TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Prior Authorization Timeline Requirements

Behavioral Health Technical Advisory Council (TAC)

September 11, 2025

Managed Care Organization Utilization Management Program

- Managed Care Organization (MCO) must have a Utilization Management (UM) Program that meets the requirements in the MCO contract and as defined in KRS 304.17A-600.
- The UM Program, processes, and timeframes shall be in accordance with 42 C.F.R. 456, 42 C.F.R. 431, 42 C.F.R. 438
- If the Contractor utilizes a private review agent, as defined in KRS 304.17A-600, the agent shall comply with all applicable requirements of KRS 304.17A-600 to 304.17A-633.
- The MCOs Medical Director and Behavioral Health Director shall supervise the UM Program and shall be accessible and available for consultation as needed.

Standard (non-urgent) Authorization

- **No later than five (5) Days** of receiving the necessary information* for the request.
- Standard authorization decisions may have an extension to the timeframes up to 14 additional calendar days if—

  (A) The enrollee or the provider requests the extension; or

  (B) The MCO justifies a need for additional information and how the extension is in the enrollee's interest.
- **Retrospective:** review **within five (5) Days** or, within fourteen (14) Days if the Enrollee or the Provider requests an extension.

Necessary Information*

Limited to:

- The 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 make a utilization review determination.

- Defined by KRS 304.17A-607

Expedited (Urgent) Authorization

- Complete an expedited authorization decision within **twenty-four (24) hours <u>after obtaining all necessary information</u>** to make the utilization review decision and provide notice as expeditiously as the Enrollee's health condition.
- **Substance use disorder primary diagnosis:** considered an Expedited Authorization **(24 hours)**;

Peer to Peer (P2P)

- P2P is not a Department for Medicaid Service (DMS) requirement.
- P2P is initiated by the provider prior to a formal appeal of the prior authorization denial.
- P2P should occur before the prior authorization denial is finalized.
- If the P2P review does not resolve the issue, the provider or member can file a formal appeal.
- Each Medicaid Managed Care organization has a P2P policy.