

Key UM Procedures

Kentucky Health Cooperative's health insurance plans include a Utilization Management (UM) program. This program examines plan members' care and services. The program also looks at services that require approval before the service is provided. This is called preapproval. For example inpatient hospital care that is not an emergency requires approval. This means your physician must call us for approval prior to admitting you to the hospital. It is the physician's responsibility to obtain approval for services when indicated. If approval is not granted, the process to appeal the decision will be explained.

The plan also ensures that the care is the right approach before it begins. The following are some checks that take place:

Preservice: Before you get care, we check to see if this is the best care for you.

Some services do not require preservice approval. These include:

- Emergency services.
- Family planning services.
- Basic prenatal care in-network.
- Sexually transmitted disease services.
- HIV testing and counseling.
- Office visits to Primary Care Practitioners.

Concurrent: We look at care while you are receiving it to determine if you need to continue receiving it, and/or if other care would better meet your needs.

If you are hospitalized or if you are receiving care over a long period of time, we will review your condition on a regular basis to determine if your care continues to be covered. To be covered your care must continually meet criteria for the level of care you are receiving. This process of ongoing review is called concurrent review. Our staff will discuss the status of your condition with your provider. If we do not approve your provider's request for continued care in the hospital or other setting, the process to appeal the decision will be explained to your provider and to you.

Retrospective: We check to determine if you needed the care you got, after you received it.

In some cases you may obtain care and ask us to pay for it after you have received the care and services. We will review the situation and make a decision. This is called post-service approval. If the information about the situation does not meet our criteria we will not approve the request for payment. We will tell your provider and you about the process to appeal this decision.

We do these reviews to measure the health care and services you receive. We measure this based on your health plan coverage. We check to see if the care and services are provided at the right place and at the right time. Then, we determine how much coverage we can provide according to your benefits. And, we decide how to pay health care providers who provide care and services.