COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
Frankfort, Kentucky

BULLETIN
2011-04

The following Bulletin is to advise the reader of the current position of the Kentucky Department of Insurance (the "Department") on the specified issue.

TO: Health Insurers Issuing or Renewing Health Benefit Plans in Kentucky

FROM: Sharon P. Clark, Commissioner

RE: External Review Preemption Issues

DATE: May 10, 2011

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The Patient Protection and Affordable Care Act of 2010 ("PPACA") was signed into law on March 23, 2010. Section 2719 of PPACA and related proposed regulations create certain minimum requirements with regard to the external review of certain denied claims. External review is a process by which an insured can appeal a claim denied on the basis that the service is not medically necessary or is experimental or investigational. External reviews are performed by independent review entities ("IRE"s) and not by the insurer. Any state law that does not meet the federal minimum standard is preempted. Certain areas of Kentucky law are preempted by PPACA, therefore insurers should be adhering to the requirements of PPACA according to the attached chart.

Although Section 2719 of PPACA applies only to grandfathered plans, the Department is applying this bulletin to all insurers issuing or renewing health benefit plans in the Commonwealth of Kentucky, regardless of whether the health benefit plans are grandfathered.

Questions regarding this Bulletin may be directed to the Andrea Fegley at (502) 564-6032.

/s/ Sharon P. Clark

Sharon P. Clark, Commissioner
Kentucky Department of Insurance
On this 10th day of May, 2011

External Review Preemption Guide

Effective Date: July 1, 2011

Issue	Current Kentucky law	New standard
Exhaustion of internal appeals prior to external review	KRS 304.17A-623(3)(b): requires that a covered person must exhaust an insurer's internal appeal process prior to pursuing an external review	Covered persons may pursue an expedited external review while simultaneously pursuing an expedited internal appeal under the following circumstances: 1) The scenarios listed in 304.17A-623(10), or 2) The covered person is requesting review of a determination that a recommended or requested service is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested service that is the subject of the review would be significantly less effective if not promptly initiated. The internal appeal process will be considered exhausted under 304.17A-623(3)(b) if the insurer failed to strictly adhere to the requirements of 45 CFR 147.136(b)(2) with respect to the related claim or internal appeal.
Filing Fees for review	KRS 304.17A-623(5) allows for a $25 filing fee to be paid by the covered person, while the insurer pays for the cost of the review. This fee is waived if the IRE finds in favor of the covered person. The fee is waived if the payment of the fee would impose an undue financial hardship.	The provisions of KRS 304.17A-623(5) still apply but a $75 annual limit applies for each covered person for a single plan year.
Threshold amount of claim to be eligible for review	KRS 304.17A-623(3)(d) requires that the entire course of treatment or service must cost the covered person at least $100 to be eligible for external review.	The threshold amount is no longer applicable.
Timeframe to file an external review	KRS 304.17A-623(4) requires that an	An external review must be filed by the covered person

	external review be filed by the covered person within 60 days of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process.	within four months of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process.
Submission of additional information to the Independent Review Entity	806 KAR 17:290 Section 2(e) requires that an insurer notify the person requesting an external review of the determination regarding whether an external review is warranted within the following timeframes: 1) For expedited reviews, within 24 hours of the receipt of the request, and 2) For non-expedited reviews, within five business days of the receipt of the request.	In addition to the requirements of 806 KAR 17:290 Section 2(e), in the case of non-expedited reviews, the insurer shall notify the covered person in writing of the assignment to an IRE and the right to submit additional information to be considered by the IRE within the first five days of receipt of the letter. If an IRE receives information within the five day timeframe, the information shall be considered in the review and shall be forwarded to the insurer within one business day of receipt by the IRE.
Timeframes for decision	KRS 304.17A-623(11), (12) and (13) and 806 KAR 17:290 Section 2(1)(e) set forth the time frames for expedited and non-expedited external review.	In no event shall the time period set forth in 304.17A-623(11) and (12) and 806 KAR 17:290 Section 2(1)(e) exceed 72 hours from the receipt of request for expedited external review by an insurer. In no event shall the time period set forth in 304.17A-623(13) and 806 KAR 17:290 Section 2(1)(e) exceed 45 days from the insurer's receipt of a request by a covered person for a non-expedited external review.
Experimental/Investigational Review	KRS 304.17A-623(10) sets forth the scenarios when an expedited external	In addition to the scenarios already set forth under KRS 304.17A-623(10), a covered person can request an

	review is available.	expedited external review if the covered person is requesting review of a determination that a recommended or requested service is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested service that is the subject of the review would be significantly less effective if not promptly initiated. Such a request for expedited external review may be made orally.
Conflict of Interest Rules for Independent Review Entities	KRS 304.17A-627(3) and (4) prohibit an IRE from being owned or controlled or in any way affiliated with an insurer, or trade or professional association of payors or providers.	To clarify the terms "in any way affiliated with", an IRE shall not own or control an insurer, or trade or professional association of payors or providers.
Assignment of Independent Review Entity to a case	304.17A-623(7) requires insurers to utilize a rotation of IREs established by the Department.	Insurers shall determine if an external review is available to the covered person pursuant to KRS 304.17A-623(3) and shall notify the Department of a request for assignment. The Department shall assign to the insurer an IRE for each case based upon the rotational system. An insurer shall verify that no conflict of interest pursuant to KRS 304.17A-627(8) exists with the assignment given by the Department. If a conflict does exist, the insurer shall contact the Department for an additional assignment.
Binding Nature	KRS 304.17A-625(9) states that the decision of an IRE is binding on the insurer with respect to that covered person.	An external review is binding on the insurer and covered person except to the extent there are remedies available under applicable State or Federal law.