

KMAP GENERAL BULLETIN 2015

UPDATED - External Independent Third-Party Review

Effective for denials issued by Aetna, Sunflower or United Healthcare on or after January 1, 2020, providers may request an external independent third-party review of a KanCare Managed Care Organization (MCO)'s appeal decision. Providers may not request an external independent third-party review of an MCO's reconsideration decision.

Qualifying for External Review: The external reviewer may review adverse MCO appeal decisions related to a denial of an authorization for a new healthcare service to an MCO member or a denial of a claim for reimbursement from a provider for a healthcare service to an MCO member. A new healthcare service is a service an MCO has not previously authorized or a service that an MCO has previously authorized, but the authorized time-period has expired at the time of the request for additional services. Denials of an authorization for a new healthcare service or a denial of a claim due to the service being non-covered are eligible for review by the external independent third-party reviewer. Authorization decisions that terminate, suspend, or reduce previously authorized services are not eligible for review by the external independent third-party reviewer. **Denials of authorization due to untimely submission or a failure to submit a required authorization are not eligible for review by the external reviewer.**

Documentation for External Review: The decision of the external reviewer will be based on the documents submitted by the provider in the MCO's appeal process. The provider requesting an external review may not submit additional documents to the external reviewer. The external reviewer will decide whether to uphold or reverse the MCO's appeal decision based on the documents submitted by the provider during the MCO's appeal process. In addition to a review of the provider's appeal documents, the external reviewer will have available for review the medical necessity criteria applied in the appeal decision for denials of a healthcare service, the MCO's notice of appeal resolution, and the provider's request for external review.

Appeals: A provider must complete the MCO appeal process prior to requesting an external review. A member's appeal of a denial of a new healthcare service will not fulfill the requirement for a provider to complete an MCO appeal process prior to requesting an external review.

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A provider may request an appeal involving a denial of a new healthcare service on behalf of the member with signed authorization from the member. Completion of the member appeal process with authorization will qualify as completion of the provider appeal process that is required prior to requesting an external review. If a member no longer wants the denied service, the MCO is not required to process the appeal.

Appeal Resolution Notices: Beginning January 1, 2020, MCO notices of appeal resolution will include a statement that the provider has completed the MCO internal appeal process, a statement that the provider is entitled to an external review, and the process required to request an external review. Failure of the MCO to include this information in the provider's notice of appeal resolution will subject the MCO to a penalty of \$333, \$666 or \$1,000 owed to the provider requesting the third-party review in accordance with Kansas Statutes Annotated 39-709i(a)(2).

A provider receiving a notice that does not contain all the required information may submit the notice to KDHE.providerexternalreview@ks.gov. The Medicaid agency will determine the amount of the penalty fee after review of the deficient notice. The Medicaid agency will issue a letter to the MCO and provide a copy to the provider notifying the MCO of the amount of the fee. The fee must be paid within 10 business days of the date of the agency's notification letter. The agency will resolve any disputes regarding the fee. The dispute is not eligible for resolution through the reconsideration, appeal or state fair hearing processes.

Requests for External Review:

- Requests for an external review must be in writing and submitted to the MCO that issued the appeal decision to be reviewed.
- Each request for external review should involve only one appeal. Providers may not combine appeal documents from multiple appeals into one external review request.
- Providers must submit requests for external review to the MCO's address, as indicated on the notice of appeal resolution, within 63 calendar days of the date of the notice of appeal resolution.

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A request for external review will be denied if the provider has not completed the MCO appeal process, is untimely, does not involve a denied authorization for a new healthcare service or a denied claim, the member no longer wants the denied service, or lacks any of the following:

- Identification of each specific issue and dispute directly related to the adverse appeal decision issued by the MCO;
- The basis upon which the provider believes the MCO's decision to be erroneous; and
- The provider's designated contact information, including name, mailing address, phone number, fax number and email address.

Processing Requests for External Review: Within five business days of receipt of the review request, the MCO will send an acknowledgement letter to the provider's designated contact, notify Kansas Department of Health & Environment, Division of Health Care Finance (KDHE-DHCF) of the provider's request, and notify the affected member of the provider's request for review, if related to the denial of an authorization for a new healthcare service. Failure by an MCO to comply with the requirements above may result in an automatic reversal of the MCO's denial of the authorization for a new healthcare service or denial of a claim. The MCOs are not required to reverse their decisions for requests submitted by providers who fail to meet all the requirements for an external review request.

Submission by MCO of Appeal Documentation: Within 15 business days of receipt of the approved review request, the MCO will provide all documentation submitted by the provider for the MCO's appeal process to KDHE-DHCF or notify KDHE-DHCF that the provider has not completed the appeal process. The MCO will provide its designated contact information, including name, mailing address, phone number, fax number and email address. Failure by an MCO to comply with the requirements above may result in an automatic reversal of the MCO's denial of the healthcare service or denial of payment. The MCOs are not required to reverse their decisions for requests submitted by providers who fail to meet all the requirements for an external review request.

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Reversal of MCO's Decision: When an automatic reversal of the MCO's decision occurs or the MCO decides to reverse its decision, the MCO will send an approval notice within five business days to the provider and affected member, if applicable. The MCO will authorize the service or process the claim for payment within five business days from the date of the approval notice.

Assignment of External Review Requests: KDHE-DHCF will provide the appeal documentation, any medical necessity criteria applied by the MCO during the appeal process, the provider's appeal resolution notice, and the request for an external review to the external reviewer within five business days of receipt. KDHE-DHCF will notify the MCO and provider of the identity of the external independent third-party reviewer's Medical Director.

Multiple External Review Requests: The external reviewer may combine multiple requests for an external review upon request of the MCO or provider, if the request involves the same beneficiary, a common question of fact or interpretation of common applicable regulations or reimbursement requirements. The provider that submitted a request for an external review, or one or more other providers, may add additional claim denials to the review, prior to the external reviewer's decision, if the claims involve a common question of fact or interpretation of common applicable regulations or reimbursement requirements.

Providers adding additional claims to the review must:

- Complete the MCO's provider appeal process for each claim added to the review.
- Submit a request for external review to the MCO that denied the claim for each additional claim.

The external reviewer will provide separate decision letters, as needed, to protect health information.

Costs and External Reviewer's Letters: The external reviewer must complete their review of the provider's request within 30 calendar days of receipt of the review request and appeal documentation from KDHE-DHCF. The external reviewer must issue a letter to the provider, the

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MCO and to KDHE-DHCF or Kansas Department of Aging and Disability (KDADS). **The external reviewer's letter will direct the losing party of the review to pay an amount equal to the costs of the review to the third-party reviewer.**

If a provider withdraws the request for external review or the MCO reverses its decision after the external review has begun, the external review letter will include costs for partial reviews.

If the decision by the external reviewer is reviewed in a state fair hearing, any payment ordered will be stayed until a decision in the state fair hearing. If the state fair hearing decision reverses the decision of the external reviewer, the losing party of the hearing decision will be required to pay the costs of the review to the third-party reviewer within 45 calendar days of service of the hearing decision. If the decision of the Initial Order is reviewed by the State Appeals Committee, any payment ordered shall be stayed pending the decision of the State Appeals Committee. If the decision of the State Appeals Committee reverses the decision of the state fair hearing, the losing party of the State Appeals Committee's decision will be required to pay the costs of the review to the third-party reviewer within 45 calendar days of service of the Final Order.

State Fair Hearings and External Reviews: Providers and members are entitled to request a state fair hearing for denials by an MCO of an authorization for a new healthcare service before and after a review of the denial by the external reviewer. Providers are entitled to request a state fair hearing for denials by an MCO of reimbursement before and after a review of the denial by the external reviewer. Providers and members should avoid requesting hearings both before and after an external review.

If a provider or member requests a hearing about a decision that will be reviewed by the external reviewer, KDHE-DHCF or KDADS will ask OAH's presiding officer to extend the due date for the agency summary until after receipt of the external reviewer's decision. KDHE-DHCF or KDADS will ask OAH's presiding officer to consolidate hearing requests that involve the same issue reviewed by the external reviewer.

Providers and members are encouraged to wait until receipt of the external reviewer's decision before requesting a hearing. A party to the state fair hearing may appeal the decision of the state fair hearing in accordance with the Kansas Judicial Review Act.

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