806 KAR 17:280. Registration, utilization review, and internal appeal.

RELATES TO: KRS 304.2-140, 304.17-412, 304.17A-600 - 304.17A-619, 304.17A-623, 304.17C-010, 304.17C-030, 304.18-045, 304.32-147, 304.32-330, 304.38-225

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-609, 304.17A-613

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the executive director to promulgate reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.17A-609 requires the office to promulgate administrative regulations regarding utilization review and internal appeal. KRS 304.17A-613 requires the office to promulgate administrative regulations to develop a process for the registration of insurers or private review agents. EO 2008-507, effective June 16, 2008, established the Department of Insurance and the Commissioner of Insurance as head of the department. This administrative regulation establishes requirements for the registration of insurers or private review agents, and the utilization review process, including internal appeal of decisions.

Section 1. Definitions.

(1) "Adverse determination" is defined in KRS 304.17A-600(1).

(2) "Authorized person" is defined in KRS 304.17A-600(2).

(3) "Board" means one (1) of the following governing bodies:

(a) The American Board of Medical Specialties;

(b) The American Osteopathic Association; or

(c) The American Board of Podiatric Surgery.

(4) "Coverage denial" is defined in KRS 304.17A-617(1).

(5) "Department" means Department of Insurance.

(6) "Enrollee" is defined in KRS 304.17C-010(2).

(7) "Insurer" is defined in KRS 304.17A-600(8).

(8) "Limited health service benefit plan" is defined in KRS 304.17C-010(5).

(9) "Nationally recognized accreditation organization" is defined in KRS 304.17A-600(10).

(10) "Notice of coverage denial" means a letter, a notice, or an explanation of benefits statement advising of a coverage denial as defined by KRS 304.17A-617(1).

(11) "Policies and procedures" means the documentation which outlines and governs the steps and standards used to carry out functions of a utilization review program.

(12) "Private review agent" is defined in KRS 304.17A-600(11).

(13) "Provider" is defined in KRS 304.17A-600(13).

(14) "Registration" is defined in KRS 304.17A-600(15).

(15) "Utilization review" is defined in KRS 304.17A-600(18).

(16) "Utilization review plan" is defined in KRS 304.17A-600(19).

Section 2. Registration Required.

(1) The department shall issue a registration to an applicant that has met the requirements of KRS 304.17A-600 through 304.17A-619 and 304.17A-623, if applicable, and Sections 2 through 11 of this administrative regulation.

(2) An applicant seeking registration to provide or perform utilization review shall:

(a) Submit an application to the department as required by Section 4 of this administrative regulation; and

(b) Pay an application fee as required by Section 3 of this administrative regulation.

(3) An application shall be accompanied by the required documentation listed in Section 4 of this administrative regulation.

(4) If an insurer or private review agent desires a renewal of registration to perform utilization review, an application for renewal of registration shall be submitted to the

department at least ninety (90) days prior to expiration of the current registration.

Section 3. Fees.

(1) An application for registration shall be accompanied by a fee of $1,000.

(2) A submission of changes to utilization review policies or procedures to the department shall be accompanied by a fee of fifty (50) dollars.

(3) A fee as established in subsection (1) or (2) of this section shall be made payable to the Kentucky State Treasurer.

Section 4. Application Process.

(1) An applicant shall complete and submit to the department an application, HIPMC-UR-1, as incorporated by reference in 806 KAR 17:005, and documentation to support compliance with KRS 304.17A-600 through 304.17A-623, as applicable, including:

(a) A utilization review plan;

(b) The identification of utilization review criteria, including criteria for review of inpatient and outpatient services;

(c) Types and qualifications of personnel, employed directly or under contract, performing utilization review in compliance with KRS 304.17A-607(1)(a), including names, addresses, and telephone numbers of the medical director and contact persons for questions regarding the filing of the application;

(d) A toll-free telephone number to contact the insurer, limited health service benefit plan, or private review agent, as required by KRS 304.17A-607(1)(e) and 304.17A-609(3);

(e) A copy of the policies and procedures required:

1. By KRS 304.17A-609(4); and

2. To ensure availability to conduct utilization review, including the response time to return telephone calls if an answering machine is used, in accordance with KRS 304.17A-607(1)(f);

(f) A copy of the policies and procedures by which:

1. A limited health service benefit plan provides a notice of review decision which complies with KRS 304.17A-607(1)(h) and (j) and includes:

a. Date of the review decision; and

b. Instructions for filing an internal appeal; or

2. An insurer or private review agent provides a notice of review decision, which complies with KRS 304.17A-607(1)(h) and (j) and 806 KAR 17:230, and includes:

a. Date of the review decision;

b. Instructions for filing an internal appeal, including information concerning:

(i) The availability of an expedited internal appeal; and

(ii) For an adverse determination, the right to request that the appeal be conducted by a board eligible or certified physician pursuant to KRS 304.17A-617(2)(c); and

c. Information relating to the availability of:

(i) A review of a coverage denial by the department following completion of the internal appeal process; or

(ii) A review of an adverse determination by an independent review entity following completion of the internal appeal process, in accordance with KRS 304.17A-623;

(g) If a part of the utilization review process is delegated, a description of the:

1. Delegated function;

2. Entity to whom the function was delegated, including name, address, and telephone number; and

3. Monitoring mechanism used by the insurer or private review agent to assure compliance of the delegated entity with paragraph (f) of this subsection;

(h) A sample copy of an electronic or written notice of review decision, which compiles with paragraph (f) of this subsection;

(i) A copy of the policies and procedures by which a covered person, authorized person, or provider may request an appeal of an adverse determination or coverage denial in accordance with KRS 304.17A-617, including:

1. The method by which an appeal may be initiated, including:
   a. An oral request followed by a brief written request, or a written request for an expedited internal appeal;
   b. A written request for a nonexpedited internal appeal; and
   c. If applicable, the completion of a specific form, including a medical records release consent form;
2. Time frames for:
   a. Conducting a review of an initial decision; and
   b. Issuing an internal appeal decision;
3. Procedures for coordination of expedited and nonexpedited appeals;
4. Qualifications of the person conducting internal appeal of the initial decision;
5. Information to be included in the internal appeal determination in accordance with KRS 304.17A-617(2)(e), including the:
   a. Title and, if applicable, the license number, state of licensure, and certification of specialty or subspecialty of the person making the internal appeal determination;
   b. Clear, detailed decision; and
   c. Availability of an expedited external review of an adverse determination;; and
6. A sample copy of the internal appeal determination in compliance with paragraph(i)5 of this subsection; and

(j) A copy of the policies and procedures, which:

1. Address and ensure the confidentiality of medical information in accordance with KRS 304.17A-609(5), 806 KAR 3:210, 806 KAR 3:220, and 806 KAR 3:230;
2. Comply with requirements of KRS 304.17A-615 if the insurer or private review agent fails to:
   a. Provide a timely utilization review decision; or
   b. Be accessible, as determined by verifiable documentation of a provider's attempts to contact the insurer or private review agent, including verification by:
      (i) Electronic transmission records; or
      (ii) Telephone company logs;
3. Comply with requirements of KRS 304.17A-619, regarding the submission of new clinical information prior to the initiation of the external review process;
4. Address and ensure consistent application of review criteria for inpatient and outpatient services in review decisions; and
5. Comply with requirements of KRS 304.17A-607(1)(k), as applicable.

(2) Upon review of an application for registration, or submitted changes to utilization review policies and procedures in accordance with KRS 304.17A-607(3), the department shall:

(a) Inform the applicant if supplemental information is needed;

(b) Identify and request that supplemental information be submitted to the department within thirty (30) days;

(c) If requested information is not provided to the department within the timeline established in paragraph (b) of this subsection:

1. Deny the application for registration or proposed changes to utilization review policies and procedures; and
2. Not refund the application or filing fee; and

(d) Approve or deny registration or proposed changes to utilization review policies and procedures.

(3) In order to be registered to perform utilization review in Kentucky, an applicant which holds accreditation or certification in utilization review by a nationally recognized accreditation organization in accordance with KRS 304.17A-613(10) shall be required to submit with its completed application to the department:

(a) Evidence of current accreditation or certification in utilization review, including an expiration date; and

(b) Documentation to demonstrate compliance with requirements of KRS 304.17A-613(10).

Section 5. Denial or Revocation Hearing Procedure. Upon denial of an application for registration, or suspension or revocation of an existing registration, the department shall:

(1) Give written notice of its action; and

(2) Advise the applicant or registration holder that if dissatisfied, a hearing may be requested and filed in accordance with KRS 304.2-310.

Section 6. Complaints Relating to Utilization Review.

(1) A written complaint regarding utilization review shall be reviewed by the department in accordance with KRS 304.17A-613(8).

(2) Upon receiving a copy of the complaint, an insurer or private review agent shall provide a response in accordance with KRS 304.17A-613(8)(a), including:

(a) Any information relating to the complaint; and

(b) Corrective actions to address the complaint, if applicable, including a timeframe for each action.

(3) Within thirty (30) days of implementation of a corrective action, as identified in subsection (2) of this section, an insurer or private review agent shall notify the department in writing of the implementation of the corrective action.

(4) If an insurer or private review entity fails to comply with this section, the department may impose a penalty in accordance with KRS 304.2-140.

(5) The number, recurrence, and type of complaints, as identified in subsection (1) of this section, shall be considered by the department in reviewing an application for registration pursuant to KRS 304.17A-613(9).

Section 7. Internal Appeals for a Health Benefit Plan. In addition to the requirements of KRS 304.17A-617, and as part of an internal appeals process, an insurer or private review agent shall:

(1) Allow a covered person, authorized person, or provider acting on behalf of a covered person to request an internal appeal at least sixty (60) days following receipt of a denial letter;

(2) Provide written notification of an internal appeal determination decision as required by KRS 304.17A-617(2)(a), (b), and (e), which shall include the:

(a) Title and, if applicable, the license number, state of licensure and specialty or subspecialty certifications of the person performing the review;

(b) Elements required in a letter of denial in accordance with 806 KAR 17:230, Sections 4 and 5, if applicable;

(c) Position and telephone number of a contact person who may provide information relating to the internal appeal; and

(d) Date on which the decision was rendered;

(3) Maintain written records of an internal appeal, including the:

(a) Reason for the internal appeal;

(b) Date that the internal appeal was received by the insurer or private review agent;

(c) Date of the internal appeal decision;

(d) Internal appeal decision; and

(e) Information required by Section 4(1)(i)5 of this administrative regulation; and

(4) Retain a record of an internal appeal decision for five (5) subsequent years in accordance with 806 KAR 2:070.

Section 8. Internal Appeals for a Limited Health Service Benefit Plan.

(1) An insurer offering a limited health service benefit plan shall have an internal appeals process which shall:

(a) Be disclosed to an enrollee in accordance with KRS 304.17C-030(2)(g); and

(b) Include provisions, which:

1. Allow an enrollee, authorized person, or provider acting on behalf of the enrollee to request an internal appeal within at least sixty (60) days of receipt of a notice of adverse determination or coverage denial; and

2. Require the limited health service benefit plan to provide a written internal appeal determination within thirty (30) days following receipt of a request for an internal appeal.

(2) A notice of adverse determination or coverage denial shall include a disclosure of the availability of the internal appeals process.

Section 9. Reporting Requirements. By March 31 of each calendar year, an insurer or private review agent shall complete and submit to the department a HIPMC-UR-2, as incorporated by reference in 806 KAR 17:005, for the previous calendar year.

Section 10. Maintenance of Records. An insurer or private review agent shall maintain documentation to assure compliance with KRS 304.17A-600 through 304.17A-619, 304.18-045, 304.32-147, 304.32-330, 304.38-225, and 304.47-050, including:

(1) Proof of the volume of reviews conducted per the number of review staff broken down by staff answering the phone;

(2) Information relating to the availability of physician consultation;

(3) Information which supports that based on call volume, the insurer or private review agent has sufficient staff to return calls in a timely manner;

(4) Proof of the volume of phone calls received on the toll-free phone number per the number of phone lines;

(5) Telephone call abandonment rate; and

(6) Proof of the response time of insurer or private review agent for returned phone calls to a provider if a message is taken.

Section 11. Cessation of Operations to Perform Utilization Review.

(1) Upon a decision to cease utilization review operations in Kentucky, an insurer or private review agent shall submit the following to the department thirty (30) days or as soon as practicable prior to ceasing operations:

(a) Written notification of the cessation of operations, including the proposed date of cessation and the number of pending utilization review decisions with projected completion dates; and

(b) A written action plan for cessation of operations, which shall be subject to approval by the department prior to implementation.

(2) Annual reports required pursuant to Section 9 of this administrative regulation shall be submitted to the department within thirty (30) calendar days of ceasing operations.

(27 Ky.R. 1698; Am. 2453; eff. 3-19-2001; 29 Ky.R. 1375; 1845; 2099; eff. 2-16-03; 31 Ky.R. 435; 708; eff. 11-5-04; TAm eff. 8-9-2007; 35 Ky.R. 654, eff. 12-5-08; Crt eff. 2-26-2020.)