOND CONTROL

Neither party shall be responsible for delays or failure in performance resulting from acts beyond the control of such party. Such acts shall include but not be limited to acts of God, strikes, riots, lockouts, acts of war, epidemics, governmental regulations superimposed after the fact, fire, communication line failures, power failure, earthquakes, or other disasters, or by reason of judgment, ruling, or order of any court or agency of

competent jurisdiction.

29.0 HEADINGS

Descriptive headings in this contract are for convenience only and shall not affect the construction or meaning of contractual language.

30.0 WORKER'S COMPENSATION

Contract is not in lieu of and does not affect any requirements of coverage under the Louisiana Worker's Compensation Act or any other federal or state mandated employer liability laws.

31.0 SUBCONTRACTORS

Upon approval of OGB the Contractor can use its affiliates or other subcontractors to perform its services under this contract. However, the Contractor will be responsible for those services to the same extent that the Contractor would have been had the Contractor performed those services without the use of an affiliate or Subcontractor.

32.0 INDEPENDENT CONTRACTOR RELATIONSHIP

No provision of this Contract is intended to create nor shall it be deemed or construed to create any relationship between the Contractor and OGB other than that of independent entities Contracting with each other hereunder solely for the purpose of effecting the provisions of this Contract. The terms "Contractor" and "OGB" shall include all officers, directors, agents, employees or servants of each party.

33.0 WAIVER OF BREACH

The waiver by either party of a breach or violation of any provision of the contract shall not operate as, or be construed to be, a waiver of any subsequent breach of the contract.

34.0 SEVERABILITY

The invalidity or unenforceability of any terms or conditions of the contract shall in no way effect the validity or enforceability of any other terms or provisions.

35.0 NOTICE

Any notice, demand, communication or payment required under the contract shall be deemed effectively given when personally delivered or mailed, postage prepaid, as follows:

OGB: Office of Group Benefits Program
Attention: Tommy D. Teague
Chief Executive Officer
7389 Florida Blvd., Ste. 400
Baton Rouge, LA 70806
or
Post Office Box 44036
Baton Rouge, LA 70804

CONTRACTOR: TBD

36.0 ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

36.1 This contract (together with the NIC issued thereto by the State, the Proposal submitted by CONTRACTOR in response to the State's NIC, and any exhibits specifically incorporated herein by reference) constitutes the entire agreement between the parties with respect to the subject matter.

36.2 This contract shall, to the extent possible, be constructed to give effect to all provisions contained therein: however, where provisions are in conflict, first priority shall be given to the provisions of the contract, excluding the NIC and the Proposal; second priority shall be given to the provisions of the NIC and amendments thereto; and third priority shall be given to the provisions of the Proposal.

THUS DONE AND SIGNED ON THE DATE(S) LISTED BELOW:

STATE OF LOUISIANA
DIVISION OF ADMINSTRATION
OFFICE OF GROUP BENEFITS

_____
Tommy D. Teague
Chief Executive Officer

_____
Witness

_____
Witness

CONTRACTOR

_____

_____
Witness

_____
Witness

EXHIBIT 1

SAMPLE

BUSINESS ASSOCIATE ADDENDUM (BAA)

State of Louisiana, Division of Administration
Office of Group Benefits
Protected Health Information Addendum

I. Definitions

a) "Administrative Safeguards" shall mean administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information., as more particularly set forth in 45 CFR § 164.308.
b) "Agreement" shall mean the agreement between Business Associate and OGB, dated _____, pursuant to which Business Associate is to provide certain services to OGB involving the use or disclosure of PHI, as defined below.
c) "Business Associate" shall mean _____.
d) "ePHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
e) "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
f) "HIPAA Regulations" shall mean the Privacy Rule and the Security Rule.
g) "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
h) "OGB" shall mean the State of Louisiana, Division of Administration, Office of Group Benefits, which is a covered entity under the HIPAA Regulations, as defined herein.
i) "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
j) "Physical Safeguards" shall mean physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion as more particularly set forth in 45 CFR § 164.310.
k) "Privacy Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Privacy of Individually Identifiable Health Information at 45 CFR, Part 160 and Part 164, Subparts A and E.
l) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
m) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
n) "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.
o) "Security Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Security Standards for Electronic Protected Health Information at 45 CFR, Part 160 and Part 164, Subparts A and C.

p) “Technical Safeguards” shall mean the technology and the policy and procedures for its use that protect electronic protected health information and control access to it, as more particularly set forth in 45 CFR § 164.312.
q) Any other terms used in this Addendum that are not defined herein but are defined in the HIPAA Regulations shall have the same meaning as given in the HIPAA Regulations.

II. Obligations and Activities of Business Associate

a) Business associate agrees to comply with OGB policies and procedures regarding the use and disclosure of PHI.
b) Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Addendum, or as Required by Law.
c) Business Associate agrees to limit all requests to OGB for PHI to the minimum information necessary for Business Associate to perform functions, activities, or services for or on behalf of OGB as specified in the Agreement.
d) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum.
e) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum.
f) Business Associate agrees to report to OGB any use or disclosure of the PHI not provided for by this Addendum of which it becomes aware. Such report shall be made within two (2) business days of Business Associate learning of such use or disclosure.
g) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, OGB agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information. However, Business Associate shall not enter into any subcontractor or other agency relationship with any third party that involves use or disclosure of such PHI without the advance written consent of OGB.
h) Business Associate agrees to provide access, at the request of OGB, and in the time and manner designated by OGB, to PHI maintained by Business Associate in a Designated Record Set, to OGB or, as directed by OGB, to an Individual in order to meet the requirements under 45 CFR § 164.524.
i) Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that OGB directs or agrees to pursuant to 45 CFR § 164.526 at the request of OGB or an Individual, and in the time and manner designated by OGB.
j) Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, OGB available to OGB, or at the request of OGB to the Secretary, in a time and manner designated by OGB or the Secretary, for purposes of the Secretary determining OGB's compliance with the Privacy Rule.
k) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

l) Business Associate agrees to provide to OGB or an Individual, in a time and manner designated by OGB, information collected in accordance with Section II.j of this Addendum, to permit OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
m) At any time(s) requested by OGB, Business Associate agrees to return to OGB or destroy such PHI in its possession as directed by OGB.
n) Business Associate shall defend and indemnify OGB from and against any and all claims, costs, and/or damages arising from a breach by Business Associate of any of its obligations under this Addendum. Any limitation of liability provision set forth in the Agreement, including but not limited to any cap on direct damage liability and any disclaimer of liability for any consequential, indirect, punitive, or other specified types of damages, shall not apply to the defense and indemnification obligation contained in this Addendum.
o) Business Associates shall relinquish to OGB all control over responses to subpoenas Business Associate receives related to PHI.
p) Business Associate shall:
    1. Implement and document Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of OGB, specifically including, but not limited to, the following:
        i) Ensuring the confidentiality, integrity, and availability of all ePHI that it creates, receives, maintains, or transmits on behalf of OGB;
        ii) Protecting against any reasonably anticipated threats or hazards to the security or integrity of such information;
        iii) Protecting against any reasonably anticipated uses or disclosures of such information that are not permitted or required by this Addendum or Required by Law; and
        iv) Ensuring compliance with these requirements by its workforce;
    2. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate safeguards to protect it;
    3. Report to OGB any Security Incident of which it becomes aware. If no Security Incidents are reported, Business Associate shall certify to OGB in writing within ten (10) days of each anniversary date of the Agreement that there have been no Security Incidents during the previous twelve months.
q) Business Associate shall not permit PHI to be disclosed to or used by any individual or entity outside of the territorial and jurisdictional limits of the fifty United States of America.

III. Permitted Uses and Disclosures by Business Associate

a) Except as otherwise limited in this Addendum, Business Associate may use or disclose PHI to perform functions, activities, or services for or on behalf of OGB as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by OGB or the minimum necessary policies and procedures of OGB.
b) Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

c) Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that such disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that it will remain confidential and be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person promptly notifies the Business Associate of any known instances of breach of the confidentiality of the PHI
d) Except as otherwise limited in this Addendum, Business Associate may use PHI to provide Data Aggregation services to OGB as permitted by 45 CFR § 164.504(e)(2)(i)(B), provided that such services are contemplated by the Agreement.
e) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

IV. Obligations and Activities of OGB

a) With the exception of Data Aggregation services as permitted by 45 CFR § 164.504(e)(2)(i)(B), OGB shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by OGB.
b) OGB shall notify Business Associate of any limitation(s) in OGB's Notice of Privacy Practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
c) OGB shall notify Business Associate of any changes in, or revocation of, permission by any Individual to use or disclose PHI, to the extent such changes may affect Business Associate's use or disclosure of PHI.
d) OGB shall notify Business Associate of any restriction to the use or disclosure of PHI that OGB has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI.

V. Term and Termination

a) Term. The Term of this Addendum shall commence on the effective date set forth below, and shall terminate when all of the PHI provided by OGB to Business Associate, or created or received by Business Associate on behalf of OGB, is destroyed or returned to OGB, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.
b) Termination of Agreement for Cause. In the event that OGB learns of a material breach of this Addendum by Business Associate, OGB shall, in its discretion:
    1. Provide a reasonable opportunity for Business Associate to cure the breach to OGB's satisfaction. If Business Associate does not cure the breach within the time specified by OGB, OGB may terminate the Agreement for cause; or
    2. Immediately terminate the Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or
    3. If neither termination nor cure is feasible, OGB may report the violation to the Secretary.

c) Effect of Termination.
    1. Except as provided in paragraph (2) below, upon termination of the Agreement for any reason, Business Associate shall return or destroy all PHI received from OGB, or created or received by Business Associate on behalf of OGB. Business Associate shall retain no copies of the PHI. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate.
    2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to OGB written notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the parties that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such PHI.

VI. Miscellaneous

a) A reference in this Addendum to a section in the HIPAA Regulations means the section as in effect or as amended, and for which compliance is required.
b) The parties agree to amend this Addendum from time to time as necessary for OGB to comply with the requirements of the HIPAA Regulations and the Health Insurance Portability and Accountability Act, Public Law 104-191.
c) If applicable, the obligations of Business Associate under Section V.c.2 of this Addendum shall survive the termination of this Addendum.
d) Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits OGB to comply with the HIPAA Regulations. It is the intent of the parties that neither this Addendum, nor any provision in this Addendum, shall be construed against either party pursuant to the common law rule of construction against the drafter.
e) Except as expressly stated herein, the parties to this Addendum do not intend to create any rights in any third parties. Nothing in this Addendum shall confer upon any person other that the parties and their respective successors or assigns any rights, remedies, obligations, or liabilities whatsoever.
f) In the event of any conflict between the terms of the Agreement and the terms of this Addendum, the terms of this Addendum will control, with the exception that if the Agreement contains any provisions relating to the use or disclosure of PHI that are more protective of the confidentiality of PHI than the provisions of this Addendum, then the more protective provisions will control. The provisions of this Addendum are intended to establish the minimum limitations on Business Associate's use and disclosure of PHI.
g) The terms of this Addendum shall be construed in light of any applicable interpretation or guidance on HIPAA and/or the HIPAA Regulations issued from time to time by the Department of Health and Human Services or the Office for Civil Rights.
h) This Addendum may be modified or amended only by a writing signed by the party against which enforcement is sought.
i) Neither this Addendum nor any rights or obligations hereunder may be transferred or assigned by one party without the other party's prior written consent, and any attempt to the contrary shall be void. Consent to any proposed transfer or assignment may be withheld by either party for any or no reason.

j) Waiver of any provision hereof in one instance shall not preclude enforcement thereof on future occasions.
k) For matters involving the HIPAA Regulations, this Addendum and the Agreement will be governed by the laws of the State of Louisiana, without giving effect to choice of law principles.

In witness whereof, the parties have executed this Addendum through their duly authorized representatives. This Addendum shall be effective as of the _____ day of _____, 20___.

State of Louisiana,
Division of Administration
Office of Group Benefits

By:_____ By:_____

Name: Tommy D. Teague Name:_____

Title: Chief Executive Officer Title:_____

EXHIBIT 1

ATTACHMENT - A

FINANCIAL AGREEMENT
SELF-FUNDED ONLY

1. PAYMENT FACTORS:

Listed below identifies the applicable Administrative Fee charge Per Employee/Retiree Per Month (PEPM) for each Contract Year during the Contract term.

Administrative Fees

Plan Year 7/1/10 – 6/30/11	$ _____ PEPM
Plan Year 7/1/11 – 6/30/12	$ _____ PEPM
Plan Year 7/1/12 – 6/30/13	$ _____ PEPM

The Contractor agrees that the Administrative Fees includes services to be provided by the Contractor to pay run out claims and continue reporting to OGB those claims.

2. CLAIM PAYMENT PROCEDURES

The Contractor will provide OGB with an invoice, with an accompanying electronic check register file, on a daily basis showing all paid claims. The total of the claims paid on the invoice shall match the total of the claims paid on the file. The Contractor shall use its best efforts to forward the invoice and file to OGB no later than 2:00 p.m. on each day. OGB shall pay the invoice (assuming the totals on the file and invoice match) within 48 hours after receiving the invoice(s) together with supporting details provided by the Contractor, by wire transfer or other method acceptable to the Contractor.

Separate invoices shall be prepared by the Contractor with respect to claims for active and retiree participants.

The Contractor agrees to pay its providers within 48 hours from receipt of payment from OGB. If the contractor pays its network providers on other than a daily basis, OGB agrees to pay the contractor within 48 hours of contractor's payment date.

OGB shall pay interest on all delinquent payments. The interest rate shall be the average of the Money Market Fund rates reported on each day of delinquency in The

Wall Street Journal.

3. FINAL SETTLEMENT

Within sixteen (16) months of the Contract termination date there shall be a final settlement between OGB and the Contractor. At the final settlement, the Contractor shall report all claims which were incurred prior to the termination of the Contract, but which were paid during the twelve months immediately following termination. If the estimate of incurred claims calculated in the interim settlement is greater than the actual amount, the difference plus interest shall be refunded to OGB. The interest rate shall be the average of the weekly Money Market Fund rates reported each Thursday in The Wall Street Journal. If the estimate of incurred claims calculated in the interim settlement is less than the actual amount, OGB shall pay the difference to the Contractor with ten (10) business days.

EXHIBIT 2

Chapter 62. Regulation 77—Medical Necessity Review Organizations

§6201. Purpose

A. The purpose of this regulation is to enforce the statutory requirements of Title 22 of the Louisiana Revised Statutes of 1950 that require health insurance issuers who seek to establish exception criteria or limitations on covered benefits that are otherwise offered and payable under a policy or certificate of coverage sold in this state, by requiring a medical necessity determination to be made by the health insurance issuer. The statutory requirements also apply to any health benefit plan that establishes exception criteria or limitations on covered benefits that are otherwise offered and payable under a non-federal government benefit plan. Additionally, the statute establishes a process for Medical Necessity Review Organizations to qualify for state licensure and Independent Review Organizations to become certified by the Department of Insurance. The statutory requirements establish the intent of the legislature to assure licensed health insurance issuers and non-federal government benefit plans meet minimum quality standards and do not utilize any requirement that would act to impinge on the ability of insureds or government employees to receive appropriate medical advice and/or treatment from a health care professional. This regulation has no effect on the statutory requirements of R.S. 22:657. Emergency medical conditions as defined in R.S. 22:657 shall be covered and payable as provided therein.

B. This regulation implements the statutory requirements of R.S. §§22:2021, and Chapter 7 of Title 22 of the Louisiana Revised Statutes regarding the use of medical necessity to limit stated benefits in a fully insured health policy or HMO certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:844 (April 2002).

§6203. Definitions

Adverse Determination—a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and denied, reduced, or terminated by a reviewer based on medical necessity, appropriateness, health care setting, level of care, or effectiveness.

Ambulatory Review—a review of health care services performed or provided in an outpatient setting.

Appropriate Medical Information—all outpatient and inpatient medical records that are pertinent to the evaluation and management of the covered person and that permit the Medical Necessity Review Organization to determine compliance with the applicable clinical review criteria. In the review of coverage for particular services, these records may include, but are not necessarily limited to, one or more of the following portions of the covered person's medical records as they relate directly to the services under review for medical necessity:

1. admission history and physical examination report;
2. physician's orders;
3. progress notes;
4. nursing notes;
5. operative reports;

6. anesthesia records;
7. hospital discharge summary;
8. laboratory and pathology reports;
9. radiology or other imaging reports;
10. consultation reports;
11. emergency room records; and
12. medication records.

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.

Case Management—a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

Certification or *Certify*—a determination by a reviewer regarding coverage of an admission, continued stay, or other health care service for the purpose of determining medical necessity, appropriateness of the setting, or level of care.

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.).

Clinical Review Criteria—the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a reviewer to determine the necessity and appropriateness of covered health care services.

Commissioner—the Commissioner of Insurance.

Concurrent Review—a review of medical necessity, appropriateness of care, or level of care conducted during a patient's stay or course of treatment.

Covered Benefits or *Benefits*—those health care services to which a covered person is entitled under the terms of a health benefit plan.

Covered Person—a policyholder, subscriber, enrollee, or other individual covered under a policy of health insurance or HMO subscriber agreement.

Discharge Planning—the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

Disclose—to release, transfer, or otherwise divulge protected health information to any individual, entity, or person other than the individual who is the subject of the protected health information.

Emergency Medical Condition—a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the health of the individual in serious jeopardy;
2. with respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy;
3. serious impairment to bodily function; or
4. serious dysfunction of any bodily organ or part.

Entity—an individual, person, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, any similar entity, agent, or contractor, or any combination of the foregoing.

External Review Organization—an independent review organization that conducts independent external reviews of adverse determinations and final adverse determinations and whose accreditation or certification has been reviewed and approved by the Department of Insurance.

Facility—an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing facilities, inpatient hospice facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

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 as set forth in this Chapter.

Health Benefit Plan—group and individual health insurance coverage, coverage provided under a group health plan, or coverage provided by a nonfederal governmental plan, as those terms are defined in R.S. 22:250.1. Health benefit plan shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:250.1(3).

Health Care Professional—a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law.

Health Care Provider or *Provider*—a health care professional, the attending, ordering, or treating physician, or a facility.

Health Care Services—services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Information—information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to any of the following:

1. the past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;
2. the provision of health care services to a covered person; or
3. payment for the provision of health care services to a covered person.

Health Insurance Coverage—benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

Health Insurance Issuer—an insurance company, including a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

Medical Necessity Review Organization or *MNRO*—a health insurance issuer or other entity licensed or authorized pursuant to this Chapter to make medical necessity determinations for purposes other than the diagnosis and treatment of a medical condition.

Prospective Review—a review conducted prior to an admission or a course of treatment.

Protected Health Information—health information that either identifies a covered person who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify a covered person.

Retrospective Review—a review of medical necessity conducted after services have been provided to a patient, but shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

Second Opinion—an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:845 (April 2002).

§6205. Authorization or Licensure as an MNRO

A. No health insurance issuer or health benefit plan, as defined in this Chapter, shall act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar medical determinations unless authorized to act as an MNRO by the commissioner as provided in this Chapter. Benefits covered under a health benefit plan sold or in effect in this state on or after January 1, 2001 shall be limited, excluded, or excepted from coverage under any medical necessity determination requirement, appropriateness of care determination, level of care needed, or any other similar determination only when such determination is made by an authorized or licensed MNRO as provided in this Chapter.

B. No entity acting on behalf of or as the agent of a health insurance issuer may act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations unless licensed as an MNRO by the commissioner as provided in this Chapter.

C. Any other entity may apply for and be issued a license under this Chapter to act as an MNRO for the purposes of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations on behalf of a health benefit plan.

D. Any entity licensed or authorized as an MNRO shall be exempt from the requirements of R.S. 40:2721 through 2736. The licensure, authorization, or certification of any entity as an MNRO or independent or external review organization shall be effective beginning on the date of first application for all entities who receive formal written authorization, licensure, or certification by the Commissioner of

Insurance. This provision shall remain in effect until December 31, 2001. Any application filed after December 31, 2001 shall become effective upon final approval by the Department of Insurance and not upon date of first application. Therefore any application submitted and filed after December 31, 2001, the licensure, authorization or certification of an entity as an MNRO or independent or external review organization shall be effective upon the date final approval is granted by the Commissioner of Insurance.

E. An integrated health care network or other entity contracting with a health insurance issuer for provision of covered services under a risk sharing arrangement, shall be allowed to make initial adverse medical necessity determinations provided the health insurance issuer remains responsible for provision of internal and external review requirements and has submitted the information required under Paragraph B.5 of §6207 for review and approval. In such instances, a covered person's request for an internal or external appeal of an adverse determination shall not require concurrence by a provider reimbursed under a risk sharing arrangement with the health insurance issuer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:846 (April 2002).

§6207. Procedure for Application to Act as an MNRO

A. Any applicant for licensure other than a health insurance issuer shall submit an application to the commissioner and pay an initial licensure fee as specified in §6211.D. The application shall be on a form and accompanied by any supporting documentation required by the commissioner and shall be signed and verified by the applicant. The information required by the application shall include:

1. the name of the entity operating as an MNRO and any trade or business names used by that entity in connection with making medical necessity determinations;
2. the names and addresses of every officer and director of the entity operating as an MNRO, as well as the name and address of the corporate officer designated by the MNRO as the corporate representative to receive, review, and resolve all grievances addressed to the MNRO;
3. the name and address of every person owning, directly or indirectly, five percent or more of the entity operating as an MNRO;
4. the exact street and mailing address of the principal place of business where the MNRO will operate and conduct medical necessity review determinations;
5. a general description of the operation of the MNRO, which includes a statement that the MNRO does not engage in the practice of medicine or acts to impinge or encumber the independent medical judgment of treating physicians or health care providers;
6. a description of the MNRO's program that evidences it meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis. (Such program description shall evidence compliance with requirements of §6213 of this Chapter);
7. a sample copy of any contract, absent fees charged, with a health insurance issuer, nonfederal government health benefit plan, or other group health plan for making determinations of medical necessity;
8. for each individual that will be designated to make adverse medical necessity determinations pursuant to this Chapter:
    a. a description of the types of determinations that will be made by the individual and the type of license that will be required to support such determinations; and

b. a written policy statement that the individual shall have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character;

c. a written policy statement that the individual will be required to attest that no adverse determination will be made regarding any medical procedure or service outside the scope of such individual's expertise.

B. A health insurance issuer holding a valid certificate of authority to operate in this state may be authorized to act as an MNRO under the requirements of this Chapter following submission to the commissioner of appropriate documentation for review and approval that shall include, but need not be limited, to the following:

1. the exact street and mailing address of the principal place of business where the MNRO will operate and conduct medical necessity review determinations;
2. a general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgment of treating physicians or health care providers;
3. a description of the MNRO's program that evidences it meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis. (Such program description shall evidence compliance with requirements of §6213 of this Chapter);
4. a sample copy of any contract, absent fees charged, with another health insurance issuer for making determinations of medical necessity;
5. for each individual that will be designated to make adverse medical necessity determinations pursuant to this Chapter:
   a. a description of the types of determinations that will be made by the individual and the type of license that will be required to support such determinations;
   b. a written policy statement that the individual shall have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and
   c. a written policy statement that the individual will be required to attest that no adverse determination will be made regarding any medical procedure or service outside the scope of such individual's expertise.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and, 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:847 (April 2002).

§6211. Expiration and Renewal of License for Entities other than Health Insurance Issuers

A. Licensure pursuant to this Chapter shall expire two years from the date approved by the commissioner unless the license is renewed for a two-year term as provided in this Section.

B. Before a license expires, it may be renewed for an additional two-year term if the applicant pays a renewal fee as provided in this Section and submits to the commissioner a renewal application on the form that the commissioner requires.

C. The renewal application required by the commissioner shall include, but need not be limited to, the information required for an initial application.

D. The fee for initial licensure and the fee for renewal of licensure shall each be $1,500.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014 and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6213. Scope and Content of Medical Necessity Determination Process

A. An MNRO shall implement a written medical necessity determination program that describes all review activities performed for one or more health benefit plans. The program shall include the following:

1. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;
2. data sources and clinical review of criteria used in decision-making. The appropriateness of clinical review criteria shall be fully documented;
3. the process for conducting appeals of adverse determinations including informal reconsiderations;
4. mechanisms to ensure consistent application of review criteria and compatible decisions;
5. data collection processes and analytical methods used in assessing utilization of health care services;
6. provisions for assuring confidentiality of clinical and proprietary information;
7. the organizational structure, including any review panel or committee, quality assurance committee, or other committee that periodically accesses health care review activities and reports to the health benefit plan;
8. the medical director's responsibilities for day-to-day program management;
9. any quality management program utilized by the MNRO.

B. An MNRO shall file with the commissioner an annual summary report of its review program activities that includes a description of any substantive changes that have been implemented since the last annual report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6215. Medical Necessity Review Organization Operational Requirements

A. An MNRO shall use documented clinical review criteria that are based on sound clinical evidence. Such criteria shall be evaluated at least annually and updated if necessary to assure ongoing efficacy. An MNRO may develop its own clinical review criteria or it may purchase, license or contract for clinical review criteria from qualified vendors. An MNRO shall make available its clinical review criteria upon request to the commissioner who shall be authorized to request affirmation of such criteria from other appropriate state regulatory agencies.

B. An MNRO shall have a medical director who shall be a duly licensed physician. The medical director shall administer the program and oversee all adverse review decisions. Adverse determinations shall be made only by a duly licensed physician or clinical peer. An adverse determination made by an MNRO in

the second level review shall become final only when a clinical peer has evaluated and concurred with such adverse determination.

C. An MNRO shall issue determination decisions in a timely manner pursuant to the requirements of this Chapter. At the time of the request for review, an MNRO shall notify the requestor of all documentation required to make a medical review determination. The requestor may include the covered person, an authorized representative, or a provider. In the event that the MNRO determines that additional information is required, it shall notify the requestor by telephone, within one workday of such determination, to request any additional appropriate medical information required. An MNRO shall obtain all information required to make a medical necessity determination, including pertinent clinical information, and shall have a process to ensure that qualified health care professionals performing medical necessity determinations apply clinical review criteria consistently.

D. At least annually, an MNRO shall routinely assess the effectiveness and efficiency of its medical necessity determination program and report any deficiencies or changes to the commissioner. Deficiencies shall include complaint investigations by the department or grievances filed with the MNRO that prompted the MNRO to change procedures or protocols.

E. An MNRO's data systems shall be sufficient to support review program activities and to generate management reports to enable the health insurance issuer or other contractor to monitor its activities.

F. Health insurance issuers who delegate any medical necessity determination functions to an MNRO shall be responsible for oversight, which shall include, but not be limited to, the following:

1. a written description of the MNRO's activities and responsibilities, including reporting requirements;

2. evidence of formal approval of the medical necessity determination program by the health insurance issuer;

3. a process by which the health insurance issuer monitors or evaluates the performance of the MNRO.

G. Health insurance issuers who perform medical necessity determinations shall coordinate such program with other medical management activities conducted by the health insurance issuer, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

H. An MNRO shall provide health care providers with access to its review staff by a toll-free number that is operational for any period of time that an authorization, certification, or approval of coverage is required.

I. When conducting medical necessity determinations, the MNRO shall request only the information necessary to certify an admission to a facility, procedure or treatment, length of stay, frequency, level of care or duration of health care services.

J. Compensation to individuals participating in a medical necessity determination program shall not contain incentives, direct or indirect, for those individuals to make inappropriate or adverse review determinations. Compensation to any such individuals shall not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

K. An adverse determination shall not be based on the outcome of care or clinical information not available at the time the certification was made, regardless of whether the covered person or provider assumes potential liability for the cost of such care while awaiting a coverage determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6217. Procedures for Making Medical Necessity Determinations

A. An MNRO shall maintain written procedures for making determinations and for notifying covered persons and providers and other authorized representatives acting on behalf of covered persons of its decisions.

B.1. In no less than 80 percent of initial determinations, an MNRO shall make the determination within two working days of obtaining any appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. In no instance shall any determination of medical necessity be made later than 30 days from receipt of the request unless the patient's physician or other authorized representative has agreed to an extension.

2. In the case of a determination to certify a nonemergency admission, procedure, or service, the MNRO shall notify the provider rendering the service within one work day of making the initial certification and shall provide documented confirmation of such notification to the provider within two working days of making the initial certification.

3. In the case of an adverse determination of a nonemergency admission, the MNRO shall notify the provider rendering the service within one workday of making the adverse determination and shall provide documented confirmation of the notification to the provider within two working days of making the adverse determination.

C.1. For concurrent review determinations of medical necessity, an MNRO shall make such determinations within one working day of obtaining the results of appropriate medical information that may be required.

2. In the case of a determination to certify an extended stay or additional services, the MNRO shall notify the provider rendering the service within one working day of making the certification and shall provide documented confirmation to the provider within two working days of the authorization. Such documented notification shall include the number of intended days or next review date and the new total number of days or services approved.

3. In the case of an adverse determination, the MNRO shall notify the provider rendering the service within one working day of making the adverse determination and shall provide documented notification to the provider within one workday of such notification. The service shall be authorized and payable by the health insurance issuer without liability, subject to the provisions of the policy or subscriber agreement, until the provider has been notified in writing of the adverse determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider unless notified of such liability in advance.

D.1. For retrospective review determinations, the MNRO shall make the determination within 30 working days of obtaining the results of any appropriate medical information that may be required, but in no instance later than 180 days from the date of service. The MNRO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon prior approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider or unless the coverage was duly canceled for fraud, misrepresentation, or nonpayment of premiums.

2. In the case of an adverse determination, the MNRO shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

E. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the

instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. An MNRO shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures.

F. An MNRO shall have written procedures listing the health or appropriate medical information required from a covered person or health care provider in order to make a medical necessity determination. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall also outline the process to be followed in the event that the MNRO determines the need for additional information not initially requested.

G. An MNRO shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where the provider or a covered person will not release necessary information, the MNRO may deny certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:849 (April 2002).

§6219. Informal Reconsideration

A. In a case involving an initial determination or a concurrent review determination, an MNRO shall give the provider rendering the service an opportunity to request, on behalf of the covered person, an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination. Allowing a 10-day period following the date of the adverse determination for requesting an informal reconsideration shall be considered reasonable.

B. The informal reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the MNRO'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 working day.

C. If the informal reconsideration process does not resolve the differences of opinion, the adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Informal reconsideration shall not be a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6221. Appeals of Adverse Determinations; Standard Appeals

A. An MNRO shall establish written procedures for a standard appeal of an adverse determination, which may also be known as a first level internal appeal. Such procedures shall be available to the covered person and to the provider acting on behalf of the covered person. Such procedures shall provide for an appropriate review panel for each appeal that includes health care professionals who have appropriate expertise. Allowing a 60-day period following the date of the adverse determination for requesting a standard appeal shall be considered reasonable.

B. For standard appeals, a duly licensed physician shall be required to concur with any adverse determination made by the review panel.

C. The MNRO shall notify in writing both the covered person and any provider given notice of the adverse determination, of the decision within thirty working days following the request for an appeal,

unless the covered person or authorized representative and the MNRO mutually agree that a further extension of the time limit would be in the best interest of the covered person. The written decision shall contain the following:

1. the title and qualifying credentials of the physician affirming the adverse determination;
2. a statement of the reason for the covered person's request for an appeal;
3. an explanation of the reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the MNRO's position;
4. if applicable, a statement including the following:
   a. a description of the process to obtain a second level review of a decision;
   b. the written procedures governing a second level review, including any required time frame for review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6223. Second Level Review

A. An MNRO shall establish a second level review process to give covered persons who are dissatisfied with the first level review decision the option to request a review at which the covered person has the right to appear in person before authorized representatives of the MNRO. An MNRO shall provide covered persons with adequate notice of this option, as described in §6221.C. Allowing a 30-day period following the date of the notice of an adverse standard appeal decision shall be considered reasonable.

B. An MNRO shall conduct a second level review for each appeal. Appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination. A majority of any review panel used shall be comprised of persons who were not previously involved in the appeal. However, a person who was previously involved with the appeal may be a member of the panel or appear before the panel to present information or answer questions. The panel shall have the legal authority to bind the MNRO and the health insurance issuer to the panel's decision.

C. An MNRO shall ensure that a majority of the persons reviewing a second level appeal are health care professionals who have appropriate expertise. An MNRO shall issue a copy of the written decision to a provider who submits an appeal on behalf of a covered person. In cases where there has been a denial of service, the reviewing health care professional shall not have a material financial incentive or interest in the outcome of the review.

D. The procedures for conducting a second level review shall include the following.

1. The review panel shall schedule and hold a review meeting within 45 working days of receiving a request from a covered person for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, an MNRO shall offer the covered person and any provider given a notice of adverse determination the opportunity to communicate with the review panel, at the MNRO's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified of the time and place of the review meeting in writing at least 15 working days in advance of the review date; such notice shall also advise the covered person of his rights as specified in Paragraph 3 of this Subsection. The MNRO

shall not unreasonably deny a request for postponement of a review meeting made by a covered person.

2. Upon the request of a covered person, an MNRO shall provide to the covered person all relevant information that is not confidential or privileged.

3. A covered person shall have the right to the following:

   a. attend the second level review;

   b. present his case to the review panel;

   c. submit supporting material and provide testimony in person or in writing or affidavit both before and at the review meeting;

   d. ask questions of any representative of the MNRO.

4. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

5. For second level appeals, a duly licensed and appropriate clinical peer shall be required to concur with any adverse determination made by the review panel.

6. The MNRO shall issue a written decision to the covered person within five working days of completing the review meeting. The decision shall include the following:

   a. the title and qualifying credentials of the appropriate clinical peer affirming an adverse determination;

   b. a statement of the nature of the appeal and all pertinent facts;

   c. the rationale for the decision;

   d. reference to evidence or documentation used in making that decision;

   e. the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination;

   f. notice of the covered person's right to an external review, including the following:

   i. a description of the process to obtain an external review of a decision;

   ii. the written procedures governing an external review, including any required time frame for review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6225. Request for External Review

A. Each health benefit plan shall provide an independent review process to examine the plan's coverage decisions based on medical necessity. A covered person, with the concurrence of the treating health care provider, may make a request for an external review of a second level appeal adverse determination.

B. Except as provided in this Subsection, an MNRO shall not be required to grant a request for an external review until the second level appeal process as set forth in this Chapter has been exhausted. A request for external review of an adverse determination may be made before the covered person has exhausted the MNRO's appeal, if any of the following circumstances apply.

1. The covered person has an emergency medical condition, as defined in this Chapter.

2. The MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both.

C. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B.1 of this Section, the covered person's treating health care provider may request an expedited external review. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B.2 of this Section, a standard external review shall be performed.

D. Nothing in this Section shall prevent an MNRO from establishing an appeal process, approved by the commissioner, that provides persons who are dissatisfied with the first level review decision an external review in lieu of requiring a second level review prior to requesting such external review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 22:3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:851 (April 2002).

§6227. Standard External Review

A. Within 60 days after the date of receipt of a notice of a second level appeal adverse determination, the covered person whose medical care was the subject of such determination may, with the concurrence of the treating health care provider, file a request for an external review with the MNRO. Within seven days after the date of receipt of the request for an external review, the MNRO shall provide the documents and any information used in making the second level appeal adverse determination to its designated independent review organization. The independent review organization shall review all of the information and documents received and any other information submitted in writing by the covered person or the covered person's health care provider. The independent review organization may consider the following in reaching a decision or making a recommendation:

1. the covered person's pertinent medical records;

2. the treating health care professional's recommendation;

3. consulting reports from appropriate health care professionals and other documents submitted by the MNRO, covered person, or the covered person's treating provider;

4. any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations;

5. any applicable clinical review criteria developed exclusively and used by MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria had been reviewed and certified by the appropriate licensing board of this state.

B. The independent review organization shall provide notice of its recommendation to the MNRO, the covered person or his authorized representative and the covered person's health care provider within 30 days after the date of receipt of the second level determination information subject to an external review, unless a longer period is agreed to by all parties.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: La. R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:851 (April 2002).

§6229. Expedited Appeals

A. An MNRO shall establish written procedures for the expedited appeal of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. An expedited appeal shall be available to and may be initiated by the covered person, with the consent of the treating health care professional, or the provider acting on behalf of the covered person.

B. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or a similar specialty as would typically manage the case under review. The clinical peer or peers shall not have been involved in the initial adverse determination.

C. An MNRO shall provide an expedited appeal to any request concerning an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility. Such emergency services may include services delivered in the emergency room, during observation, or other setting that resulted in direct admission to a facility.

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

E. In an expedited appeal, an MNRO shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the appeal is commenced. If the expedited appeal is a concurrent review determination, the service shall be authorized and payable, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the determination in writing. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider until documented notification of such liability is provided to the covered person.

F. An MNRO shall provide written confirmation of its decision concerning an expedited appeal within two working days of providing notification of that decision if the initial notification was not in writing. The written decision shall contain the information specified in R.S. 22:3079.C(1) through (3).

G. An MNRO shall provide reasonable access, within a period of time not to exceed one workday, to a clinical peer who can perform the expedited appeal.

H. In any case where the expedited appeal process does not resolve a difference of opinion between the MNRO and the covered person or the provider acting on behalf of the covered person, such provider may request a second level appeal of the adverse determination.

I. An MNRO shall not provide an expedited appeal for retrospective adverse determinations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6231. Expedited External Review of Urgent Care Requests

A. At the time that a covered person receives an adverse determination involving an emergency medical condition of the covered person being treated in the emergency room, during hospital observation, or as a hospital inpatient, the covered person's health care provider may request an expedited external review. Approval of such requests shall not unreasonably be withheld.

B. For emergency medical conditions, the MNRO shall provide or transmit all necessary documents and information used in making the adverse determination to the independent review organization by telephone, telefacsimile, or any other available expeditious method.

C. In addition to the documents and information provided or transmitted, the independent review organization may consider the following in reaching a decision or making a recommendation:

1. the covered person's pertinent medical records;
2. the treating health care professional's recommendation;
3. consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider;
4. any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations;
5. any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation, unless the criteria had been reviewed and certified by the appropriate state licensing board of this state.

D. Within 72 hours after receiving appropriate medical information for an expedited external review, the independent review organization shall do the following:

1. make a decision to uphold or reverse the adverse determination;
2. notify the covered person, the MNRO, and the covered person's health care provider of the decision. Such notice shall include the principal reason or reasons for the decision and references to the evidence or documentation considered in making the decision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6233. Binding Nature of External Review Decisions

A. Coverage for the services required under this Chapter shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under a health insurance policy or HMO subscriber agreement. Nothing in this Chapter shall be construed to require payment for services that are not otherwise covered pursuant to the evidence of coverage under the health insurance policy or HMO subscriber agreement or otherwise required under any applicable state or federal law.

B. An external review decision made pursuant to this Chapter shall be binding on the MNRO and on any health insurance issuer or health benefit plan that utilizes the MNRO for making medical necessity determinations. No entity shall hold itself out to the public as following the standards of a licensed or authorized MNRO that does not adhere to all requirements of this Chapter including the binding nature of external review decisions.

C. An external review decision shall be binding on the covered person for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered.

D. A covered person or his representatives, heirs, assigns, or health care providers shall have a cause of action for benefits or damages against an MNRO, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to

this Chapter if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition. Causes of action for benefits or damages for actions involving or resulting from a decision made pursuant to this Chapter shall be limited to the party acting in bad faith, or involved in negligence, gross negligence or intentional misrepresentation of factual information about the covered person's medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6235. Minimum Qualifications for Independent Review Organizations

A. The licensure, authorization, or certification of any entity as an MNRO or independent or external review organization shall be effective beginning on the date of first application for all entities who receive formal written authorization, licensure, or certification by the Commissioner of Insurance. This provision shall remain in effect until December 31, 2001. Any application filed after December 31, 2001 shall become effective upon final approval by the Department of Insurance and not upon date of first application. Therefore any application submitted and filed after December 31, 2001, the licensure, authorization or certification of an entity as an MNRO or independent or external review organization shall be effective upon the date final approval is granted by the Commissioner of Insurance. To qualify to conduct external reviews for an MNRO, an independent review organization shall meet the following minimum qualifications:

1. develop written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum, the following:
   a. procedures to ensure that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner;
   b. procedures to ensure the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases;
   c. procedures to ensure the confidentiality of medical and treatment records and clinical review criteria;
   d. procedures to ensure that any individual employed by or under contract with the independent review organization adheres to the requirements of this Chapter;
2. establish a quality assurance program;
3. establish a toll-free telephone service to receive information related to external reviews on a 24-hour-day,
   7-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

B. Any clinical peer reviewer assigned by an independent review organization to conduct external reviews shall be a physician or other appropriate health care provider who meets the following minimum qualifications:

1. be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

2. be knowledgeable about the recommended health care service or treatment through actual clinical experience that may be based on either of the following:
   a. the period of time spent actually treating patients with the same or similar medical condition of the covered person;
   b. the period of time that has elapsed between the clinical experience and the present;
3. hold a nonrestricted license in a state of the United States and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review;
4. have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

C. In addition to the requirements of Subsection A of this Section, an independent review organization shall not own or control, be a subsidiary of, in any way be owned or controlled by, or exercise control with a health insurance issuer, health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

D. In addition to the other requirements of this Section, in order to qualify to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor the clinical peer reviewer assigned by the independent organization to conduct the external review shall have a material professional, familial, or financial interest with any of the following:

1. the MNRO that is the subject of the external review;
2. any officer, director, or management employee of the MNRO that is the subject of the external review;
3. the health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;
4. the facility at which the recommended health care service or treatment would be provided;
5. the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review;
6. the covered person who is the subject of the external review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:853 (April 2002).

§6237. External Review Register

A. An MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, hereinafter referred to as the "register". For each request for external review, the register shall contain, at a minimum, the following information:

1. a general description of the reason for the request for external review;
2. the date received;
3. the date of each review;

4. the resolution;

5. the date of resolution;

6. except as otherwise required by state or federal law, the name of the covered person for whom the request for external review was filed.

B. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

C. The register compiled for a calendar year shall be retained for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

D. The MNRO shall submit to the commissioner, at least annually, a report in the format specified by the commissioner. The report shall include the following for each health insurance issuer and health benefit plan:

1. the total number of requests for external review;

2. the number of requests for external review resolved and their resolution;

3. a synopsis of actions being taken to correct problems identified.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6239. Emergency Services

A. Emergency services shall not be limited to health care services rendered in a hospital emergency room.

B. When conducting medical necessity determinations for emergency services, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency or if a provision of federal, state, or local law requires the use of a specific provider.

C. If a participating provider or other authorized representative of a health insurance issuer or health benefit plan authorizes emergency services, the MNRO shall not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item, treatment, or service furnished in reliance upon approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider of emergency services.

D. Coverage of emergency services shall be subject to state and federal laws as well as contract or policy provisions, including co-payments or coinsurance and deductibles.

E. For immediately required post-evaluation or post-stabilization services, an MNRO shall provide access to an authorized representative 24-hours a day, 7 days a week, to facilitate review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6241. Confidentiality Requirements

A. An MNRO shall annually provide written certification to the commissioner that its program for determining medical necessity complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6243. Severability

A. If any provision or item of this regulation, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the regulation that can be given effect without the invalid provisions, item, or application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statute of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6245. Effective Date

A. This regulation shall become effective upon final publication in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statute of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner

§1121. Legislative findings; purpose; short title

A. Without standards for entities that determine the medical necessity of health care services, Louisianians may face unreasonable delays or denials of requests for coverage from their health benefit plans.

B. Health insurance issuers are not authorized by law to engage in the practice of medicine or adopt administrative treatment guidelines that impinge upon or encumber the independent medical judgment of treating physicians or health care providers.

C. Only entities that are licensed to practice medicine or otherwise authorized by law to determine what medical services or procedures are medically necessary for an individual should be allowed to make medical necessity determinations.

D. The purpose of this Chapter is to establish the minimum standards required for any entity that determines what medical services or procedures will be covered under a health benefit plan based on medical necessity.

E. This Chapter shall be known and may be cited as the "Medical Necessity Review Organization Act".

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3070 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1122. Definitions

As used in this Subpart, the following terms shall be defined as follows:

(1) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and denied, reduced, or terminated by a reviewer based on medical necessity, appropriateness, health care setting, level of care, or effectiveness, or because an item or health care service for which benefits are otherwise provided is determined to be experimental or investigational.

(2) "Ambulatory review" means review of health care services performed or provided in an outpatient setting.

(3) "Appropriate medical information" means all outpatient and inpatient medical records that are pertinent to the evaluation and management of the covered person and that permit the Medical Necessity Review Organization to determine compliance with the applicable clinical review criteria. In the review of coverage for particular services, these records may include but are not necessarily limited to one or more of the following portions of the covered person's medical records as they relate directly to the services under review for medical necessity: admission history and physical examination report, physician's orders, progress notes, nursing notes, operative reports, anesthesia records, hospital discharge summary, laboratory and pathology reports, radiology or other imaging reports, consultation reports, emergency room records, and medication records.

(4) "Authorized representative" means 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 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, and the covered person or his authorized representatives thereafter requests the services, nothing shall prohibit the provider from charging usual and customary charges for all nonmedically necessary services provided.

(5) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

(6) "Certification" or "certify" means a determination by a reviewer regarding coverage of an admission, continued stay, or other health care service which, based on the information provided, satisfies the clinical review criteria requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(7) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review.

(8) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a reviewer to determine the necessity and appropriateness of covered health care services, including those used in the determination of an item or health care service as experimental or investigational.

(9) "Commissioner" means the commissioner of insurance.

(10) "Concurrent review" means a review of medical necessity, appropriateness of care, or level of care conducted during a patient's stay or course of treatment.

(11) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(12) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

(13) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(14) "Disclose" means to release, transfer, or otherwise divulge protected health information to any individual, entity, or person other than the individual who is the subject of the protected health information.

(15) "Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) Placing the health of the individual in serious jeopardy.

(b) With respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy.

(c) Serious impairment to bodily function.

(d) Serious dysfunction of any bodily organ or part.

(16) "Entity" means an individual, person, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, any similar entity, agent, or contractor, or any combination of the foregoing.

(17) "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(18) "External review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations and whose accreditation or certification has been reviewed and approved by the Department of Insurance.

(19) "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing facilities, inpatient hospice facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(20) "Final adverse determination" means an adverse determination that has been upheld by a reviewer at the completion of the medical necessity review organization's internal review process as set forth in this Chapter.

(21) "Health benefit plan" means group and individual health insurance coverage, coverage provided under a group health plan, or coverage provided by a nonfederal governmental plan, as those terms are defined in R.S. 22:1061. "Health benefit plan" shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:1061(3).

(22) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law.

(23) "Health care provider" or "provider" means a health care professional or a facility.

(24) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(25) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to any of the following:

(a) The past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family.

(b) The provision of health care services to a covered person.

(c) Payment for the provision of health care services to a covered person.

(26) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

(27) "Health insurance issuer" means an insurance company, including a health maintenance organization as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

(28) "Medical Necessity Review Organization" or "MNRO" means a health insurance issuer or other entity licensed or authorized pursuant to this Subpart to make medical necessity determinations for purposes other than the diagnosis and treatment of a medical condition.

(29) "Medical or scientific evidence" means evidence found in the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most

of their published articles for review by experts who are not part of the editorial staff.

(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) or the Manual, Alternative, and Natural Therapy Index System and Elsevier Science Ltd. for indexing in Excerpta Medica (EMBASE).

(c) Medical journals recognized by the secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act as well as the American Journal of Psychiatry, Treatment of Psychiatric Disorders and the American Society for Addiction Medicine.

(d) The following standard reference compendia:

(i) The American Hospital Formulary Service-Drug Information.

(ii) Drug Facts and Comparisons.

(iii) The American Dental Association Accepted Dental Therapeutics.

(iv) The United States Pharmacopoeia-Drug Information.

(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the following:

(i) The federal Agency for Healthcare Research and Quality.

(ii) The National Institutes of Health.

(iii) The National Cancer Institute.

(iv) The National Academy of Sciences.

(v) The Centers for Medicare & Medicaid Services.

(vi) The federal Food and Drug Administration.

(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

(viii) Any other medical or scientific evidence that is comparable to the sources listed in Items (i) through (vii) of this Subparagraph.

(30) "Prospective review" means a review conducted prior to an admission or a course of treatment.

(31) "Protected health information" means health information that either identifies a covered person who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify a covered person.

(32) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(33) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

(34) "Working day" means Monday through Friday, excluding holidays and days upon which an emergency has been declared by state or local government authorities, on which days an MNRO is not able to conduct business in a normal manner.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Acts 2003, No. 1109, §1; Redesignated from R.S. 22:3071 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2008, No. 442, §1, eff. Jan. 1, 2009.
NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1123. Authorization or licensure as an MNRO

A. No health insurance issuer shall act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar medical determinations unless authorized as an MNRO by the commissioner as provided in this Chapter.

B. No entity acting on behalf of or as the agent of a health insurance issuer may act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations unless licensed as an MNRO by the commissioner as provided in this Chapter.

C. Any other entity may apply for and be issued a license under this Chapter to act as an MNRO for the purposes of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations on behalf of a health benefit plan.

D. Any entity licensed as an MNRO shall be exempt from the requirements of R.S. 40:2721 through 2736.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3072 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1124. Procedure for application to act as an MNRO

A. Any applicant for licensure other than a health insurance issuer shall submit an application to the commissioner and pay the initial licensure fee specified in R.S. 22:1125(D). R.S. 22:821. The application shall be on a form and accompanied by any supporting documentation required by the commissioner and shall be signed and verified by the applicant. The information required by the application shall include but need not be limited to the following:

(1) The name of the entity operating as an MNRO and any trade or business names used by that entity in connection with making medical necessity determinations.

(2) The names and addresses of every officer and director of the entity operating as an MNRO, as well as the name and address of the corporate officer designated by the MNRO as the corporate representative to receive, review, and resolve all grievances addressed to the MNRO.

(3) The name and address of every person owning, directly or indirectly, five percent or more of the entity operating as an MNRO.

(4) The principal place of business of the MNRO.

(5) A general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge or encumber the independent medical judgement of treating physicians or health care providers.

(6) A copy of the MNRO's procedures manual which meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis.

(7) A sample copy of any contract, absent fees charged, with a health insurance issuer, nonfederal government health benefit plan, or other group health plan for making determinations of medical necessity.

(8) The names, addresses, and qualifications of individuals being designated to make adverse

medical necessity determinations pursuant to this Chapter.

B. A health insurance issuer holding a valid certificate of authority to operate in this state may be authorized to act as an MNRO under the requirements of this Chapter following submission to the commissioner of appropriate documentation for review and approval that shall include but need not be limited to the following:

(1) A general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgement of treating physicians or health care providers.

(2) A copy of the MNRO's program description or procedures manual which meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis.

(3) A sample copy of any contract, absent fees charged, with another health insurance issuer for making determinations of medical necessity.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3073 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 33.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1125. REPEALED

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Acts 2003, No. 1109, §1; Redesignated from R.S. 22:3074 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 33, §2.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1126. Scope and content of medical necessity determination process

A. An MNRO shall implement a written medical necessity determination program that describes all review activities performed for one or more health benefit plans. The program shall include the following:

(1) Methodology to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services.

(2) Data sources and clinical review of criteria used in decision-making.

(3) The process for conducting appeals of adverse determinations.

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.

(5) Data collection processes and analytical methods used in assessing utilization of health care services.

(6) Provisions for assuring confidentiality of clinical and proprietary information.

(7) The organizational structure, including any review panel or committee, quality assurance committee, or other committee that periodically accesses health care review activities and reports to the health benefit plan.

(8) The medical director's responsibilities for day-to-day program management.

(9) Any quality management program utilized by the MNRO.

B. An MNRO shall file with the commissioner an annual summary report of its review program activities that includes a description of any substantive changes that have been implemented since the last annual report.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3075 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1127. Medical necessity review organization operational requirements

A. An MNRO shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. An MNRO may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. An MNRO shall make available its clinical review criteria upon request to the commissioner who shall be authorized to request affirmation of such criteria from other appropriate state regulatory agencies.

B. An MNRO shall have a medical director who shall be a duly licensed physician. The medical director shall administer the program and oversee all review decisions. Adverse determinations shall be made only by a duly licensed physician or clinical peer. An adverse determination made by an MNRO in the second level review shall become final only when a clinical peer has evaluated and concurred with such determination.

C. An MNRO shall issue determination decisions in a timely manner pursuant to the requirements of this Chapter. At the time of the request for review, an MNRO shall notify the covered person or his authorized representative and the provider of all documentation required to make a medical review determination. In the event that the MNRO determines that additional information is required, it shall notify the covered person or his authorized representative and the provider, by telephone, within one work day of such determination, to request any additional appropriate medical information required. An MNRO shall obtain all information required to make a medical necessity determination, including pertinent clinical information, and shall have a process to ensure that qualified health care professionals performing medical necessity determinations apply clinical review criteria consistently.

D. At least annually, an MNRO shall routinely assess the effectiveness and efficiency of its medical necessity determination program and report any deficiencies or changes to the commissioner.

E. An MNRO's data systems shall be sufficient to support review program activities and to generate management reports to enable the health benefit plan to monitor its activities.

F. Health insurance issuers who delegate any medical necessity determination functions to an MNRO shall be responsible for oversight, which shall include the following:

(1) A written description of the MNRO's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the medical necessity determination program by the health insurance issuer.

(3) A process by which the health insurance issuer monitors or evaluates the performance of the MNRO.

G. Health insurance issuers who perform medical necessity determinations shall coordinate such program with other medical management activities conducted by the health insurance issuer, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

H. An MNRO shall provide health care providers with access to its review staff by a toll-free number that is operational for any period of time that an authorization, certification, or approval of coverage is required.

I. When conducting medical necessity determinations, the MNRO shall collect only the

information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of services.

J. Compensation to individuals participating in a medical necessity determination program shall not contain incentives, direct or indirect, for those individuals to make inappropriate review determinations. Compensation to any such individuals shall not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3076 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1128. Procedures for making medical necessity determinations

A. An MNRO shall maintain written procedures for making determinations and for notifying covered persons and providers and other authorized representatives acting on behalf of covered persons of its decisions.

B.(1) In no less than eighty percent of initial determinations, an MNRO shall make the determination within two working days of obtaining any appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. In no instance shall any determination of medical necessity be made later than thirty days from receipt of the request unless the patient's physician or other authorized representative has agreed to an extension.

(2) In the case of a determination to certify a nonemergency admission, procedure, or service, the MNRO shall notify the provider rendering the service within one work day of making the initial certification and shall provide documented confirmation of such notification to the provider within two working days of making the initial certification.

(3) In the case of an adverse determination of a nonemergency admission, the MNRO shall notify the provider rendering the service within one work day of making the adverse determination and shall provide documented confirmation of the notification to the provider within two working days of making the adverse determination.

C.(1) For concurrent review determinations of medical necessity, an MNRO shall make such determinations within one working day of obtaining the results of appropriate medical information that may be required.

(2) In the case of a determination to certify an extended stay or additional services, the MNRO shall notify the provider rendering the service, whether a health care professional or facility or both, and the covered person receiving the service within one working day of making the certification. A copy or telefacsimile of the certification delivered to the provider and addressed to the covered person shall be deemed full compliance with the requirement to notify the covered person. The MNRO shall also provide documented confirmation to the provider within two working days of the authorization. Such documented notification shall include the number of intended days or next review date and the new total number of days or services approved.

(3) In the case of an adverse determination, the MNRO shall notify the provider rendering the service, whether a health care professional or facility or both, and the covered person receiving the service within one working day of making the adverse determination. A copy or telefacsimile of the adverse determination delivered to the provider and addressed to the covered person shall be deemed full compliance with the requirement to notify the covered person. The MNRO shall also provide documented notification to the provider within one work day of such notification. The service shall be

authorized and payable by the health insurance issuer without liability, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the adverse determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider unless notified of such liability in advance.

D.(1) For retrospective review determinations, the MNRO shall make the determination within thirty working days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty days from the date of service. The MNRO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon prior approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider or unless the coverage was duly canceled for fraud or nonpayment of premiums.

(2) In the case of an adverse determination, the MNRO shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

E. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. An MNRO shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures.

F. An MNRO shall have written procedures listing the information required from a covered person or health care provider in order to make a medical necessity determination. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall also outline the process to be followed in the event that the MNRO determines the need for additional information not initially requested.

G. An MNRO shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where the provider or a covered person will not release necessary information, the MNRO may deny certification.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Acts 2001, No. 778, §1; Redesignated from R.S. 22:3077 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.
NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1129. Informal reconsideration

A. In a case involving an initial determination or a concurrent review determination, an MNRO shall give the provider rendering the service an opportunity to request on behalf of the covered person an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination. Allowing a ten-day period following the date of the adverse determination for requesting an informal reconsideration shall be considered reasonable.

B. The informal reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the MNRO'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 working day.

C. If the informal reconsideration process does not resolve the differences of opinion, the

adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Informal reconsideration shall not be a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Acts 2004, No. 450, §1; Redesignated from R.S. 22:3078 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.
NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1130. Appeals of adverse determinations; standard appeals

A. An MNRO shall establish written procedures for a standard appeal of an adverse determination, which may also be known as a first level internal appeal. Such procedures shall be available to the covered person and to the provider acting on behalf of the covered person. Such procedures shall provide for an appropriate review panel for each appeal that includes health care professionals who have appropriate expertise.

B. For standard appeals, a duly licensed physician shall be required to concur with any adverse determination made by the review panel.

C. The MNRO shall notify in writing both the covered person and the attending or ordering provider of the decision within thirty working days following the request for an appeal, unless the covered person or authorized representative and the MNRO mutually agree that a further extension of the time limit would be in the best interest of the covered person. The written decision shall contain the following:

(1) The title and qualifying credentials of the physician affirming the adverse determination.

(2) A statement of the reason for the covered person's request for an appeal.

(3) An explanation of the reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the MNRO's position.

(4) If applicable, a statement including the following:

(a) A description of the process to obtain a second level review of a decision.

(b) The written procedures governing a second level review, including any required time frame for review.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3079 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.
NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§1131. Second level review

A. An MNRO shall establish a second level review process to give covered persons who are dissatisfied with the first level review decision the option to request a review at which the covered person has the right to appear in person before authorized representatives of the MNRO. An MNRO shall provide covered persons with adequate notice of this option.

B. An MNRO shall conduct a second level review for each appeal. Appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination. A majority of any review panel used shall be comprised of persons who were not previously involved in the appeal. However, a person who was previously involved with the appeal may be a member of the panel or appear before the panel to present information or answer questions. The panel shall have the legal authority to bind the MNRO and the health benefit plan to the panel's

decision.

C. An MNRO shall ensure that a majority of the persons reviewing a second level appeal are health care professionals who have appropriate expertise. An MNRO shall issue a copy of the written decision to a provider who submits an appeal on behalf of a covered person. In cases where there has been a denial of service, the reviewing health care professional shall not have a financial incentive or interest in the outcome of the review.

D. The procedures for conducting a second level review shall include the following:

(1) The review panel shall schedule and hold a review meeting within forty-five working days of receiving a request from a covered person for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, an MNRO shall offer the covered person the opportunity to communicate with the review panel, at the MNRO's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified of the time and place of the review meeting in writing at least fifteen working days in advance of the review date; such notice shall also advise the covered person of his rights as specified in Paragraph (3) of this Subsection. The MNRO shall not unreasonably deny a request for postponement of a review meeting made by a covered person.

(2) Upon the request of a covered person, an MNRO shall provide to the covered person all relevant information that is not confidential or privileged.

(3) A covered person shall have the right to the following:

(a) Attend the second level review.

(b) Present his case to the review panel.

(c) Submit supporting material both before and at the review meeting.

(d) Ask questions of any representative of the MNRO.

(4) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

(5) For second level appeals, a duly licensed and appropriate clinical peer shall be required to concur with any adverse determination made by the review panel.

(6) The MNRO shall issue a written decision to the covered person within five working days of completing the review meeting. The decision shall include the following:

(a) The title and qualifying credentials of the appropriate clinical peer affirming an adverse determination.

(b) A statement of the nature of the appeal and all pertinent facts.

(c) The rationale for the decision.

(d) Reference to evidence or documentation used in making that decision.

(e) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

(f) Notice of the covered person's right to an external review.

E. An MNRO may establish a procedure that requires that a health care provider pay the cost of a second level appeal when all of the following occur:

(1) The health care provider has made the appeal on behalf of a covered person.

(2) The result of the second level appeal is that the MNRO's previous adverse determination is upheld.

(3) The MNRO's records indicate a consistent practice by the health care provider of

requesting second level reviews in an extremely high percentage of cases that were not warranted by available medical information.

(4) The commissioner approves the MNRO's action to require payment by the health care provider.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Acts 2004, No. 450, §1; Redesignated from R.S. 22:3080 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1131 redesignated as R.S. 22:1541 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1132. Request for external review

A. Each health benefit plan shall provide an independent review process to examine the plan's coverage decisions based on medical necessity. A covered person, with the concurrence of the treating health care provider, may make a request for an external review of a second level appeal adverse determination.

B. Except as provided in this Subsection, an MNRO shall not be required to grant a request for an external review until the second level appeal process as set forth in this Chapter has been exhausted. A request for external review of an adverse determination may be made before the covered person has exhausted the MNRO's appeal, if any of the following circumstances apply:

(1) The covered person has an emergency medical condition.

(2) The MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both.

C. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B(1) of this Section, the covered person's treating health care provider may request an expedited external review. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B(2) of this Section, a standard external review shall be performed.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3081 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1132 redesignated as R.S. 22:1542 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1133. Standard external review

A. Within sixty days after the date of receipt of a notice of a second level appeal adverse determination, the covered person whose medical care was the subject of such determination may, with the concurrence of the treating health care provider, file a request for an external review with the MNRO. Within seven days after the date of receipt of the request for an external review, the MNRO shall provide the documents and any information used in making the second level appeal adverse determination to its designated independent review organization. The independent review organization shall review all of the information and documents received and any other information submitted in writing by the covered person or the covered person's health care provider. The independent review organization may consider the following in reaching a decision or making a recommendation:

(1) The covered person's pertinent medical records.

(2) The treating health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, covered person, or the covered person's treating provider.

(4) Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations.

(5) Any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria had been reviewed and certified by the appropriate licensing board of this state.

B. The independent review organization shall provide notice of its recommendation to the MNRO, the covered person or his authorized representative, and the covered person's health care provider within thirty days after the date of receipt of the second level determination information subject to an external review, unless a longer period is agreed to by all parties.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3082 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1133 redesignated as R.S. 22:1543 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1134. Expedited appeals

A. An MNRO shall establish written procedures for the expedited appeal of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. An expedited appeal shall be available to and may be initiated by the covered person, with the consent of the treating health care professional, or the provider acting on behalf of the covered person.

B. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or a similar specialty as would typically manage the case under review. The clinical peer or peers shall not have been involved in the initial adverse determination.

C. An MNRO shall provide an expedited appeal to any request concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who has received emergency services but has not been discharged from a facility.

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

E. In an expedited appeal, an MNRO shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the appeal is commenced. If the expedited appeal is a concurrent review determination, the service shall be authorized and payable, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider until documented notification of such liability is provided to the covered person.

F. An MNRO shall provide written confirmation of its decision concerning an expedited appeal within two working days of providing notification of that decision if the initial notification was not in writing. The written decision shall contain the information specified in R.S. 22:1130(C)(1) through (3).

G. An MNRO shall provide reasonable access, within a period of time not to exceed one work day, to a clinical peer who can perform the expedited appeal.

H. In any case where the expedited appeal process does not resolve a difference of opinion between the MNRO and the covered person or the provider acting on behalf of the covered person, such provider may request a second level appeal of the adverse determination.

I. An MNRO shall not provide an expedited appeal for retrospective adverse determinations.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3083 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1134 redesignated as R.S. 22:1544 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1135. Expedited external review

A. At the time that a covered person receives an adverse determination involving an emergency medical condition of the covered person, the covered person's health care provider may request an expedited external review.

B. For emergency medical conditions, the MNRO shall provide or transmit all necessary documents and information used in making the adverse determination to the independent review organization by telephone, telefacsimile, or any other available expeditious method.

C. In addition to the documents and information provided or transmitted, the independent review organization may consider the following in reaching a decision or making a recommendation:

(1) The covered person's pertinent medical records.

(2) The treating health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider.

(4) Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations.

(5) Any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation, unless the criteria had been reviewed and certified by the appropriate state licensing board of this state.

D. Within seventy-two hours after receiving appropriate medical information for an expedited external review, the independent review organization shall do the following:

(1) Make a decision to uphold or reverse the adverse determination.

(2) Notify the covered person, the MNRO, and the covered person's health care provider of the decision. Such notice shall include the principal reason or reasons for the decision and references to the evidence or documentation considered in making the decision.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3084 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.
NOTE: Former R.S. 22:1135 redesignated as R.S. 22:1545 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1136. Binding nature of external review decisions

A. Coverage for the services required under this Chapter shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the plan. Nothing in this Chapter shall be construed to require the plan to pay for services that are not otherwise covered pursuant to the evidence of coverage under the plan or otherwise required under any applicable state or federal law.

B. An external review decision made pursuant to this Chapter shall be binding on the MNRO and on any health insurance issuer or health benefit plan that utilizes the MNRO for making medical necessity determinations.

C. An external review decision shall be binding on the covered person for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered.

D. A covered person or his representatives, heirs, assigns, or health care providers shall have a cause of action for benefits or damages against an MNRO, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to this Chapter if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3085 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.
NOTE: See Acts 1999, No. 401, §2, regarding applicability.
NOTE: Former R.S. 22:1136 redesignated as R.S. 22:1546 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1137. Minimum qualifications for independent review organizations

A. To qualify to conduct external reviews for an MNRO, an independent review organization shall meet the following minimum qualifications:

(1) Develop written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum, the following:

(a) Procedures to ensure that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner.

(b) Procedures to ensure the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

(c) Procedures to ensure the confidentiality of medical and treatment records and clinical review criteria.

(d) Procedures to ensure that any individual employed by or under contract with the independent review organization adheres to the requirements of this Chapter.

(2) Establish a quality assurance program.

(3) Establish a toll-free telephone service to receive information related to external reviews on a twenty-four-hour-day, seven-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

B. Any clinical peer reviewer assigned by an independent review organization to conduct external reviews shall be a physician or other appropriate health care provider who meets the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through actual clinical experience that may be based on either of the following:

(a) The period of time spent actually treating patients with the same or similar medical condition of the covered person.

(b) The period of time that has elapsed between the clinical experience and the present.

(3) Hold a nonrestricted license in a state of the United States and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

C. In addition to the requirements of Subsection A of this Section, an independent review organization shall not own or control, be a subsidiary of, in any way be owned or controlled by, or exercise control with a health insurance issuer, health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

D. In addition to the other requirements of this Section, in order to qualify to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor the clinical peer reviewer assigned by the independent organization to conduct the external review shall have a material professional, familial, or financial interest with any of the following:

(1) The MNRO that is the subject of the external review.

(2) Any officer, director, or management employee of the MNRO that is the subject of the external review.

(3) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review.

(4) The facility at which the recommended health care service or treatment would be provided.

(5) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3086 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.
NOTE: Former R.S. 22:1137 redesignated as R.S. 22:1547 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1138. External review register

A. An MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, hereinafter referred to as the "register". For each request for external review, the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the request for external review.

(2) The date received.

(3) The date of each review.

(4) The resolution.

(5) The date of resolution.

(6) The name of the covered person for whom the request for external review was filed.

B. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

C. The register compiled for a calendar year shall be retained for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

D. The MNRO shall submit to the commissioner, at least annually, a report in the format specified by the commissioner. The report shall include the following for each health insurance issuer and health benefit plan:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and their resolution.

(3) A synopsis of actions being taken to correct problems identified.

D.(1) The MNRO shall submit to the commissioner, at least annually, a report in the format specified by the commissioner. The report shall include the following for each health insurance issuer and health benefit plan:

(a) The total number of requests for external review.

(b) The number of requests for external review resolved and their resolution.

(c) A synopsis of actions being taken to correct problems identified.

(2) At the time of filing its annual report, an MNRO other than a health insurance issuer shall pay a filing fee in the amount set forth in R.S. 22:821.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3087 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 33.
NOTE: See Acts 1999, No. 401, §2, regarding applicability.
NOTE: Former R.S. 22:1138 redesignated as R.S. 22:1548 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1139. Emergency services

A. When conducting medical necessity determinations for emergency services, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services if a prudent lay person acting reasonably would have

believed that an emergency medical condition existed. With respect to care obtained from a noncontracting provider within the service area of a managed care plan, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency or if a provision of federal, state, or local law requires the use of a specific provider.

B. If a participating provider or other authorized representative of a health insurance issuer or health benefit plan authorizes emergency services, the MNRO shall not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item, treatment, or service furnished in reliance upon approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider of emergency services.

C. Coverage of emergency services shall be subject to state and federal laws as well as contract or policy provisions, including copayments or coinsurance and deductibles.

D. For immediately required post-evaluation or post-stabilization services, an MNRO shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3088 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1139 redesignated as R.S. 22:1551 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1140. Confidentiality requirements

An MNRO shall annually provide written certification to the commissioner that its program for determining medical necessity complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3089 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1140 redesignated as R.S. 22:1552 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1141. Regulations

The commissioner may, after notice and hearing, promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Chapter. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3090 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 317.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1141 redesignated as R.S. 22:1553 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1142. Examination of MNRO and other parties

A. The commissioner or a member of his staff may make an examination of the affairs of any MNRO or any health insurance issuer authorized to act as an MNRO as often as it is reasonably necessary for the protection of the interest of the people of this state, but not less frequently than once every three years, to determine whether the MNRO is adhering to the requirements of this Chapter.

B. The commissioner shall be authorized to assess health insurance issuers and licensed MNROs for the cost of performing examinations to determine compliance with this Chapter.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3091 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1142 redesignated as R.S. 22:1554 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1143. Fines; cease and desist orders; grounds for suspension or revocation of licensure or certificate of authority

A. Whenever the commissioner has reason to believe that any health insurance issuer or licensed MNRO is not in full compliance with the provisions of this Subpart, he shall notify such person and the commissioner shall, in accordance and compliance with R.S. 49:961, issue and cause to be served an order requiring the health insurance issuer or MNRO to cease and desist from any violation and order any one or more of the following: (1) Payment of a monetary penalty of not more than twenty-five dollars for each day that a determination was not made within the time frames established by this Chapter.

(2) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of one hundred thousand dollars. However, if the health insurance issuer or MNRO knew or reasonably should have known it was in violation of this Chapter, the penalty shall be not more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

(3) Suspension or revocation of the license of the health insurance issuer's certificate of authority to operate in this state or the license of an MNRO if the health insurance issuer or MNRO knew or reasonably should have known it was in violation of this Chapter.

B. Any health insurance issuer or licensed MNRO who violates a cease and desist order issued by the commissioner pursuant to this Subpart while such order is in effect shall, be subject at the discretion of the commissioner to any one or more of the following:

(1) A monetary penalty of not more than twenty-five thousand dollars for each and every act or violation, not to exceed an aggregate of two hundred fifty thousand dollars.

(2) Suspension or revocation of the health insurance issuer's certificate of authority to operate in this state or the license of the MNRO to operate in this state.

C. The license of an MNRO or authorization of a health insurance issuer to act as an MNRO shall be suspended or revoked, or, in lieu of such revocation, a fine may be imposed for each separate violation, not to exceed five thousand dollars per violation, or twenty-five thousand dollars in the aggregate, if the commissioner finds that the MNRO has engaged in any of the following:

(1) Using such methods or practices in the conduct of its business so as to render its further determinations of medical necessity in this state hazardous or injurious to covered persons or the public.

(2) Failing to comply with any independent review organization determination within sixty days after the determination has become final.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Redesignated from R.S. 22:3092 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 317.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

NOTE: Former R.S. 22:1143 redesignated as R.S. 22:1557 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1144. Appeal and external review of experimental or investigational determinations

A. All appeals pursuant to this Section shall be subject to the provisions of R.S. 22:1122 et seq., and shall be conducted by a medical necessity review organization licensed or authorized pursuant to this Subpart or a certified independent review organization.

B. In order to be eligible for the second level internal appeal or external review process described in this Subpart, an item or health care service deemed to be experimental or investigational in an adverse determination shall meet all of the following criteria:

(1) The allowable charge designated by the health insurance issuer shall be greater than five hundred dollars.

(2)(a) An item or health care service shall be approved by the federal Food and Drug Administration (FDA), if subject to FDA approval; however, absence of FDA approval for off label use shall not preclude eligibility.

(b) If not subject to approval by the federal Food and Drug Administration (FDA), support of use of the item or health care service by medical or scientific evidence.

C. At any time during the appeal process, an MNRO may, at its option, send the item or proposed health care service to the standard external review process described in R.S. 22:1133.

D. During its review of a proposed item or health care service, a medical necessity review organization or an independent review organization shall make its decision or recommendation as follows:

(1) It shall ensure that the criteria described in Subsection B of this Section are met.

(2)(a) Except for an opinion provided pursuant to R.S. 22:1135, each reviewer's opinion shall be in writing and include the following information:

(i) A description of the covered person's medical condition.

(ii) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested item or health care service or treatment is more likely than not to be beneficial to the covered person than any available standard item or health care services or treatments and the adverse risks of the recommended or requested item or health care service or treatment would not be substantially increased over those of available standard items or health care services or treatments.

(iii) A description and analysis of any medical or scientific evidence considered in reaching the opinion.

(iv) A description and analysis of any evidence-based standard.

(v) Information on whether the reviewer's rationale for the opinion is based on Subparagraph (E)(5)(a) or (b) of this Section.

(b)(i) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the covered person, the medical necessity review organization and the covered person's health care provider as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five calendar days.

(ii) If the opinion provided pursuant to Subparagraph (a) of this Paragraph was not in writing, within forty-eight hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2) of this Subsection.

E. In addition to the documents and information provided pursuant to Paragraph (D)(2) of this Section, to the extent the information or documents are available and the reviewer considers appropriate, the reviewer shall consider the following in reaching an opinion pursuant to Subsection D of this Section:

(1) The covered person's pertinent medical records.

(2) The attending physician or health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional.

(4) The terms of coverage under the covered person's health benefit plan with the health insurance issuer to ensure that, but for the determination by the health insurance issuer that the item or health care service is experimental or investigational, such item or health care service would be a covered service under the covered person's health benefit plan.

(5) Whether one of the following items has occurred:

(a) The recommended or requested item or health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition.

(b) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested item or health care service or treatment is more likely than not to be beneficial to the covered person than any available standard item or health care service or treatment and the adverse risks of the recommended or requested item or health care service or treatment would not be substantially increased over those of available standard items or health care services or treatments.

F. An MNRO may establish a procedure that requires that a health care provider pay the cost of an appeal of a determination that an item or health care service is experimental or investigational when all of the following occur:

(1) The health care provider has made the appeal on behalf of a covered person.

(2) The result of the appeal is that the MNRO's previous adverse determination is upheld.

(3) The MNRO's records indicate a consistent practice by the health care provider of requesting appeals in an extremely high percentage of cases that were not warranted by available medical information.

(4) The commissioner approves the MNRO's action to require payment by the health care provider.

Acts 2008, No. 443, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1144 redesignated as R.S. 22:1558 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

EXHIBIT 3

CENSUS DATA

Available on request

Appendix A – File requirements and layout

The Contractor shall send and receive data files and act on the received data files as detailed in this section (Appendix A):

Files to be sent by the contractor to OGB:

The contractor shall provide the following two files to OGB on a monthly basis and no later than the 20th day of the following month. (For example, the files for January shall be received by OGB by the 20th of February). All files shall be constructed using strictly the layout as described in Appendix A-1 and A-2. All files shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

1. **Medical Claims File (Appendix A-1)**
   The contractor shall send OGB all claims for which EOBs (Explanation of Benefits) or checks were sent or issued to the provider and/or claimant during a month. This is a file of records containing claim charge lines or service lines for a physician claim (CMS-1500), facility claim (UB-92), or a dental claim (ADA-1500) that has been received and processed. No claims in process are included.

2. **Provider File (Appendix A-2)**
   This is a file of providers that performed the medical services for which checks and EOBs were issued in (1) above. This will include, for example, physicians, hospitals, urgent care facilities, etc.

Files to be sent to the contractor by OGB:

The contractor shall receive the following file from OGB. This file shall be constructed using strictly the layout as described in Appendix A-3. This file shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

3. **Eligibility File (Appendix A-3)**
   This file shall be received the evening of every work day by the contractor and posted to their system before the next day. It will contain the contractor's entire membership plus any terminations that have been done in the last two months.

4. **Administrative Fee Billing file(Appendix A-4)**
   This file shall be received monthly by the contractor and will contain the amount per contract holder that OGB will pay for administrative fee. OGB will pay UBH based on this file. The file will contain adjustments to prior months billing resulting form retro terms and enrollment. The file will be named ubhadm.pgp. It will be in the outbound directory. It will be there once a month based on the Billing schedule in Appendix 5.

5. **Billing Schedule- NOTE THE COLUMN BILLINGS AND FILES COMPLETED AND THE LINES FOR THE ACTIVE BILL.**

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	CLAIM_ID	A/N	40	001-040	THE SOURCE SYSTEM'S UNIQUE IDENTIFIER FOR THIS CLAIM.
2	CLAIM_LINE_ID	A/N	40	041-080	THE SOURCE SYSTEM'S IDENTIFIER FOR THIS CLAIM LINE.
3	FROM_SERVICE_DATE	A/N	8	081-088	THE START DATE OF SERVICE ON THIS CLAIM. FORMAT- CCYYMMDD
4	THRU_SERVICE_DATE	A/N	8	089-096	THE THRU DATE OF SERVICE ON THIS CLAIM. FORMAT- CCYYMMDD
5	RECEIVED_DATE	A/N	8	097-104	THE DATE THIS CLAIM WAS RECEIVED IN THE MAIL OR VIA EDI. FORMAT- CCYYMMDD
6	PAID_DATE	A/N	8	105-112	THE DATE THE CLAIM PROCESSED WAS FINALIZED (PAID OR ADJUSTED).FORMAT- CCYYMMDD
7	SERVICE UNITS COUNT	N	10	113-122	THE NUMBER OF UNITS OF SERVICES DESCRIBED BY THE PROCEDURE RENDERED ON THIS CLAIM LINE.
8	INPATIENT DAYS COUNT	N	10	123-132	THE NUMBER OF INPATIENT HOSPITAL DAYS THIS CLAIM LINE INDICATES.
9	ANESTHESIA_MINUTES	N	10	133-142	THE NUMBER OF MINUTES OF ANESTHESIA THAT WAS RENDERED ON THIS CLAIM LINE.
10	CHARGE_AMOUNT	N	15	143-157	THE DOLLARS BILLED/CHARGED FOR THIS CLAIM LINE. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 15 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE EXAMPLE: 123.45 WOULD BE EXPRESSED AS "000000000123.45" -123.45 WOULD BE EXPRESSED AS "-00000000123.45"
11	ALLOWED_AMOUNT	N	15	158-172	THE AMOUNT OF THE CHARGE_AMOUNT THAT IS ALLOWED PER THE PROVIDERS PRICING CONTRACT (DETERMINED AFTER REPRICING AND APPLYING RATE TABLES) EXAMPLE: 123.45 WOULD BE EXPRESSED AS "000000000123.45" -123.45 WOULD BE EXPRESSED AS "-00000000123.45"
12	EXCLUDED_AMOUNT	N	15	173-187	THE AMOUNT OF THE CHARGE_AMOUNT THAT IS NOT ALLOWED DUE TO NEGOTIATED PROVIDER DISCOUNTS OR IN ELIGIBLE PORTIONS OF THE SERVICE LINE CHARGE. EXAMPLE: 123.45 WOULD BE EXPRESSED AS "000000000123.45" -123.45 WOULD BE EXPRESSED AS

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					"-00000000123.45"
13	WITHHELD_AMOUNT	N	15	188-202	THE AMOUNT THAT IS BEING WITHHELD FROM PAYMENT TO THE PROVIDER UNDER A RISK-SHARING ARRANGEMENT. THIS AMOUNT MAY BE PAID BACK TO THE PROVIDER UNDER OTHER MEANS BASED UPON PERFORMANCE OR OTHER RISK-SHARING EVALUATIONS ABOVE. EXAMPLE: 123.45 WOULD BE EXPRESSED AS "000000000123.45" -123.45 WOULD BE EXPRESSED AS "-00000000123.45"
14	COPAY_AMOUNT	N	15	203-217	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER BUT IS NOT DUE TO MEMBER COPAY ARRANGEMENTS. THIS AMOUNT SHOULD BE PAID TO THE PROVIDER BY THE MEMBER DIRECTLY SEPARATELY FROM THIS CLAIM. EXAMPLE: 123.45 WOULD BE EXPRESSED AS "000000000123.45" -123.45 WOULD BE EXPRESSED AS "-00000000123.45"
15	COINSURANCE AMOUNT	N	15	218-232	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT IS NOT DUE TO MEMBER COINSURANCE ARRANGEMENTS. THIS AMOUNT SHOULD BE PAID TO THE PROVIDER BY THE MEMBER DIRECTLY SEPARATELY FROM THIS CLAIM. ABOVE EXAMPLE: 123.45 WOULD BE EXPRESSED AS "000000000123.45" -123.45 WOULD BE EXPRESSED AS "-00000000123.45"
16	DEDUCTIBLE_AMOUNT	N	15	233-247	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT IS NOT DUE TO MEMBER COINSURANCE ARRANGEMENTS. THIS AMOUNT SHOULD BE PAID TO THE PROVIDER BY THE MEMBER DIRECTLY SEPARATELY FROM THIS CLAIM. EXAMPLE: 123.45 WOULD BE EXPRESSED AS "000000000123.45" -123.45 WOULD BE EXPRESSED AS "-00000000123.45"
17	COB_PAID_AMOUNT	N	15	248-262	THE AMOUNT PAID BY THE MEMBER'S OTHER CARRIER. EXAMPLE 123.45 WOULD BE EXPRESSED AS

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					“000000000123.45” -123.45 WOULD BE EXPRESSED AS “-00000000123.45”
18	PROVIDER PAID AMOUNT	N	15	263-277	THE NET AMOUNT THAT WAS EVENTUALLY PAID TO THE PROVIDER FOR THIS CLAIM LINE. EXAMPLE: 123.45 WOULD BE EXPRESSED AS “000000000123.45” -123.45 WOULD BE EXPRESSED AS “-00000000123.45”
19	MEMBER PAID AMOUNT	N	15	278-292	THE NET AMOUNT THAT WAS EVENTUALLY PAID TO THE MEMBER, SUBSCRIBER OR EMPLOYEE FOR THIS CLAIM LINE. EXAMPLE: 123.45 WOULD BE EXPRESSED AS “000000000123.45” -123.45 WOULD BE EXPRESSED AS “-00000000123.45”
20	NET_PAID_AMOUNT	N	15	293-307	THE TOTAL NET AMOUNT THAT WAS PAID IN TOTAL BY THE HEALTH PLAN FOR THIS CLAIM LINE. EXAMPLE: 123.45 WOULD BE EXPRESSED AS “000000000123.45” -123.45 WOULD BE EXPRESSED AS “-00000000123.45”
21	TRANSACTION_TYPE	A/N	20	308-327	THE TRANSACTION TYPE (OUTCOME). 'APPROVED' 'DENIED' 'REVERSED' 'REVERSAL'
22	ADJUSTED FROM CLAIM ID	A/N	20	328-347	IF THIS CLAIM IS AN ADJUSTMENT FROM ANOTHER CLAIM, THIS FIELD WILL CONTAIN THE ID OF THE OLD CLAIM.
23	PLACE_OF_SERVICE	A/N	20	348-367	THE HCFA STANDARD PLACE OF SERVICE CODE
24	SUBMITTED_DRG	A/N	20	368-387	THE DRG CODE THAT WAS SUBMITTED ON THE CLAIM
25	DENIED_REASON	A/N	20	388-407	THE DENIED REASON CODE FOR THIS CLAIM. CONTRACTOR MUST SEND THE LIST OF DENIED REASONS THAT THEY USE (THE CODE AND THE NAME)
26	DENIED REASON NAME	A/N	20	408-427	THE NAME OF THE DENIED REASON FOR THIS CLAIM.
27	DISCHARGE STATUS	A/N	2	428-429	THE STANDARD DISCHARGE STATUS (ALSO KNOWN AS PATIENT STATUS) FROM FIELD 22 ON A UB-92 CLAIM FORM.
28	TYPE_OF_BILL	A/N	3	430-432	THE STANDARD TYPE OF BILL CODE FROM FIELD 4 ON A UB-92 CLAIM FORM

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
29	MEDICAL CLAIM DOC TYPE	A/N	20	433-452	THE TYPE OF DOCUMENT SUBMITTED ('UB92', 'CMS-1500' OR 'ADA-1500')
30	TYPE_OF_SERVICE	A/N	20	453-472	THE HCFA STANDARD TYPE OF SERVICE CODE ON THE CLAIM.
31	EMPLOYEE_SSN	A/N	20	473-492	THE EMPLOYEE'S SOCIAL SECURITY NUMBER- LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT
32	EMPLOYEE LAST NAME	A/N	40	493-532	THE LAST NAME OF THE EMPLOYEE.
33	EMPLOYEE_SEX	A/N	20	533-552	THE GENDER OF THE EMPLOYEE. 'F' = FEMALE 'M' = MALE 'U' = UNKNOWN
34	EMPLOYEE DATE OF BIRTH	A/N	8	553-560	THE EMPLOYEE'S DATE OF BIRTH FORMAT- CCYYMMDD
35	EMPLOYEE_ZIP_CODE	A/N	20	561-580	THE EMPLOYEE'S FULL ZIP CODE (5 OR 9 DIGITS AS AVAILABLE)
36	MEMBER_SSN	A/N	20	581-600	THE MEMBER'S SOCIAL SECURITY NUMBER
37	MEMBER_FIRST_NAME	A/N	40	601-640	THE FIRST NAME OF THE MEMBER (PATIENT)
38	MEMBER_LAST_NAME	A/N	40	641-680	THE LAST NAME OF THE MEMBER (PATIENT)
39	MEMBER_SEX	A/N	20	681-700	THE GENDER OF THE MEMBER. 'F' = FEMALE 'M' = MALE 'U' = UNKNOWN
40	MEMBER DATE OF BIRTH	A/N	8	701-708	THE MEMBER'S DATE OF BIRTH. FORMAT- CCYYMMDD
41	MEMBER_ZIP_CODE	A/N	20	709-728	THE MEMBER'S FULL ZIP CODE (5 OR 9 DIGITS AS AVAILABLE)
42	RELATIONSHIPTO EMPLOYEE	A/N	2	729-730	THE RELATIONSHIP THIS MEMBER HAS WITH THE EMPLOYEE. '01 = EMPLOYEE '02' = SPOUSE '03' = OTHER DEPENDENTS
43	MEMBER ELIGIBILITY ID	A/N	20	731-750	THE MEMBER'S OGB MEMBER INTERNAL ID PROVIDED IN THE ELIGIBILITY FILE.
44	PRIMARY DIAG CODE	A/N	10	751-760	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE PRIMARY DIAGNOSIS FOR THE SERVICE
45	DIAGNOSIS_CODE_2	A/N	10	761-770	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE SECOND DIAGNOSIS FOR THE SERVICE
46	DIAGNOSIS_CODE_3	A/N	10	771-780	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE THIRD DIAGNOSIS FOR THE SERVICE
47	DIAGNOSIS_CODE_4	A/N	10	781-790	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE FOURTH DIAGNOSIS FOR THE SERVICE

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
48	DIAGNOSIS_CODE_5	A/N	10	791-800	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE FIFTH DIAGNOSIS FOR THE SERVICE
49	DIAGNOSIS_CODE_6	A/N	10	801-810	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE SIXTH DIAGNOSIS FOR THE SERVICE
50	DIAGNOSIS_CODE_7	A/N	10	811-820	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE SEVENTH DIAGNOSIS FOR THE SERVICE
51	DIAGNOSIS_CODE_8	A/N	10	821-830	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE EIGHTH DIAGNOSIS FOR THE SERVICE
52	DIAGNOSIS_CODE_9	A/N	10	831-840	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE NINTH DIAGNOSIS FOR THE SERVICE
53	ADMIT_DIAG CODE	A/N	10	841-850	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE ADMIT DIAGNOSIS FOR THIS CLAIM
54	ICD9_PROCEDURE CODE 1	A/N	10	851-860	THE PRIMARY ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
55	ICD9_PROCEDURE CODE 2	A/N	10	861-870	THE SECOND ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
56	ICD9_PROCEDURE CODE 3	A/N	10	871-880	THE THIRD ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
57	ICD9_PROCEDURE CODE 4	A/N	10	881-890	THE FOURTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
58	ICD9_PROCEDURE CODE 5	A/N	10	891-900	THE FIFTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
59	ICD9_PROCEDURE CODE 6	A/N	10	901-910	THE SIXTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
60	PROCEDURE_CODE	A/N	10	911-920	THE PROCEDURE CODE ORIGINATING AS THE CPT PROCEDURE CODE ON HCFA FORMS, HCPCS PROCEDURE CODE ON UB92 FORMS OR ADA PROCEDURE CODE ON DENTAL FORMS.
61	REVENUE_CODE	A/N	10	921-930	THE 3 CHARACTER REVENUE CODE USED ON UB92 CLAIM FORMS.
62	RX_DRUG_CODE	A/N	20	931-950	THE 13 CHARACTER PRESCRIPTION DRUG CODE
63	OCCURRENCE CODE 1	A/N	20	951-970	THE FIRST OCCURRENCE CODE ORIGINATING FROM A UB92 CLAIM FORM
64	OCCURRENCE_DATE_1	A/N	8	971-978	CONTAINS THE DATE OF THE FIRST OCCURRENCE FROM A UB92 CLAIM FORM. FORMAT- CCYYMMDD

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
65	OCCURRENCE CODE 2	A/N	20	979-998	THE SECOND OCCURRENCE CODE ORIGINATING FROM A UB92 CLAIM FORM
66	OCCURRENCE_DATE_2	A/N	8	999-1006	CONTAINS THE DATE OF THE SECOND OCCURRENCE FROM A UB92 CLAIM FORM. FORMAT- CCYYMMDD
67	OCCURRENCE CODE 3	A/N	20	1007-1026	THE THIRD OCCURRENCE CODE ORIGINATING FROM A UB92 CLAIM FORM
68	OCCURRENCE_DATE_3	A/N	8	1027-1034	CONTAINS THE DATE OF THE THIRD OCCURRENCE FROM A UB92 CLAIM FORM. FORMAT- CCYYMMDD
69	OCCURRENCE CODE 4	A/N	20	1035-1054	THE FOURTH OCCURRENCE CODE ORIGINATING FROM A UB92 CLAIM FORM
70	OCCURRENCE_DATE_4	A/N	8	1055-1062	CONTAINS THE DATE OF THE FOURTH OCCURRENCE FROM A UB92 CLAIM FORM. FORMAT- CCYYMMDD
71	OCCURRENCE SPAN CODE	A/N	20	1063-1082	THE OCCURRENCE SPAN CODE ORIGINATING FROM A UB92 CLAIM FORM
72	OCCUR SPAN FROM DATE	A/N	8	1083-1090	THE BEGINNING DATE OF THE OCCURRENCE SPAN CODE FORMAT- CCYYMMDD
73	OCCUR SPAN THRU DATE	A/N	8	1091-1098	THE ENDING DATE OF THE OCCURRENCE SPAN CODE FORMAT- CCYYMMDD
74	MODIFIER CODE 1	A/N	20	1099-1118	THE FIRST MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
75	MODIFIER CODE 2	A/N	20	1119-1138	THE SECOND MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
76	MODIFIER_CODE_3	A/N	20	1139-1158	THE THIRD MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
77	NETWORK INDICATOR	A/N	20	1159-1178	IDENTIFIES WHETHER THE PROVIDER FOR THIS CLAIM WAS IN THE NETWORK OR OUT OF THE NETWORK AT THE TIME OF SERVICE 'I' = IN NETWORK 'O' = OUT OF NETWORK
78	PROVIDER INTERNAL ID	A/N	20	1179-1198	THE UNIQUE ID OF THE PROVIDER AS ASSIGNED BY THE CLAIMS PROCESSING SYSTEM.
79	NATIONAL PROVIDER ID	A/N	10	1199-1208	NATIONAL PROVIDER ID (NPI)

Appendix A-2 Provider File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	PROVIDER_INTERNAL_ID	A/N	20	001-020	THE UNIQUE ID OF THE PROVIDER AS ASSIGNED BY THE CLAIMS PROCESSING (SEE FIELD 78 IN APPENDIX A)
2	PROVIDER_TAX_ID	A/N	10	021-030	TAX ID OF THIS PROVIDER
3	PROVIDER_DEA_ID	A/N	10	031-040	THE FEDERAL DEA NUMBER OF THIS PROVIDER
4	PROVIDER_LAST_NAME	A/N	20	041-060	THE LAST NAME FOR THIS PROVIDER
5	PROVIDER_FIRST_NAME	A/N	20	061-080	THE FIRST NAME FOR THIS PROVIDER
6	PROVIDER_MIDDLE_INITIAL	A/N	1	081-081	THE MIDDLE INITIAL FOR THIS PROVIDER
7	PROVIDER_OFFICE_NAME	A/N	40	082-121	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE THIS PROVIDER OFFERS SERVICES.
8	PROVIDER_ADDRESS_LINE1	A/N	40	122-161	LINE 1 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
9	PROVIDER_ADDRESS_LINE2	A/N	40	162-201	LINE 2 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
10	PROVIDER_CITY	A/N	40	202-241	THE CITY PORTION OF THIS PROVIDER'S ADDRESS
11	PROVIDER_STATE	A/N	2	242-243	THE STATE PORTION OF THIS PROVIDER'S ADDRESS
12	PROVIDER_ZIP	A/N	10	244-253	THE ZIP PORTION OF THIS PROVIDER'S ADDRESS
13	PROVIDER_UPIN	A/N	20	254-273	THE UNIVERSAL PROVIDER IDENTIFICATION NUMBER FOR THIS PROVIDER
14	PROVIDER_MEDICARE_ID	A/N	20	274-293	THE MEDICARE IDENTIFIER FOR THIS PROVIDER
15	PROVIDER_SPECIALTY	A/N	20	294-313	THE SPECIALTY #1 CODE FROM THE SOURCE SYSTEM. CONTRACTOR SHOULD SEND SPECIALTY CODES AND NAMES THAT THEY USE TO OGB
116	PROVIDER_SPECIALTY NAME	A/N	40	314-353	THE DESCRIPTION FOR THE SPECIALTY #1 FROM THE SOURCE SYSTEM
17	PROVIDER_TYPE	A/N	20	354-373	AN INDICATOR OF "PROFESSIONAL" OR "FACILITY"
18	SOURCE_PAY_TO_ID	A/N	20	374-393	THE IDENTIFIER FROM THE SOURCE SYSTEM FOR THIS PROVIDER'S TO WHICH THE CLAIMS PAYMENT IS MADE. ('PAY-TO" PROVIDER')

Appendix A-2 Provider File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
19	PAY_TO_LAST_NAME	A/N	20	394-413	THE LAST NAME FOR THE PAY-TO FOR THIS PROVIDER
20	PAY_TO_FIRST_NAME	A/N	20	414-433	THE FIRST NAME FOR THE PAY-TO FOR THIS PROVIDER
21	PAY_TO_MIDDLE_INITIAL	A/N	1	434-434	THE MIDDLE INITIAL NAME FOR THE PAY-TO FOR THIS PROVIDER
22	PAY_TO_OFFICE_NAME	A/N	40	435-474	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE NAME FOR THE PAY-TO FOR THIS PROVIDER
23	PAY_TO_ADDRESS_LINE 1	A/N	40	475-514	LINE 1 THE STREET ADDRESS PORTION OF THE PAY-TO FOR THIS PROVIDER
24	PAY_TO_ADDRESS_LINE 2	A/N	40	515-554	LINE 2 THE STREET ADDRESS PORTION OF THE PAY-TO FOR THIS PROVIDER
25	PAY_TO_CITY	A/N	40	555-594	THE CITY PORTION OF THIS ADDRESS FOR THE PAY-TO FOR THIS PROVIDER
26	PAY_TO_STATE	A/N	2	595-596	THE STATE PORTION OF THIS ADDRESS FOR THE PAY-TO FOR THIS PROVIDER
27	PAY_TO_ZIP	A/N	10	597-606	THE ZIP PORTION OF THIS ADDRESS FOR THE PAY-TO FOR THIS PROVIDER
28	PAY_TO_TAX_ID	A/N	9	607-615	THE TAX ID NUMBER FOR THE PAY-TO ENTITY FOR THIS PROVIDER.
29	NATIONAL PROVIDER ID (NPI)	A/N	10	616-625	NATIONAL PROVIDER ID

Appendix A-3 Eligibility File					
NO	**Field Name**	**TYPE**	**Len**	**LOC**	**DESCRIPTION**
1	OGB Division	A/N	3	001-003	Division: 001 – Active 002 – Retired/No Medicare 003 – Retired/1 on Medicare 004 – Retired/2 on Medicare 005 – COBRA 006 – COBRA – Part Time
2	Enrollee SSN	A/N	9	004-012	Enrollee SSN
3	Dependent Code	A/N	2	013-014	Dependent Code: 01 – Enrollee 02 – Spouse 03 - Child
4	Member Last Name	A/N	15	015-029	Last Name
5	Member First Name	A/N	15	030-044	First Name, Space, Middle Initial
6	Sex Code	A/N	1	045-045	Sex: M - Male F - Female
7	Date of Birth	A/N	10	046-055	Date of Birth Format - CCYYMMDD
8	Effective Date	A/N	10	056-065	Date Employee becomes Eligible Format - CCYYMMDD
9	Termination Date	A/N	10	066-075	Date Coverage is Terminated Format - CCYYMMDD
10	Job Site	A/N	8	076-083	Blank Filled
11	Job Category	A/N	5	084-088	Agency Number
12	Hire Date	A/N	10	089-098	Employee Hire Date Format - CCYYMMDD
13	Type	A/N	2	099-100	“02”
14	Coverage Code	A/N	2	101-102	Employee’s Coverage: 01 – Employee Only 02 – Employee + Spouse 03 – Employee + Spouse + Child(ren) 04 – Employee + Child(ren)
15	Address 1	A/N	30	103-132	Enrollee Address
16	City	A/N	16	133-148	Enrollee City
17	State	A/N	2	149-150	Enrollee State
18	Zip Code	A/N	9	151-159	Enrollee Zip Code
19	Phone	A/N	10	160-169	Enrollee Home Phone Number

Appendix A-3 Eligibility File					
NO	**Field Name**	**TYPE**	**Len**	**LOC**	**DESCRIPTION**
20	OGB Plan	A/N	3	170-172	OGB Plan: 001 – PPO 002 – EPO 003 – HMO 004 – PPO w/Psych 005 – EPO w/Psych 006 – HMO w/Psych
21	Relation	A/N	2	173-174	Relationship Code: EE – Employee RR – Retired Employee CC – Cobra Employee SP – Spouse CH – Child Relationship Code (Continued): ST – Student Child HC – Handicapped Child SD – Sponsored Dependent Employee
22	Lifetime Accum	N	10	175-184	9999999.99 Leading spaces: Sum of Drugs, Medic & Mental Health claims paid

APPENDIX A-4 ADMINISTRATIVE FEE BILLING FILE					
	FIELD NAME	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Invoice Date	N	8	001-008	CCYYMMDD
2	Enrollee SSN	N	9	009-017	SOCIAL SECURITY NUMBER
3	Enrollee Last Name	A	20	018-037	Last Name
4	Enrollee First Name	A	20	038-057	First Name
5	Enrollee Middle Initial	A	1	058-058	Initial
6	Enrollee Network	A	5	059-063	Value PPO EPO HMO DHH
7	Enrollee Product	N	5	064-068	Value PPO EPO HMO CHIP5
8	Billing OR Coverage	N	8	069-76	CCYYMMDD
9	Admin Fee Amount	N	7	077-083	leading sign only when negative Example: 123.45 would be expressed as “0123.45” -123.45 would be expressed as “-123.45”

STATE EMPLOYEES GROUP BENEFITS PROGRAM
2010 BILLING SCHEDULE

Billing Preparation	Billing Month	Agency Transactions Received By	Billings and Files Completed
12/29 & 12/30	January Active Bill	12/22/2009	12/31/2009
01/07 & 01/08	February Retiree Bill	01/05/2010	01/10/2010
01/28 & 01/29	February Active Bill	01/26/2010	01/302010
02/08 & 02/09	March Retiree Bill	02/05/2010	02/10/2010
02/25 & 02/26	March Active Bill	02/22/2010	02/28/2010
03/08 & 03/09	April Retiree Bill	03/05/2010	03/10/2010
03/29 & 03/30	April Active Bill	03/25/2010	03/31/2010
04/08 & 04/09	May Retiree Bill	04/06/2010	04/10/2010
04/28 & 04/29	May Active Bill	04/26/2010	04/30/2010
05/06 & 05/07	June Retiree Bill	05/03/2010	05/09/2010
05/27 & 05/28	June Active Bill	05/25/2010	05/30/2010
06/08 & 06/09	July Retiree Bill	06/04/2010	06/10/2010
06/28 & 06/29	July Active Bill	06/23/2010	06/30/2010
07/08 & 07/09	August Retiree Bill	07/06/2010	07/10/2010
07/29 & 07/30	August Active Bill	07/27/2010	07/31/2010
08/06 & 08/09	September Retiree Bill	08/04/2010	08/10/2010
08/27 & 08/30	September Active Bill	08/26/2010	08/31/2010
09/08 & 09/09	October Retiree Bill	09/03/2010	09/10/2010
09/28 & 09/29	October Active Bill	09/24/2010	09/30/2010
10/07 & 10/08	November Retiree Bill	10/05/2010	10/10/2010
10/28 & 10/29	November Active Bill	10/23/2010	10/30/2010
11/08 & 11/09	December Retiree Bill	11/03/2010	11/10/2010
11/26 & 11/29	December Active Bill	11/23/2010	11/30/2010
12/08 & 12/09	January Retiree Bill	12/03/2010	12/10/2010