UTILIZATION MANAGEMENT REVIEW GUIDE – LIMITED/SELF-FUNDED GUIDE

ENTITY NAME: _____ UM ENTITY ID #: _____ UM CERT. EXPIRATION DATE: _____

ACCREDITATION STATUS: ☐ Accredited: ☐ URAC ☐ NCQA ☐ Other: _____ ☐ Not Accredited (provide copies of current accreditation certificates)

URAC Health UM Accreditation Version _____

TYPE OF ENTITY: ☐ Insurer ☐ Private Review Agent (PRA) For Insurer ☐ Private Review Agent (PRA) For Self-Funded Plan ☐ Limited Health Services

Private Review Agents Client Listing* (KRS 304.17A-607(4) & KRS 304.17A-609(7))

FOR DEPARTMENT USE ONLY		
Appropriate Fee Received		
Proof of Registration w/Sec. of State/COA		
Section A: Corporate Profile		
Section B: Administration/Operation		
Section C: Corporate Attestation		
Medical Necessity Determinations		
Coverage Denials		
Internal Appeals		
Determination Notices		

_____
Reviewer's Signature

*If additional clients, please provide a listing within the application binder.

Pursuant to KRS 304.17A-603
Insurers must maintain written procedures for determining whether a requested services, treatment, drug, or device is covered. **Insurers & Private Review Agents** must maintain written procedures for making utilization review determinations. **Insurers & Private Review Agents** must maintain a website for publishing UR policies & procedures accessible by covered persons, authorized representatives, and providers. Please provide the website address link: _____

ACCREDITATION ACCEPTED IN LIEU OF THE FOLLOWING REQUIREMENTS:	COMPLIANT
If the entity holds an unrestricted accreditation in any of the three (3) accreditation organizations listed in the Compliant column the Department will not require specific policies or procedures related to the items with the accreditation organization boxes within the compliant column. However, please check the appropriate accreditation entity box in each item.	**URAC ☐ NCQA ☐ AAAHC ☐**

All UR entities are required to provide the requirements on the following pages in the Utilization Review Binder with the tab location, the policy number, and page of the policy that demonstrates compliance with the requirements as outlined in the tables.

ACCESSIBILITY REQUIREMENTS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES
UR Telephonic Access – Provide a toll-free telephone number (KRS 304.17A-607(1)(e))	**URAC ☐ NCQA ☐ AAAHC ☐**		
Hours of Operation – Be accessible 40 hours a week during normal business hours in Kentucky (KRS 304.17A-607(1)(e))			
Extended Hours of Operation – Insurers/PRAs are required to be available to conduct utilization review during normal business hours & extended hours in this state on Monday and Friday through 6:00 pm, including federal holidays (KRS 304.17A-607(1)(f))			
Non-Contact Denial Prohibition – No insurer shall deny or reduce payment for a service, treatment, drug or device covered under the covered person's health plan if: (KRS 304.17A-615(1)) (a) During normal business hours, provider contacts insurer/PRA the day covered person is expected to be discharged in order to request review of a continued hospitalization, and a timely UR decision is not provided; or (b) Provider makes 3 documented attempts in 4 consecutive hour period during normal business hours to contact insurer/PRA for review of a continued hospital stay, for pre-authorization for treatment of hospitalized person or for retrospective review of an emergency admission, where the covered person remains hospitalized at the time the request is made, and insurer or PRA is not accessible			
Insurer's Liability via Non-Contact – The insurer's liability to pay for covered person's hospitalization under these circumstances shall extend until insurer/PRA issues a UR decision, applicable to requests in (b) above. [This section applies only to covered health benefits. This section shall not apply if provider does not furnish information requested by insurer or PRA to make UR decisions or if actions by provider impede insurer's or PRA's ability to issue decision. (KRS 304.17A-615(2) through (5)).			

ACCESSIBILITY REQUIREMENTS

ACCESSIBILITY REQUIREMENTS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	ACCESSIBILITY REQUIREMENTS
UR Reviews Documentation Compliance – Insurers/PRAs are required to maintain the following: (806 KAR 17:280 Section 10) (a) Proof of the volume of reviews conducted per the number of staff broken down by staff answering the phone (b) Availability of physician consultation (c) Other information which shall provide proof that, based on the call volume the insurer/PRA has sufficient staff to return calls in a timely manner (d) Proof of the volume of phone calls received on the toll-free phone number per the number of phone lines (e) An abandonment rate, and (f) Proof of the insurer's/PRA's response time for returned phone calls to a provider when a message is taken				

PERSONNEL REQUIREMENTS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	PERSONNEL REQUIREMENTS
Sufficient Personnel – Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation to carry out utilization review activities. (KRS 304.17A-607(1)(a))				
Utilization Review Reviewer – All utilization reviews are completed by only licensed physicians who are of the same or similar specialty and subspecialty, when possible, as the ordering provider (KRS 304.17A-607(1)(b))				
Specialty/Subspecialty Personnel – Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty & subspecialty cases. (KRS 304.17A-607(1)(c))				
Protocol Review & Comment – Afford participating physicians the opportunity to review & comment on all medical, surgical, and ER protocols; and to other participating providers, the same opportunity to see protocols that are within their scope of practice. (KRS 304.17A-607(1)(k))	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Licensed Supervision – Ensure that only licensed physicians supervise qualified personnel conducting case reviews. (KRS 304.17A-607(1)(b)1 and 2)	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Licensed Chiropractor/Optometrist – ensure that only Kentucky licensed chiropractors/optometrists render denials for services rendered by a chiropractor/optometrist (KRS 304.17A-607(1)(b)1)				
Medical Information Non-Disclosure – No disclosure or publishing of individual medical records or any other confidential medical information in the performance of utilization review activities. (KRS 304.17A-607(1) (d))	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			

PERSONNEL REQUIREMENTS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	PERSONNEL REQUIRMENTS
Managed Care Plan (includes HMO) – A PRA acting on behalf of a Managed Care Plan (includes HMO) must appoint a Medical Director who is licensed in Kentucky, and who shall sign any adverse determination letters (electronic signature may be used). (KRS 304.17A-545).				
Conflict of Interest – Ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the decision. In addition to ensuring impartiality of the medical expert making the appeals decision, the federal rules provide that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (claims adjudicator or medical expert) must not be made based on the likelihood that the individual will support a denial of benefits. (KRS 304.17A-617(2)(c) and KY DOI Bulletin 2011-08)				

PRESCRIPTION PRIOR AUTHORIZATION	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	PRESCRIPTION PRIOR AUTHORIZATION
Electronic Prior Authorization – All insurers & PRA's performing prescription prior authorizations must develop, coordinate, or adopt a process for electronically requesting & transmitting prior authorization for a drug by providers. The process must be accessible by providers & meet the most recent National Council for Prescription Drug Programs SCRIPT standards for electronic prior authorization transactions adopted by the US Department of Health & Human Services. Provide the link for providers to access this system. (KRS 304.17A-167(1))				
Electronic Submission – Facsimile, proprietary payer portals, & electronic forms shall not be considered electronic transmission. (KRS 304.17A-167(1))				
Authorization Approval Length – All prior authorizations for drugs for a ongoing condition must be valid for the lesser of: (KRS 304.17A-167(2) & (3) 1) One (1) year form the date the provider receives the prior authorization or 2) Until the last day of coverage under the covered person's health benefit plan during a single plan year; and **3)** Cover any change in dosage prescribed by the provider during the period of authorization.				

Timeframes for Review	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES
Pre-Authorization timeframe – URGENT = 24 of receipt of all necessary information (KRS 304.17A-607(1)(i)1). All necessary information is limited to: a. The results of any face-to-face clinical evaluation; b. Any second opinion that may be required; & c. Any other information determined by the department to be necessary to making a utilization review determination. **Kentucky's is not preempted by URAC, NCQA, or AAAHC standards.** (KRS 304.17A-607(1)(i)2 and 29 CRF 2560.503-1)			
Pre-Authorization timeframe – NON-URGENT = 5 days of obtaining all necessary information to make the utilization review decision. All necessary information is limited to: a. The results of any face-to-face clinical evaluation; b. Any second opinion that may be required; & c. Any other information determined by the department to be necessary to making a utilization review determination **Kentucky's is not preempted by URAC, NCQA, or AAAHC standards.** (KRS 304.17A-607(1)(i)2 and 29 CFR 2650.503-1)			
Retrospective Review – 5 days of obtaining all necessary information to make the utilization review decision. All necessary information is limited to: a. The results of any face-to-face clinical evaluation; b. Any second opinion that may be required; & c. Any other information determined by the department to be necessary to making a utilization review determination. **Kentucky's is not preempted by URAC, NCQA, or AAAHC standards.** (KRS 304.17A-607(1)(i)2 and 29 CFR 2560.503-1)			
Retrospective Denial – A UR decision shall not retrospectively deny coverage for services when prior approval has been given unless the approval was based on fraudulent, materially inaccurate, or misrepresented information submitted by the claimant (covered person, authorized person, or provider). (KRS 304.17A-611) This would include any any authorized services due to the failure of the insurer/PRA to comply with the timeframes stated above. (KRS 304.17A-607(1)(i))			
Urgent Care Definition (KRS 304.17a-600(16) and KY DOI Bulletin 2011-08)			
Concurrent Review (Inpatient) – Review of continued inpatient stay, includes retrospective reviews of emergency admissions where the covered person is still hospitalized at the time the request is made is required within **24 hours** of receipt of request, and prior to the time when the previous authorization will expire. **Kentucky's is not preempted by URAC, NCQA, or AAAHC standards.** (KRS 304.17A-607(1)(h) and 29 CFR 2560.503-1)			
Preadmission/Outpatient Surgery Designation – All preadmission reviews of hospital admissions and any preauthorization for outpatient surgery must be treated as urgent care requests. (KRS 304.17A-600(16)(b))			
Determination Timeframe Failure – An insurer's or PRA's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be a prior authorization for the health care services or benefits subject to the review. (This provision shall not apply where the failure to make the determination or provide the notice results from circumstances, which are documented to be beyond the insurer's control.) (KRS 304.17A-607(2).			

REVIEW TIMEFRAMES

Timeframes for Review	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	REVIEW TIMEFRAMES
Drug Utilization Review – Exceptions Policy – Any Insurer/PRA that determines the necessity of prescription drugs shall include an Exceptions Policy that allows for the review of clinically appropriate drugs that are not otherwise covered by the health benefit plan, as follows: (Affordable Care Act) (a) Within 72 hours following the receipt of a Standard request or, (b) Within 24 hours following the receipt of an Expedited request based on exigent circumstances, which exist when the covered person is suffering from a health condition that may serious jeopardize the covered person's life, health, or ability to regain maximum function or undergoing a current course of treatment using a non-formulary drug				

Determination Notices	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	DETERMINATION NOTICES
Utilization Review Reviewer – All utilization reviews are completed by only licensed physicians who are of the same or similar specialty and subspecialty, when possible, as the ordering provider (KRS 304.17A-607(1)(b))				
Determination Notices – Written notice of the review decision for a treatment, procedure, drug that requires prior authorization or a device to the claimant (covered person, authorized person, or provider). This notice may be provided in electronic format, including e-mail or facsimile, where the claimant (covered person, authorized person, or provider) has agreed in advance in writing to receive such notices electronically. Written notice is required for both approvals and denials. (KRS 304.17A-607(1)(h) and (j) and KRS 304.17A-617(2)(e))	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Present Additional Information – Providers shall be given the opportunity to present additional information concerning the review (KRS 304.17A-617(2)(d)).	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Federal Preemption (KY DOI Bulletin 2011-08**) – RE: Notices** – An insurer/PRA must provide notice to enrollees, in a culturally and linguistically appropriate manner. Please review the KY DOI Bulletin 2011-08 for the specific requirements for inclusion in the policy as appropriate.				

Determination Notices	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	DETERMINATION NOTICES
Initial Notice of Adverse Benefit Determination – POLICY – The policy for the initial notice of adverse benefit determinations must include the following items: a) The date of the review decision (806 KAR 17:280 Section 7(2)(b) & Section 4(1)(f)); b) The date of service in question; c) A statement of the specific medical or scientific reasons for denial or reduction of payment (KRS 304.17A-607(1)(j)2 & KRS 304.17A-617(2)(e)1); d) The state of licensure, medical license number, & title of the reviewer making decision (KRS 304.17A-607(1)(j)2 & KRS 304.17A-617(2)(e)2); e) Except for retrospective reviews, a description of alternative benefits, services or supplies that the plan covers, or instructions on contact information for any alternative benefits that may be available (KRS 304.17A-607(1)(j)3 & KRS 304.17A-617(2)(e)3); f) Instructions for the internal appeals process (including the availability of expedited internal appeal), including whether it must be in writing, any specific filing procedures, any applicable timeframes or schedules, & the position & phone number of a contact person who can give additional information (KRS 304.17A-607(1)(j)4); g) Information concerning the right of the covered person, authorized person, or provider to request that a board-certified or eligible physician in the appropriate specialty or subspecialty conduct the appeal (KRS 304.17A-617(2)(c) & 806 KAR 17:280 Section 4(1)(f)2b(ii)); h) Information concerning the availability of the external review process following appeal (KRS 304.17A-617(2)(e)4); and i) Any Adverse Determination Letter issued on behalf of a Managed Care Plan must be signed by a KY-licensed Medical Director (electronic signature can be used) (KRS 304.17A-545).	☐ (a) ☐ (b) ☐ (c) ☐ (d) ☐ (e) ☐ (f) ☐ (g) ☐ (h) ☐ (i)			
Initial Notice of Coverage (Administrative) Denial – POLICY – The policy for the initial notice of coverage denials must include the following items: a) The date of the review decision (806 KAR 17:280 Section 7(2)(b) and Section 4(1)(f)); b) The date of service in question; c) Identification of the schedule of benefits provision or exclusion that demonstrates that coverage is not available (KRS 304.17A-617(1) & (2)(e)1); d) The title of the person making the decision (KRS 304.17A-617(2)(e)2); e) Except for retrospective reviews, a description of alternative benefits, services or supplies that the plan covers, or instructions on contact information for any alternative benefits that may be available (KRS 304.17A-617(2)(e)3); f) Instructions for the internal appeals process (including the availability of expedited internal appeal), including whether it must be in writing, any specific filing procedures, any applicable timeframes or schedules, & the position & phone number of a contact person who can give additional information (KRS 304.17A-607(1)(j)4); and g) Information regarding the availability of a review by the Kentucky Department of Insurance of a coverage denial that is upheld on internal appeal (806 KAR 17:280 Section 4(1)(f)2c(i))	☐ (a) ☐ (b) ☐ (c) ☐ (d) ☐ (e) ☐ (f) ☐ (g)			

Internal Appeals	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	INTERNAL APPEALS
Internal Appeals Process – Every insurer or its designee is required to have an internal appeals process (KRS 304.17A-617 & KRS 304.17A-619)	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Internal Appeal Definitions – The following definitions should be included in the internal appeals policy & procedure: a. Adverse Determination – a determination by the insurer/PRA that the health care services furnished or proposed to be furnished are not medically necessary, as determined by the insurer/PRA, or are experimental or investigational, as determined by the insurer/PRA (KRS 304.17A-600(1)). b. "Adverse Benefit Determination" – means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the following: (KRS 304.17A-600(1)(a) & KY DOI Bulletin 2011-08) 1. A determination of a participant's or beneficiary's eligibility to participate in a plan, & including, with respect to health benefit plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; 2. A determination that a benefit is experimental, investigational, or not medically necessary or appropriate; 3. A determination of an individual's eligibility to participate in a plan or health insurance coverage; 4. A determination that a benefit is not a covered benefit; 5. The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; c. Coverage denial – an insurer/PRA's determination that a services, treatment, drug or device is specifically limited or excluded under the health benefit plan (KRS 304.17A-617(1))				
Initiation of Internal Appeals – Internal appeals can be initiated by the covered person, authorized person, or a provider acting on behalf of the covered person (NOTE: Insurers & PRAs should not require the provider to haven written permission from the covered person to file an internal appeal on his/her behalf). (KRS 304.17A-617(2))	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Case Involves Medical or Surgical Specialty or Sub-specialty – A covered person, authorized person or provider can request that a board eligible or certified physician in the appropriate specialty or subspecialty area conduct the internal appeal. (KRS 304.17A-617(2)(c))	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Licensed Physician Requirement – An internal appeal of an adverse determination shall only be conducted by licensed physician whom did not participate in the initial review and denial.(KRS 304.17A-617(2)(c))	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Appeal Request Timeframe – An insurer/PRA is required to allow a minimum of 60 days from the covered person's receipt of the initial denial letter in which to file a request for an internal appeal. (KRS 304.17A-617, KRS 304.17A-619 and 806 KAR 17:280 Sections 7 & 8)	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			

Internal Appeals	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	INTERNAL APPEALS
Appeal Decision Timeframes – The appeals policy and procedure should contain the following timeframes: **(a) Standard:** Decision provided within 30 days of receipt of request (KRS 304.17A-617(2)(a) & KY DOI Bulletin 2011-08) **(b) Expedited:** Decision provided within 72 hours of receipt of request (KRS 304.17A-617(2)(b) & KY DOI Bulletin 2011-08)	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Expedited Internal Appeals – An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard timeframe could, in the absence of immediate medical attention, result in any of the following: (KRS 304.17A-617(2)(b)) (a) Place the health of the covered person (or with respect to a pregnant woman, the health of the covered person or the unborn child) in jeopardy; (b) Serious impairment to bodily functions; (c) Serious dysfunction of bodily organ or part; or (d) 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. (KY DOI Bulletin 2011-08)	**URAC** ☐ **NCQA** ☐ **AAAHC** ☐			
Notice Failure – The insurer's failure to make a determination or provide a written notice within the internal appeals timeframes provided shall be deemed to be an adverse benefit determination for the purpose of initiating an external review. (KRS 304.17A-619(2))				

FEDERAL PREEMPTION RE: APPEALS (BULLETIN 2011-08)	Complaint	Binder Tab Location	IDENTIFY POLICY WHICH COMPLIES	FEDERAL PREEMPTION RE: APPEALS
Continued Coverage – The insurer is required to provide continued coverage pending the outcome of an internal appeal, and is prohibited from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review.				
Urgent Care Expedited External Review – Individuals in urgent care situations and individuals receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process.				
Urgent Care Appeal Timeframe – A "claim involving urgent care" is subject to the internal claims & appeal processes. Urgent care appeals may also be referred to an "expedited appeal" as referenced in KRS 304.17A-617. A plan or issuer shall notify the claimant of any adverse benefit determination with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but no later than **72 hours** after the receipt of the claim, provided that the plan defers to the attending provider with respect to the decision as to whether a claim constitutes "urgent care". The 72-hour timeframe is only an outside limit and, in cases where a decision must be made more quickly based on the medical exigencies involved, the requirement remains that the decision should be made sooner than 72 hours after receipt of the claim.				

FEDERAL PREEMPTION RE: APPEALS (BULLETIN 2011-08)	Complaint	Binder Tab Location	IDENTIFY POLICY WHICH COMPLIES
Appeal Levels – ***Individual*** health insurance benefit plan coverage may have only **one level** of internal appeals. ***Group*** health benefit plan coverage may provide more than one level of internal appeals, but the process for multiple levels shall not take more than 60 days from the date of initial appeal by the member to issuance of the final adverse benefit determination. No additional requests from the covered person or provider for second or third levels should be required (the process should be seamless to the covered person).			
Appeals Deemed Exhausted – The internal claims and appeals process will not be deemed exhausted based on de minimus violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the insurer demonstrates that the violation was for good cause or due to matters beyond the control of the insurer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. • The de minimus exception is not available if the violation is part of a pattern or practice of violations by the insurers; • The claimant may request a written explanation of the violation from the insurer, and the insurer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted; • If an external reviewer or a court rejects the claimant's request for immediate review on the basis that the plan met the standards for the exception, the claimant has the right to resubmit and pursue the internal appeal of the claim; • If an external reviewer or court rejects the claim for immediate review, the insurer shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim; and • Time periods for re-filing the claim shall begin to run upon claimant's receipt of notice of the rejection of immediate review.			
Full & Fair Reviews – To clarify the requirements for a full and fair review, the Department emphasizes that an insurer's claims and appeals procedures must: • Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination; • Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; • Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and • Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.			
Appeal Record Requirements – Insurers and PRA conducting internal appeals are required to maintain written records to document all internal appeals received during a calendar year, including 1) the reason for the internal appeal; 2) the date the appeal request was received; 3) the date the review was conducted; 4) the date of the decision; 5) the internal appeal decision; & 6) the name, title, license number, state of licensure, certification of specialty of the person making the internal appeal decision. Records must be kept for five subsequent years. (806 KAR 17:280 Section 7 & 806 KAR 2:070 Section 1)			

FEDERAL PREEMPTION RE: APPEALS

REVIEW OF COVERAGE DENIALS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	COVERAGE DENIALS
Coverage Denial Review Request – On receipt of a written request for review of a coverage denial from a covered person authorized person, or provider, the Department shall notify the insurer or its designee, which issued the denial of the request for review and shall call for the insurer or its designee to response. Within 10 business days of receiving the notice, the insurer or its designee is required to provide the following: (KRS 304.17A-617(3)(a through c)) (a) Confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person under a health benefit plan issued by the insurer on the date the service was sought or denied. (b) Confirmation that all rights were exhausted under the internal appeal process. (c) The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available. (d) Any requested information from insurer that is germane to DOI's review.				
External Review Option – If the KY DOI determines that treatment, procedure, drug or device is not specifically limited or excluded, or if the determination requires resolution of a medical issue, the insurer is directed to either cover the service or afford the covered person access to external review (KRS 304.17A-617(3)(d))				
KY DOI Decision – If the KY DOI determines that treatment, procedure, drug or device is specifically limited or excluded, the insurer is not required to cover the service or afford the covered person an external review (KRS 304.17A-617(3)(d))				

DEPARTMENT REQUIREMENTS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	DEPARTMENT REQUIREMENTS
Company Demographic Changes – An insurer or PRA is required to submit company name or address changes to the KY DOI within 30 days of the change. (KRS 304.2-120(4))				
UR Policy & Procedure Changes – An insurer/PRA is required to submit a copy of any changes to UR policies & procedures to the KY DOI prior to implementing the change. No changes to policies & procedures shall be effective or used until after the change has been filed with and approved by the KY DOI. (KRS 304.17A-607(3))				
UR Client List – All insurers/PRA must provide the Department with a client list as part of the application and submit updates to that client list within 30 days of any change. (KRS 304.17A-607(4) and KRS 304.17A-609)				
Changes Filing Fee – The changes must be accompanied by a $50 filing fee, made payable to the Kentucky State Treasurer (806 KAR 17:280 Section 3)				
Cessation of Operations – Insurers/PRAs are required to submit to the KY DOI written notice of the intent to cease operations in the state, 30 days prior to the planned date or as soon as practicable. The plan is subject to the KY DOI's approval prior to implementation. The notice must include: 1) A written action plan for cessation of operations, 2) The proposed date of cessation, 3) The number of pending UR reviews with corresponding assignment dates, & 4) any required annual reports must be submitted within 30 days of ceasing operations (806 KAR 17:280 Section 11)				
Utilization Review Annual Report – Insurers/PRAs must submit the Utilization Review Annual Report, HIPMC-UR-2 by March 31st of each year for the preceding year regardless of whether reviews were completed during the reporting year or not. (806 KAR 17:280, Section 9)				
Medical Director Report Form – An insurer/PRA shall submit the information specified on form HIPMC-MD-1, as well as a biographical resume of the Medical Director & Alternative Medical Director. This format shall be used to report information initially and to report any subsequent change in the information within thirty (30) days of the change. **This form should also be submitted with the application and any future renewal applications.** (806 KAR 17:230 Section 3)				
Complaints – If the KY DOI receives a complaint against an insurer/PRA, a copy of the complaint will be forwarded to the insurer/PRA within 10 days of receipt. A written response from the insurer/PRA is due within 10 days of receipt of the complaint. If a corrective action plan is required, the insurer/PRA is required to notify the KY DOI UR Branch within 30 days of its implementation. (KRS 304.17A-613(8) & (9) and 806 KAR 17:280 Section 6))				

EXTERNAL REVIEWS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	EXTERNAL REVIEWS
External Review Process – Pursuant to the Affordable Care Act, all SELF-FUNDED plans must have something in writing verifying an external review process once the appeal process has been exhausted.				

ADVERSE BENEFIT DETERMINATION LETTER TEMPLATE REQUIREMENTS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	LETTER TEMPLATE REQUIREMENTS
Adverse Benefit Determination – Medical Necessity Letters – The following items must be included within the Adverse Benefit Determination letters pursuant to KRS 304.17A-607(1)(j), KRS 304.17A-617(2)(e), KRS 304.17A-545(1), 806 KAR 17:280 Section 4(1)(f), 806 KAR 17:280 Section 7(2)(b), & 806 KAR 17:230(4) & (5))				
a) The date of the review decision (806 KAR 17:280 Section 7(2)(b) & 806 KAR 17:280 Section 4(1)(f))				
b) The date of service in question				
c) A statement of the specific medical or scientific reasons for denial or reduction of payment (KRS 304.17A-607(1)(j)1 & KRS 304.17A-617(2)(e)1)				
d) The state of licensure, license number, and title of the reviewer making the decision (KRS 304.17A-607(1)(j)2 & KRS 304.17A-617(2)(e)3)				
e) Except for retrospective reviews, a description of alternative benefits, services, or supplies the plan covers, if any (KRS 304.17A-607(1)(j)3 & KRS 304.17A-617(2)(e)3)				
f) Instructions for the internal appeals process (including the availability of expedited internal appeal), including whether it must be in writing, any specific filing procedures, any applicable timeframes or schedules, and the position and phone number of a contact who can give additional information (KRS 304.17A-607(1)(j)4)				
g) Information concerning the right of the covered person, authorized person, or provider to request that a board-certified or eligible physician in the appropriate specialty or subspecialty conduct the appeal (KRS 304.17A-617(2)(c) & 806 KAR 17:280 Section 4(1)(f)2b(ii))				
h) Information concerning the availability of the external review process following appeal, including $25 filing fee (KRS 304.17A-617(2)(e)(4))				
i) Any adverse determination letter issued on behalf of a Managed Care Plan(HMO) must be signed by a KY-licensed medical director (electronic signature can be used) (KRS 304.17A-545)				

COVERAGE DENIAL LETTER TEMPLATE REQUIREMENTS	Compliant	BINDER TAB LOCATION	IDENTIFY POLICY WHICH COMPLIES	LETTER TEMPLATE REQUIREMENTS
Adverse Benefit Determination – Coverage Denial Letters – The following items must be included within the Adverse Benefit Determination letters relating to a coverage denial pursuant to KRS 304.17A-607(1)(j), KRS 304.17A-617(2)(e), KRS 304.17A-545(1), 806 KAR 17:280 Section 4(1)(f), 806 KAR 17:280 Section 7(2)(b), & 806 KAR 17:230(4) & (5))				
a) The date of the review decision (806 KAR 17:280 Section 7(2)(b) & 806 KAR 17:280 Section 4(1)(f))				
b) The date of service in question				
c) A statement of the specific medical or scientific reasons for denial or reduction of payment (KRS 304.17A-607(1)(j)1 & KRS 304.17A-617(2)(e)1)				
d) The state of licensure, license number, and title of the reviewer making the decision (KRS 304.17A-607(1)(j)2 & KRS 304.17A-617(2)(e)3)				
e) Except for retrospective reviews, a description of alternative benefits, services, or supplies the plan covers, if any (KRS 304.17A-607(1)(j)3 & KRS 304.17A-617(2)(e)3)				
f) Instructions for filing a request for review by KY DOI, including that the request must be in writing and must include a copy of all denial letters. The letter should contain KY DOI's address (806 KAR 17:280 Section 4(1)(f)2c(i))				
g) The position and phone number of contact person who can provide information about a coverage denial.				
h) Any adverse determination letter issued on behalf of a Managed Care Plan(HMO) must be signed by a KY-licensed medical director (electronic signature can be used) (KRS 304.17A-545)				