

## 907 KAR 17:035. External independent third-party review.

RELATES TO: KRS 194A.025(3), 205.646, 304.17A-607(1)(b), 42 C.F.R. Part 438

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.646, 42 C.F.R. Part 438

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. KRS 205.646 requires the department to promulgate administrative regulations to implement the external independent third-party review required by that statute. This administrative regulation establishes provisions regarding a Medicaid provider's right to an external independent third-party review of a managed care organization's adverse final decision of a provider's appeal of a denial of a claim for reimbursement or a service.

Section 1. Managed Care Organization Notice to Provider. (1) If an MCO issues an adverse final decision to a provider of a denial, in whole or in part, of a health care service, or claim for reimbursement as referenced in KRS 205.646(2) for a date of service or request for service on or after December 1, 2016, the MCO shall notify the provider in writing of the provider's right to an external independent third-party review pursuant to KRS 205.646.

(2) The MCO's notice shall:

- (a) Comply with the requirements established in KRS 205.646(3) regarding an external independent third-party review; and
- (b) State the reason for the adverse decision.

Section 2. External Independent Third-Party Review Preliminary Requirements. (1)(a) To request an external independent third-party review afforded to a provider pursuant to KRS 205.646(2), a provider shall submit a written request for external independent third-party review to the MCO within sixty (60) calendar days of receiving the MCO's final decision resulting from the MCO's internal appeal process.

(b) The sixty (60) day count shall begin on the:

1. Date that the notice was received electronically, if received electronically;
2. Date that the notice was received via fax, per the date and time documented on the fax transmission, if the notice was faxed; or
3. Post mark date on the envelope containing the notice, if the notice was sent via postal mail. An additional three (3) days shall be added if the service is by mail.

(c) A request for an external independent third-party review shall be sent to the MCO:

1. Electronically;
2. By fax; or
3. By postal mail.

(2) A provider's request for an external independent third-party review shall:

- (a) Identify each specific issue and dispute directly related to the adverse final decision issued by the MCO;
- (b) State the basis on which the MCO's decision on each issue is believed to be erroneous;
- (c) Limit disputes to the:
  1. Documentation the provider submitted for the MCO's internal appeal process; and
  2. Any other information contained in the MCO's final decision; and
- (d) State the provider's designated contact information, including name, phone number, mailing address, fax number, and email address.

(3) Within five (5) business days of receiving a provider's request for an external independent third-party review, the MCO shall:

(a) Confirm in writing to the provider's designated contact the MCO's receipt of the external independent third-party review request from the provider;

(b) Notify the department of the provider's request for an external independent third-party review; and

(c) Notify the enrollee of the provider's request for an external independent third-party review, if related to the denial of a health care service.

(4)(a) An external independent third-party review shall not be granted regarding a claim about which the enrollee has already requested an administrative hearing pursuant to 907 KAR 17:010, Section 5.

(b) If an enrollee files a request for an administrative hearing pursuant to 907 KAR 17:010, Section 5, regarding a claim about which a provider has already filed a request for an external independent third-party review, the external independent third-party review shall be held in abeyance until the enrollee's appeal has been fully adjudicated.

(5) Upon receiving a request for an external independent third-party review, the department shall:

(a) Assign the review to an external independent third-party reviewer; and

(b) Notify the:

1. MCO of the external independent third-party reviewer; and

2. Provider's designated contact of the external independent third-party reviewer.

(6) The department shall deny a request to initiate the external independent third-party review process, or a part thereof, if a party fails to:

(a) Exhaust the MCO's internal appeal process; or

(b) Submit a timely request for an external independent party review in accordance with subsection (1) of this section.

(7) Within fifteen (15) business days of a provider's request for an external independent third-party review, the MCO shall:

(a) Submit to the department a record on appeal, which shall consist of:

1. All documentation submitted by the provider in the MCO's internal review process; and

2. Any other information contained in the MCO's final decision;

(b) Designate a contact, including name, phone number, mailing address, fax number, and email address;

(c) Submit a copy of the provider's appeal request;

(d) Submit the MCO's final decision from its internal review process; and

(e) Include with the submission an attestation that the submitted documents required by paragraphs (a) through (d) of this subsection are accurate and complete.

Section 3. External Independent Third-Party Review. (1) The following shall be the categories of external independent third-party reviews:

(a) Medical necessity, which shall include a claim involving a medical necessity determination; or

(b) Service coverage requirements, which shall include:

1. A claim involving whether the given service is covered by the Medicaid program; or

2. A claim involving whether the provider followed the MCO requirements for the covered service.

(2)(a) A claim involving a medical necessity determination shall be reviewed by a clinician or clinicians who:

1. Have clinical expertise regarding the subject matter; and

2. Are currently licensed regarding the subject matter.

(b) A claim involving service coverage requirements shall be reviewed by the department.

(3) Only one (1) claim shall be reviewed per external independent third-party review unless the department determines that reviewing multiple claims related to one (1) member is expedient and appropriate.

(4) The documentation to be reviewed by an external independent third-party reviewer shall be limited to the information specified in Section 2(7) of this administrative regulation.

(5)(a) An external independent third-party reviewer shall:

1. Except as established in paragraph (c) of this subsection, conduct an external independent third-party review and issue a final decision within thirty (30) calendar days from the receipt of the documentation referenced in Section 2(7) of this administrative regulation; and

2. Issue the final decision to:

- a. The provider's designated contact;
- b. The MCO's designated contact; and
- c. The department.

(b) Within ten (10) business days of receiving the final decision of the external independent third party reviewer, the MCO shall notify the enrollee of the final decision, if related to the denial of a health care service.

(c) An extension of up to fourteen (14) calendar days on a final decision of an external independent third-party review may be allowed upon agreement of both parties.

Section 4. Right to an Administrative Hearing. (1) Upon the issuance of a final decision by an external independent third-party reviewer, the department shall notify in writing the MCO and the provider's designated contact of the right of the party that received an adverse final decision to appeal the decision by requesting an administrative hearing pursuant to 907 KAR 17:040.

(2)(a) A request for an administrative hearing referenced in subsection (1) of this section shall be received by the department within thirty (30) calendar days of receipt of the department's written notice referenced in subsection (1) of this section.

(b) The request for an administrative hearing shall be sent to the department:

1. Electronically;
2. By fax; or
3. By postal mail.

Section 5. Within sixty (60) calendar days from the exhaustion of appeal rights after a final decision against an MCO, whether rendered in an administrative proceeding or a court of law, the MCO shall submit complete payment as required by the decision.

Section 6. Appeals. (1) Except as provided by subsection (2) of this section, an appeal from denial of a service or services provided by a Medicaid managed care organization for medical necessity or denial, limitation, or termination of a health care service in a case involving a medical or surgical specialty or subspecialty, shall, upon request of the recipient, authorized person, or provider, include a review by a board-eligible or board-certified physician in the appropriate specialty or subspecialty area.

(2) If the health care service was rendered by a chiropractor or optometrist, the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky as required by KRS 304.17A-607(1)(b).

(3) The reviewer shall not have participated in the initial review and denial of service and shall not be the provider of service or services under consideration in the appeal. (43 Ky.R.

1350; 1786; 1978; eff. 6-2-2017; -- Amd 1450, 2226; eff. 5-4-2018.)