304.17A-540 Disclosure of limitations on coverage -- Denial letter.

(1) Any insurer that limits coverage for any treatment, procedure, a drug, or device shall define the limitations and fully disclose those limits in the health insurance policy or certificate coverage.

(2) (a) Any insurer that denies coverage for a treatment, procedure, a drug that requires prior approval, or device for an enrollee shall provide the enrollee with a denial letter that shall include:

1. The name, license number, state of licensure, and title of the person making the decision;
2. A statement setting forth the specific medical and scientific reasons for denying coverage of a service, if the coverage is denied for reasons of medical necessity; and
3. Instructions for initiating or complying with the plan's grievance or appeal procedure stating at a minimum whether the appeal must be in writing, any time limitations or schedules for filing appeals and the name and phone number of a contact person who can provide additional information.

(b) The denial letter shall be provided within:

1. Two (2) regular working days of the submitted request where preauthorization for a treatment, procedure, drug, or device is involved;
2. Twenty-four (24) hours of the submitted request where hospital preadmission review is sought;
3. Twenty (20) working days of the receipt of requested medical information where the plan has initiated a retrospective review; and
4. Twenty (20) working days of the initiation of the review process in all other instances.

Effective: July 14, 2000

History: Amended 2000 Ky. Acts ch. 500, sec. 6, effective July 14, 2000. -- Created 1998 Ky. Acts ch. 496, sec. 33, effective April 10, 1998.