907 KAR 3:130. Medical necessity and clinically appropriate determination basis.

RELATES TO: KRS 205.520, 42 C.F.R. 440.230, 441 Subpart B, 42 U.S.C. 1396d (r)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396a, b, d

CERTIFICATION STATEMENT:

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 any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the basis for the determination of the medical necessity and clinical appropriateness of benefits and services for which payment shall be made by the Medicaid Program on behalf of both the categorically and the medically needy.

Section 1. Definitions.

(1) "Clinically appropriate" means appropriate pursuant to the nationally-recognized clinical criteria known as Interqual developed by McKesson Health Solutions:

(a) For which the department has contracted; and

(b) Which is available for purchase from McKesson Health Solutions by:

1. Visiting www.mckesson.com;

2. Calling 1-800-522-6780; or

3. Submitting a written request to McKesson Health Solutions, 275 Grove Street Suite 1 - 210, Newton, MA 02466-2273.

(2) "Covered benefit" or "covered service" means a health care service or item for which the department shall reimburse in accordance with state and federal regulations.

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Prudent layperson standard" means the standard for determining the existence of an emergency medical condition whereby a prudent layperson who possesses an average knowledge of health and medicine determines that a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that the person could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Section 2. Medical Necessity Determination.

(1) The determination of whether a covered benefit or service is medically necessary shall:

(a) Be based on an individualized assessment of the recipient's medical needs; and

(b) Comply with the requirements established in this paragraph. To be medically necessary or a medical necessity, a covered benefit shall be:

1. Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;

2. Appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice;

3. Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons;

4. Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;

5. Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard;

6. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 1396d(r) and 42 C.F.R. Part 441 Subpart B for individuals under twenty-one (21) years of age; and

7. Provided in accordance with 42 C.F.R. 440.230.

(2) The department shall have the final authority to determine the medical necessity and clinical appropriateness of a covered benefit or service and shall ensure the right of a recipient to appeal a negative action in accordance with 907 KAR 1:563.

Section 3. Criteria to Establish Clinical Appropriateness.

(1) The department shall utilize criteria to determine if a given Medicaid service or benefit is clinically appropriate.

(2) The criteria referenced in subsection (1) of this section shall be the nationally-recognized clinical criteria that meets the definition established in Section 1(1) of this administrative regulation.

Section 4. Medical Director Role in Service Denials.

(1) If a request for a service is denied for failing to meet medical necessity or clinical appropriateness criteria, the department's medical director shall have the authority to reverse or approve the denial.

(2) The letter of denial shall include the specific clinical reason that the service was denied including any appropriate Interqual or other criteria.

(27 Ky.R. 1713; eff. 2-1-2001; 33 Ky.R. 626; 1412; 1590; eff. 1-5-2007; TAm 1-13-2014; Crt eff. 12-6-2019; Crt eff. 9-24-2026.)