The following regulations have been adopted and published in the Kansas Register. They will become effective on the final date listed in the history section that follows each regulation. Regulations become effective 15 days after publication in the Kansas Register unless a later effective date is given in the body of the regulation.

State of Kansas
Department of Health and Environment
Division of Health Care Finance

Permanent Administrative Regulation

Article 9.—MANAGED CARE PROVIDER GRIEVANCES, RECONSIDERATIONS, APPEALS, EXTERNAL INDEPENDENT THIRD-PARTY REVIEW, AND STATE FAIR HEARINGS; FEE-FOR-SERVICE PROVIDER GRIEVANCES AND STATE FAIR HEARINGS

129-9-9. External independent third-party review for providers. (a) Effective with each denial issued by a managed care organization (MCO) on or after January 1, 2020, each provider who has been denied an authorization for a new healthcare service to an enrollee or a claim for reimbursement to the provider for a healthcare service rendered to an enrollee shall be entitled to an external independent third-party review pursuant to K.S.A. 39-709j, and amendments thereto. Each MCO denial reviewed by the external independent third-party reviewer shall have been issued pursuant to a contract between the MCO and the Kansas medical assistance program (KMAP). The contract shall have been effective January 1, 2020 or later.

(b) The request for an external independent third-party review shall apply only to denials for which the provider has completed the internal written appeals process of an MCO on or after January 1, 2020. Each provider shall have the right to submit a request for an external independent third-party review following receipt of the MCO’s adequate notice of appeal resolution or remittance advice.

(c) The MCO shall send an adequate notice of appeal resolution to the provider when the MCO reviews the request for an appeal of an action or adverse benefit determination. Each adequate notice of appeal resolution shall meet the requirements of the secretary and shall include the following:

1. The date of the adequate notice of appeal resolution;
2. The action or adverse benefit determination that is the subject of the appeal;
3. The results of the resolution process and the date of the appeal resolution;
4. The reasons for the appeal resolution, including an explanation of the medical basis for the resolution, application of policy, or accepted standard of medical practice to the enrollee’s medical circumstances, if the MCO based its resolution upon a determination that the service is not medically necessary;
5. The statute, regulation, policy, or procedure supporting the appeal resolution;
6. A statement that the provider has completed the appeal process with the MCO;
7. A statement of the provider’s right to request an external independent third-party review following receipt of the adequate notice of appeal resolution;
8. A statement of the required procedures by which a provider may request an external independent third-party review with the MCO issuing the decision to be reviewed within 60 days of the date of the adequate notice of appeal resolution. Pursuant to K.S.A. 77-531 and amendments thereto, three days shall be added to the 60-day response period if the notice is served by U.S. mail or by electronic means. The statement shall include the address and contact information for submission of the request;
9. A statement that if the provider does not request an external independent third-party review, the provider has a right, pursuant to K.S.A. 39-709j(e)(4) and amendments thereto, to request a state fair hearing within 120 days of the date of the adequate notice of appeal resolution. Pursuant to K.S.A. 77-531 and amendments thereto, three days shall be added to the 120-day response period if the notice is served by U.S. mail or by electronic means;
10. The procedures by which the provider may request a state fair hearing and the address and contact information for submission of the request or, for an action based on a change in law, the circumstances under which a state fair hearing will be granted;
11. A statement of the provider’s right to have self-representation or use legal counsel, a relative, a friend, or a spokesperson; and
12. Any other information required by Kansas statute or regulation that involves the MCO’s adequate notice of appeal resolution.

(d) Each provider receiving an adequate notice of appeal resolution from an MCO that does not include the information specified in paragraphs (c)(6) through (c)(8) shall be entitled to a penalty fee of $333.00, $666.00, or $1,000.00 pursuant to paragraphs (d)(1)(A) through (C). The provider shall notify the secretary of the deficient notice.

(1) The penalty fee for each deficient notice of appeal resolution shall be calculated by the secretary according to the following fee structure:

(A) A notice failing to include one of the three requirements specified in paragraphs (c)(6) through (c)(8) shall incur a penalty fee of $333.00.

(B) A notice failing to include two of the three requirements specified in paragraphs (c)(6) through (c)(8) shall incur a penalty fee of $666.00.

(C) A notice failing to include three of the three requirements specified in paragraphs (c)(6) through (c)(8) shall incur a penalty fee of $1,000.00.

(2) The MCO issuing the deficient notice shall pay the penalty fee to the provider receiving the deficient notice within 10 business days of the secretary’s notification to the MCO of the deficient notice.

(3) The provider shall notify the secretary of any dispute that arises regarding the penalty fee. This dispute shall be resolved by the secretary and shall not include the right to request a reconsideration, an appeal, or a state fair hearing.
(e) Any provider may submit a written request for an external independent third-party review to the MCO issuing the decision to be reviewed. The provider’s request for this review shall include the following:

(1) Identification of each specific issue and dispute directly related to the adverse appeal decision issued by the MCO;

(2) a statement of the basis upon which the provider believes the MCO’s decision to be erroneous; and

(3) the provider’s designated contact information, including name, postal mailing address, telephone number, fax number, and electronic-mail address.

(f)(1) Within five business days of receiving a provider’s request for external independent third-party review, the MCO shall perform the following:

(A) Send to the provider’s designated contact a written acknowledgement letter specifying that the MCO has received the request for review;

(B) notify the secretary of the provider’s request for review; and

(C) send a copy of the written acknowledgement letter to the enrollee, if related to the denial of an authorization for a new healthcare service.

(2) If the secretary determines that the MCO failed to meet the requirements of paragraphs (f)(1)(A) through (C), then the provider who submitted the request for review shall automatically prevail in the review. Within five business days of receipt of the secretary’s notification that the provider automatically prevails, the MCO shall issue an approval letter regarding the reversal of the MCO’s appeal decision to the prevailing provider and the secretary. The MCO shall also issue an approval letter to the affected enrollee if the request for review is related to the denial of an authorization for a new healthcare service. The MCO shall not be required to reverse its decision for a request that does not include the information specified in paragraphs (e)(1) through (e)(3), is submitted by a provider who fails to complete the MCO’s appeal process, is untimely, or does not involve a denied authorization for a new healthcare service or a claim for reimbursement.

(h) Each request for an external independent third-party review shall be approved or denied by the secretary. A request for an external independent third-party review that does not include the information specified in paragraphs (e)(1) through (e)(3), is submitted by a provider who fails to complete the MCO’s appeal process, is untimely, or does not involve a denied authorization for a new healthcare service or a claim for reimbursement shall be denied by the secretary. A letter regarding the denial of the request for an external independent third-party review shall be issued by the secretary to the requesting provider and the MCO. A denial letter shall also be issued to the affected enrollee if the request for review is related to the denial of an authorization for a new healthcare service.

(i) The decision by the external independent third-party reviewer shall be based solely upon the documentation submitted by the provider during the MCO’s appeal process.

(j) The parties to each external independent third-party review shall be the following:

(1) A provider or the provider’s authorized representative; and

(2) the MCO that made the decision involved in the review.

(k) Upon the request of a party, the external independent third-party reviewer may determine in one action multiple requests made to the reviewer regarding the same enrollee, a common question of fact, a common interpretation of applicable regulations, or a common reimbursement requirement. The provider shall complete the MCO’s appeal process and submit a request for external review for each denial of an authorization for a new healthcare service or denial of a claim for reimbursement that the reviewer determines in one action.

(l) Any provider that initiated a request for an external independent third-party review, or one or more other providers, may add other initial denials of claims to the review before the reviewer’s decision if the claims involve a common question of fact, a common interpretation of applicable regulations, or a common reimbursement requirement. The provider shall complete the MCO’s appeal process for each denial of a claim for reimbursement reviewed by the reviewer. The provider shall submit a request for external independent third-party review to the MCO that denied the claim, for each additional claim.

(m) The external independent third-party reviewer shall conduct an external independent third-party review of any denial of authorization for a new healthcare service or denial of a claim for reimbursement submitted to the reviewer.

(n) The external independent third-party reviewer shall issue the reviewer’s final decision in a letter to the provider’s designated contact, the MCO’s designated contact, and the department within 30 days from the date of receipt of the appeal documentation forwarded by the secretary. The reviewer may extend the time to issue a final decision by 14 days upon agreement of both parties to the
review. The reviewer’s letter shall include the following:

1. The date of the reviewer’s decision letter;
2. the date of receipt of the provider’s appeal documentation from the secretary;
3. the date of the reviewer’s decision and, if an extension was requested by the reviewer, the date of the extension request;
4. the name and address of the requesting provider. If the reviewer determines in one action multiple provider requests or requests involving multiple claims, the reviewer shall issue a separate decision letter for each MCO, enrollee, and provider as required to protect health information;
5. a summary statement of the reason the provider requested the external independent third-party review;
6. the specialty or professional certification of each individual reviewing the provider appeal documentation;
7. a summary statement of the reviewer’s rationale for affirming or reversing the MCO’s appeal decision. The statement shall include citation to the applicable policies, research articles, medical necessity criteria, or any other documentation relied upon by the reviewer in reaching its decision;
8. the name of the medical director who reviewed and approved the reviewer’s decision;
9. a statement directing the losing party of the review to pay an amount equal to the costs of the review to the reviewer and the due date for payment. The statement shall include the following:
   A. A statement that if the decision of the external independent third-party reviewer is reviewed in a state fair hearing, the payment due to the reviewer under this subsection shall be delayed until the decision of the state fair hearing has been issued in the initial order;
   B. a statement that the losing party of the state fair hearing’s initial order shall pay the costs of the review to the reviewer within 45 days of service of the initial order;
   C. a statement that if the decision in the initial order is reviewed by the state appeals committee, the payment due to the reviewer under this subsection shall be delayed until the decision by the state appeals committee has been issued in the final order; and
   D. a statement that the losing party of the state appeals committee’s final order shall pay the costs of the review to the reviewer within 45 days of service of the final order;
10. the unique number assigned by the MCO to each provider appeal;
11. the unique number assigned by the reviewer to each request for external independent third-party review; and
12. a statement that the provider will receive an additional notice from one or more MCOs that includes the right to request a state fair hearing regarding the reviewer’s decision.

(p) Each request for an external independent third-party review shall automatically extend the deadline to request a state fair hearing pending the outcome of the review. Any party, including the affected enrollee, may request a state fair hearing within 30 days of the date of the MCO’s notice of the reviewer’s decision. Pursuant to K.S.A. 77-531 and amendments thereto, three days shall be added to the 30-day response period if the notice is served by U.S. mail or by electronic means.

(q) The decision of the external independent third-party reviewer shall be reviewed by the secretary or the secretary’s designee. If the MCO is the losing party of the review, a determination regarding a review by OAH of the reviewer’s decision shall be made by the secretary.

(r) The scheduling of any state fair hearing that involves a denial of an authorization for a new healthcare service or a claim for reimbursement for which the provider has requested an external independent third-party review shall be delayed until after the reviewer’s decision has been issued. The reviewer’s decision letter, the documents relevant to the reviewer’s decision, and the MCO’s notice of the reviewer’s decision shall be included in the state fair hearing case file for consideration by the presiding officer, together with any other facts of the case.

(s) Any provider requesting an external independent third-party review may withdraw the request for review and request a state fair hearing within 123 days of the date of the MCO’s adequate notice of appeal resolution. (Authorized by and implementing K.S.A. 2019 Supp. 39-709j, K.S.A. 65-1,254, and K.S.A. 75-7403; effective, T-129-5-4-20, May 4, 2020; effective Aug. 21, 2020.)

Lee A. Norman, M.D.
Secretary

State of Kansas
Board of Nursing

Permanent Administrative Regulations

Article 11.—ADVANCED PRACTICE REGISTERED NURSES (APRN)

60-11-116. Reinstatement of inactive or lapsed license. (a) Each nurse anesthetist whose Kansas APRN license is inactive or has lapsed and who wants to obtain a reinstatement of APRN licensure shall meet the same requirements as those in K.A.R. 60-13-110.

(b) Any nurse practitioner, clinical nurse specialist, or nurse-midwife whose Kansas APRN license is inactive or has lapsed may, within five years of its expiration date, reinstate the license by submitting proof that the individual has met either of the following requirements:

1. Obtained 30 hours of continuing nursing education related to the advanced practice registered nurse role within the preceding two-year period; or
2. been licensed in another jurisdiction and, while licensed in that jurisdiction, has accumulated 1,000 hours of advanced practice registered nurse practice within the preceding five-year period.

(c) Any nurse practitioner, clinical nurse specialist, or
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nurse-midwife whose Kansas APRN license is inactive or has lapsed for more than five years beyond its expiration date may reinstate the license by submitting evidence of having attained either of the following:

(1) A total of 1,000 hours of advanced practice registered nurse practice in another jurisdiction within the preceding five-year period and 30 hours of continuing nursing education related to the advanced practice registered nurse role; or


60-11-119. Payment of fees. Payment of fees for advanced practice registered nurses shall be as follows:

(a) Initial application for license $50.00
(b) Biennial renewal of license $55.00
(c) Application for reinstatement of license without temporary permit $75.00
(d) Application for license with temporary permit $100.00
(e) Application for exempt license $50.00
(f) Renewal of exempt license $50.00
(g) Inactive license $20.00
(h) Renewal of inactive license $20.00


Article 13.—FEES; REGISTERED NURSE ANESTHETIST

60-13-110. Reinstatement of inactive or lapsed authorization. (a) Any nurse anesthetist whose Kansas authorization is inactive or has lapsed may, within five years of its expiration date, reinstate the authorization by submitting proof that the individual has met either of the following requirements:

(1) Obtained 30 hours of continuing nursing education related to nurse anesthesia within the preceding two-year period; or

(2) been authorized in another jurisdiction and, while authorized in that jurisdiction, has accumulated 1,000 hours of nurse anesthesia practice within the preceding five-year period.

(b) Any nurse anesthetist whose Kansas authorization is inactive or has lapsed for more than five years beyond its expiration date may reinstate the authorization by submitting evidence of having attained either of the following:

(1) A total of 1,000 hours of nurse anesthesia practice in another jurisdiction within the preceding five-year period and 30 hours of continuing nursing education related to nurse anesthesia within the preceding two-year period; or

(2) satisfactory completion of a refresher course approved by the board. (Authorized by K.S.A. 65-1164; implementing K.S.A. 65-1155; effective Sept. 2, 1991; amended May 9, 1994; amended March 22, 2002; amended Aug. 21, 2020.)

Carol Moreland
Executive Administrator
Doc. No. 048338