

Kentucky Department for Medicaid Services

Provider Complaints

Appeals & Grievances

External Independent Review

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Provider Forums 2019



Provider Complaints

1. Provider has reached out to the Managed Care Organization (MCO) Provider Representative regarding issue(s) and has not been able to come to a mutual resolution.
2. Provider submits a complaint regarding the MCO(s) to the Department for Medicaid Services (DMS).

Complaint examples:

- Claim issues
- Payment issues
- Credentialing issues
- Coverage of services provided to members, etc....

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

PROVIDER COMPLAINT FORM

Please complete this information and submit by mail, email or fax to:

Division of Program Quality & Outcomes
Department for Medicaid Services
275 E. Main Street 6C-C
Frankfort, KY 40621

502-564-9444
502-564-0223 Fax
ProviderMCOInquiry@ky.gov

GENERAL PROVIDER INFORMATION

Provider Name:

NPI #:

Provider Specialty:

Provider's Place of Service Address:

City:

St:

ZIP:

Provider's Contact Person's Name:

Contact Person's Company:

Mailing Address:

City:

St:

ZIP:

Phone:

Fax:

E-mail:

Managed Care Organization (MCO) Name:

Were you a participating provider with this MCO on the dates of service? Yes No

Who have you contacted at the MCO?

Medicaid Member's Name:

Medicaid Member ID #:

MCO Internal Appeal & Grievances

MCO Appeal Process

Two Paths to Appeal

Member

KAR 17:010 Member Appeals

907 KAR 1:563 State Fair Hearing

Provider

907 KAR 17:015 Provider Appeals

907 KAR 17:035 External Independent Third-Party Review

907 KAR 17:040 Administrative Hearing

KRS 205.646



MCO Internal Appeal & Grievances continued...

Member Appeals

- Providers may appeal on behalf of the member, but it is still considered a member appeal
- Member must provide written consent for their provider to represent them in an appeal
- Must be received within 60 days from the date of the adverse determination notice
- Decision within 30 days
- Expedited appeals must be resolved in 3 working days
- Continuation of services is allowed
- Next step is state fair hearing

MCO Internal Appeal & Grievances continued...

Provider Appeals

- Timeframe for provider to request is determined by MCO provider internal appeal process
- There is only one provider internal appeal and it applies to prior authorizations, service denials, claim denials, etc...
- MCO must make an internal appeal decision within 30 calendar days
- 14 day extensions shall be granted if requested by the MCO or provider
- Peer to peer reviews are not required, but may occur separately from the internal process. This does not affect the 30-day decision requirement
- It is important that providers **submit all documentation** to support the appeal
- Upon receipt of the final internal appeal decision, providers have 60 calendar days to request an External Independent Third-Party Review

External Independent Third-Party Review

- Senate Bill 20, KRS 205.646, or 907 KAR 17:035
- Must be requested within 60 calendar days of the internal provider appeal denial decision
- Only applies to dates of service after 12-1-16
- Each MCO will have directions on how to request the review on the appeal decision letters
- Providers send the request to the MCO. The MCO forwards the request to the DMS
- If a member has an active state fair hearing request for the same service, the external review will not be granted
- External review decision will be rendered in no more than 45 days



Know the process

1. Contact your MCO provider representatives

*This gives the MCO/provider an opportunity to resolve the issue.

2. Providers can submit a provider complaint to DMS or they can choose to file an MCO Appeal

3. If an MCO appeal is completed and the MCOs initial decision is upheld, the provider has **60** calendar days from that decision to send an External Independent Review request to the MCO

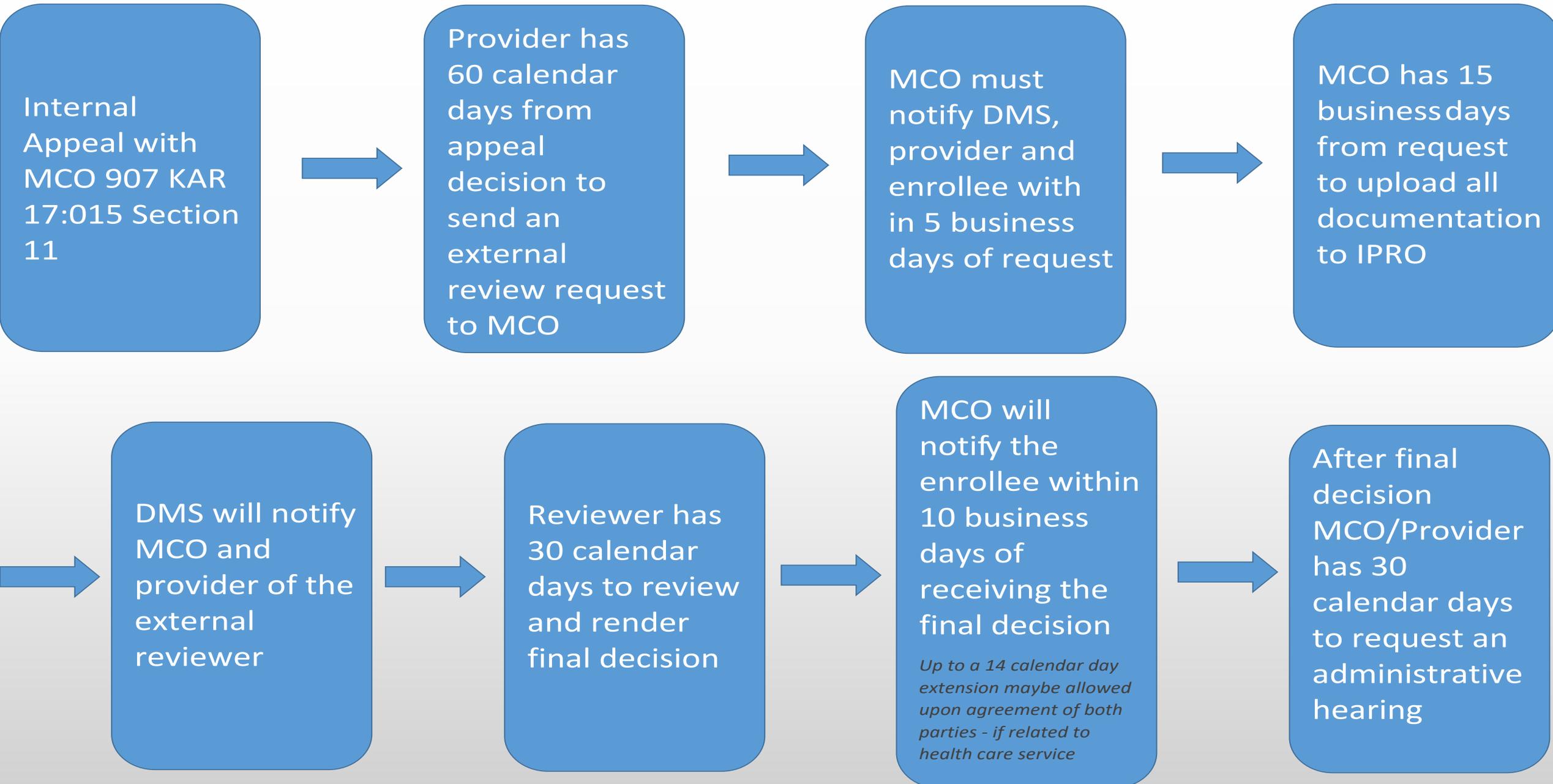
*If a provider wants to do a complaint directly with DMS you can but keep in mind that you still only have that **60** day deadline and please include in your complaint any information regarding the MCO appeal and decisions.

4. External Independent Review (EIR)

5. State Fair Hearing/Provider Administrative Hearing



External Independent Review (EIR) Process



EIR request
Deficiency
letter



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

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Governor

275 East Main Street, 6C-C
Frankfort, KY 40621
www.chfs.ky.gov

Adam M. Meier
Secretary

Angela W. Parker
Division Director

Carol H. Steckel, MPH
Commissioner

May 17, 2018

RE: External Independent Third Party Review Request –

The Kentucky Department for Medicaid Services (DMS) has reviewed your request for an external independent third party review.

Your request is being returned due to being deficient for the following reason(s).

1. Request was not submitted by the provider (self or through attorney) or designee as authorized in writing _____
2. Date of service prior to 12/01/18 _____
3. Did not identify each specific issue and dispute _____
4. Does not state the basis for which the decision is believed to be erroneous _____
5. Designated contact information missing _____
6. Was not received within 60 days of MCO final decision _____
7. Did not exhaust internal appeal _____
8. Rate/Contract disputes are not eligible for review under KRS 205.646 _____

Should you have any questions in regard to this determination, please contact DMS by email at SB20@ky.gov or call 502-564-8444.

State Fair Hearing/Provider Administrative Hearing

- Must be requested within **30** calendar days of the external independent third-party review decision
- May be requested by either the MCO or provider
- The party that receives the adverse final order pays a fee of **\$600** to the DMS within **30** days

Key takeaways EIR

REMEMBER



- **Keep in mind the type of appeal you are requesting from the MCO.**
For example... if a provider requests an expedited appeal this will lead to a member appeal which does not qualify for the external independent review.
- **Always make the request in writing and submit ALL documentation that supports the reason the provider disagrees with the MCO's decision.**
 - The External Reviewer can only review items that were reviewed during the internal appeal
 - If no medical records are provided – a provider cannot prove medical necessity *send all documents*
- **If a billing service handles the provider's appeals, the request must be on the provider's letterhead with the provider's signature or an appeal may be sent by an attorney.**

Key takeaways Provider Complaints....

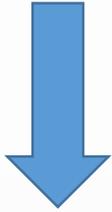


Don't forget to remember!

- **Always** contact the MCO provider representative
- **Provide** all documentation that applies to the complaint(s) including email correspondence, a brief description of issue, claims information, etc....
- **Identify** the MCO(s) when requesting a complaint. This is important if a provider has similar issues with multiple MCOs
- If a provider has completed the MCO internal appeal process and wants to file a complaint **include** that information in the complaint

Website information/Navigation

chfs.ky.gov



Department for Medicaid Services



Division of Program Quality and Outcomes



Managed Care Oversight Branch and Disease and Case Management Branch



** Managed Care Oversight process Provider Complaints and Disease Case Management process all EIRs and State Fair Hearings

For more information, contact us:

Division of Program Quality and Outcomes

275 E. Main St. 6C-C

Frankfort, KY 40621

(502) 564-9444

(502)564-0223 Fax

Email: ProviderMCOInquiry@ky.gov – Provider Complaints

SB20@ky.gov – External Independent Review

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Questions

