

Department of Health and Human Services  
**Office of Inspector General**



Office of Audit Services

March 2026 | A-06-24-02000

# **Louisiana Healthcare Connections Generally Complied With Federal and State Process Requirements When Denying Prior Authorization Requests**



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## Louisiana Healthcare Connections Generally Complied With Federal and State Process Requirements When Denying Prior Authorization Requests

### Why OIG Did This Audit

- OIG has identified longstanding challenges, including limited oversight and access to specialists, that may reduce the quality of behavioral health care services provided to Medicaid enrollees.
- We audited Louisiana Healthcare Connections (LHCC), a Louisiana Medicaid managed care organization (MCO), because it had the highest number of denied service requests of any MCO in Louisiana.
- This audit, part of a series of reports examining Medicaid MCO service denials, assessed whether LHCC complied with Federal and State requirements when it denied requested behavioral health services that required a prior authorization.

### Results of Audit

LHCC complied with Federal and State requirements when it denied 64 of the 76 sampled behavioral health service requests that required a prior authorization. However, the remaining 12 denied service requests did not meet the administrative or procedural requirements. Specifically, LHCC did not:

- Provide written notices of adverse determinations (11 prior authorization denials)
- Provide written notice of adverse determination within the specified timeframe (1 prior authorization denial)

Based on the sample results, we estimated that 3,209 prior authorization denials for behavioral health service requests during our audit period (15.8 percent) did not comply with Federal and State requirements.

### What OIG Recommends

This report does not contain recommendations.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of behavioral health care services provided to individuals enrolled in Medicaid. In Louisiana, Medicaid managed care organizations (MCOs) provide Medicaid enrollees with a variety of health care services including behavioral health services, which consist of all mental health, drug, and alcohol services, through a network of health care providers.

This audit is part of a series of OIG audits examining Medicaid MCO denials, including work examining the use of prior authorizations that may result in delays for enrollees seeking to access behavioral health services. Previous OIG reports have highlighted concerns related to the Medicaid managed care program and its oversight, such as high prior authorization denial rates and limited State oversight.<sup>1</sup> We selected Louisiana Healthcare Connections (LHCC), a Louisiana MCO, for audit because it had the highest number of denied behavioral health service requests of any MCO in Louisiana between January 1 and December 31, 2023 (audit period).

### OBJECTIVE

Our objective was to determine whether LHCC complied with Federal and State requirements when it denied requested behavioral health services that required a prior authorization.

### BACKGROUND

#### Medicaid Program

The Medicaid program provides medical and behavioral health services to eligible low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its own Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

To enhance access to and the quality of behavioral health care for Medicaid enrollees, many States implemented managed care delivery systems. Under these systems, States contract with MCOs to deliver covered services. In risk-based managed care arrangements, State Medicaid agencies pay MCOs a capitation payment, which is a fixed amount per enrollee per month, for each enrollee. The State Medicaid agency makes the capitation payment regardless of whether the enrollee receives services during the period covered by the payment.

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<sup>1</sup> See Appendix B for a list of prior OIG reports related to Medicaid MCO denials.

The contractual risk-based arrangements between State Medicaid agencies and MCOs shift financial risk for the costs of Medicaid services from the State Medicaid agency and the Federal Government to the MCO. If an MCO spends more on covered services than it receives in capitation payments, the MCO absorbs the loss; if it spends less, it keeps the gain. This financial risk gives MCOs a potential incentive to inappropriately limit what they pay their network providers either by improperly denying enrollees' access to covered services, constraining their reimbursements to providers, or both.

Federal regulations require each State Medicaid agency to monitor its Medicaid managed care program comprehensively. The State Medicaid agency's monitoring system must address all aspects of the managed care program, including the performance of each MCO's administration and management, appeal and grievance systems, and claims management (42 CFR §§ 438.66(a) and (b)). Each contract between a State and an MCO must provide that the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee (42 CFR § 438.210(a)(3)(ii)).

### **Louisiana's Medicaid Managed Care Program**

The Louisiana Department of Health, Bureau of Health Services Financing (State agency), oversees Louisiana's Medicaid managed care program, known as Healthy Louisiana. This program is administered by several MCOs, which are contracted to provide enrollees with comprehensive health care services, including primary care, hospital services, behavioral health, prescription drugs, and other essential health care benefits.

Within the State agency, the Office of Behavioral Health (OBH) manages and delivers the services and support necessary to improve the quality of life for enrollees with mental illnesses and addictive disorders. OBH is responsible for monitoring and providing consultation on the behavioral health components of MCO operations to ensure that behavioral health services are clinically appropriate, accessible to enrollees, and effective in meeting the needs of the population.

During our audit period, the State agency paid a total of approximately \$14 billion to the six MCOs with which it had contractual agreements.

To facilitate its monitoring of MCO operations, the State agency requires MCOs to submit quarterly reports detailing prior authorization activity. Specifically, those reports must include the: (1) total number of prior authorization requests received; (2) adjudication outcomes (i.e., approved, denied, or modified); and (3) rationale for each decision, particularly in cases of modification or denial. This reporting mechanism enables the State agency to monitor trends, identify potential access barriers, and assess the consistency and appropriateness of MCO decision making related to behavioral health services.

## **Louisiana Healthcare Connections**

LHCC, headquartered in Baton Rouge, Louisiana, and with regional offices in Lafayette, Covington, and New Orleans, is the largest Healthy Louisiana Medicaid health plan. LHCC is responsible for administering behavioral health services pursuant to Federal and State requirements. During our audit period, LHCC received approximately \$3.91 billion in Medicaid capitation payments from the State agency to provide health care services to more than 508,000 Medicaid enrollees in Louisiana. LHCC reported spending approximately \$220 million on behavioral health treatment during the same period.

LHCC provides general direction and support for its network providers and assists its providers in delivering covered services such as behavioral health services, hospitalizations, and therapy services.

### **Louisiana Healthcare Connections's Prior Authorization Process**

LHCC's Healthy Louisiana contract defines prior authorization as the process of determining medical necessity for specific services before they are rendered. Under LHCC's Medicaid MCO plan, health care services must be deemed medically necessary, as defined in LHCC's Healthy Louisiana contract between the State agency and LHCC, to be covered. LHCC's *Provider Manual* includes a list of covered services that may require prior authorization. LHCC's online resources allow providers to access a variety of useful tools, references, and resources designed especially for Louisiana Medicaid providers, such as provider notices, clinical practice guidelines, and a prior authorization lookup tool. Behavioral health services requiring prior authorization must be approved by LHCC before the services are delivered.

LHCC's Medicaid managed care prior authorization process begins when an enrollee's health care provider submits to LHCC a prior authorization request for a new or renewed service, along with supporting documentation.

LHCC's prior authorization denial process is depicted in the figure on the following page. LHCC's utilization management (UM) clinical team members and medical directors use appropriate medical necessity criteria approved by the State agency to review prior authorization requests. If the UM clinical team member determines that a request has insufficient clinical support to meet those criteria, the clinical team member reaches out to the relevant provider via phone or fax and asks that the necessary medical information be submitted within the timeframe specified by the health plan.

If the provider does not furnish the required information within the specified timeframe after being contacted, the LHCC UM clinical team member evaluates the prior authorization request on the basis of only the medical information provided and either sends the request to the medical director to determine medical necessity or denies the request for lack of information.<sup>2</sup> In general, LHCC issues a prior authorization decision within 2 business days from receipt of necessary medical information for standard service authorization requests (not to exceed a total of 14 calendar days from the receipt of the request unless an extension is requested), and within 72 hours after receipt of the request for expedited service authorization requests.<sup>3</sup>

If a request is denied following the review process described above, LHCC sends a written notice of adverse determination to the provider and the enrollee, explaining the reason for the denial along with information explaining rights to appeal the decision.<sup>4</sup> For this report, we refer to LHCC's denials of prior authorization requests as "prior authorization denials."

## HOW WE CONDUCTED THIS AUDIT

During our audit period, LHCC received a total of 154,531 behavioral health service requests that required a prior authorization. Of these, LHCC approved 134,206 requests and denied 20,325 requests. We selected and reviewed a random sample of 76 of the 20,325 denied

### Figure: LHCC's Prior Authorization Denial Process

1. The MCO UM clinical team member determines that the request has insufficient clinical support to meet medical necessity.
2. The MCO UM clinical team member reaches out to the provider for additional necessary medical information.
3. The MCO UM clinical team member evaluates the medical information furnished by the provider and makes a decision or sends the request to the medical director to determine medical necessity.
4. The UM clinical team member or medical director informs the provider of the decision.
5. If the request is denied, the MCO mails the denial letter to the enrollee and the provider.

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<sup>2</sup> Failure to submit necessary clinical information can result in an administrative denial of the requested service.

<sup>3</sup> The information in this paragraph and the preceding paragraph is summarized from LHCC's *Provider Manual*.

<sup>4</sup> According to LHCC's *Provider Manual*, the appeals process allows the enrollee, the enrollee's authorized representative, or the provider acting on the enrollee's behalf, to request a review of a notice of adverse determination to verify whether the right decision was made. The appeal must be filed within 60 calendar days from the date of the notice of adverse determination.

service requests that required a prior authorization to determine whether LHCC's prior authorization process complied with Federal and State requirements.<sup>5, 6</sup>

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains related OIG audit reports, Appendix C contains the details of our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains Federal and State requirements pertaining to prior authorization for Medicaid managed care services.

## **RESULTS OF AUDIT**

LHCC complied with Federal and State requirements when it denied 64 of the 76 sampled behavioral health service requests that required a prior authorization. However, the remaining 12 denied service requests did not meet the administrative or procedural requirements. Specifically, LHCC did not:

- Provide written notices of adverse determinations (11 prior authorization denials)
- Provide written notice of adverse determination within the specified timeframe (1 prior authorization denial)

These errors in LHCC's administration of its prior authorization denial process were primarily the result of inadequate internal policies and procedures and training deficiencies that resulted in human error. Based on the sample results, we estimated that 3,209 prior authorization denials for behavioral health service requests during our audit period (15.8 percent) did not comply with Federal and State requirements.

## **WRITTEN NOTICES OF ADVERSE DETERMINATIONS NOT PROVIDED**

Federal regulations state that each Medicaid managed care contract must require the MCO to notify the requesting provider, and give the enrollee written notice, of any decision by the MCO

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<sup>5</sup> We initially selected a random sample of 100 service requests. After doing so, we determined that 24 of those service requests had been approved. We did not review those 24 requests, which left a random sample of 76 denied service requests that we did review.

<sup>6</sup> We did not submit these requests for medical review to determine medical necessity; instead, we looked at the administrative process that LHCC used when it denied requested behavioral health services that required a prior authorization.

either to deny a service authorization (i.e., prior authorization) request, or to authorize a service in an amount, duration, or scope that is less than requested (42 CFR § 438.210(c)).

For 11 of the 76 sampled denied service requests, LHCC did not provide written notices of adverse determinations to the enrollees as required by Federal and State requirements. All 11 of the denied service requests involved reviews of concurrent inpatient services.<sup>7</sup> LHCC's internal policy in effect at the beginning of our audit period stated that both the enrollee and the requesting provider would receive a written notice of adverse determination regarding any denial, reduction, or termination of service, with the exception of concurrent inpatient services. LHCC officials told us that their understanding was that because the enrollees were in inpatient settings, the enrollees would not receive the written notice, so LHCC sent written notices of denied concurrent inpatient services only to the providers.

However, LHCC revised its internal policy on June 22, 2023, to remove that exception based on a reinterpretation of the Healthy Louisiana contract language and to ensure that written notices were sent to enrollees regardless of the enrollees' inpatient status.<sup>8</sup>

In addition, for 1 of the 11 denied service requests, LHCC did not provide the written notice of adverse determination to the provider as well as the enrollee. LHCC attributed this error to a new UM clinical team member's oversight of a procedural step regarding the creation of the written notices. LHCC officials said, however, that once LHCC had identified this error, LHCC re-trained the clinical team member and implemented a checklist process to ensure that no procedural steps were missed.

#### **WRITTEN NOTICE OF ADVERSE DETERMINATION WITHIN THE SPECIFIED TIMEFRAME NOT PROVIDED**

The Healthy Louisiana contract between LHCC and the State agency that was in effect throughout our audit period states that the contractor (i.e., LHCC) shall provide written notification to the requesting provider of a determination to deny any authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested, and to do so within 2 business days of making the determination (Healthy Louisiana contract, Attachment A, section 2.12.6.4.2.2).

For 1 of the 76 sampled denied service requests, LHCC did not provide a written notice of adverse determination to the relevant provider within the specified timeframe. This delay was the result of an adverse determination having been made right before a long holiday weekend,

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<sup>7</sup> A review of concurrent inpatient services is the review and determination of medical necessity of hospital or other health care facility admissions, upon or within a short time following an admission, and periodic review of services provided during the course of treatment.

<sup>8</sup> All of the denied service requests in our random sample that involved concurrent inpatient services and that had written notices dated after the effective date of this internal policy change conveyed written notices of adverse determinations to the enrollees as well as to the providers.

when LHCC was closed both for Thanksgiving and the following day. LHCC stated that a new UM clinical team member misunderstood the timeframe requirements as they were affected by this holiday office closure and inadvertently provided the written notice of adverse determination to the relevant provider 3 business days after the determination.

### **EFFECT OF ERRORS IN ADMINISTRATION OF PRIOR AUTHORIZATION DENIAL PROCESS**

Based on the sample results, we estimated that 3,209 prior authorization denials for behavioral health service requests during our audit period (15.8 percent) did not comply with Federal and State requirements.

### **CONCLUSION**

Because LHCC revised its internal policy during our audit period to ensure that written notices of adverse determinations were sent to enrollees regardless of the enrollees' inpatient status, and because we did not identify any additional concerns after the effective date of this policy change, we are not making a formal recommendation.<sup>9</sup>

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<sup>9</sup> We deemed the one prior authorization denial that was not conveyed within the specified timeframe (because of the holiday office closure) as an isolated instance.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

During our audit period (January 1 through December 31, 2023), LHCC received a total of 154,531 behavioral health service requests that required a prior authorization. Of these, LHCC approved 134,206 requests and denied 20,325 requests. We selected and reviewed a random sample of 76 of the 20,325 denied service requests that required a prior authorization to determine whether LHCC's prior authorization process complied with Federal and State requirements (footnote 5).

We reviewed the design, implementation, and operating effectiveness of LHCC's internal controls as they related to our objective. We obtained an understanding of the laws, regulations, and guidance that were relevant to LHCC's and the State agency's monitoring process to determine whether LHCC complied with requirements for denials of behavioral health services that required a prior authorization.

We conducted our audit work from October 2024 to February 2026.

### METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal regulations, State laws, and the Louisiana Medicaid Managed Care (Healthy Louisiana) contract between the State agency and LHCC that was in effect for our audit period
- Interviewed State agency officials to gain an understanding of the State agency's monitoring of LHCC's prior authorization denial process
- Obtained and reviewed LHCC's policies and procedures covering its approval and denial processes for behavioral health service requests that require a prior authorization
- Interviewed LHCC personnel to understand LHCC's processes for reviewing enrollees' behavioral health service requests that require a prior authorization
- Obtained documentation related to the prior authorization requests, such as the denial logs (database), LHCC's *Provider Manual*, and LHCC's *Member Handbook*
- Selected from the 20,325 prior authorization denials during our audit period a simple random sample of 76 prior authorization denials (footnote 5) and for each:

- Requested the entire denial package (documentation of behavioral health service request; prior authorization denial including timelines, notes, and related material)
  - Reviewed notices of adverse determinations to determine whether they were sent to the enrollees and providers within the required timeframes and whether they included the required content and details (e.g., reason for denial, policy citation, facts underlying finding, language that is easily understood, appeal rights)
  - Reviewed whether the denial decision was made by an individual who had appropriate expertise in addressing the services requested
- Discussed the results of our audit with LHCC and State agency officials

On February 20, 2026, we provided LHCC with our draft audit report, and on March 9, 2026, LHCC notified us that it had no comments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Availability of Surveyed Behavioral Health Providers to Treat New Patients Enrolled in Medicare and Medicaid</i>	<a href="#"><u>OEI-09-21-00410</u></a>	6/23/2025
<i>CMS Did Not Ensure That Selected States Complied with Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements</i>	<a href="#"><u>A-02-22-01016</u></a>	3/25/2024
<i>New York Did Not Ensure That a Managed Care Organization Complied With Requirements For Denying Prior Authorization Requests</i>	<a href="#"><u>A-02-21-01016</u></a>	9/18/2023
<i>Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, but Improvements Can Be Made</i>	<a href="#"><u>A-07-22-07007</u></a>	9/13/2023
<i>High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care</i>	<a href="#"><u>OEI-09-19-00350</u></a>	7/17/2023
<i>Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization</i>	<a href="#"><u>A-03-20-00201</u></a>	12/20/2022
<i>Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care</i>	<a href="#"><u>OEI-09-18-00260</u></a>	4/27/2022
<i>Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate</i>	<a href="#"><u>OEI-02-19-00180</u></a>	3/26/2021

## **APPENDIX C: STATISTICAL SAMPLING METHODOLOGY**

### **SAMPLING FRAME**

The sampling frame contained information about LHCC's behavioral health service requests that required a prior authorization and that were denied between January 1 and December 31, 2023 (audit period). The sampling frame included 20,325 prior authorization denials.

### **SAMPLE UNIT**

The sample unit was a behavioral health service request that required a prior authorization and that LHCC denied.

### **SAMPLE DESIGN AND SAMPLE SIZE**

We used a simple random sample of 76 LHCC denied service requests (footnote 5).

### **SOURCE OF RANDOM NUMBERS**

The source of the random numbers was the OIG, Office of Audit Services, statistical software.

### **METHOD OF SELECTING SAMPLE UNITS**

We sorted the sample units by "Authorization Number" and "Sequence" and then consecutively numbered the items in the sampling frame. After generating the random numbers according to our sample design, we selected the corresponding frame items for review.

### **ESTIMATION METHODOLOGY**

We used the OIG, Office of Audit Services, statistical software to estimate the number and percentage of improperly denied service requests in the sampling frame that required prior authorization. We used the software to calculate the point estimate and the corresponding two-sided 90-percent confidence interval.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**Table 1: Sample Details and Results**

<b>Prior Authorization Denials in Sampling Frame</b>	<b>Sample Size</b>	<b>Written Notices of Adverse Determinations Not Provided</b>	<b>Written Notice of Adverse Determination Within the Specified Timeframe Not Provided</b>
20,325	76	11	1

**Table 2: Estimated Number and Percentage of Improperly Denied Service Requests in the Sampling Frame That Required Prior Authorization  
(Limits Calculated for a 90-Percent Confidence Interval)**

	<b>Number</b>	<b>Percentage</b>
<b>Point Estimate</b>	3,209	15.79%
<b>Lower Limit</b>	1,907	9.38%
<b>Upper Limit</b>	4,940	24.31%

## APPENDIX E: FEDERAL AND STATE REQUIREMENTS

### FEDERAL REQUIREMENTS

#### Availability of Services, 42 CFR § 438.206(c)

(1) *Timely access.* Each MCO . . . must do the following:

- (i) Meet and require its network providers to meet State standards for timely access to care and services taking into account the urgency of the need for services.<sup>10</sup>

#### Coverage of Services, 42 CFR § 438.210(a)(3)(ii)

This section states that each contract between a State and an MCO must provide that the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.

#### Notice of Adverse Benefit Determination, 42 CFR § 438.210(c)

Each contract between a State and an MCO must provide for the MCO to notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs . . . , the enrollee's notice must meet the requirements of § 438.404.

#### Timeframe for Decisions, 42 CFR § 438.210(d)

- (1) For standard authorization decisions, the MCO must provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if –
  - (i) the enrollee, or the provider, requests an extension; or
  - (ii) the MCO . . . justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- (2) For expedited authorization decisions,

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<sup>10</sup> Office of Inspector General Note—This language was effective during our audit period.

- (i) For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.
- (ii) The MCO may extend the 72-hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the State Medicaid agency upon request) a need for additional information and how the extension is in the enrollee's interest.

## **STATE REQUIREMENTS**

### **Healthy Louisiana contract, section 2.12.6, Service Authorization Determination Timing and Notices**

#### 2.12.6.4 Notices of Determinations

##### 2.12.6.4.2 Adverse Action

- 2.12.6.4.2.1 The Contractor shall notify the enrollee, in writing using language that is easily understood by the enrollee, of determinations to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.
- 2.12.6.4.2.2 The Contractor shall notify the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Contractor shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) business days of making the determination.

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