Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Health Care Management Denial - Core Process - KY**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
02/02/2018	12/27/2019	12/27/2019	12/27/2019

Department Approval/Signature :

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

This procedure is designed to ensure timely utilization decisions which accommodate the clinical urgency and necessity of a situation.

DEFINITIONS:

Adverse Benefit Determination: means, as defined in 42 C.F.R. 438.400(b), the

A. denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
B. reduction, suspension, or termination of a service previously authorized by the Department, its agent or Contractor;
C. denial, in whole or in part, of payment for a service;
D. failure to provide services in a timely manner, as defined by Department;
E. failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 C.F.R. 438.408(b);
F. for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 C.F.R. 438.52(b)(2)(ii), to obtain services outside a Contractor's Network; or
G. denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Administrative Denial: The denial for payment of a requested service or confinement for reasons that are unrelated to medical necessity and do not require medical director review. Examples of administrative denial:

1) Late notification by a practitioner of an admission
2) Failure of a practitioner to pre-certify a service that requires precertification

All Necessary Information is limited to the items listed in statute KRS 304.17A-607(1)(i):

- Results of any face-to-face clinical evaluation;
- Any second opinion that may be required; and
- Any other information determined by the department to be necessary to making a utilization review determination (current guidance 806 KAR 17:370 for attachments to a claim)

Business Day: A business day is considered Monday through Friday, not including weekends and Federal holidays.

Concurrent Request: a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the Health Plan did not previously approve the earlier care. In performing concurrent request, clinicians assess member progress and needs during the episode of care and coordinate such needs prior to discharge to help facilitate a smooth transition for the member between levels of care or home, and to avoid delays in discharge due to unanticipated care needs

Diagnosis Related Group (DRG): A system developed by the U.S. government for determining how much Medicare should reimburse hospitals for medical care. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, discharge status, and the presence of complications or co-morbidities. DRG classification may vary by state and product.

Health Care Acquired Conditions (HCAC): Term used by **Medicaid** to identify medical conditions that occur during the course of a hospital admission. The reviewer will need to identify and utilize the associated HCAC code when certain conditions are identified. See the References section to access the Center for Medicare and Medicaid website link with a list of the HCAC.

Health Care Service: means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed.

Medically Necessary or Medical Necessity: Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Medically Necessary Health Care Services: means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
(a) In accordance with generally accepted standards of medical practice; and
(b) Clinically appropriate in terms of type, frequency, extent, and duration.

Medical Necessity Review: The process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies

Not Liable Denial: An administrative denial of a request for services based on a lack of the health plan liability for the requested services (e.g. member is no longer eligible for services through the health plan).

Notice of Adverse Benefit Determination: The communication of a proposed or actual benefit determination.

Olmstead Act: The "integration mandate" of the Americans with Disabilities Act requires public agencies to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Peer to Peer: The process of giving a practitioner the opportunity to discuss a medical necessity denial decision with an appropriate health plan Medical Director within 7 calendar days of the denial decision.

Post-Service Review (Retrospective): The review process performed on all requests for certification of services that have already been rendered by a physician. If the request is made while the member is in the process of receiving care National Committee for Quality Assurance (NCQA) considers this to be an urgent concurrent request if the medical care meets the definition of urgent, even if the services were not precertified prior to care.

Pre-Service Review: The review process performed on all requests that require precertification, in whole or in part, in advance of a member obtaining services (e.g. urgent or elective inpatient admissions and outpatient services, including primary care, outpatient behavioral health and specialty care).

Prospective review: means a utilization review that is conducted prior to the provision of health care services. "Prospective review" also includes any insurer's or agent's requirement that a covered person or provider notify the insurer or agent prior to providing a health care service, including but not limited to prior authorization, step therapy, preadmission review, pretreatment review, utilization, and case management.

Quality of Care (QOC) Issue: A medical, social, environmental, or economical event that has the potential to have an adverse effect on the health and welfare of our internal and external customers, members, or the organization.

QOC Issue Referral Form: An internal document completed by associates receiving the potential QOC complaint/issue to document facts and information. The completed form is immediately forwarded to the Plan/Regional's Quality Management (QM) Department for investigation of the issue.

Urgent Care (Expedite): Urgent care (expedite) is any request for care or treatment with respect to which the application of the time periods for making non-urgent care (standard) determinations could result in the following circumstances:

1) Could seriously jeopardize the life, health or safety of the member or others due to the member's psychological state, or
2) In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For urgent care (expedite) decisions, the organization allows a health care practitioner with knowledge of a member's behavioral health condition (e.g., a treating practitioner) to act as the authorized representative of the member.

Urgent health care services include all participating provider requests for hospitalization and outpatient surgery.

PROCEDURE:

Medical Necessity Review

Medical necessity review requires that denial decisions be made only by an appropriate clinical professional as specified in all applicable accreditation and/or regulatory requirements, such as NCQA or CMS standards. As applicable, denials resulting from medical necessity review are within NCQA scope of review.

Decisions about the following **require** medical necessity review:

1) Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.
2) Care or services whose coverage depends on specific circumstances.
3) Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
4) Out-of-network services that are only covered in clinically appropriate situations.
5) Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
6) "Experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in the organization's policies, medical necessity review is not required.

Decisions about the following **do not require** medical necessity review:

1) Services in the member's benefits plan that are limited by number, duration or frequency.
2) Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
3) Care that does not depend on any circumstances.
4) Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other ADL-related activities.

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

1) **Medical Necessity Review (DRG and Non-DRG):**
   a) Any medical necessity decision (Medical or Behavioral Health), to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a licensed physician who is of the same specialty and subspecialty, when possible, as the ordering provider, and as consistent with state and federal regulations and state contracts.
      i) Efforts are made to obtain the necessary information to provide additional support for decisions based on established medical necessity criteria.
      ii) In the event there is insufficient information to render an approval, the case is managed as a medical necessity decision and therefore forwarded to the appropriate Medical Director for final determination.
   b) The Medical Director is available to make decisions in urgent cases and on an as needed basis for all other cases, as required by the medical situation. The failure to complete the precertification request in a timely manner will be deemed authorized by the health plan.
   c) The designated Clinical HCM or Clinical Behavioral Health (BH) staff documents the attempts to obtain the clinical information prior to sending to the Medical Director. Based upon the Medical Director determination, the Medical Director will enter the appropriate denial decision/rationale. The HCM or BH staff will enter the appropriate status reason and will generate the notice of adverse benefit determination in the medical management system.
   d) When performing reviews, the clinician will comply with American Disabilities Act (ADA) and the Olmstead Act.

Note: In the event there is a pre-service request entered into the medical management system that has been identified as appropriate for lower level of care (i.e., elective inpatient admission appropriate for outpatient) and the member has not received the service, the health plan clinician discusses with the provider/facility clinician the most appropriate level of care. If the provider/facility is in agreement with the decision, the designated Clinical HCM or Clinical BH staff updates the applicable medical management system fields and documents all the applicable information. This does not constitute a denial and a notice of adverse benefit determination is not required.

If a provider requests a procedure/service that was previously denied within the last sixty (60) calendar days, the provider is referred to their appeals rights.

1) **Administrative Denial (DRG and Non-DRG)**
   For the following administrative denials, the designated health plan HCM or BH staff documents all applicable information, enters the appropriate status reason and generates the notice of adverse benefit determination in medical management system.

   a) **Late Notification of Admission** (not applicable to Emergency Services during post stabilization care): Practitioners are required to notify the National Customer Care department (NCC) or Clinical BH staff within twenty-four (24) hours, or the next business day, of an inpatient admission for admission review. Failure to provide timely admission notification could result in an administrative denial of the entire inpatient admission.
      i) **A Late Notification is issued for a request greater than one (1) business day after admission or actual date of service:**
         (1) ER/Direct admit to a general floor (i.e. Medical Surgical) bed
         (2) OB not resulting in a delivery
         (3) Inpatient transfers between acute facilities LTAC (Long Term Acute Care Facility) to LTAC transfers
         (4) Notification occurred greater than one (1) business day **AFTER** the member was transferred to a general bed from a ICU/Telemetry/Neonatal Intensive Care Unit (NICU) III or post surgery
         (5) Notification occurred after member discharged home
         (6) Notification >ten (10) days after member admitted regardless of status
         (7) Outpatient procedure that is listed as "notification"
      ii) **A Late Notification is issued for a request greater than eleven (11) business days after admission or actual date of service:**
         (1) ER/Direct admit to Operating Room and not yet admitted to a general ward bed
         (2) ER/Direct admit to any ICU and not yet admitted to a general ward bed.
      iii) **A Late Notification is not issued for:**
         (1) Facilities with a Gold Card

(2) Retro Enrollment
(3) Member was under observation care and rolls to inpatient, provide inpatient notification is within notification timeframe (i.e.: member in obs 1/1-1/2 and rolls to inpatient on 1/3. Facility notifies on 1/3 = accept and review)

b) **Failure to precertify** a service: Precertification is required for coverage of elective inpatient procedures and certain non-emergent outpatient and ancillary services from providers within 72 hours before services are rendered. For up-to-date precertification requirements, providers are encouraged to utilize the list of services and codes for which preauthorization is required on the health plan's publically accessible website (https://mediproviders.anthem.com/ky/pages/precert.aspx). The Precertification Lookup Tool is available on the health plan's provider website. Precertification is also required for all services provided by nonparticipating providers.
Precertification is not required for births or the inception of NICU services and shall not be required as a condition of payment. Continued hospital NICU stays require authorization.
The written precertification procedures are readily accessible on the health plan's website for providers at https://mediproviders.anthem.com/ky/pages/precert.aspx; a link to these procedures is provided to covered and authorized persons at https://mss.anthem.com/ky/care/referrals-preapprovals.html.

Note: Reference Coverage for Post-Stabilization Care Services and Emergency Services Procedures for notification standards and timeframes.

2) **Not Liable Denial**
For the following Not Liable Denials, the designated health plan HCM, NCC or BH staff enters the appropriate status reason in the medical management system and documents all applicable information.

a) **Ineligible on Date of Service:** The designated health plan Clinical HCM, NCC or Clinical BH staff advises the requesting practitioner that the member is not eligible with the health plan and no action is taken.
b) There are instances when the health plan Medical Director reviews and renders a determination for Not Liable Reasons:
i) **Non-Covered Service/Benefit:**
(1) The designated health plan Clinical HCM or Clinical BH staff notifies the requesting practitioner of the health plan Medical Director decision to deny the non-covered service/benefit and generates the denial notification letter.
Note: If the requested service is non-covered under any circumstance, NCQA does not require a Medical Director review of requests for medical services specifically excluded from the health plan's benefit plan.

ii) **Benefit Exhausted:**
(1) The designated health plan Clinical HCM or Clinical BH staff notifies the requesting practitioner of the health plan Medical Director decision to deny extension of treatment and generates the notice of adverse benefit determination.

iii) **Other Health Insurance:** If a member has other health insurance (OHI), the designated health plan HCM, NCC or BH staff advises the requesting practitioner that the authorization is not required by the health plan and no action is taken.

Note: If OHI is reported on a request by a facility or provider and it is not listed under coordination of benefits COB in the UM system or there is a discrepancy in the information:

(1) The associate obtains as much information as offered during the pre-certification request review
(2) The associate notifies the Cost Containment Unit via email at ccuohi@amerigroupcorp.com
(3) The associate proceeds with processing the pre-certification request as long as the member remains eligible.

4) **HCAC Denial (Non-DRG)**
a) The health plan staff enters the appropriate denial HCAC code (see HCAC DTP) in the medical management system and documents all applicable information for the following:
i) Inpatient admission resulting from a HCAC during an Emergency Room visit or Observation stay.
ii) HCAC denial occurred during the admission and member has discharged.
iii) Inpatient continued stay resulting from a HCAC (partial hospital HCAC denied days).

Please note:
All other identified or potential quality concerns are forwarded to the health plan QM Department electronically, using a *Quality of Care Issue Referral* form, for investigation and intervention, as necessary. Refer to the Quality of Care – Core Procedure policy for specific details on the types of issues that should be referred.

5) **Peer to Peer (P2P):**
The process of giving a practitioner the opportunity to discuss a medical necessity denial decision with an appropriate health plan Medical Director must occur within 7 calendar days of the denial decision. A P2P is not considered to be an appeal and does not limit subsequent appeal rights. The P2P process does not affect the appeal time frame of sixty (60) calendar days from the date on the adverse benefit determination notice.
Note: Kentucky Medicaid does not allow reconsiderations.

a) When a P2P discussion has taken place, the health plan Medical Director completes the process by either of the following:
   i) Informing the practitioner that he/she is **upholding the original denial decision** and of appeal rights, documents the decision in the medical management system and routes the case back to the designated health plan Clinical HCM or Clinical BH staff.
   ii) Informing the practitioner that he/she is **reversing the original denial decision**, documents the decision in the medical management system and routes the case back to the designated health plan Clinical HCM or Clinical BH staff for completion in the medical management system.

b) The designated health plan HCM or BH staff documents all applicable information in the medical management system. If the decision was reversed, the appropriate status reasons are updated in the medical management system and the appropriate letter is generated.

6) **Documentation of Medical Director Medical Necessity Review Decisions (Approvals or Denials)**:
   a) The health plan Medical Director, documents all their decisions as a note in the medical management system. The documentation must contain the following:
      1) Criterion or guideline utilized
      2) Reference of the clinical information;
      3) Peer-to-peer review results if applicable ; and
      4) Decision rationale.
   b) The name of the health plan Medical Director who rendered the decision must be in the notes and their user identification number populated in the Reviewer field.
   c) The medical management system must reflect all necessary information in the appropriate screens and fields.

7) Although medical necessity criteria, such as InterQual, are reviewed with each level of care request, these items are only guidelines and just one factor that is considered in level of care medical necessity reviews. Because each level of care review represents a unique clinical scenario that may not be fully described by the above mentioned guidelines, other considerations, including but not limited to things such as practice patterns and professional experience and judgement, may also be factored into each final level of care medical necessity determination.

8) **Standard Timeframes and Notice of Adverse Benefit Determination:**
   Note: NCQA does not require an initial oral notification of a determination for Urgent Pre-Service and Urgent Concurrent Reviews. The organization records the time and date of notification and the staff member who spoke with the practitioner.
   - A voicemail is not an acceptable form of oral notification.

- A fax may be sent as the initial notification. For urgent concurrent denials, the fax includes a statement asking the hospital Utilization Review (UR) department staff to notify the attending/treating practitioner of the decision.
- Electronic or written notification must be provided within the timeframes specified below.

The health plan will provide the member written notice that meets the language and formatting requirements for member materials, of any adverse benefit determination with the timeframes for each type of adverse benefit determination pursuant to 42 CFR 438.210(d) and in compliance with 42 CFR 438.404, KRS 304.17A-607 and other contract provisions.

Non-Urgent Pre-Service Reviews: The health plan will make a determination and provide written notification to the member and provider as expeditiously as the member's health condition requires and no later than two (2) business days from receipt of request, with a possible extension of up to fourteen (14) additional days if the member or provider requests an extension, or if the health plan justifies, in writing, to the Department a need for additional information and how the extension is in the member's best interest. If an extension is taken by the health plan, written notice will be given to the member with the reason for the decision to extend the time frame and of the member's right to file a grievance if he or she disagrees with that decision; and carry out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Urgent Pre-Service Review: For cases in which a Provider indicates, or the health plan determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the health plan will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than twenty-four (24) hours after obtaining all necessary information to make the utilization review decision per KRS 304.17A-607(1)(i). If all necessary information is not received, the health plan has up to 2 business days after receipt of the request for service to make the utilization review decision and provide notice per Kentucky Medicaid Managed Care Contract 21.3 (or 3 calendar days per NCQA, whichever is lesser).

The health plan will give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations.

Urgent Concurrent Review: The health plan will provide a utilization review decision and notification within 24 hours after obtaining all necessary information to make the

utilization review decision

Post-service Review: The health plan will make a determination and provide written notification within fourteen (14) calendar days of receipt of the request or, if the member or the provider requests an extension or the health plan justifies a need for additional information and how the extension is in the member's interest, may extend up to an additional fourteen (14) days.

A failure to make a determination and provide written notice on a requested service within the required timeframes shall be deemed authorized.

A staff member that provides oral notification of a decision, documents the time and date notification occurred, and whom was notified.

If the denial is due to lack of clinical information and there is insufficient clinical information to reference a specific guideline or criterion (for a given condition, service request), the notification must state the inability to reference the most appropriate criteria, and must describe the information needed to render a decision in a manner specific enough for the member or member's authorized representative to understand what is needed.

A written notification in electronic format, including e-mail or facsimile, may suffice where the member or provider has agreed in advance in writing to receive such notices electronically.

The member and provider must be notified on all adverse determinations. The health plan will give notice on the date of the adverse benefit determination when the adverse benefit determination is a denial of payment.
All written notifications of an adverse benefit determination include the following:

i) Statement of the adverse benefit determination the health plan has made or intends to make;
ii) Explanation of denial reason in easily understood language that is clear and non-technical and understandable by a layperson; including specific reference to utilization criteria guidelines, protocols or benefits provisions used in the determination; the federal or state regulation supporting the action, if applicable.
iii) Explanation of peer-to-peer rights of the practitioner; and that a peer-to-peer request is not considered to be an appeal and does not limit subsequent appeal rights.
iv) The right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the member's adverse benefit determination, including medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
v) The specific and detailed clinical reason for the medical necessity denial, in whole or in

part, specific to the Member shall be cited.

vi) The Member's right to appeal including information on exhausting the Contractor's one level of appeal as required by 42 C.F.R. 438.402(b);
vii) The Member's right to request a State Fair Hearing after receiving notice that the adverse benefit determination is upheld;
viii) Procedures for exercising Member's rights to Appeal or file a Grievance;
ix) Circumstances under which the appeal process can be expedited and how to request it;
x) The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;
xi) Be available in English, Spanish, and each prevalent non-English language;
xii) Be available in alternative formats for persons with special needs; and
xiii) Be easily understood in language and format.
xiv) The health plan notifies all members (via the member handbook) that information is available in alternative formats and how to access those formats.

In the event that a member or provider requests written confirmation of an approval, the health plan will provide written confirmation of its decision within three (3) working days of providing notification of a decision if the initial decision was not in writing. The written confirmation will be written in accordance with Member Rights and Responsibilities.

The health plan shall give notice at least:

A. Ten (10) Days before the date of an adverse benefit determination when the adverse benefit determination is a termination, suspension or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to five (5) Days if Enrollee Fraud or Abuse has been determined.

B. The health plan must give notice by the date of the adverse benefit determination for the following:
   (1) In the death of a Member;
   (2) A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);
   (3) The Member's admission to an institution where he is ineligible for further services;
   (4) The Member's address is unknown and mail directed to him has no forwarding address;
   (5) The Member has been accepted for Medicaid services by another local jurisdiction;
   (6) The Member's physician prescribes the change in the level of medical care;

(7) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;
(8) The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.

In addition to what is outlined in this policy, all written notifications of adverse benefit determinations must include:

1. The state of licensure, medical license number, and the title of the reviewer making the decision, as applicable;
2. The medical director signature; and
3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health plan benefit, if any.

In compliance with and as defined by; 42 CFR §438.400 through 438.424 and 907 KAR 17:010:
Members and authorized member representatives have sixty (60) calendar days to file an appeal from the date of notice of adverse benefit determination.

Providers have sixty (60) calendar days from the date of notice of adverse benefit determination to file an appeal for medical necessity or administrative denials.
907 KAR 17:035 established the right for a provider, who has exhausted the written internal appeals process of a Medicaid managed care organization (MCO), to be entitled to an external independent third party review of the MCO's final decision that denies, in whole or in part, a health care service to an enrollee or claim for reimbursement to a provider for a health care service rendered by the provider to an enrollee of the MCO, the legislation also afforded a provider or an MCO the right to an administrative hearing.

REFERENCES:

42 CFR §438
42 C.F.R. § 438.210(a)(3),
42 CFR 438.210(d)
42 U.S.C. § 1396r-8(d)(5)
Center for Medicare and Medicaid Services Provider Preventable Conditions
42 CFR §§438.400 through 438.424
907 KAR 17:010
Kentucky 907 KAR 17:035
907 KAR 17:040
Kentucky Revised Statute 304.17A-607

Kentucky Medicaid Managed Care Contract Section 21.0
NCQA Accreditation Standards and Guidelines: Appropriate Professional
NCQA Accreditation Standards and Guidelines: Clinical Information
NCQA Accreditation Standards and Guidelines: Denial Notices
NCQA Accreditation Standards and Guidelines: Timeliness of UM Decisions

Related Policies or Procedures:
Clinical Criteria for Utilization Management Decisions – Core Process
Clinical Information for Utilization Management Reviews – Core Process
Coverage for Post Stabilization Care Services
Emergency Services – Core Process
Governance of Utilization Management Practice
Member Appeals and Provider Medical Necessity/Administrative Denial Appeals - KY
Non-Covered and Cost Effective Alternative Services
OHI Verification – KY
Health Care Acquired Condition DTP
Precertification of Requested Services – Core Process
Quality of Care Core Procedure
Retrospective Review
Utilization Management - Medicaid Delegation and Oversight

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management – Utilization Management

Secondary Department(s):
Behavioral Health
Claims
National Customer Care
Provider Services Organization
Quality Management

REVISION HISTORY:

Review Date	Changes
2/2/2018	• New Policy • Removed from Corporate policy made a standalone policy
9/11/2018	• Off-Cycle Review • Edits made to procedure section with current contract language
1/29/2019	• For Annual Review

	• Definition section updated • Updates to procedure section with current contract language • Reference section updated
5/27/2019	• Off-Cycle review • Updates to match updates by Corp already made in 2019 UM Program Description.
12/27/2019	• Annual Review. • Revised definitions and procedure section