New Appeals Requirements

Provider Update
All CSoC Network Providers

Subject Line: New Appeals Requirements

The purpose of this communication is to make you aware of recent amendments to federal Medicaid managed care regulations that have required changes to the grievance and appeal process to be more advantageous to members.

In accordance with the Center for Medicare & Medicaid Services (CMS) federal mandate and Louisiana Department of Health Guidelines, the changes that are effective as of June 1, 2018 are:

- Magellan will allow 60 calendar days, a change from the previous 30-day timeline, from the date on the adverse benefit determination notice in which to file a request for an appeal.
- Magellan will be required to obtain written confirmation following a non-expedited oral appeal request that must be received within fifteen (15) days of the oral request and Magellan will send a written reminder of the confirmation being needed upon receipt of the appeal. This will permit individuals to start the appeal process with an oral request in order to establish the earliest possible date to begin the appeal process following an adverse event.

These changes do not impact Magellan's timeframe for processing appeals once an appeal is received.

Please refer to the Appeal Determinations section of the Louisiana Provider Handbook Supplement for the Louisiana Coordinated System of Care on pages 38-39 for complete details regarding the Appeals process. The Notice of Action Letters and Appeal Request Forms have also been updated to reflect the new sixty (60) day timeline to request an appeal.

Please reach out to your Provider Relations Liaison (PRL) with any questions or concerns. Your PRL is available for support.

Thank you for all you do in supporting the members of CSoC.

Magellan Health in Louisiana