STATE OF LOUISIANA

OFFICE OF GROUP BENEFITS (OGB)

NOTICE OF INTENT TO CONTRACT (NIC)

FOR

CASE MANAGEMENT/UTILIZATION MANAGEMENT (CM/UM) SERVICES

Issued
October 31, 2008

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SECTION I

GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT

A. Introduction/Purpose

The State of Louisiana, Office of Group Benefits (hereinafter called "OGB" or the "Program") requests proposals from any qualified firm/organization (hereinafter called "Proposer") to provide effective Case Management and Utilization Management (CM/UM) Services.

OGB is seeking a relationship with a CM/UM firm that can work in partnership with OGB to improve health care for plan participants and provide lower costs for its plan.

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 offers three self-insured health plan options: (1) The PPO plan, self-administered by OGB, (2) the EPO plan, administered by UnitedHealthcare; and the HMO Plan, administered by Humana. OGB also offers several fully-insured Medicare Advantage options for qualified retirees.

Pharmacy benefits for all self-insured health plans are administered by Catalyst Rx, and behavioral health services are provided by OptumHealth (formerly United Behavioral Health). Disease management services for individuals identified with Asthma, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Chronic Heart Failure are provided by Health Dialog.

The CM/UM services sought pursuant to this NIC are currently provided by CareGuide.

Pursuant to an interagency agreement with the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing, OGB provides administrative services for 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).

The CM/UM services sought pursuant to this NIC are to be provided for active employees, retired employees who are not Medicare primary, and the dependents of such active and retired employees enrolled in the OGB-administered PPO plan and the children enrolled

in the LaCHIP Affordable plan. Non-Medicare retirees include those under age 65 as well as retirees over age 65 who are not eligible for premium free Medicare A. **The CM/UM services sought pursuant to this NIC will not include those enrolled in the EPO and HMO plans, Medicare primary retirees in the PPO plan or those enrolled in the Medicare Advantage plans.**

Enrollment in the PPO and LaCHIP Affordable Plans as of October 1, 2008 is as follows:

	Enrollees (Contracts*)	Dependents	Covered Lives
PPO Actives	19,642	23,314	42,956
PPO Non-Medicare Retirees	13,776	12,097	25,873
LaCHIP Affordable	945	1,468	1,468
TOTALS	**34,363**	**36,879**	**70,297**

* Fees will be paid on a per contract per month basis. See Section X, Fee Quotation.

C. GB Information Technology Architecture

Desktop: Dell 450 Workstations running Windows 2000

LAN: 10/100 Ethernet using Cisco switches

Servers: Windows servers and AIX UNIX servers

WAN: Frame Relay using Cisco routers, switches, and firewalls. In addition, Scan Optics scanners, Mark Read Scanners, and various laser printers are used

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

D. Standard Contract Provisions

It is expected that a 3-year contract will be awarded with the contract terms provided in Section XI - Exhibit 1. Any deviation sought by a Proposer from these contract terms should be set forth in detail and explained 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.

E. 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 existing 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. Submit (2) electronic versions of the proposal on a CD.

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 & Executive Summary
   - ❑ Tab 1 (See Section V) - Completed Proposers Checklist
   - ❑ Tab 2 (See Section VI) – Completed Narrative Questionnaire
   - ❑ Tab 3 (See Section VII) – Proposer Information
   - ❑ Tab 4 (See Section VIII) – Attachments to Proposal Response
   - ❑ Tab 5 (See Section IX) – Mandatory Signature Page

   Your Executive Summary should not exceed three (3) pages. Please highlight in your Executive Summary what sets you apart from your competitors and state the reason(s) why you believe you are qualified to partner with OGB.

4. Submit an original and eight (8) numbered copies of the Fee Proposal Form, in a separate, sealed envelope clearly marked, “CM/UM NIC Fee Proposals” on the outside of such envelope. See Section X of NIC. Proposal must be received on or before 4:30 pm CST on the date listed in the Schedule of Events.

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

6. You are to submit one (1) redacted copy of the proposal as explained in Subsection F(4), below.

F. 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.

However, the State/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 sole purpose of assisting the State/OGB shall require said individuals to protect the confidentiality of any specifically identified proprietary information or privileged business information obtained as a result of their participation in these evaluations.

3. Costs of preparation, development and submission of the response to this NIC are entirely the responsibility of the Bidder and will not be reimbursed in any manner.

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

G. Definitions

1. Admission: confinement in a public or private facility, licensed and operating as an acute care hospital which provides care and treatment by physicians and nurses on a 24-hour basis for an illness or injury through the medical, surgical and diagnostic facilities on its premises. "Admission" is further defined as an incident where a plan member is confined or placed under observation for a period of 24 hours or more. An admission may also refer to a confinement in a skilled nursing facility or any other type of health care facility approved through Short Term and Long Term Case Management.

2. 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.

3. 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:
   (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.

4. Emergency Admission: an admission that results from an emergency medical condition. An emergency admission is also defined as one where the physician admits the individual to an acute care hospital due to a sudden or unexpected change in the individual's physical condition which is severe enough to require immediate confinement as an inpatient.

5. Medically Necessary: the proven need for intervention to improve or preserve health.

6. Certification: review and approval of proposed health care services before such services are rendered.

7. 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.

8. Utilization Management: the process for assessing the necessary, appropriate and cost-effective allocation of health care resources and services given or proposed for a plan participant. CM/UM includes all services performed by the CM/UM firm for OGB including, but not limited to, pre-certification, discharge planning and outpatient procedure certification.

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

10. Long Term Case Management: a program administered by the CM/UM firm whose medical professionals work with the patient, family/caregivers, physician and health care providers and OGB to coordinate and develop a timely and cost-effective treatment program. Case Management services are used for patients with complex, costly and/or high-tech services and continues throughout the entire continuum of care (locations and providers from which the patient receives services).

11. Short Term Case Management: a special program designed by OGB to facilitate discharge from a hospital or to prevent a hospital admission through the management

    of health care for patients requiring the following services:

    - Skilled nursing facility admissions
    - Use of home health/home infusion services, if not self administered
    - Home uterine monitoring for high risk OB patients
    - Hospice care
    - Physical or occupational therapy services rendered in the home

12. Outpatient Procedure Certification: Refers to the CM/UM firm's review and certification that certain outpatient procedures and therapies are Medically Necessary.

H. Cost Proposals

1. All proposed fees must reflect the following:

    a. Fees must be quoted on a per contract per month basis. The number of eligible contracts will be reported to the CM/UM firm by OGB monthly.

    The term "contract" as used in this context means any class of coverage in which a plan participant is enrolled, whether employee/retiree only, employee/retiree and spouse, employee/retiree and child(ren), or family. Therefore, a single contract includes the employee or retiree and all dependents.

    Fees must include all services described in this NIC and must take into account start up costs and all expenses associated with providing the services, including, but not limited to, expenses for required meetings in Baton Rouge with the OGB staff and OGB's actuarial consultant. Your fees must also include such expenses as medical records fees charged by providers in pursuit of reviews. No pass-through of any cost will be permitted.

    b. Fees must be guaranteed for the three (3) year period of the contract. 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 CM/UM firm's responsibilities.

    c. Fee may be proposed as a level per-contract per month fee for the entire three-year contract or may contain a flat, pre-determined dollar escalator for year two and three.

2. The Cost Proposal form provided with the NIC must be used to propose the per contract per month fee for all requested services as outlined in the NIC.

SECTION II
SCHEDULE OF EVENTS

A. Time Line

Public notice by advertising in the official journal of the State/posted OGB Website/posted to LAPAC	October 31, 2008
NIC mailed or available to prospective Proposers Posted to OGB Website; Posted to LAPAC	October 31, 2008
Deadline to notify OGB of interest to submit a Proposal (**MANDATORY)**	November 10, 2008
Deadline to receive written questions	November 10, 2008
Issue answers to written questions	November 14, 2008
Proposers Conference- Attendance in Person (**MANDATORY)**	November 18, 2008
Proposals due	December 2, 2008
Finalist's interviews/site visits	TBD
Probable selection and notification of award	TBD
Contract effective date	July 1, 2009

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
Post Office Box 44036
7389 Florida Blvd., Suite 400
Baton Rouge, LA 70804
Fax: (225) 925-4721
E-Mail: prahl@ogb.state.la.us

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 on Page 8, Section B.

D. Proposers Conference

The Proposers Conference will be held in the boardroom at 10:00 a.m. at the following location:

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

A representative of your organization must participate in person at the Mandatory Proposers Conference scheduled for 10:00 a.m., Central Time on the date listed in the Schedule of Events. OGB staff will be available to discuss the proposal specifications with you and answer any questions you may have in regards to submitted questions.

Proposals will only be considered 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 Section B, above.

SECTION III

SCOPE OF SERVICES

The following CM/UM services must be provided pursuant to the Contract resulting form this NIC:

1. Confirmation of eligibility;
2. Certification of admissions;
3. Outpatient Procedure Certification;
4. Second Opinion Referral for Transplant cases only;
5. Appeal of Adverse determinations;
6. Case Management;
7. Quarterly Management Reports with an Annual Summary including an Executive summary that provides strategic insight on how the program is running and suggested improvements;
8. On-Site Presentation of CM/UM Reports upon request; and
9. Transmission of CM/UM Recommendations to OGB Claims Department
10. All services, including, but not limited to, notices, appeals, and independent reviews, required for compliance with Louisiana law and regulations pertaining to Medical Necessity Review Organizations (MNRO), in particular, Louisiana Revised Statutes, Title 22, Sections 1121-1144, and Louisiana Department of Insurance Regulation 77, codified in the Louisiana Administrative Code, Title 37, Part VIII, Sections 6201-6245;
11. Cooperation with OGB's Disease Management contractor.

A. Eligibility Confirmation

The CM/UM firm must confirm the patient's eligibility in OGB's plans with each request for Precertification (all inpatient admissions and certain outpatient procedures), Continued Stay Review, Short Term and Long Term Case Management. Eligibility information will be transmitted weekly via FTP PCP encrypted. The layout and details of OGB's Eligibility Rules are provided in the Exhibit section of this NIC.

The CM/UM firm shall verify the patient's mailing address and phone number with each member encounter so that any written notification of a review decision is mailed by the CM/UM firm to the patient's current address. Members will be encouraged to contact their department directly to update their address in the system.

A violation of these requirements may result in a fine of $500 per documented incident. In addition, the CM/UM firm shall indemnify OGB, (See Exhibit 1, Section 11.0, Indemnification) against any claim for or on behalf of an individual whose eligibility is not properly and correctly verified as outlined above.

B. Review Notification

The CM/UM firm shall mail written notification of review decisions (approval confirmation notices, denial notices) to appropriate parties (patients and providers) within 48 hours of initial notification with complete medical information.

1. Approval confirmation notices must be mailed to the patient (or designated relative), admitting physician, and facility.

2. Denial notices must be mailed to the patient, admitting physician, and facility. Such notices must provide the specific reason for denial and contain all information necessary for the parties to request reconsideration.

All forms/letters used to communicate review determinations must be easily understandable to members and providers. All forms/letters are subject to advance approval of OGB.

A violation of these requirements may result in a fine of $500 per documented incident.

C. Certification of All Admissions

The CM/UM firm shall precertify all hospital admissions in accordance with the following requirements:

1. For each elective inpatient admission of a covered person, the CM/UM firm will obtain clinical information from the patient's attending physician to determine if the admission is medically necessary and if the proposed treatment can be provided at a lower level of care, *e.g.*, outpatient surgicenter, physician's office, or through home health. If the admission is determined to be medical necessary and appropriate, the CM/UM firm will determine a reasonable length of stay and authorize certification of the admission. In rendering a determination, the CM/UM firm shall reference the clinical information against written screening criteria to ensure consistent review decisions.

   To the extent possible, the CM/UM firm shall redirect patients to OGB PPO network providers. The CM/UM firm shall maintain current OGB PPO provider directories.

2. For each inpatient admission of a covered person that is non-elective, *i.e.,* urgent or emergency, the CM/UM firm will conduct a post-admission review. In such cases, certification of the plan member's admission must be obtained from the CM/UM firm within 48 hours of the admission in order to establish eligibility for covered services under the plan. The CM/UM firm shall obtain clinical information from the patient's attending physician and authorize a length of stay of the admission. In rendering a determination, the CM/UM firm shall reference the clinical information against written screening criteria to ensure consistent review decisions.

3. In the event no written criteria exists or where the nurse reviewer cannot justify the request based on the written screening criteria, the case shall be referred for review to the CM/UM firm's peer physician advisor prior to issuing a final non-approval or non-certification of the admission.

4. At a minimum, the CM/UM firm shall refer to case management any precertified hospital admission, which is expected to exceed an eight-day length of stay, has a complex diagnosis or is estimated to result in billed charges in excess of $20,000. The CM/UM firm may develop additional criteria under which a case is referred to case management.

5. Any plan member who contacts the CM/UM firm regarding certification of a hospital admission, including any request for review of an outpatient surgical procedure, shall be given a verification number, which is different from the certification authorization number. The CM/UM firm shall maintain a written log of the date a person called to certify an admission and the verification number assigned to the caller. This information may be used to assist OGB claims department in determining when to institute a penalty for non-compliance with the CM/UM guidelines set forth by the plan.

6 The CM/UM firm shall complete the certification process within three working days from the date the CM/UM firm is first notified of the admission, provided sufficient medical information is obtained.

7 OGB's PPO Plan Document describes the preadmission certification requirements and set forth the financial penalties to the covered person for non-compliance.

Failure to follow the above procedures may result in a fine of $500 per documented incident.

D. Discharge Planning

The CM/UM firm shall communicate directly with the hospital discharge planner, utilization review coordinator, and/or the attending physician(s) and develop appropriate, cost-effective, and timely plans for patient discharge. The CM/UM firm may assist the physician in developing alternative care arrangements covered by the plan or refer to the CM/UM firm's case manager any situations which may qualify for Short Term Case Management.

E. Case Management

Short Term

1. The CM/UM firm shall have the authority to authorize up to 14 days of care, without prior approval of OGB for select services. The primary goals of the Short Term Case Management Program are to coordinate the delivery of cost efficient patient care through early identification of cases, including early discharge planning, and the negotiation of fee discounts with the health care providers/firms, in the event the use of OGB's PPO providers is not possible.

2. Under the Short Term Case Management program the CM/UM's case manager may authorize care for the following services:

   a. Skilled nursing facility admissions
   b. Home health and home infusion services, if not self-administered
   c. Home uterine monitoring
   d. Hospice care

   In the absence of Short Term Case Management, the above services would not be covered under OGB's PPO plan, with the exception of home uterine monitoring devices which would be covered subject to the plan's $50,000 lifetime benefit limitation for durable medical equipment.

3. Short Term Case Management services provided by the CM/UM firm shall include:

   a. Screening all referred cases to confirm the patient's remaining lifetime maximum benefits prior to case management intervention;

   b. Screening all referred cases using OGB criteria to determine the eligibility of the service for Short Term Case Management review;

   c. Analyzing the Physician's proposed treatment plan to determine if it is necessary, appropriate and cost-effective and utilized appropriate PPO providers when possible. If the treatment plan is not necessary, appropriate or cost-effective, the case manager should negotiate an alternative. OGB is to be notified in the event the CM/UM firm is unable to negotiate a acceptable alternative approach;

   d. Determining the appropriate duration and frequency of treatment, as well as the level of personnel required to perform the service (e.g., home health provider plans to use RN's when LPN/LVN's can perform the same service at a more reasonable visit fee);

   e. Negotiating fee discounts with health care providers in the event the use of OGB's PPO providers is not possible. The CM/UM firm shall notify OGB where services are not available within the existing PPO networks;

   f. Communicating all Short Term Case Management decisions to OGB claims department in a timely and thorough manner to ensure proper adjudication of the claim; and

   g. Forwarding any proposed treatment plans which are expected to exceed 14 days to OGB for consideration and approval under the Long Term Case Management program.

   Failure to follow the above procedures may result in a fine of $500 per documented incident.

Long Term

1. In the event a covered person suffers a long-term, intensive illness or injury requiring extensive care, a cost efficient alternate treatment plan may be facilitated through the use of covered services and non-covered care, not to exceed the patient's remaining lifetime maximum benefit under the Plan. Each case will be individually reviewed. To qualify for Long Term Case Management there must be agreement between the CM/UM firm, OGB, the covered person, and the covered person's attending physician as to the proposed treatment plan.

2. OGB's PPO Plan Document provide a description of the provisions under which benefits will be payable through Long Term Case Management.

3. Long Term Case Management services provided by the CM/UM firm shall include:

    a. Screening all referred cases to confirm the patient's remaining lifetime maximum benefits prior to case management intervention;

    b. Screening all referred cases using OGB criteria to determine the eligibility for case management pursuant to OGB's PPO Plan Document;

    c. Analyzing the Physician's proposed treatment plan to determine if it is necessary, appropriate and cost-effective and utilizes appropriate PPO providers when possible. If the treatment plan is not necessary, appropriate or cost-effective, the case manager should propose an alternate approach. OGB is to be notified in the event the CM/UM firm is unable to negotiate a acceptable alternative approach;

    d. Determining the appropriate duration and frequency of treatment, as well as the level of personnel required to perform the service (e.g., home health provider plans to send RN's when LPN/LVN's can perform the same service at a more reasonable visit fee);

    e. Negotiating fee discounts with health care providers in the event the use of OGB's PPO providers is not possible. The CM/UM firm shall notify OGB where services are not available within the existing PPO networks; and

    f. Communicating all case management decisions to OGB claims department in a timely and thorough manner to ensure proper adjudication of the claim.

    Failure to follow the above procedures may result in a fine of $500 per documented incident.

F. Outpatient Management Program

The CM/UM firm shall provide a customized outpatient management program for procedures identified in the Exhibit section of this NIC. The CM/UM firm will work collaboratively with OGB to modify the procedures as appropriate, based on actual utilization and demonstrated need to change procedures.

G. Review Personnel Requirement

The CM/UM firm's review staff must possess the greater of (a) the minimum training/qualifications specified in La.R.S. 22:1121-1144 and Louisiana Department of Insurance Regulation 77; or (b) the minimum training/qualifications specified below:

1. First Level Review:

    a. Minimum of licensed nurse with two (2) years clinical experience.

    b. Minimum of an RN license with specialty training and/or clinical experience required for specialty review areas, *e.g.,* neonatal.

2. Physician Advisors (including medical directors);

    a. Minimum credentials of current state approved license and three (3) years professional experience in the practice of medicine.

    b. For specialty reviews board certification and active professional experience in the appropriate specialty area required.

The CM/UM firm is required to maintain a panel of specialty physician advisors who are available for peer review on select cases.

Failure to maintain a review staff with the above minimum training/qualifications may result in a fine of $1,000 per month for any month in which the CM/UM firm is in violation of the requirement.

H. Appeal Procedures

The CM/UM firm shall maintain a review and appeals process that, at minimum, must satisfy the requirements set forth in the OGB Plan Document pertaining to appeals from medical necessity determinations, together with all requirements relating to review and appeals of medical necessity determinations under Louisiana law and regulations, including, but not limited to La. R. S. 22:1121-1144 and Louisiana Department of Insurance Regulation 77, LAC 37:VIII.6201-6245.

I. Telephone Service Requirement

1. OGB has established a toll-free CM/UM telephone number that shall remain the property of OGB, the cost of which must be paid by the CM/UM firm on a monthly basis. The toll-free telephone number exists currently on OGB plan member's I.D. card. Toll-free telephone service must be available at a minimum from 8:00 a.m. to 6:00 p.m. CST, Monday-Friday. The CM/UM firm shall also maintain an after-hours answering system capable of collecting caller information, with a CM/UM staff member "on call" to respond to after hour calls seven (7) days a week, 24 hours per day.

2. The CM/UM firm must provide adequate personnel to respond to all incoming calls with a live operator within 45 seconds or less time at all times, including peak calling periods.

3. Members/providers should not be placed on hold for longer than 30 seconds without a recurring recorded message letting the person know that their call will be acknowledged. The maximum period of time a call may be placed on hold should not exceed three (3) minutes and the average abandonment rate should be no greater than 3%. If the number of calls placed on hold, the abandonment rate is high (*i.e.,* over 3%) or the waiting time is excessive, the CM/UM firm will be required to add additional phone lines as necessary to meet the required standards. AN electronic phone system capable of tracking call volume, and abandonment rates is required. Please provide samples of your telephone logs/reports with your NIC response.

4. Staff responding to incoming calls must have on-line computer terminals available for instant access to member eligibility and medical review status data, and to allow immediate retrieval of other participant and/or plan information.

A violation of the above requirements may result in a fine of up to $1,000 for each month in which the CM/UM firm is not in compliance with the requirements.

J. Transfer of CM/UM Decision Requirement

The CM/UM firm shall implement a procedure for transferring all pertinent decisions rendered during certification, continued stay, short term and long term case management and appealed review to OGB's claim department. Electronic transfer is required at a frequency that is to be specified by OGB; however, hard copy may be necessary in certain review situations. See Section 1(D) of this NIC for a description of OGB's computer system.

The record format for exchange of CM/UM data is provided in the Exhibit section of this NIC.

K. Strategic Account Executive Requirements

The CM/UM firm shall provide a dedicated, experienced Account Executive and at least one back-up staff member to handle the overall responsibility of OGB's program. The individual who serves as Account Executive must be experienced in working with large accounts (15,000 plus). Additionally, this representative must assist with program implementation and ongoing account support and must not b an Account Executive to more than 2 employer accounts (15,000 plus) including OGB (i.e. the Account Executive can only represent one other account in addition to OGB).

L. Meeting Requirement

Attendance by the Account Executive or back up CM/UM personnel at OGB Policy and Planning Board meetings is mandatory. The Account Executive for the CM/UM firm shall also be available for management meetings with OGB staff. These meetings are generally held in conjunction with Board meetings, but are sometimes on an ad-hoc basis, and the Account Executive and CM/UM firm need to be aware of this. You may assume eight such meeting per year. At these meetings, the Account Executive and/or other members of the CM/UM 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 improvements.

M. Precertification, Short Term Management and Long Term Case Management Reporting Requirements

The CM/UM firm shall submit accurate and timely required reports to OGB.

A description of the required reports, including a penalty provision for failure to provide reports on a timely basis is included in the Exhibit section of this NIC.

N. OGB's PPO Plan Documents

Copies of OGB's PPO and the LaCHIP Affordable Plan Documents are available on the Office of Group Benefits website, www.groupbenefits.org. The CM/UM firm shall maintain a current copy of OGB's Plan Documents to ensure that only admissions for the types of service and treatment that are covered by OGB plans are authorized at any point during the CM/UM process.

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
Cost – Per Contract Per Month	400
Qualitative Services:	
Effectiveness of review services for pre-certification, concurrent and case management, including effectiveness of screening criteria	125
Physician and non-physician reviewer experience and capability	75
Ability to accommodate the volume of plan participants for the required CM/UM services considering the telephone and computer system, staff and facility/location	100

Experience and internal quality control as a CM/UM Vendor, responsiveness and willingness demonstrated by CM/UM Vendor's response to NIC, discussion, interviews and/or site visits, and the CM/UM Vendor's ability to identify, define and resolve Program concerns	200
Performance metrics and fees at risk	100
Total Qualitative Points	600
Total Maximum Points	1,000

C. Cost Evaluation

The Proposer that provides the lowest fee per contract 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.

Evaluation of Cost:

The total contract charge shall be quoted on The Fee Proposal Form (Attachment IV) 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:

$$\frac{L}{P} \times 400 = S$$

Where:

L = lowest proposed average 3-year cost

P = each proposer's average 3-year cost

S = each proposer's cost score

SECTION V

PROPOSERS REQUIREMENTS/CHECKLIST

A. Proposers Requirements

1. Your firm must have a minimum of five (5) years experience in independent CM/UM.

2. Your firm must currently provide CM/UM services to at least one (1) health plan group with a minimum size of twenty-five thousand (25,000) covered employees and/or retirees (not counting dependents).

3. Your firm must be URAC accredited. Please advise of any other type of accreditation.

4. Your firm must agree to provide utilization management services, as specified in this NIC.

5. Your firm must be properly certified as a Medical Necessity Review Organization in Louisiana in compliance with La. R.S. 22:1121-1144.

6. Your firm must have a representative attend the Mandatory Proposer's Conference in person.

7. Your firm must submit audited financial statements for your most recent two fiscal years.

8. Your firm must have the capability to record calls and have an access system that will be available to the Office of Group Benefits.

9. Agree to fund up to $20,000 each for an onsite pre- and post-implementation audit of your CM/UM services.

B. Proposers Requirements Checklist

Instructions for Completion of the Proposers Requirements Checklist:

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

The CM/UM 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 CM/UM firm, if and when the proposal is accepted and accompanied by a separate formal written contract document.

Proposal Checklist	Indicate	
	Yes	No
1. Does your organization have a minimum of five years experience in performing utilization management/review services?	☐	☐
2. Are you currently providing CM/UM services to a group of at least 25,000 covered employees and/or retirees (not including dependents)?	☐	☐
3. Do you agree to provide utilization management services, as specified in this NIC, recognizing the unique benefit plan design of OGB?	☐	☐
4. Do you agree to use the State's dedicated toll-free number for all utilization review calls for OGB plan participants? This toll-free number is on the participant's ID card and will be transferred to the newly selected CM/UM firm for the duration of the contract.	☐	☐
5. Do you have the ability and are you willing to customize your CM/UM services to meet the needs/desires of OGB's programs?	☐	☐
6. Do you agree to <u>not</u> provide utilization management services for mental health or substance abuse (MHSA) cases (which are under the responsibility of the State's mental health carve-out contractor) but to route any misdirected callers or written material immediately to OGB MHSA Contractor.	☐	☐
7. Do you agree to provide review for those mental health and substance abuse cases requiring acute medical hospitalization (e.g. detox, overdose) and to notify OGB MHSA Contractor promptly after case review initiation to enhance their ability to direct the patient toward their network and management services?	☐	☐
8. Do you agree to maintain evidence of the following insurance throughout the duration of the contract? a. Medical malpractice insurance of at least $1 million/$3 million for physicians on staff. b. Minimum $5 million comprehensive coverage to be carried by the CM/UM firm contracted with OGB.	☐ ☐	☐ ☐
9. Is your organization properly certified as a Medical Necessity Review Organization in Louisiana in compliance with La. R.S. 22:1121-1144?	☐	☐
10. Do you agree to interface with OGB's incumbent CM/UM firm in determining which cases have been precertified within the past 90 day period prior to the contract implementation date and which patients are hospitalized in order to coordinate a seamless transition from one CM/UM firm to another?	☐	☐
11. Do you understand that for all questions and transmission of medical information, the CM/UM firm is to communicate with OGB staff designated to be the CM/UM liaison?	☐	☐
12. Do you maintain a computer system capable of accommodating the requirements of the contract and the volume of plan participants, with daily electronic transfer of UM determinations to OGB?	☐	☐
13. Have you included in your proposal audited financial statements for your most recent two fiscal years?	☐	☐
14. Do you agree to provide all of the required reports set forth in the Exhibit section of this NIC?	☐	☐
15. Do you acknowledge that no commission or finder fees of any type will be payable by the CM/UM firm with regard to the contract?	☐	☐
16. Have you submitted a complete response to all questions set forth in the Narrative Section of this NIC?	☐	☐
17. Have you included all of the attachments outlined in this NIC with your complete proposal response?	☐	☐
18. Have you submitted a complete Cost Proposal utilizing the format requested in this NIC?	☐	☐

SECTION VI

NARRATIVE QUESTIONNAIRE

You are required to respond to all of the following questions. Reference should not be made to a prior response nor should an overall response be used to answer more than one question. Each question has been written to address a specific area of concern. A full answer to each question is required even when such answers may appear repetitious.

A. General Background

1. Please provide a brief general description of your company size, staff, history and experience.

2. Has your company undergone any reorganization/restructuring within the past three years? If so, explain.

3. Is your organization anticipating any reorganization within the next 12 months? If so explain.

4. Do you anticipate having to materially modify any of your operational procedures to accommodate this contract should you be the successful proposer?

5. Within the last two years, has your CM/UM firm, any senior officer and/or any board member been a party to a lawsuit in relation to the operation of your company? If so, please provide a brief description of each incident.

6. Indicate your acceptance of the contractual provisions set forth in Exhibit I of this NIC. Please specify any exceptions or proposed modifications to any of the provisions.

7. Provide information related to your proposed, dedicated operational review personnel utilizing the format below:

Staff (last name only)	**Primary area of work (e.g. pre-service, concurrent, LCM)**	**Professional degree if applicable (RN, LPN, none)**	**# of years in health care field**	**# of years with your organization**	**Areas of health care expertise**
* EXAMPLES:					
* JONES	Pre-service	RN	3 yrs.	Less than 1 yr.	Adult, med-surg, ortho

*Smith	LCM	RN	15 yrs.	4 yrs.	Home health, psych

8. Address any requirements of the MNRO Act with which you are not currently in compliance and outline your plan of action (including your timeline) for full compliance.

B. Systems

1. Regarding your computer system, how much longitudinal data (in months) is maintained in your working data set and how much is archived?

2. At any point in time, how much data is available for analytical purposes?

3. Fully describe your telephone system. Include any call tracking capabilities. Indicate how you would know if the number of incoming lines is insufficient and the steps you would take to correct the problem.

4. Describe any modifications to your existing telephone system you anticipate needing to make to accommodate OGB volume. Please provide screen shots

5. Fully describe your computer system. Discuss hardware, software, model, capacity, redundancy, access protocol, etc.

6. Is your telephone system able to track and provide monthly reports regarding waiting time, abandonment rates and call volume? Please confirm whether you are able to provide this information exclusively for OGB plan participants.

C. CM/UM Services

1. Discuss the process and expected data set relative to the transition of the OGB plan from one CM/UM firm to another?

2. Indicate what occurs if you are unable to gather adequate concurrent review information.

3. Briefly describe your usual case management/utilization management services

from case identification to resolution.

4. List the specific desired outcomes of your high risk maternity program and the methods used to accomplish these outcomes.

5. Describe your internal quality control program.Indicate two areas that your Utilization Management Organization regularly monitors to ensure quality services are provided.

6. Describe an internal quality problem which occurred within the past year and the steps your organization implemented to resolve the problem/issue.

7. List the *DATE* and *TITLE* of three *RECENT* operational staff education programs.

8. Screening criteria:

    a. Describe your organization's process for development of screening criteria (e.g., what prompts creation, revision, deletion, etc.).

    b. Indicate the name (source) and date of each type of screening criteria used during certification, continued stay review and case management.

    c. How often is each of the screening criteria identified in (b) above updated?

9. What criteria do you use to determine length of stay for hospital admissions? Describe how these criteria are used to precertify a proposed length of stay. How frequently is the length of stay criteria updated?

10. Does your criteria for determining length of stay vary by state or geographic region?

11. BRIEFLY describe a Utilization Management program/process/tool developed by your organization which you believe is innovative in controlling or measuring health care costs.

12. What is your organization's standard frequency for conducting continued stay review for (a) acute inpatient hospital care; (b) skilled nursing facilities; and (c) inpatient physical rehabilitation?

13. Does your proposal contemplate conducting on-site continued stay review? If so, under what situations would on-site review be used versus telephonic continued stay review?

14. Complete the following grid regarding the proposed, designated physician advisors (FT, PT & subcontracted) who perform review services for your organization.

Physician Advisor Name	Specialty	Employment Status with your Organization as: F = full-time employee, P = part-time employee, or S = subcontracted per review needs	Length of time reviewer with the organization
Example: Paul Bunyon, M.D.	Orthopedics	S	4 years

15. How does your organization handle providers who complain that the admission and/or continued stay review criteria are too restrictive?

D. Performance measures and fees at risk

1. Please indicate specific, aggressive, measurable operational and clinical performance metrics your organization can report on and which you are willing to put a percentage of your fees at risk for successful outcomes.

2. What percentage of fees at risk are you willing to put on the table for successful outcomes?

3. Are you willing to report on the performance metrics quarterly and settle up annually?

SECTION VII

PROPOSER INFORMATION

A. PRIMARY PROPOSER

Please provide the following for your Organization:

- Name
- Address
- Principals
- Date Founded
- Contact Person Name and Title
- Telephone Number and Extension
- Fax Number
- E-Mail Address

B. PARENT COMPANY

SAME INFORMATION AS LISTED IN (A).

C. SUBSIDIARIES/AFFILIATES TO PERFORM SIGNIFICANT SERVICES

SAME INFORMATION AS LISTED IN (A) FOR EACH SUBSIDIARY AND AFFILIATE.

D. CM/UM Client References

Please provide three (3) references for your organization's three largest existing clients. One of these must be for a client with at least 25,000 or more covered employees and retirees (not counting dependents).

Please provide the following for all three (3) references:

- Name
- Address
- Industry
- Contact Person and Title
- Telephone Number and Extension
- Fax Number

- Your Organization Account Executive Assigned to This Account
- How Long Has This Account Been With Your Organization
- Total # of Employees and Total # of Members
- Plan Design Currently in Place
- Services Provided For This Account

E. Please provide three (3) references that left your organization within the last three (3) years. Please state the reason(s) why.

Please provide the following for all three (3) references:

- Name
- Address
- Industry
- Contact Person and Title
- Telephone Number and Extension
- Fax Number
- Your Organization Account Executive Assigned to This Account
- Total # of Employees and Total # of Members
- Plan Design
- Services Provided For This Account
- Reason Services Terminated

SECTION VIII

ATTACHMENT TO PROPOSAL RESPONSE

Please provide the following:

(a) Sample precert CONFIRMATION/APPROVAL notice/letter.

(b) Sample precert DENIAL/NON-CONFIRMATION notice/letter.

(c) A copy of the detailed appeal process a patient physician or provider would need to follow in the resolution of a complaint/disagreement *INCLUDING KEY TIMEFRAMES.*

(d) Sample appeal closure letter which would be forwarded to a physician/patient.

(e) Sample letter indicating that continued stay is no longer able to be certified/approved.

(f) The criteria you typically use to identify appropriate cases for your case management services.

(g) Sample case management summary report WITH savings analysis.

(h) Sample standard report package with an explanation of abbreviations and categories of data. This must include telephone call reports which identify abandonment rates, average call answer statistics, etc.

(i) Samples of customized report capabilities.

(j) Sample patient education material from your high-risk maternity program.

(k) Brief outline of the contents of your organization's orientation/training program for nursing personnel and physician advisors.

(l) Resume(s) of your Medical Director(s).

(m) Resumes of your organization's key management staff and owners.

(n) An organizational chart HIGHLIGHTING THE UTILIZATION MANAGEMENT DIVISION.

(o) Your organization's policy/procedure on maintenance of confidentiality.

(p) Sample education material that informs enrollees regarding your Utilization Management Organization's overall services.

(q) Attach a copy of the current screening criteria you use for inpatient rehab, Repair rotator cuff tear, lumbar spinal fusion, and PTCA. Be sure to note how many indicators must be met in order to approve the service.

(r) Your Organization's most recent audited financial statements.

SECTION IX

MANDATORY SIGNATURE PAGE

UTILIZATION MANAGEMENT SERVICES (CM/UM)

This proposal, together with all attachments and the fee proposal form, is submitted on behalf of:

Proposer:_____

I hereby certify that:

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

2. This proposal was not prepared or developed using assistance or information illegally or unethically obtained.

3. I am solely responsible for this proposal meeting the requirements of the NIC.

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

5. Proposer is properly certified as certified as a Medical Necessity Review Organization in Louisiana in compliance with La. R.S. 22:1121-1144

6. All information contained in this proposal is true and accurate.

Date: _____ Printed Name: _____

Title: _____ Signature:_____

SECTION X
FEE QUOTATION

Case Management/Utilization Management Services

Annual Rate – Fee

July 1, 2009 - June 30, 2010 $_____ per contract per month

July 1, 2010 – June 30, 2011 $_____ per contract per month

July 1, 2011 - June 30, 2012 $_____ per contract per month

NOTE: (1) Your fees must be all-inclusive of administrative expenses, travel, Communications materials and any other requirement of this NIC.

(2) The original and eight (8) copies of the Fee Proposal Form are to be submitted in a separate envelope marked "CM/UM NIC" on the outside of such envelope. **Do not include the Fee Proposal Form in the three ring binder with the other required portions of your proposal.**

CM/UM Firm_____

BY (Print Name) _____ Title_____

Signature_____ Date_____

SECTION XI

EXHIBITS

EXHIBIT 1	OGB Standard Contract/Business Associate Agreement
EXHIBIT 2	Utilization Information/Statistics
EXHIBIT 3	CM/UM Report Requirements
EXHIBIT 4	Outpatient Procedure Certification (OPC)
EXHIBIT 5	Long Term Case Management
EXHIBIT 6	Medical Necessity Review Organization Act and Louisiana Department of insurance Regulation 77
EXHIBIT 7	PPO Plan Document
EXHIBIT 8	Census Data

EXHIBIT 1

STANDARD CONTRACT

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS (OGB)

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

1.0 SCOPE OF SERVICES/DELIVERABLES

Contractor will provide Utilization Management (CM/UM) Services to the OGB for it's plan participants in self administered health plans, exclusive of those whose primary coverage is Medicare.

The objective of this Contract is to assure that medically necessary care is rendered appropriately, and cost effectively, without sacrificing the quality of care, utilizing recognized medical management protocols, in cooperation with treating physicians and other health care professionals, for pre-admission certification of inpatient hospital services, monitoring length of stay, prior authorization of certain outpatient services, determining alternative care settings, and designing creative and effective alternative treatment plans.

Contractor agrees to provide OGB the following Utilization Management Services:

a. Eligibility Confirmation: Confirm the patient's eligibility with each request for Pre-certification (all inpatient admissions and certain outpatient procedures), Continued Stay Review, Short Term Case Management and Long Term Case Management, utilizing eligibility information provided by OGB to Contractor.

b. Pre-certification: Review of proposed hospital admissions in accordance with established criteria for assessing the necessary, appropriate and cost-effective allocation of health care resources and services given or proposed for a plan participant.

c. Discharge Planning: Preparing a patient to leave a health care facility. The discharge planning process is an integral part of the Continued Stay Review process, beginning upon admission with the gathering of pertinent information needed to coordinate a timely discharge, and involving the coordination of providers, patient education, home health, outpatient equipment/supplies, etc. necessary to facilitate a timely and safe transition from the inpatient setting.

d. Outpatient Procedure Certification: Provide review and certification that outpatient procedures and therapies (identified and delineated by OGB in Statements of Work and changed from time to time) are necessary, appropriate and cost-effective allocation of health care resources and services given or proposed for a plan participant.

e. Short Term Case Management: Administering special program designed by OGB to facilitate discharge from a hospital or to prevent a hospital admission through the management of health care for patients requiring the following services:

- Skilled Nursing Facility Admissions
- Use of Health/Home Infusion Services, if not self-administered
- Home Uterine Monitoring for High Risk OB Patients
- Hospice Care
- Physical or Occupational Therapy Services Rendered in the Home

Contractor will work collaboratively with OGB to modify Short Term Case Management program, as appropriate, based on experience with OGB's patient population and demonstrated need to change procedures.

f. Long Term Case Management: For covered persons suffering long-term, intensive illness or injury requiring extensive care, utilize medical professionals to work with the patient, family/caregivers, physician and health care providers and OGB to coordinate/develop a cost-effective alternate treatment plan that may be facilitated through the use of covered services and non-covered care, not to exceed the patient's remaining lifetime maximum benefit under the PPO Plan. Each case will be individually reviewed. There must be agreement between the Contractor, OGB and the covered person, and the covered person's attending physician as to the proposed treatment plan.

g. Appeal Procedures: Maintain procedures for review of non-certification recommendations at the request of any patient, physician or provider who is dissatisfied with an initial determination.

h. Definition of Medical Necessity: The terms "Medical Necessity" or "Medically Necessary" shall mean that medical care, goods, services, or hospitalization is appropriate for the effective treatment of an incident. The fact that any physician may prescribe, order, recommend, or approve a treatment, service, supply or medicine, does not, of itself, make the treatment, service, supply or medicine, Medically Necessary. Determination of Medical Necessity does not constitute approval of the claim for services provided, and all expenses are subject to the terms, limitations and exclusions of the OGB’s health plans. Moreover, when reviewing Medical Necessity, neither Contractor nor any of its employees shall engage in the practice of medicine.

Nothing herein shall be interpreted or construed as a determination by Contractor as to the payment or the denial of payment of any claim or the delivery of any health care services. Contractor recognizes that the determination as to payment or denial of payment of any claim and/or the authorization of payment for any health care service will be made only by OGB, and that the decision or determination to obtain or deliver any health care services is always made only by the covered person and/or his or her physician.

All services pursuant to this contract shall be provided in accordance with the terms, conditions, requirements and specifications set forth in the Notice of Intent to Contract (NIC) and pursuant to the proposal submitted by Contractor in response to the NIC.

Effective upon termination of the contract, Contractor will transfer and convey to OGB the toll free telephone numbers used for plan member and provider contacts with Contractor. Contractor will execute and deliver to OGB in a timely manner such documentation as may be required to effect the transfer.

2.0 OGB FURNISHED INFORMATION

OGB will 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:

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

b. 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 will 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 TERM OF CONTRACT

This contract shall begin July 1, 2009 and end June 30, 2012.

This contract is not effective until approved by the Director of the Office of Contractual Review in accordance with La. R.S. 39:1502.

4.0 PAYMENT TERMS

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

Fee Rate

7/1/09 – 6/30/10	$_____per contract per month
7/1/10 – 6/30/11	$_____per contract per month
7/1/11 – 6/30/12	$_____per contract per month

4.01.1 The amount of each monthly payment will be based upon the number of employees and retirees (exclusive of dependents) enrolled in OGB's PPO Plan on the first day of the month in which services are rendered, exclusive of retired employees with Medicare as primary coverage.

4.01.2 Contractor and OGB acknowledge and agree that Contractor shall produce a monthly invoice for services provided pursuant to this Contract. The OGB will make payment of the fees listed above directly to the Contractor by the 5th day of receipt of the invoice. 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. Contract Supervisor must issue written approval of all payments.

4.01.3 In consideration of the services described in this contract the maximum the OGB will pay Contractor is _____.

5.0 INSURANCE

Staff Insurance

Contractor shall procure and maintain for the duration of this contract insurance against 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, his agents, representatives, employees or subcontractors.

Liability Insurance

Contractor shall procure and maintain for the duration of the contract liability insurance and comprehensive liability insurance, with a combined single limit liability of not less than $5,000,000. The State of Louisiana, Office of Group Benefits must be named as an additional insured.

Contractor shall on request furnish OGB with certificate(s) of insurance affecting coverage required by the 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.

6.0 TAXES

Contractor hereby agrees that the responsibility for payment of taxes from the funds thus received under this contract and/or legislative appropriation shall be contractor's obligation and identified under Federal Tax Identification Number _____.

7.0 SECURITY

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

8.0 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.

9.0 PROJECT MANAGEMENT

Basic Reports: Contractor will provide reports of performance activities under this Contract as designated in writing by OGB. Said reports shall be provided in a format and within timeframes agreed upon by the parties in writing.

Basic Reporting includes the following data:

- Telephone statistics
- Overall Savings
- Inpatient Utilization
- Inpatient Utilization by Age and Gender
- Appeals Outcomes
- Longest Lengths of Stay
- Most Frequent Inpatient Diagnoses by Age Category
- Most Frequent Inpatient Procedures by Age Category
- Top 40 Inpatient Diagnoses
- Top 40 Inpatient Procedures
- Outpatient Service Reviews
- Outpatient Activity Summaries

Special Reports: Subject to the limits of its capabilities, Contractor agrees to provide such special reports as requested in writing by OGB. If Contractor incurs additional expense in preparing such special reports, then Contractor will promptly provide a written cost estimate and schedule, and obtain OGB's approval of such cost prior to preparing any such reports.

Personnel: Personnel assigned by Contractor to perform the services pursuant to this contract will be qualified to perform the assigned duties, and Contractor will determine which personnel will be assigned for any particular project and to replace and reassign such personnel doing such project. Contractor assumes responsibility for its personnel providing services pursuant to this contract.

Meeting Requirements: Contractor's Account Executive will be available to attend and participate in OGB Policy and Planning Board meetings as well as management meetings with OGB staff, and such other meetings deemed necessary from time to time by OGB.

10.0 TERMINATION FOR CAUSE

OGB 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 OGB shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) days after receipt of such notice, the 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 OGB may, at its option, place the 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 OGB to comply with the terms and conditions of this contract; provided that the Contractor shall give the OGB written notice specifying the OGB's failure. Furthermore, the Contractor shall be entitled to suspend any and all services until such time as when the OGB is not in default of its obligations under this contract.

11.0 TERMINATION FOR CONVENIENCE

The OGB may terminate the contract at any time without penalty by giving sixty (60) days written notice to Contractor. Upon any termination of this contract the Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

12.0 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.

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.

13.0 INDEMNIFICATION

a. 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 negligent 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 negligent act or omission of a State Affiliated Indemnified Party. Contractor agrees to investigate, handle, respond to, provide defense for and defend any such claim, demand or suit at its sole expense, even if such claim, demand or suit 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.

b. OGB agrees to protect, defend, indemnify and hold harmless Contractor, its affiliates, contractors, shareholders, directors, officers, employees, and agents (each a 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 negligent act or omission of OGB, its agents, servants, and employees, or arising out the actions or inactions of Contractor taken or not taken at the direction of the OGB, 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 negligent act or omission of a Contractor Indemnified Party. OGB agrees to investigate, handle, respond to, provide defense for and defend any such claim, demand or suit at its sole expense, even if such claim, demand or suit 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.

14.0 OWNERSHIP OF PRODUCT

All records, reports, documents and other material delivered or transmitted to Contractor by OGB shall remain the property of OGB, and shall be returned by Contractor to OGB, 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 the OGB in connection with the performance of the services contracted for herein shall become the property of the OGB, and shall, upon request, be returned by Contractor to OGB, at Contractor's expense, at termination or expiration of this contract.

15.0 ASSIGNMENT

Contractor shall not assign any interest in this contract and shall not transfer any interest in same (whether by assignment or notation), without prior written consent of the OGB, provided however, that claims for money due or to become due to the Contractor from the OGB 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 OGB and to the Office of Contractual Review, Division of Administration.

16.0 RIGHT TO AUDIT

Contractor grants to the Office of the Legislative Auditor, Inspector General's Office, the Federal Government, and any other duly authorized agency of the State the right to inspect and review all books and records pertaining to services rendered under this contract. Contractor shall comply with federal and/or state laws authorizing an audit of Contractor's operation as a whole, or of specific program activities. Any audit shall be conducted during ordinary business hours and upon reasonable advance notice to the Contractor.

17.0 RECORD RETENTION

Contractor agrees to retain all books, records, and other documents relevant to this contract and the funds expended hereunder for at least four (4) years after project completion of contract, or as required by applicable Federal law, whichever is longer.

18.0 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, 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.

19.0 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.

20.0 NON-DISCRIMINATION

The contractor agrees to abide by the requirements of the following as applicable: Title VI of the Civil Rights Act of 1964 and Title VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972, Federal Executive Order 11246 as amended, the 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 Discrimination Act of 1975, the Fair Housing Act of 1968 as amended, 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, sexual orientation, national origin, veteran status, political affiliation, or disabilities.

Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this contract.

21.0 AVAILABILITY OF FUNDS

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 OGB except for payments which have been earned prior to the termination.

22.0 HEADINGS

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

23.0 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 or any subsequent breach of the contract.

24.0 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.

25.0 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: Tommy D. Teague
Chief Executive Officer
Office of Group Benefits
7389 Florida Blvd, Suite 400
Baton Rouge, LA 70804

Contractor:

26.0 ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

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

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.

BY SIGNING BELOW, THE PARTIES AGREE TO ALL OF THE TERMS AND CONDITIONS SET FORTH ABOVE.

STATE OF LOUISIANA	**CONTRACTOR**
_____	_____
Name, Title	**Name, Title**
_____	_____
Signature	**Signature**
_____	_____
Date	**Date**

CONTRACT APPENDIX

Business Associate Agreement (BAA)
Protected Health Information Addendum

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)
q) "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.
r) 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

d) 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
e) 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.
f) 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 2

OGB UTILIZATION STATISTICS

Medical Management Statistics 2007

1) Average number of incoming calls per day

The current CM/UM firm averages 119 incoming calls on a daily basis.

2) Number of inpatient certifications per month

The current CM/UM firm averages 491 inpatient pre-certifications per month.

3) Number of outpatient reviews per month

The current CM/UM firm averages 90 outpatient pre-certifications per month. This includes occupational and physical therapy in the home. It also includes outpatient speech therapy.

4) Number of case management cases per month

The current CM/UM firm averages 48 new case management cases per month.

5) Number of medical panel referrals (physician reviews) per month

The current CM/UM firm averages 9 medical panel referrals per month.

EXHIBIT 3

CM/UM REPORT REQUIREMENTS

A. Intent

The intent of the required CM/UM reports is to provide OGB sufficient detail to have an in-depth understanding of type of activity and impact of the CM/UM activities on the plan's total cost. If your standard reporting format fulfills the intent, then upon mutual agreement between OGB, the consultant and the CM/UM firm's standard format may be accepted in lieu of the reporting formats indicated herein.

B. Required Report Elements

OGB will require a number of regular daily, weekly, monthly, quarterly and annual claim reports. The final format of the reports and the number of copies of such reports, and to whom they are to be sent, will be determined prior to implementation of the contract.

The following outlines the required report elements.

1. Telephone Statistics
2. Overall Savings
3. Inpatient Utilization
4. Inpatient Utilization by Age & Gender
5. Inpatient Utilization by MDC
6. Inpatient Stay Reviews Summary
7. Inpatient Service Reviews Summary
8. Appeal Outcomes
9. Longest Lengths of Stay
10. Most Frequent Inpatient Diagnoses by Age Category
11. Most Frequent Inpatient Procedures by Age Category
12. Top 40 Inpatient Diagnoses
13. Top 40 Inpatient Procedures
14. Outpatient Service Reviews Summary
15. Outpatient Activity Summaries
16. Admissions and days
17. Average length of stay
18. Readmission rate (per 1,000 and within 30 – 60 days)
19. Percentage of cases sent for Medical Director review
20. Admits by facility
21. Admits by DRG category
22. Outlier report (length of stay > 20)

Case management metrics:

Total identified and eligible population
Members contacted (by modality)
Case status (e.g. opened, closed, ongoing, pending)
Referral source
Case source (i.e. what triggered CM)
Cases managed
Length of time managed
End of life care needs

Call center metrics:

Call volume (inbound and outbound)
Average speed to answer
Abandonment rates
Reasons for non enrollment (declined abruptly, refuses service, confidentiality concerns, denies medical condition, etc.)
Outcomes of calls (e.g. enrollment assessment, intervention follow up, left message, reached a family member, rescheduled call)

NOTE: Savings is not to be reported as the difference between number of days requested versus number of certified or stayed.

C. Report Due Dates

All reports are due as follows:

1. Monthly reports are due on or before 15 days following the end of the month.

2. Quarterly reports are due on or before 45 days following the end of the quarter.

3. Annual reports are due on or before 60 days following the end of the contract year.

4. Daily continued stay review census log is due by the Wednesday following the end of each week.

5. Case management logs are due by the Wednesday following the end of each week.

D. Ad hoc Reports

Ad hoc reports may be required from time to time and shall be in a format and shall be due as may be mutually agreed upon by OGB and the CM/UM firm.

E. Penalties

OGB may assess a penalty of $300 per day for each day a report is late. All penalties will be deducted from the monthly fees paid to the CM/UM firm.

EXHIBIT 4

OUTPATIENT PROCEDURE CERTIFICATION (OPC)

A. OPC certifies that certain outpatient procedures and therapies are Medically Necessary.

1. It is the Plan Member's responsibility to assure that OPC is requested on services performed by non-PPO providers.

2. On services performed by a PPO provider, it is the provider's responsibility to obtain OPC. The Plan Member cannot be billed if the provider fails to do so.

B. OPC is required on all outpatient speech therapy.

C. No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility and professional fee in connection with speech therapy:

1. Unless OPC is requested at least 72 hours prior to the planned date of procedure or therapy;
2. For charges incurred on any listed procedure for which OPC was requested but not certified as Medically Necessary by the OGB's utilization review contractor.

D. Benefits otherwise payable for services rendered by a non-PPO provider will be reduced by 25% for any procedure or therapy on which OPC was not obtained.

SHORT TERM CASE MANAGEMENT

At this time, there is no "in plan" benefit structure for:
(1) home health care services and home infusion therapy, if not self administered;
(2) hospice care;
(3) skilled nursing facilities; and
(4) home uterine monitoring.

Coverage for the targeted items will be provided for medically necessary care, only as determined through a pre-authorization and concurrent review process that would be administered by the CM/UM firm.

EXHIBIT 5

LONG TERM CASE MANAGEMENT

A. Case Management (CM) is the managed care program available in cases of illness or injury where critical care is required and/or Treatment of extended duration is anticipated.

B. Case Management may provide coverage for services that are not normally covered. To be eligible, the condition being treated must be a covered condition, and Case Management must be approved prior to the service being rendered.

C. These charges are subject to the deductible, co-insurance, fee schedule and maximum benefit limitations.

D. The following criteria must be met:

1. The Program must be the primary carrier at the time Case Management is requested. Any Case Management plan will be contingent upon the OGB remaining the primary carrier;

2. The patient must not be confined in any type of nursing home setting at the time Case Management is requested;

3. There must be a projected savings to the OGB through Case Management; OR a projection that Case Management expenses will not exceed normal Plan benefits; and

   a. The proposed Treatment plan will enhance the patient's quality of life;
   b. Benefits will be utilized at a slower rate through the alternative Treatment plan.

E. If approved, Case Management may provide any of the following:

1. Alternative care in special rehabilitation facilities;

2. Alternative care in a skilled nursing facility/unit or swing bed (not nursing home), or the patient's home, subject to the deductible and coinsurance.

3. Avoidance of complications by earlier Hospital discharge, alternative care and training of the patient and/or family.

4. Home health care services limited to 150 visits per Plan year.

5. Hospice care:

   a. Not subject to the deductible;

b. Benefits are always payable at 80%, never at 100%.

6. Private duty nursing care.

7. Total parental nutrition, provided that the home visits for TPN are not reimbursable separately.

8. Enteral nutrition up to a single 90-day period for instances were through surgery or euromuscular mechanisms the patient cannot maintain nutrition and the condition can reasonably be expected to improve during this one 90-day time span.

9. Physical and occupational therapy rendered in a home setting.

F. Mental health and substance abuse Treatments or conditions are not eligible for Case Management.

G. Benefits are considered payable only upon the recommendation of the OGB's contractor, with the approval of the attending Physician, patient or his representative, and the OGB or its representative. Approval is contingent upon the professional opinion of the OGB's medical director, consultant, or his designee as to the appropriateness of the recommended alternative care.

H. If a condition is likely to be lengthy or if care could be provided in a less costly setting, the OGB's contact may recommend an alternative plan of care to the Physician and patient.

EXHIBIT 6

Louisiana Revised Statutes, Title 22
Subpart F. Medical Necessity Review Organizations

§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). 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.

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

§1125. 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 that has changed.

D. The fee for initial licensure and the fee for renewal of licensure shall each be one thousand five hundred dollars.

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.

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.

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.

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.

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 Chapter, he shall notify such person and, after notice and opportunity for hearing pursuant to Chapter 12 of this Title, subject to Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950, the commissioner shall 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 Chapter while such order is in effect shall, after notice and opportunity for hearing, 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.

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.

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 7

PPO PLAN DOCCM/UMENT

Available on Office of Group Benefits website

Website Address: www.groupbenefits.org

EXHIBIT 8

CENSUS DATA

AVAILABLE ON REQUEST