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| Utilization Management Program: State of Kentucky Utilization Review Policy & Procedure | |  |
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**POLICY:** Innovative Medical Risk Management, Inc. dba Payer Compass shall comply with state regulations where they differ from existing procedures when such state regulations are applicable to the review being conducted. The requirements and timeframes indicated in this policy shall apply to all services completed for Kentucky members and supersedes other Payer Compass Utilization Review Policy & Procedures.

**PURPOSE/GOALS:** To define specific exceptions to Payer Compass Utilization Review Policy & Procedures to comply with State of Kentucky regulations.

**DEFINITIONS** *(\*URAC Definitions)***:**

**Adverse Determination:** a determination by an insurer or its agent that the health care services furnished or furnished or proposed to be furnished are not medically necessary, as determined by the insurer or its agent, or are experimental or investigational, as determined by the insurer or its agent.

**Adverse benefit determination:** a denial or reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on:

* A determination of a participant’s or beneficiary’s eligibility to participate in a plan, and 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;
* A determination that a benefit is experimental, investigational, or not medically necessary or appropriate;
* A determination of an individual’s eligibility to participate in a plan or health insurance coverage;
* A determination that a benefit is not a covered benefit.

**Coverage Denial:** an insurer’s determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person’s health benefit plan.

**External Review:** a review that is conducted by an independent review entity which meets specified criteria as established by the State of Kentucky Department of Insurance.

**Internal Appeals Process:** a formal process, as set forth by the State of Kentucky, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent.

**Private Review Agent:** means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth. “Private Review Agent” does not include an independent review entity which performs external review of adverse determinations.

**KENTUCKY UTILIZATION REVIEW TIMEFRAMES**

Pre-Authorization Timeframe-Urgent:

* Timeframe is 24 hours of receipt of all necessary information. All necessary information is limited to:
* The results of any face-to-face clinical evaluations;
* Any second opinion that may be required;
* Any other information determined by the department to be necessary to making a utilization review determination.

Pre-Authorization Timeframe-Non-Urgent:

* Timeframe is 5 days of obtaining all necessary information to make the utilization review decision. All necessary information is limited to:
* The results of any face-to-face clinical evaluation;
* Any second opinion that may be required;
* Any other information determined by the department to be necessary to making a utilization review determination.

Retrospective Review:

* Timeframe is 5 days of obtaining all necessary information to make the utilization review decision. All necessary information is limited to:
* The results of any face-to-face clinical evaluation;
* Any second opinion that may be required;
* Any other information determined by the department to be necessary to making a utilization review determination

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). This would include any authorized services due to failure to comply with the timeframes stated above.

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 the receipt of the request, and prior to the time when the previous authorization will expire.

Preadmission/Outpatient Surgery Designation:

* All preadmission reviews of hospital admissions and any preauthorization for outpatient surgery must be treated as urgent care requests.

Determination Timeframe Failure:

* Failure to make a determination and provide written notice within the timeframes 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.

### The following outlines the utilization review policy & procedure for Kentucky:

1. All Payer Compass Utilization Review Policies & Procedures shall be followed unless otherwise noted in this policy regarding the State of Kentucky exceptions to Payer Compass processes. URAC timeframes will be adhered to if the State of Kentucky timeframes exceed URAC timeframes. Kentucky is not preempted by URAC, NCQA, or AAHC standards.
   1. A request for a review after the member has been admitted (and remains inpatient) will be considered a concurrent review.
   2. All preadmissions review of hospital admissions and any preauthorization for outpatient surgery must be treated as urgent requests.
2. The provider will be promptly notified of the determination.
3. Payer Compass Utilization Review shall not deny or reduce payment for a service, treatment, drug, or device covered under the person’s health plan if:
   * 1. During normal business hours, provider contacts Payer Compass Utilization Review 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
     2. Provider makes three (3) documented attempts in four (4) consecutive hour periods during normal business hours to contact Payer Compass Utilization Review for review of a continued hospital stay, for preauthorization 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 Payer Compass Utilization Review is not accessible.
4. Payer Compass Utilization Review shall continue the authorization applicable to item #3b until the UR decision is completed. However, this does not include situations where the provider failed to furnish the requested information to make the UR decision.
5. Only licensed physicians may make a decision to deny, reduce, limit, or terminate a health care benefit or to deny or reduce payment for a health care service because that service is not medically necessary, or is experimental/investigational, except in the case of services rendered by an optometrist or a chiropractor. All physician reviews for optometry and chiropractic services will be done utilizing Kentucky licensed optometrist and chiropractors.
6. Payer Compass Utilization Review will notify the claimant of any adverse benefit determinations with respect to a claim involving urgent care as soon as possible, taking into account the medical emergencies, but no later than 72 hours after the receipt of the claim by the plan or issuer, provided that the plan issuer 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. In cases where a decision must be made more quickly based on the medical emergencies involved, the requirement remains that the decision should be made sooner than 72 hours after receipt of the claim.
7. The denial (and appeal upheld) letter for medical necessity including experimental/investigational includes the following information:
   1. The date of the review decision
   2. The date of service in question
   3. A statement of the specific medical and scientific reasons for denying coverage or reduction of payment or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available
   4. The name, title, the state of licensure, license number, and certification of specialty of the person making the decision
   5. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any and
   6. Instructions for initiating or complying with the insurer’s internal appeal procedure (including the availability of an expedited internal appeal), stating, at a minimum, whether the appeal shall be in writing, and any specific filing procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information
   7. 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
   8. Information concerning the availability of the external review process following internal appeals
8. Signature of the Medical Director
9. Culturally linguistic language
10. The denial letter for coverage denials due to the benefit is limited or excluded must include the following:
    * 1. The date of the review decision
      2. The date of service in question
      3. Identification of the schedule of benefits provision or exclusion that demonstrates that coverage is not available
      4. The name, title, the state of licensure, license number, and certification of specialty of the person making the decision
      5. Except for retrospective review, a description of alternative benefits, services, or supplies that the plan covers, if any
      6. Instructions for filing a request for review by Department of Insurance (DOI), including that the request must be in writing and must include a copy of all denial letters. The letter should contain DOI’s address.
      7. The position and phone number of contact person who can provide information about a coverage denial.
      8. Culturally linguistic language
11. The failure to make a determination and provide written notice within the timeframes set forth shall be deemed to be an adverse determination by the insurer for the purposes of initiating an internal appeal. This 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.
12. Payer Compass Utilization Review will not retrospectively deny coverage for a health care service provided to a covered person when approval has been obtained previously for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or the provider.
13. Once an expedited appeal is upheld, the next step should be access to external review. A standard appeal can be offered. All levels of appeals much be completed within 60 days of receipt of the original request. 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.
14. An insurer is required to provide continued coverage pending the outcome of an internal appeal. An insurer is prohibited from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review.
15. If Payer Compass Utilization Review fails to adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the claimant may initiate an external review or pursue any available remedies under state law on the basis that the provider or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.
16. The internal claims and appeals process will not be deemed exhausted based on de minimus (trivial) 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.
    * 1. The de minimus exception is not available if the violation is part of a pattern or practice of violations by the insurers;
      2. 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;
      3. 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 appeals of the claim;
      4. If an eternal 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
      5. Time periods for re-filing the claim shall begin to run upon claimant’s receipt of notice of the rejection of immediate review.
17. Full and Fair Review
    1. Payer Compass Utilization Review will provide:
       1. At least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
       2. The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
       3. 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
       4. 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 submitted by the claimant relating to the claim, without regard to whether such information, was submitted or considered in the initial benefit determination.
    2. Payer Compass will provide the claimant, free of charge:
       * 1. Any new or additional evidence considered, relied upon, or generated by the insurer in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give a reasonable opportunity to respond prior to that date; and
         2. Before the insurer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.
18. If Payer Compass Utilization Review receives a request from the State of Kentucky DOI for a request for review of a coverage denial Payer Compass Utilization Review will, within ten (10) business days of the request, provide to the department the following:
    * 1. 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 services was sought or denied;
      2. Confirmation as to whether the covered person, authorized person, or provider has exhausted all his or her rights under the insurer’s appeal process under this section; and
      3. The reasons for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available;
      4. Any information requested by the department that is germane to its review.
19. If 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 assess to external review.
20. If 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.
21. Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for an internal appeal.
22. Appeal notification must include instructions for initiating an external review of an adverse determination or filing a request for review with the department if a coverage denial is upheld by the insurer on internal appeal.
23. If an initial determination is made by Payer Compass Medical Director or IRO not to authorize or certify a health care service, and the provider believes the determination warrants an immediate reconsideration, Payer Compass Utilization Review may provide the provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis within a period of time not to exceed 24 hours of the healthcare provider seeking the reconsideration.
24. Payer Compass Utilization Review will continue to certify services pending the outcome of an internal appeal. Payer Compass Utilization Review will not reduce or terminate ongoing course of treatment without providing advance notice and an opportunity for advance review.
25. Payer Compass Utilization Review will maintain written records (for five subsequent years) to document all internal appeals received during a calendar year, including the following:
    * 1. The reason for the internal appeal
      2. The date the appeal request was received
      3. The date the appeal 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
26. Payer Compass Utilization Review will facilitate an external review in those situations relating to a denial issued by Payer Compass Medical Director or IRO.
27. 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 in the following situations:
    1. Urgent care situations:
       1. If in the opinion of the treating provider, review under the standard timeframe could, in the absence of immediate medical attention, result in any of the following:
       2. Placing the health of the covered person (or with respect to a pregnant woman, the health of the covered person and her unborn child) in serious jeopardy;
       3. Serious impairment of bodily functions; or
       4. Serious dysfunction of a bodily organ or part
    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 certified in writing that the recommended or requested service that is the subject of the review would be significantly less effective if not promptly initiated.
28. An external review is available for the following:
    * 1. Payer Compass Medical Director or IRO has rendered an adverse determination.
      2. The covered person has completed the Payer Compass Utilization Review internal appeals process or Payer Compass has failed to make a timely determination or notification, or Payer Compass Utilization Review and the covered person jointly agree to waive the internal appeal requirement.
      3. The covered person was enrolled in the health benefit plan on the date of services or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the benefit plan on the date the proposed services was requested.
      4. The entire course of treatment or service will cost the covered person at least one hundred dollars ($100) if the covered person had no insurance.
29. The external review request must be submitted within four (4) months of the receipt of the final internal appeal notice.
30. The external appeal review request may be made by the covered person, authorized person, or a provider acting on behalf of and with consent of the covered person.
31. The covered person shall not be afforded an external review if the subject of the adverse determination has previously gone through the external review process and the Independent Review Entity (IRE) found in favor of the insurer unless relevant new clinical information has been submitted.
32. The IRE will assess the covered person a one-time filing fee of $25; the fee will be waived or refunded if the decision is in favor of the covered person. (The fee can be waived if the IRE determines that it creates a financial hardship on the covered person.) A $75 annual limit applies for each covered person for a single plan year.
33. The covered person is required to provide the insurer with written consent authorizing the IRE to obtain all medical records for review purposes, from both the insurer and any provider in order to move forward with the External Review.
34. The timeframes for External Review are:
    * 1. Expedited:
         1. 24 hours from the Independent Review Entity (IRE) receipt of all information required from Payer Compass.
         2. A time extension of 24 hours is available if Payer Compass and the covered person agree in advance. In no event shall the time period exceed 72 hours from receipt of the request.
      2. Non-expedited:
         1. 21 calendar days from the IRE’s receipt of all information required from Payer Compass.
         2. A time extension of 14 calendar days is available if Payer Compass Utilization Review and the covered person agree in advance. In no event shall the time period exceed 45 days from receipt of the request.
35. A request for an expedited external review must be allowed to be filed orally, followed up by an abbreviated written request.
36. If a request for an external review is denied, the person requesting the external review must be provided with written notification that includes the following:
    * 1. The date the request for the external review was received
      2. A statement relating to the subject of the service denied
      3. The rationale for denying the request
      4. A statement relating to the availability of a review by Kentucky Department of Insurance (DOI) if a dispute arises regarding the right to the external review
      5. The toll-free number of Kentucky DOI (800-595-6053)
      6. Name and phone number of a contact person who can provide additional information about the denial of the request
37. Once Payer Compass Utilization Review confirms the covered person is eligible, they will contact DOI via eServices for assignment of an IRE on a rotational cycle. Payer Compass Utilization Review shall call the IRE to confirm there is no Conflict of Interest with the assigned IRE. If a conflict of interest exists, Payer Compass will repeat the eServices process until No Conflict of Interest exists.
38. Payer Compass Utilization Review will provide the following to the IRE:
    * 1. The covered person’s medical records
      2. The standards, criteria, and clinical rationale used by the insurer to make its decision
      3. The insurer’s health benefit plan
      4. A copy of the signed medical release form and
      5. A copy of the HIPME-IRE-6, [External Review Information Face Sheet](https://insurance.ky.gov/PPC/Documents/HIPMC_IRE6_120908.pdf).
39. The insurer is responsible for the cost of the external review and is required to pay IRE within 30 days of receipt of the statement.
    * 1. Payer Compass Utilization Review will pass the invoice to the insurer for payment.
      2. The cost cannot exceed $800 unless the IRE submits justification for a higher fee to the DOI prior to billing the insurer. Any IRE statements that exceed the cap without any evidence that DOI has approved the amount should be reported to the Health Division. (HIPMC-UR-5) on the [Assignment of Independent Review Entity](https://insurance.ky.gov/ppc/documents/HIPMC-IRE%202%20%2001112021.pdf) form.
40. For Expedited External reviews, Payer Compass Utilization Review will:
    * 1. Contact the IRE by phone within 24 hours to request acceptance of the case and notify the covered person that the case is assigned.
      2. Deliver the IRE all information required to be considered within 24 hours of assignment.
      3. Send the [Assignment of Independent Review Entity](https://insurance.ky.gov/ppc/documents/HIPMC-IRE%202%20%2001112021.pdf) form (HIPMC-IRE-2(07/08) to the DOI within one (1) business day.
41. For Non-Expedited External Reviews, Payer Compass Utilization Review will:
    * 1. Within five (5) business days of receipt of request make a determination about whether the request is warranted and contact the chosen IRE by phone to request acceptance of the case.
      2. Notify the person requesting the review of the assignment to the IRE and inform them in writing they have five (5) business days from receipt of the notice to send additional information to the assigned IRE.
      3. Within three (3) business days of assignment, forward all information to the IRE to be considered.
      4. Send the [Assignment of Independent Review Entity](https://insurance.ky.gov/ppc/documents/HIPMC-IRE%202%20%2001112021.pdf) form (HIPMC-IRE-2(07/08) to the DOI within one (1) business day.
42. Payer Compass Utilization Review will maintain a record of each external review requested.
43. The decision from the external review shall be binding by the Plan. Within 30 days of the decision in favor of the covered person, Payer Compass Utilization Review shall provide written notification to the department that the decision has been implemented in accordance with the results of the external review. (If the covered person has disenrolled, the insurer is only required to provide the treatment, procedure, drug, or device for a period not to exceed 30 days.)
44. Payer Compass will submit a copy of any changes to its utilization review program to the Kentucky Department of Insurance. No change to policies and procedures shall be effective or used until after it has been filed with and approved by the commissioner. A $50 filing fee (payable to the Kentucky State Treasurer) will accompany the notification. Changes of which the Kentucky Department of Insurance should be notified include the following:
    * 1. Policies or procedures
      2. Client listing
      3. Change in Medical Directors
45. Payer Compass Utilization Review will ensure compliance with reporting requirements set forth by the State of Kentucky.
46. Payer Compass Utilization Review will respond in writing to complaints from the State of Kentucky within ten (10) days of receipt of the complaint. If a corrective action plan is required, Payer Compass will notify the Health Division within 30 days of its implementation.
47. Payer Compass Utilization Review will submit to the 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 notice must include:
    * 1. A written action plan for cessation of operations. The plan is subject to DOI approval prior to implementation.
      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 operation.

46) Payer Compass Utilization Review will submit company name or address changes to the KY DOI within 30 days of the change.

**References:** State of Kentucky Standards for utilization Review: <http://www.lrc.ky.gov/kar/906/001/080.htm>

## State of Kentucky Revised Statutes: KRS Chapter 304.17A

<http://www.lrc.ky.gov/Statutes/chapter.aspx?id=38715>

External Review Information Face Sheet: <http://insurance.ky.gov/Documents/HIPMC_IRE6_120908.pdf>

Assignment of Independent Review Entity Form (HIPMC-IRE-2 (07/08): <http://insurance.ky.gov/Documents/HIPMC_IRE2_120908.pdf>

Approval of an External Review Fee in Excess of $800: <http://insurance.ky.gov/Documents/HIPMC_IRE5_120908.pdf>