Government Business Division
Policies and Procedures

Section (Primary Department)	**SUBJECT (Document Title)**
Quality Management	**Member Appeals and Provider Medical Necessity/Administrative denial appeals - KY**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
12/09/2015	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:

To ensure that Anthem Kentucky Managed Care Plan, Inc. dba Anthem Blue Cross and Blue Shield Medicaid (Anthem) members and authorized member representatives acting on behalf of the member, in accordance with the procedures outlined in 42 Code of Federal Regulations (CFR) §§438.400 through 438.424 and 907 Kentucky Administrative Regulations (KAR) 17:010, have a full and fair process for resolving member appeals which includes access to the State's fair hearing system to request an appeal, either verbally, in person, or in writing, of any adverse medical necessity and/or benefit decision that denies or limits an authorization of a requested service, or reduces, suspends, or terminates a previously authorized service. This includes a provision that, so as to establish the earliest possible filing date for the appeal, verbal inquiries seeking to appeal an action are treated as appeals. A verbal request for an appeal must be confirmed in writing, by the member or authorized member representative, unless the request is for an expedited appeal, in which case a follow up written request is not required. In the case of an expedited appeal, the member or authorized member representative will be informed of the limited time to present evidence to support the request. With a member's permission the health plan may refer an appeal directly to an IRO without conducting an internal review.

To ensure that the health plan makes provisions for informing members of their right to have a representative act on their behalf at all levels of an appeal at the time it notifies them of an adverse decision. A Provider may also file a grievance or appeal on the Member's behalf as provided in 907 KAR 17.010.

To ensure that the appeal process and all member services and interactions are communicated and administered in a culturally and linguistically competent manner, including to individuals with limited English proficiency. All written materials, shall be geared toward persons who read at a sixth-grade level, be published in at least a fourteen (exten14) point font size, and shall comply with the Americans with Disabilities Act of 1990 (Public Law

USC 101-336). Written notices will be available in Spanish and other prevalent non-English languages as needed.

To ensure that there is no discrimination against a member solely on the basis of the Member filing a grievance or an appeal, in accordance with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, the Americans with Disability Act, and Section 1557 of the Affordable Care Act. The plan does not gather or use the following list of factors as a basis for decision-making in the appeals process:

1) Medical condition (physical and/or behavioral)
2) Medical history (physical and/or behavioral)
3) Disability
4) Genetic history
5) Utilization of health care services
6) Race/Ethnicity
7) Gender
8) Age
9) Religion
10) Primary language
11) Sexual orientation
12) Geographic area of residence, within the coverage area

In addition, external practitioners are utilized in processing appeals determinations. The above information is not actively shared with those practitioners at any time during the determination process.

To ensure that the health plan maintains an electronic documentation system for monitoring timeliness of appeals whether initiated verbally, in person, or in writing, to the health plan or a regulatory agency.

DEFINITIONS:

Acknowledgement and Order: Notice issued by the Office of Administrative Hearings acknowledging that a State Fair Hearing (SFH) has been requested.

Action: means, as defined in 42 CFR 438.400(b), the

A. Denial or limited authorization of a requested service, including the type or level of service;
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 which results in the service not being provided;
D. Failure to provide services in a timely manner, as defined by Department;
E. Failure of a Managed Care Organization (MCO) or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 CFR 438.408(b); or
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 CFR 438.52(b)(2)(ii), to obtain services outside a Contractor's Network.

Agency Summary: A document summary sent to the state in response of an acknowledgment or order for SFH. The document includes the appellant's basis for the appeal and provides an explanation for the health plan's decision. The Agency Summary provides a chronological outline of the events that have taken place; starting with the date of service and ending with the request for Fair Hearing and the health plan's SFH analyst review of the case. The document also contains attachments of (1) all correspondence between the health plan and the appellant; (2) all relevant medical records; and (3) all applicable statutes, regulations; and policies.

Appeal: A request for review of an Action, or a decision by the MCO related to Covered Services or services provided**.**

Denial: The termination, suspension or reduction in the amount, scope or duration of a Covered Service or the refusal or failure to provide a Covered Service.

Designated (Authorized) Representative: Any person or entity acting on behalf of the member and with the member's written consent.

Expedited Appeal: An appeal of an adverse decision for coverage where 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 shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. The health plan grants an expedited review for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

External Third Party Review request: A provider request to have a third party review conducted by the Department for Medicaid Services of medical necessity or administrative denials.

Grievance (Complaint): Means the definition established in 42 CFR 438.400; an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process.

Independent Review Organization/agent (IRO): Independent review organization. A third party entity not affiliated with the health plan or a providers' association that provides unbiased, objective opinions based on clinical evidence.

Notice of Action: A written explanation to the provider and/or member of an action (denial) being taken.

Pre service Appeal: An appeal of an adverse decision for coverage of care or services in advance of the member obtaining care or services.

Post service Appeal: A request to change an adverse decision for care or service that has already been received by the member.

Same/Similar Specialist Review: Review by a health care practitioner who has appropriate training and experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems or is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.

State Fair Hearing (SFH): The administrative hearing provided by the Cabinet pursuant to KRS Chapter 13B and contained in 907 KAR 17.010 for members and 907 KAR 17:035 for providers. A formal proceeding where an impartial Hearings Officer, assigned through a state's administrative process, listens to all of the facts of a case (appeal or grievance). Witnesses are sworn in by the Hearings Officer. All proceedings are tape recorded and are on the record. The Hearings Officer makes a decision within a state's mandated timeframe.

TIMEFRAMES:

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 Action.

Providers have sixty (60) calendar days from the date of Notice of Action to file an appeal for medical necessity or administrative denials.

All appeals are acknowledged in writing within five (5) calendar days of receipt.
Appeal decisions must be in writing and resolved as expeditiously as the Member's health condition requires, but not to exceed the following timeframes:

- Pre service Appeals: Within thirty (30) calendar days of receipt of the appeal request;
- Expedited Appeals: As expeditiously as the member's medical condition requires, but no later than seventy-two (72) hours receipt of the appeal request;
- Post-service Appeals: Within thirty (30) calendar days of receipt of the appeal request.

The health plan complies with the National Committee for Quality Assurance (NCQA), The Commonwealth of KY, and Federal standards.

PROCEDURE:

1) Members are informed in writing, upon enrollment in the health plan and annually of the internal and external procedures for filing a standard or expedited Grievance or Appeal, the right to an Independent Medical Review (IMR), and the right to a State Fair Hearing. Additionally, members are informed that the submission of an appeal is at no cost to them. Additionally, the member's handbook includes information of how to access the Cabinet's ombudsmen's office regarding grievances, appeals, and hearings.
2) Providers are informed of the appeal process at the time they enter the network and annually through Provider Newsletters, the health plan provider web site and the Provider Manual.
3) Appeal requests may be completed by the member, the member's authorized representative, the provider, or the provider on behalf of the member; submitted verbally, in writing, or in person at the health plan's physical location. Verbal filings will be treated as appeals to establish the earliest filing date.
4) A member or a person designated in writing by the member to act on their behalf may file an appeal and may request a State Fair Hearing. A provider may file an appeal for medical necessity denials and administrative denials. A provider may file an appeal or request a State Fair Hearing on behalf of a member, if the provider is acting as the member's authorized representative and that authorization is in writing.
5) A provider may file a request for an external third party review of a previously appealed decision with an undesirable outcome. No new information can be provided for this review. The review is conducted by the Department for Medicaid Services.
6) The provider may request a state fair hearing for decisions that were unfavorable on appeal and external third party review.
7) All appeals are entered into the electronic documentation system which automatically sends an acknowledgement letter to the appellant.
8) The health plan investigates, reviews, and makes a determination of the appeal within established timeframes and provides the covered person, and if applicable, the

authorized person and/or all providers on appeals with notification of the outcome.

9) The appeal will be reviewed by health plan associates, including the Medical Director, who were not involved in the initial determination and who are not a subordinate of any person involved in the initial determination. However, the practitioner who made the original decision may review the case and overturn the initial decision.
10) The Medical Director (including external physicians)involved in the appeal review, will hold the same or similar specialty as the treating practitioner and have experience treating the health problem as stated in the appeal, experience treating complications that may result from the service or procedure or specialty is sufficient to determine if the service or procedure is medically necessary or clinically appropriate..
11) During the investigation, additional clinical information may be requested of the provider. Documentation will reflect successful and unsuccessful attempt to gather additional information.
12) The substance of the appeal including, the reason for the appeal, clinical detail, medical records and any other additional information will be documented in the electronic documentation system and will be taken into account during the appeal investigation. Documentation of actions taken includes, but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted prior to the current appeal.
13) During the appeal process, the health plan will provide the appellant every opportunity to present evidence in person as well as in writing. Communications with the appellant will include the time available for providing this information, and in the case of an expedited resolution, the health plan will notify the appellant of the limited time to present evidence and allegations of fact or law in the case of an expedited appeal. Documentation will signify if the appellant fails to submit relevant information by the specified date. The appellant has the right, both before and during the appeals process, to examine the member's case file, including medical records and any other documents considered during the appeal process free of charge. The health plan will include, as parties to the appeal, the member, the member's representative or the legal representative of a deceased member's estate, or the provider's representative, as appropriate.
14) For members/ member's representatives with limited English proficiency, the health plan works with translation services to assist the member through the appeal process. For members/representatives with visual or other communicative impairments/ challenges, the health plan will assist the member/ member's representative by use of the TTY line. The health plan will conform to the HIPAA policies and procedures regarding the member's representative verification and sharing of information.
15) The Medical Director has ultimate responsibility and accountability for member medical necessity appeals.

16) The Medical Director and any designee must maintain licensure as a physician practicing within the Commonwealth of KY. The Medical Director or designee will make all decisions concerning medical necessity adverse actions and appeal decisions.
17) The Plan President/RVP & COO of the health plan has the responsibility for ensuring that appeals are resolved in compliance with written procedures and within the time required.

Expedited Appeals

1) An Expedited Appeal process is available for actions relating to matters which could place the Member at risk or seriously compromise the Member's health or well-being; including urgent care, care for life-threatening conditions, continued stays for hospitalized patients that have not been discharged from a facility, including admissions post emergency service visit, and any other situation for which taking the time for a standard resolution could seriously jeopardize the member's life or health.
2) No punitive action is taken against a provider who requests an expedited resolution or supports the member's appeal
3) Requests for expedited appeals are accepted orally or in writing. Verbal requests for expedited appeals do not need to be followed by a written request.
4) In addition to written notification, for notice of an expedited resolution, the health plan must also make reasonable efforts to provide oral notice to the appellant.
5) If the health plan denies a request for expedited appeal resolution, it must:
   a) Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2);
   b) Make reasonable efforts to give the appellant prompt oral notice of the denial, within seventy-two (72) hours of the expedited appeal request, and follow up with a written notice within two (2) calendar days of the oral notice.
   c) Must notify the hospital Utilization Review (UR) department staff of the denial, with the understanding that staff will inform the attending/treating practitioner.

Notification to Members and Providers of Appeal Decisions:

In compliance with and as defined by;: 42 CFR §§438.400 through 438.424, 907 KAR 17:010, KRS 304.17A-607 (1)(g) and 806 KAR 17-280

Written appeal decision notifications will include:

1) The result of the appeal process
2) The date that the appeal process was completed
3) The specific reason(s) for the appeal decision. It shall be in easily understandable language specific to the member's condition or request and not include abbreviations or acronyms that are not defined or health procedure codes that are not explained for member appeals

4) Reference to the benefit provision, clinical criteria, guideline, protocol or other similar criterion on which the decision was based
5) Right for the appellant to obtain a copy, upon request, of the actual benefit provision, clinical criteria, guideline, protocol, or other similar criterion on which the decision was based and all documents relevant to the member's appeal free of charge
   6) A list of titles and qualifications, including specialties, of all individual(s) participating in the appeal review. For a benefit appeal: The reviewers' title (name of reviewers' position or job within the organization). For a medical necessity appeal: The reviewers' title (name of reviewers' position or job within the organization), qualifications (clinical credentials, such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist). If dissatisfied with the decision, the right to appeal to the appropriate entities including the procedure for additional levels of appeal if available
7) Position and telephone number of a contact person who may provide information relating to the internal appeal.
8) If the appeal was not resolved wholly in favor of the appellant:
   a) The provider's right to An External Third Party Review, and how to do so.
   b) The member's right to request a State Fair Hearing, and how to do so
   c) The member's right to request to receive benefits while the hearing is pending, and how to make the request
   d) The member may be held liable for the cost of the benefits, if the hearing decision upholds the health plan's decision (action)

Extending the decision timeframe:

The health plan may extend the appeal decision timeframe up to fourteen (14) additional days to obtain additional information if:

1) The member voluntarily agrees to extend the appeal timeframe.
2) If the Member, or the Provider, requests an extension.
3) The health plan justifies a need for additional information on a member appeal and the extension is in the member's interest. The health plan must make reasonable efforts to give the Member prompt oral notice of the delay and provide the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file another grievance if he or she disagrees with that decision.
4) For provider appeals, the provider must agree to an extension.

Continuation of Benefits [42 CFR§438.420]

1) The health plan must continue benefits if:

a) The member or provider seeking to have benefits continue pending the appeal process files timely on or before ten (10) days of mailing the notice of action or the intended effective date of the health plan's proposed action.
b) The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
c) Services were ordered by an authorized provider.
d) The original period covered by the original authorization has not expired; and
e) The member requests extension of benefits.

2) If, at the member's or provider's request, the health plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
   a) The member withdraws the appeal.
   b) Ten (10) days pass after the health plan mails the notice, providing the resolution of the appeal against the member, unless the member, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
   c) The State Fair hearing office issues a hearing decision adverse to the member.
   d) The time period or service limits of a previously authorized service have been met.
3) If the final resolution of the appeal is adverse to the member, that is, upholds the action, the health plan may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR §431.230(b).
4) Where the health plan, or the State Fair hearing officer, reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the health plan must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
5) Where the health plan, or the State Fair hearing officer, reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan or the State must pay for those services.

Member State Fair Hearing

1) A Member shall exhaust the internal Appeal process with the health plan prior to requesting a State Fair Hearing. The health plan, the Member, or the Member's representative or legal representative of the Member's estate shall be parties to the hearing as provided in 907 KAR 17:010(5).

2) A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the health plan within one hundred and twenty (120) days of the final appeal decision by the Contractor as provided for in 907 KAR 17:010.
   a) A Member may request a State Fair Hearing for an Action taken by the health plan that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service.
3) If member/member's representative requests a hearing, the request shall:
   a) Be in writing and specify the reason for the request;
   b) Indicate the date of service or the type of service denied; and
   c) Be postmarked or filed within one hundred and twenty (120) days from the date of the health plan adverse action letter issued at the conclusion of the health plans internal appeal process.
4) A document supporting the health plans' adverse action shall be:
   a) Received by the department no later than five (5) days from the date the MCO receives a notice from the department that a request for a state fair hearing has been filed by an enrollee; and
   b) Made available to an enrollee upon request by either the enrollee or the enrollee's legal counsel.
5) The State shall provide for an expedited State Fair hearing within three (3) days of a request for an appeal that meets the requirements of an expedited appeal after a denial by the health plan.

Failure of the Health Plan to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the health plan or to appear and present evidence will result in an automatic ruling in favor of the Member.

The health plan will ensure final determinations include:

a) Eligibility criteria stating that the organization offers members the right to an independent, third party, binding review for all medical necessity denials.
b) A general communication to members announcing the availability of an independent review, at least annually.
c) Specific written or electronic notification to member with eligible appeals that details independent review rights and processes, and include contact information for the IRO.
d) A thorough review is conducted by the IRO in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence and makes a decision that is not bound by the decisions or conclusions of the internal appeal.
e) The organization has no material professional, familial or financial conflicts of interest with the IRO.

f) The organization does not attempt to interfere with the IRO's proceedings or appeal decision.
g) Members are not required to bear cost of the IRO, including any filing fees.
h) Members or their legal guardians may designate, in writing, a representative to act on their behalf.
i) In the event the IRO overturns the organization decision notification to the members of the IRO decision, including the time and procedure for claim payment or approval of service.
j) The organization will implement the IRO's decision within the timeframe specified by the IRO.
k) The organization will maintain or obtain data from the IRO on each appeal case and use this information in evaluating its medical necessity decision making process.
l) The IRO engages adequate number of actively practicing practitioners with the appropriate level and type of clinical knowledge and experience to adjudicate appeals.

Provider External Third Party Review
907 KAR 17:035. External independent third-party review.

A party shall be to an external independent third-party review in accordance with 907 KAR 17:035. An external independent third party review request shall be filed within sixty (60) days from the appealing party's receipt of the final adverse determination letter date of the health plan appeal review and be sent to the health plan by fax, electronically or by postal mail

1. A provider shall exhaust internal appeals rights prior to requesting an External Third Party Review.
2. A provider may request an External Third Party Review if he or she is dissatisfied with an appeal determination by the health plan within sixty (60) days of the appeal decision as provided in Kentucky statute and regulation 907 KAR 17:035.
    a. The sixty (60) day count shall begin on the:
        i. Date that the adverse determination was received electronically, if received electronically;
        ii. Date that the adverse determination was received via fax, per the date and time documented on the fax transmission, if the notice was faxed; or
        iii. Post mark date on the envelope containing the adverse determination, if the adverse determination was sent via postal mail. An additional three (3) days shall be added when the service is by mail.
3. A provider may request an External Third Party Review for an adverse medical necessity or administrative denial appeal.

4. If provider requests an External Third Party Review, the request shall:
    a. Be in writing and be forwarded to the health plan via postal mail, fax or electronically and specify the reason for the request;
    b. Indicate the date of service or the type of service denied; and
    c. Be postmarked or filed within sixty (60) days from the date of the health plan adverse action letter issued at the conclusion of the health plans internal appeal process.
5. The health plan must send an acknowledgment of receipt to the provider (and to the member in cases of pre-service medical necessity denials) within 5 business days of receipt.
6. The health plan will provide a copy of the provider acknowledgement letter to the Department by email at SB20@ky.gov within 5 business days of receipt of the provider request.
7. All records pertaining to the initial decision and appeal decision, along with the request for an External Third Party review, are to be uploaded to the FTP site for the Department to review within 15 business days of receipt.
8. Within 10 business days of receiving the external independent review final determination from the Department, the MCO shall notify the enrollee of the final decision if related to a denial of healthcare services.
9. In accordance to Kentucky statute and regulation 907 KAR 17:035; Upon the issuance of a final decision by an external independent third-party reviewer, the department shall notify in writing the MCO and the provider's designated contact of the right of the party that received an adverse final decision to appeal the decision by requesting an administrative hearing pursuant to 907 KAR 17:040.
    (2)(a) A request for an appeal referenced in subsection (1) of this section shall be sent to the department within thirty (30) calendar days of receipt of the department's written notice referenced in subsection (1) of this section.
    (b) The request for an appeal shall be sent to the department:
    1. Electronically;
    2. By fax; or
    3. by postal mail.

Provider State Fair Hearing

A party shall be entitled to appeal a final decision of the external independent third-party review to the administrative hearing tribunal within the Cabinet for Health and Family Services for an administrative hearing to be held in accordance with KRS Chapter 13B. An appeal shall be filed within thirty (30) days from the appealing party's receipt of the final decision of the external independent third-party review and be sent to the Department by

fax, electronically or by postal mail. A decision of the administrative hearing tribunal shall be final for purposes of judicial appeal.

Administrative appeal hearings following an external independent third-party review of a Medicaid managed care organization's final decision that denies, in whole or in part, a health care service to an enrollee or a claim for reimbursement to the provider for a health care service rendered by the provider to an enrollee of the Medicaid managed care organization, conducted under authority of Section 1 of this Act.

Quality Monitoring

The Plan shall submit to the state on a quarterly basis the total number of Member Grievances and Appeals and their disposition. The report shall be in a format approved by the state and shall include at least the following information:

1) Number of Grievances and Appeals, including expedited appeal requests;
2) Nature of Grievances and Appeals;
3) Resolution;
4) Timeframe for resolution; and
5) QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.

The state or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Plan's Program Integrity Unit.

1) All appeal documents are treated as confidential, placed in a secure location, and retained in accordance with the HIPAA policy.
2) All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the state or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the health plan, Health Services Division (HSD), an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.
3) The health plan shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the health plan and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information. Documentation regarding the grievance shall be made available to the Member, if requested.

4) Appeals trending is reviewed and analyzed quarterly by the Plan's Quality Management Committee, and is shared quarterly with the Plan's Medical Advisory Committee.

REFERENCES:

42 CFR 438 Subpart F Medicaid Programs; Medicaid Managed Care; Final Rules, June 14, 2002 through 42 CFR 438.424
42 CFR 438.10(c) and (d) Member Understanding
NCQA Accreditation Standards and Guidelines
KRS Chapter 13B
907 KAR 17:035
907 KAR 17:040

RESPONSIBLE DEPARTMENTS:

Primary Department:
Quality Management - Health Plan

Secondary Departments:
Clinical Quality Management - Corporate
Health Care Management - Health Plan

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
12/09/2015	• Created state specific policy/procedure. • Removed desk level detail
05/23/2016	• Off-cycle edit to remove obsolete appeals language
10/27/2016	• Annual review • Revisions for NCQA
03/3/2017	• Updates according to Senate Bill 20
02/15/2018	• Early annual Review • Contract revisions per SB20
01/22/2019	• For annual review • Updates to policy section with current contract language

	• Updated to procedure section with current contract language
12/27/2019	• Annual Review • Updated header • Revised definitions and procedure section