

STATEMENT OF EMERGENCY

907 KAR 17:035E

(1) This emergency administrative regulation is being promulgated pursuant to KRS 13A.190(1)(a)3. to establish external independent third-party review policy in order to comply with a deadline established in KRS 205.646(5).

(2) This action must be taken on an emergency basis to comply with the requirements of KRS 205.646(5). An ordinary administrative regulation would not allow the cabinet to satisfy the deadline provision in KRS 205.646(5).

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative is identical to this emergency administrative regulation.

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Matthew G. Bevin  
Governor

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Vickie Yates Brown Glisson, Secretary

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Commissioner's Office

4 (New Emergency Administrative Regulation)

5 907 KAR 17:035E. External Independent Third-Party Review.

6 RELATES TO: KRS 194A.025(3), 205.646, 42 C.F.R. 438

7 STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030(2),

8 194A.050(1), 205.646, 42 C.F.R. Part 438

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
10 Services, Department for Medicaid Services, has responsibility to administer the Medi-  
11 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to  
12 comply with a requirement that may be imposed or opportunity presented by federal law  
13 to qualify for federal Medicaid funds. In accordance with KRS 205.646, this administra-  
14 tive regulation establishes provisions regarding a Medicaid provider's right to an exter-  
15 nal independent third-party review of a managed care organization's adverse final deci-  
16 sion of a provider's appeal of a denial of a claim for reimbursement or a service.

17 Section 1. Managed Care Organization Notice to Provider. (1) If an MCO issues an  
18 adverse final decision to a provider of a denial, in whole or in part, of a health care ser-  
19 vice, or claim for reimbursement as referenced in KRS 205.646(2), the MCO shall notify  
20 the provider in writing of the provider's right to an external independent third-party re-  
21 view pursuant to KRS 205.646.

1 (2) The MCO's notice shall:

2 (a) Comply with the requirements established in KRS 205.646(3) regarding an exter-  
3 nal independent third-party review; and

4 (b) State the reason for the adverse decision.

5 Section 2. External Independent Third-Party Review Preliminary Requirements. (1)(a)

6 To request an external independent third-party review afforded to a provider pursuant to  
7 KRS 205.646(2), a provider shall submit a written request for external independent  
8 third-party review to the MCO within sixty (60) calendar days of receiving the MCO's fi-  
9 nal decision resulting from the MCO's internal appeal process.

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

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

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

- 17 1. Electronically;
- 18 2. By fax; or
- 19 3. By postal mail.

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

21 (a) Identify each specific issue and dispute directly related to the adverse final decision  
22 issued by the MCO;

23 (b) State the basis on which the MCO's decision on each issue is believed to be erro-

1 neous; and

2 (c) State the provider's designated contact information, including name, phone num-  
3 ber, mailing address, fax number, and email address.

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

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

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

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

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

15 (b) If an enrollee files a request for an administrative hearing pursuant to 907 KAR  
16 17:010 regarding a claim about which a provider has already filed a request for an ex-  
17 ternal independent third-party review, the external independent third-party review shall  
18 be held in abeyance until the enrollee's appeal has been fully adjudicated.

19 (5) Upon receiving a request for an external independent third-party review, the de-  
20 partment shall:

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

22 (b) Notify the:

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

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

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

4 (a) Exhaust the MCO's internal appeal process in accordance with 907 KAR 17:015;

5 or

6 (b) Submit a timely request for an external independent party review in accordance  
7 with this administrative regulation.

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

10 (a) Submit to the department all documentation submitted by the provider in the pro-  
11 vider's MCO internal appeal process, in addition to any other information related to the  
12 MCO's final decision; and

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

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

17 1. Medical necessity. A claim involving a medical necessity determination; or

18 2. Service coverage requirements including:

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

20 b. A claim involving whether the provider followed the MCO requirements for the cov-  
21 ered service.

22 (2)(a) A claim involving a medical necessity determination shall be reviewed by a cli-  
23 nician or clinicians who:

1 1. Have clinical expertise regarding the subject matter; and

2 2. Are currently licensed regarding the subject matter.

3 (b) A claim involving service coverage requirements shall be reviewed by the de-  
4 partment.

5 (3) There shall be no more than one (1) claim reviewed per external independent  
6 third-party review unless the department determines that reviewing multiple claims re-  
7 lated to one (1) member is expedient and appropriate.

8 (4) The documentation to be reviewed by an external independent third-party review-  
9 er shall be limited to the documentation referenced in Section 2(7) of this administrative  
10 regulation.

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

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

16 2. Issue the final decision to:

17 a. The provider's designated contact;

18 b. The MCO's designated contact; and

19 c. The department.

20 (b) Within ten (10) business days of receiving the final decision of the external inde-  
21 pendent third party reviewer, the MCO shall notify the enrollee of the final decision, if re-  
22 lated to the denial of a health care service.

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

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

8 (2)(a) A request for an appeal referenced in subsection (1) of this section shall be  
9 sent to the department within thirty (30) calendar days of receipt of the department's  
10 written notice referenced in subsection (1) of this section.

11 (b) The request for an appeal may be sent to the department:

- 12 1. Electronically;
- 13 2. By fax; or
- 14 3. By postal mail.

907 KAR 17:035E

REVIEWED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Stephen P. Miller, Commissioner  
Department for Medicaid Services

APPROVED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Vickie Yates Brown Glisson, Secretary  
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS  
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 17:035E

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Sharley Hughes (502) 564-4321, extension 2010;  
[sharleyj.hughes@ky.gov](mailto:sharleyj.hughes@ky.gov) or Tricia Orme (502) 564-7905; [tricia.orme@ky.gov](mailto:tricia.orme@ky.gov).

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation establishes the requirements regarding external independent third-party reviews in accordance with KRS 205.646. An external independent third-party review is an appeal option for a Medicaid provider that has received an adverse final decision from a managed care organization (MCO) that “denies, in whole or in part, a health care service rendered by the provider to an enrollee of the Medicaid managed care organization.” The party that receives an adverse decision from the review, whether it be the provider or the MCO, will then have the option to request an administrative hearing conducted by the Cabinet for Health and Family Services. A separate administrative regulation (907 KAR 17:040) is being promulgated concurrently with this administrative regulation to establish the administrative hearing provisions.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with a mandate, established in KRS 205.646, to establish the Medicaid external independent third-party review option for Medicaid providers who have received an adverse final decision from a managed care organization (MCO) regarding a claim for reimbursement or related.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 205.646 by establishing the Medicaid external independent third-party review option for Medicaid providers who have received an adverse final decision from a managed care organization (MCO) regarding a claim for reimbursement or related.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing the Medicaid external independent third-party review option for Medicaid providers who have received an adverse final decision from a managed care organization (MCO) regarding a claim for reimbursement or related.
  
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
  - (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
  - (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

- (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
- (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All Medicaid providers and all five (5) managed care organizations will be affected by this administrative regulation.
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: The entities will have to develop procedures to adhere to this Administrative Regulation. Medicaid providers will need to create an internal process that determines who, within their office, will request the external independent third-party review. Medicaid managed care organizations will have to create a new process, internally, which allows providers to submit the request for the external independent third-party review to the MCO. Medicaid managed care organizations will also need to revise all of their adverse determination letters and be prepared to submit denial documentation to the Department upon request from the providers.
- (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The Department for Medicaid Services is unable to determine the cost to the provider or MCO. For providers, it will be an added administrative step. For managed care organization, there will be an added administrative step as well as the added cost of revising all adverse determination letters.
- (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): If the provider wins the appeal, they will receive reimbursement for a previously denied claim.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: DMS estimates that this administrative regulation will increase DMS's costs by \$4.95 million (\$3.71 million federal funds/\$1.24 million state funds) annually. In order to estimate a partial potential cost estimate for the external third-party review, the Department reviewed the number of similar appeals that were upheld against the MCOs in favor of the appealing providers which was approximately 30,000 per year. The Department has modified its existent contract with the contractor Island Peer Review Organization (IPRO) based on approximately one-third of the given number of similar appeals made the year before. The contract modification will pay IPRO \$495 per case review; thus the contract modification for the SFY 2017 contract al-

lows for 10,000 case reviews for a total increase in the budget of \$4,950,000. This increase is funded at a 75/25 split with CMS paying the larger federal share.

Further, there are two positions being created for administrative assistants within DMS.

Finally, the Department is using two nurses from Community Alternatives for the independent reviews initiated for plan delivery rules and coverage denials review. These two medical professionals, if needed full time, will require a \$45,000 base salary plus 67% for state benefits per year for each positions. The total cost of both medical professionals can also be funded using 75% federal funds and 25% state funds.

- (b) On a continuing basis: The response to the question in (a) also applies here.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: DMS was not allocated any funds to implement the administrative regulation. However, the DMS contract with IPRO, the external quality review organization, has been increased to allow for IPRO to conduct the external independent third-part reviews related to medical necessity. Additionally, DMS will be hiring additional staff to administer the additional administrative work.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fee.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering was not appropriate in this administrative regulation because the administration regulation applies equally to all those individuals or entities regulated by it.

## FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 17:035E

Contact Person: Sharley Hughes (502) 564-4321, extension 2010;

[sharleyj.hughes@ky.gov](mailto:sharleyj.hughes@ky.gov) or Tricia Orme (502) 564-7905; [tricia.orme@ky.gov](mailto:tricia.orme@ky.gov).

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.646.
3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
  - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The Department for Medicaid Services (DMS) anticipates no revenue for state or local government will result from the amendment.
  - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS anticipates no revenue for state or local government will result from the amendment.
  - (c) How much will it cost to administer this program for the first year? DMS estimates that this administrative regulation will increase DMS's costs by \$4.95 million (\$3.71 million federal funds/\$1.24 million state funds) annually. In order to estimate a partial potential cost estimate for the external third-party review, the Department reviewed the number of similar appeals that were upheld against the MCOs in favor of the appealing providers which was approximately 30,000 per year. The Department has modified its existent contract with the contractor Island Peer Review Organization (IPRO) based on approximately one-third of the given number of similar appeals made the year before. The contract modification will pay IPRO \$495 per case review; thus the contract modification for the SFY 2017 contract allows for 10,000 case reviews for a total increase in the budget of \$4,950,000. This increase is funded at a 75/25 split with CMS paying the larger federal share.

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base salary plus 67% for state benefits per year for each positions. The total cost of both medical professionals can also be funded using 75% federal funds and 25% state funds.

(d) How much will it cost to administer this program for subsequent years? The response in (c) also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): \_\_\_\_\_

Expenditures (+/-): \_\_\_\_\_

Other Explanation: