304.17A-617 Internal appeals process -- Procedures -- Review of coverage denials.

(1) Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer shall disclose the availability of the internal process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements set forth in KRS 304.17A-607(1)(j). For purposes of this section, "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan. 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 internal appeal.

(2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person. The internal appeals process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse determinations made under utilization review and of coverage denials, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review. At a minimum, these procedures shall include the following:

(a) Insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal;

(b) Insurers or their designees shall render a decision not later than three (3) business days after receipt of the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part;

(c) Internal appeal of an adverse determination shall only be conducted by a licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(d) Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law,

shall be considered and providers given the opportunity to present additional information; and

(e) In addition to any previous notice required under KRS 304.17A-607(1)(j), and to facilitate expeditious handling of a request for external review of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for a covered person shall provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that shall include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
2. The state of licensure, medical license number, and the title of the person making the decision;
3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
4. 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.

(3) The department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers. For purposes of this subsection, "coverage denials" shall not include an adverse determination as defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

(a) 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 which issued the denial of the request for review and shall call for the insurer to respond to the department regarding the request for review within ten (10) business days of receipt of notice to the insurer.

(b) Within ten (10) business days of receiving the notice of the request for review from the department, the insurer shall provide to the department the following information:

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 service was sought or denied;
2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process under this section; and
3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available.

(c) In addition to the information described in paragraph (b) of this subsection, the insurer and the covered person, authorized person, or provider shall provide to the department any information requested by the department that is germane to its review.

(d) On the receipt of the information described in paragraphs (b) and (c) of this subsection, unless the department is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's health benefit plan. If the department determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review under KRS 304.17A-621, 304.17A-623, and 304.17A-625, where the conditions precedent to the review are present. If the department notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review.

(e) An insurer shall be required to cover the treatment, service, drug, or device that was denied or provide notification of the right to external review in accordance with paragraph (d) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer.

(f) If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed thirty (30) days, or provide the covered person the opportunity for external review.

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