PROVIDER ISSUES IN CABINET FOR HEALTH AND FAMILY SERVICES ADMINISTRATIVE HEARINGS

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June 27, 2013

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CHFS ADMINISTRATIVE HEARINGS

- F&C AHB: Eligibility and Other Hearings
  - ✓ 2012: 1957 cases
  - ✓ 2012: 593 Medicaid eligibility cases

- HS AHB: Service and Other Hearings
  - ✓ 2012: 1472 cases
  - ✓ 2012: 696 Medicaid service cases;
    485 MCO cases;
    211 FFS cases;
    59 Provider Repayment cases; and
    7 Provider Termination cases

CHFS ADMINISTRATIVE HEARINGS: OUR GOALS

- Expert
- Timely
- Responsive
- Fair

HEARINGS and TRIALS

- Legislative Branch: Enact Law
- Judicial Branch: Adjudicate Law
- Executive Branch: Enforce Law
  Promugate Law and
  Adjudicate Law

DUE PROCESS IN ADMINISTRATIVE HEARINGS

- Constitutional Protections
- Fundamental Fairness
- KRS Chapter 13B

DUE PROCESS IN ADMINISTRATIVE HEARINGS

- Timely and Adequate Notice
- Meaningful Opportunity to be Heard
- Impartial Decision Maker

Hearings Basics

1. Service Denial: Cabinet or MCO sends Adverse XN Letter

2. Patient Request for a Grievance Review
   - ✓ w/i 30 days event: 907 KAR 17:005 Sec. 4(2)
   - ✓ Grievance Process is now Mandatory: 907 KAR 17:005 Sec. 5(1)

3. MCO Grievance Procedure
   - ✓ 30 days for decision: 907 KAR 17:005 Sec. 4(2)(b)
   - ✓ Expedited decision if standard time would jeopardize patient's life, health, or ability to achieve maximum functioning: 907 KAR 17:005 Sec. 4(14)

Hearings Basics

4. Adverse XN Letter
   - ✓ Must provide law and facts in sufficient detail to allow adequate preparation: 907 KAR 17:005 Sec. 4(20)

5. Patient Request for a Hearing
   - ✓ w/i 45 days in MCO cases: 907 KAR 17:005 Sec 5(3)(b)
   - ✓ w/i 30 days in FFS cases: 907 KAR 1:563 Sec 4(2)

6. Hearing before AHO
   - ✓ w/i 30 days of Req for Hrg: 907 KAR 1:563 Sec 6(2)

Hearings Basics

7. Hearing Officer's Recommended Order
   - ✓ w/i 30 days of Hearing: 907 KAR 1:563 Sec. 6(2)

8. Exceptions to Recommended Order/ Request for Cabinet Level Review
   - ✓ w/i 15 days of Rec Order: 907 KAR 1:563 Sec. 6(2)

9. Review by Secretary/Final Order
   - ✓ w/i 90 days of Req. for Hrg: 907 KAR 1:563 Sec. 9(3)

10. Appeal to Circuit Court and beyond
    - ✓ w/i 30 days of Final Order: 907 KAR 1:563 Sec. 10(2)

Providers as Authorized Representatives (effective now)

- Provider must have member's "written consent"
  - ✓ 907 KAR 17:010 Sec. 4(4)(a)
- For the "specific action" being appealed
  - ✓ 907 KAR 17:010 Sec. 4(4)(a)
- Consent form must be signed and dated by member "no earlier than date of MCO action"
  - 907 KAR 17:010 Sec. 4(4)(b)

Providers as Authorized Representatives (effective soon)

- Provider must have member's "written consent"
  - ✓ 907 KAR 17:010 Sec. 4(4)(a)
- For the "specific action" being appealed
  - ✓ 907 KAR 17:010 Sec. 4(4)(a)
- "Written consent must be "unique to an appeal or state fair hearing."
- A single written consent qualifies for only one "hospital admission, provider visit, or treatment plan."
  - ✓ 907 KAR 17:010 Sec. 4(4)(b)(2)(a), (b), and (c)

Prior Authorization

- Required for all MCO listed services except "physical or behavioral emergency services":
  - ✓ *See* 907 KAR 17:015 Sec. 2(12).

- Emergency services must be:

  - ✓ "A covered service"
  - ✓ "Medically necessary"
  - ✓ "Authorized after provided"

- *See also* "Prudent layperson standard": "acute symptoms of sufficient severity such that w/o immediate medical attention the person (or unborn child) could reasonably expect serious jeopardy to health, serious impairment to bodily function, or serious dysfunction of organs:
  - ✓ *See* 907 KAR 3:130 Sec. 1(4).

MEDICAL NECESSITY

- "Clinical appropriateness" (based on Interqual standards) is only one factor considered in determining medical necessity.
  - ✓ 907 KAR 3:130 Sec. 1(1)

- "Medical necessity determination": 907 KAR 3:130 Sec. 2(1)

  - ✓ Must consider program criteria (e.g., EPSDT, 907 KAR 11:034, or Psychiatric Hospital Services, 907 KAR 10:016, etc.)
  - ✓ Reasonable and required to identify, diagnose, treat, palliate, or prevent disease, illness, injury, or disability
  - ✓ Appropriate service in amount, scope, and duration based on "generally accepted standards of practice"

MEDICAL NECESSITY

- Determination of what is a covered benefit or medically necessary must be based on individualized assessment of member's medical needs:
  - ✓ 907 KAR 3:130 Sec. 2(1)(a)

- CHFS has "final authority to determine clinical appropriateness **AND** medical necessity":
  - ✓ 907 KAR 3:130 Sec. 2(2)

LRC Website for State Law

http://www.lrc.ky.gov/law.htm

This website provides access to all of Kentucky's statutes and regulations searchable by Chapter, Title, or keyword

The End