American Health Data Institute, Inc. (AHDI)

Policies & Procedures addendum (KY)

1.) AHDI will ensure that only licensed physicians:
- make a utilization review 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 or investigational except in the case of services provided by a chiropractor or optometrist, when the denial shall be made by a chiropractor or optometrist licensed in Kentucky, when possible.
- supervise qualified personnel conducting case reviews (KRS 304.17A-607 (1) (b)(1))

2.) AHDI will provide decisions to covered persons, authorized persons, and all providers that are known on appeals of adverse determinations and coverage denials in accordance with KRS 304.17A-607(1)(g) and administrative regulations promulgated in accordance with KRS 307.17A-609 to the extent allowed by the group health benefit plan and applicable Kentucky law.

3.) Definitions:

Medically necessary health care services include those services rendered to prevent, diagnose, or treat an illness, injury, disease, or symptoms that are:
- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in terms of type, frequency, extent, and duration.
- Kentucky Revised Statutes Chapter 304 Subtitle 17A establishes this definition.

AHDI, when determining the medical necessity of services, will utilize the definition of medically necessary health care services provided in KRS 304.17A-005(35) to the extent allowed by the definition found in the group health benefit plan document and applicable Kentucky law.

Urgent Care means health care treatment with respect to which the application of the time periods for making non-urgent (standard/non-expedited appeal or external review) determinations:

(a) would seriously jeopardize the covered person's (I) life or health, or (II) ability to regain maximum function
(b) in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is subject of the utilization review

Urgent Health Care Services include all requests for hospitalization and outpatient surgery (KRS 304.17A-600(16)(b))

Prospective review means a utilization review that is conducted prior to the provision of health care services. "Prospective review" also includes any insurer's or private review agent's (PRA) requirement that a covered person or provider notify the insurer or PRA prior to providing a health care service, including but not limited to prior authorization, step therapy, preadmission review, pretreatment review, utilization, and case management (KRS 304.17A-600(12)

4.) All Necessary Information is limited to the 3 items listed in statute:

- 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 (based on guidance under 806 KAR 17:370 for attachments to a claim)

Utilization review decisions will fall within the following timeframes, with no option for an extension of the timeframes, to the extent allowed under the health care benefit plan and applicable Kentucky law.

- Urgent: 24 hours after obtained all necessary information
- Non-Urgent: 5 calendar days after obtaining all necessary information (KRS 304.17A-607(1)(i))

Failure to make the decision and provide written notice within the timeframes in KRS 304.17A-607(1)(i) will be deemed a prior authorization for the health care services or benefits subject to the review. (KRS 304.17A – 607 (2))

5.) Inpatient Concurrent Reviews: Review of a continued inpatient stay shall be made within 24 hours of receipt of request and prior to the time when the previous authorization will expire.

6.) Retrospective reviews (KRS 304.17A – 607 (1) (h) & 611):

(a) Retrospective review of an emergency admission where the covered person is still hospitalized at the time the request is made shall be treated as an inpatient concurrent review.
(b) AHDI's UR decision making 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 covered person, authorized person or provider.

7.) The following Affordable Care Act requirements which went out in a Kentucky Bulletin in November 2011 and an Advisory January 2015 are herein made part of AHDI's procedures where applicable to the services it renders to self-funded plans.

Definition of an adverse benefit determination

"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:

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; ? The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or

An adverse benefit determination includes any rescission of coverage whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.1

Urgent Care

In addition to the definition of "urgent care" provided in KRS 304.17A-600(17), a "claim involving urgent care" includes any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care.

A claim involving urgent care is subject to the internal claims and appeal processes. Urgent care appeals may also be referred to an "expedited appeal" as referenced in KRS 304.17A-617(2) (b).

AHDI 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 not later than 72 hours after the receipt of the claim by the plan or issuer, provided that the plan or 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 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.

AHDI 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.

Additionally,

AHDI must provide the claimant, free of charge, with 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 the claimant a reasonable opportunity to respond prior to that date; and

Before AHDI 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.

Conflict of Interest

304.17A-617(2) (c) sets forth the conflict of interest standard for the internal appeals process

AHDI must 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. NOTE: In addition to ensuring impartiality of the medical expert making the appeals decision, the federal rules provide that AHDI 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.

Deemed Exhaustion

KRS 304.17A-623(3)(b) provides that AHDI shall provide for an external review of an adverse determination if the covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2).

In the case of an insurer that 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. [See, 45 CFR 147.136(b)(2)]. Accordingly, the claimant may initiate an external review or pursue any available remedies under state law on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

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.

Please Note:

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, AHDI 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.

Continued Coverage of an appealed service or course of treatment

304.17A-607(1) (i) and 304.17A-615

AHDI 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.

Additionally, 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.

Concurrent external and internal review

KRS 304.17A-623(3) (b) requires AHDI to provide for an external review of an adverse determination if the covered person has completed the insurer's internal appeal process...

KRS 304.17A-623 (10) (regarding expedited external reviews).

Covered persons may pursue an expedited external review while simultaneously pursuing an expedited internal appeal under the following circumstances:

1) The scenarios listed in 304.17A-623 (10), or

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 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.

One level of appeal for individual coverage

In practice, the Department has permitted more than one level of internal appeal provided all levels of internal appeal are completed within applicable statutory time frames governing internal appeals. KRS 304.17A-617(2) (a)

Here is the advisory:

The Department has become aware that health benefit plans issued by self-funded non-ERISA plans are not complying with Kentucky's external review process. This advisory opinion clarifies that health benefit plans issued by self-funded non-ERISA plans shall comply with the external review process found in KRS 304.17A-623.

45 CFR 147.136(c) addresses the internal claims and appeals and external review processes for self-funded non-ERISA plans. If the plan is self-insured and not preempted by ERISA "then the plan must comply with the applicable state external review process and is not required to comply with the Federal external review process..."

Further, pursuant to KRS 304.11-045, if a health care benefits provider cannot show that it is subject to another jurisdiction, then Kentucky will assume jurisdiction over the provider. KRS 304.17A-005 (27) includes in the definition of insurer any "...self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA..." Moreover, the definition of health benefit plan encompasses a plan issued by a self-funded non-ERISA plan. KRS 304.17A-005 (22). Therefore, such a health benefits plan would be subject to all the requirements of Chapter 304, Subtitle 17A. This would include the external review process set forth in KRS 304.17A-623, and the requirements of insurers participating in the independent external review program set forth in 806 KAR 17:290. For that reason, self-funded non-ERISA plans must include Kentucky's external review process in its summary plan description documents.

Please be aware that any self-funded non-ERISA plan participating in the independent external review program, referenced in KRS 304.17A-621, must set up an "e" Services account; otherwise, the plan may designate the TPA to administer the appeals process, in which case the TPA would set up the "e" Services account and request the review.

American Health Data Institute, Inc. (AHDI)

PRA Drug UR:

In situations where AHDI is asked to determine the necessity of prescription drugs, AHDI will include a review of the clinical appropriateness of drugs that are not otherwise covered by the health benefit plan, using the following timeframes.

Standard request: within 72 hours of receipt of request
Urgent/expedited request: within 24 hours of receipt of request

AHDI will provide its review response to the Plan Administrator or its TPA. Decisions to deny coverage are ultimately the responsibility of the Plan Administrator, not AHDI.

AHDI provides review services for a variety of plans. The plan documents for some of those plans explicitly allow for the coverage of services that would otherwise not be covered where those services are as effective as a covered service but less costly.

Section B (4)(b)5

TITLE: Referring a Case for Physician Review

RESPONSIBILITY: AHDI Utilization Management Staff

PROCEDURE:

1. If after reviewing all submitted clinical information (see Precertification and Recertification Procedures) the AHDI nurse is unable to certify a requested service, the case will be pended to the Medical Director for review.
2. The AHDI nurse will notify the hospital UR department or the provider's office that the case is being referred for physician review and that AHDI will notify them of the determination once it is known.
3. The AHDI nurse will complete the Physician Pend form with the reason for The pend and submit the case, all clinical information and any policies (Aetna, BCBS etc) that address the service(s) requested to the Medical Director.

   If the Medical Director is unavailable for an extended period of time or at the discretion of the Manager or Medical Director of AHDI, a case may be referred to the alternate Medical Director or to an outside physician review agency per departmental guidelines.
4. The AHDI nurse will make notations in the case to indicate it has been pended, including to whom it was pended and the expected date of determination.
5. Once the physician determination is received, the AHDI nurse will contact The appropriate parties with the decision:
   A. If the requested service was approved by the physician reviewer, the AHDI nurse will complete the case according to departmental guidelines (see Precertification & Recertification procedures).
   B. If the requested service was denied by the physician reviewer, the

Section B (4)(b)5

AHDI nurse will complete the case according to departmental guidelines (see Denial of Service Procedure).

EXTERNAL UTILIZATION REVIEW PROCEDURE

Purpose: As of July 1, 2011 The Patient Protection and Affordable Care Act (PPACA) established requirements related to internal and external review processes for all insurance plans. PPACA guarantees that patients have a right to appeal denied health insurance claims directly through their plan administrator, and if need be, through the newly mandated external appeals process. The external review will be handled by an accredited independent review organization (IRO) that is accredited by URAC, a nonprofit organization promoting healthcare quality by accrediting healthcare organizations. A contract with 3 IRO's must be in place.

Application: This procedure will instruct the Utilization Review & Case Management Nurses on how to submit an appeal of denial of requested service or procedure to an accredited external review organization.

Procedure:

1. AHDI Nurse will determine that internal review process has been completed (initial denial by Medical Director and/or review of documentation a second time) with request by him to send for independent review by specialist. *** The new federal standards permit a claimant in an urgent care situation to file an expedited external review request simultaneously with filing a request for an expedited first internal review

2. AHDI Nurse will determine what type of external review is required:

A. Non-expedited External Reviews:

* A claimant has up to 4 months after receiving a final internal adverse determination to request an external review.

* The group health plan has 5 business days in which to complete a preliminary review and determine if the claimant is or was covered under the plan at the time the service was provided, that the denial is not due to failed eligibility requirements for the plan, that the internal appeals process has been exhausted & all required forms were submitted by the claimant.

* After a completed preliminary review, the plan must provide written notice within one business day notifying the claimant as to whether the claim is eligible for external review.

* The IRO must notify the claimant in writing that they may submit in writing within 10 business days additional information which the IRO must then consider when conducting the review.

* The IRO must provide a written response to AHDI & the claimant within 45 days after the receipt of the request for external review as to its decision to uphold, partially uphold or reverse the adverse benefit determination.

B. *Expedited External Reviews:*

* A claimant can file a request for an expediated external review in these situations:

1) if he/she receives a denied claim in a medical emergency situation,

2) , in continuing treatment situations & when the consumer's chance of regaining full function would otherwise be jeopardized,

3) experimental treatment denials or

4) If the claim involves admission or availability of a health care item or service.

If an expedited external review request is received, the plan must determine immediately whether it is eligible for review and must submit to an external review board in an expedited fashion. The decision must be made within 48 hrs after the claim is received by the external review board

3. AHDI Nurse will forward the review to one of three Independent Review Organizations (IROs), rotating the IROs as determined on the updated spreadsheet (see attached). All documents and information considered in making the adverse benefit determination will be forwarded to the IRO.

4. AHDI receives the response back from the IRO and notifies the Medical Director and the plan administrator immediately. If the IRO overturns the internal review decision, that indicates the services being requested were both covered and medically necessary and that the health plan's decision should be reversed. If the IRO partially overturns the internal review decision, that means that the IRO found that some of the services being requested were both covered and medically necessary and that the health plan's decision should be reversed in part. In both overturned and partially overturned decisions of the IRO the plan must immediately provide coverage or payment for the claim. If the IRO upholds the original decision to deny coverage for the services that were subject to the grievance then no action is taken by the plan. The decisions of the IRO are binding.

TITLE: **Denial of Requested Service**

RESPONSIBILITY: AHDI Utilization Management Staff

PROCEDURE:

1. The AHDI nurse has pended a case for physician review and the requested service has been determined to be NOT medically necessary (see Referring a Case for Physician Review).
2. The AHDI nurse will notify the hospital UR department or the provider of the denial. The UM RN will also explain the appeals process, which should include a letter of appeal and supporting documentation, along with the correct address where the appeal should be sent.
3. The AHDI nurse will make the appropriate notations in the case to indicate that the requested service has been denied.
4. For denied inpatient days the AHDI nurse will follow-up with the hospital UR department or medical records for a discharge date. The case will be closed with the total number of denied days (including the dates) clearly identified in the notes.
5. For denied outpatient services the AHDI nurse will close the case using the proposed date of service as the discharge date. The AHDI nurse will clearly indicate in the notes what outpatient service(s) has been denied.
6. The AHDI nurse will make an entry in UMPro under the Maintenance Physician Review screen detailing the medical determination, the rationale for the denial and the number of days denied (if inpatient).
7. A standardized denial letter will be generated by the system and given to the AHDI nurse who completed the denial. The AHDI nurse will modify the letter with specific information and send it to the patient/covered person, authorized person and provider. The letter will provide,
   a. the date of the review decision,

b. the date(s) in question or if a preauthorization,
c. a statement of the specific medical or scientific reasons for the denial or reduction of payment,
d. the state of licensure, medical license number and title of the reviewer making the decision
e. except for retrospective reviews, the phone number at the TPA where a description of alternative benefits the plan offers, if any, may be discussed
f. instruction for the internal appeal process, including whether it must be in writing, any specific filing procedures, any applicable timeframes or schedules
g. the position and phone number of the contact who can provide additional information

8. Written notice/Denial letters will be sent to the patient/covered person, authorized person and provider via regular mail. Written notices may be provided in electronic format, including secure email or facsimile, when the patient/covered person, authorized person or provider have agreed in advance to receive such notices electronically.
9. The denied case will be documented in the MD Pend log and will be filed within AHDI in the MD pend files.
10. The AHDI nurse will complete a discharge log and forward to the administrative assistant for entry into RIMs claims system.
11. If an appeal of the denial is received, AHDI nurse will follow appeal Protocol outlined in Appeal of Denial procedure.

Appeal Procedure

When there has been a denial of services the enrollee and the caller of record will be notified within two (2) business days. This notification will include the primary reason for the adverse determination as well as the procedure for initiating an appeal.

Standard appeal

A written letter of appeal along with all clinical documentation to support medical necessity should be sent to American Health Data Institute via the TPA benefits department.

Once all information necessary for the appeal of an admission, service or procedure is received by AHDI, it will be sent to a physician of like specialty for review. The adjudication of the appeal will be completed and notification made within thirty (30) days of receipt of the appeal and all pertinent information pertaining to the appeal.

Expedited appeal

An appeal on an adverse decision on a current inpatient case or ongoing service or procedure will be considered an expedited appeal. The initial call (1-800-831-1854) for the expedited appeal can come from the patient, a family member, the attending physician or someone calling on behalf of the patient. The attending physician will be connected with the American Health Data Institute Medical Director for discussion of the case.

For an expedited appeal request, all pertinent information including a written letter of appeal or a verbal request for an appeal, along with clinical documentation to support medical necessity is required.

Expedited appeal information should be sent/given directly to AHDI to be reviewed by the Medical Director for physician review for reconsideration. A physician of like specialty will review the appeal. If the outcome of the expedited appeal is not favorable, the information may be resubmitted through the standard appeal process.

Once all information necessary for an expedited appeal is received by AHDI, a response will be made within forty-eight (48) hours.

If an emergency or life-threatening situation should arise, an expedited appeal will be completed. The adjudication of such an appeal will be completed by a physician of like specialty with 48 hours of the initiation of the appeal and receipt of all pertinent information necessary to complete the appeal.

All External reviews will be rotated between three independent outside review agencies.