American Health Data Institute, Inc.

Title: Utilization Review Reviewers, Specialty Personnel, Licensed Supervision and Protocol Review/Comment

Responsibility: AHDI Management

Procedure: AHDI will regularly monitor and maintain the below:

Licensed Physician(s):

- Will be responsible for the completion of any 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;
- Will supervise the qualified personnel conducting case reviews
- Will, when possible, for services provided by a chiropractor or optometrist, such denial shall be made by a chiropractor or optometrist licensed in the State of Kentucky or in the patient's state of residence
- Will, when possible, be of similar subspecialty as the ordering provider
- Will afford other participating physicians and other participating providers the opportunity to review and comment on protocols within the provider's legally authorized scope of practice

American Health Data Institute, Inc. (AHDI)

Title: Utilization Review (UR) Definitions
Responsibility: AHDI Management and Staff
Procedure: AHDI UR definitions (State of Kentucky)

AHDI will conduct business according to and hereby agrees to the definitions outlined in Kentucky Revised Statues outlined below where applicable to the services it renders self-funded plans:

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.

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 (KRS 304.17A-600(17)

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)

American Health Data Institute, Inc. (AHDI)

Title: Timeframes for Review

Responsibility: AHDI Management and Staff

Procedure: AHDI will maintain the below

1.) All Necessary Information needed for reviews will be limited to the three items listed below:

- 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 (for both prospective & retrospective reviews).

- 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))

2.) 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.

3.) 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.

American Health Data Institute, Inc.

Title: Personnel – conflict of interest

Responsibility: AHDI Management and Staff

Procedure: AHDI will maintain the below requirements:

- All appeals will be adjudicated in such a manner to ensure the independence and impartiality of the medical staff experts involved in a decision

- AHDI decisions and procedures in hiring, compensation, termination, promotion, or other similar practices of any individual medical expert are not based on the probability that the individual will or will not support a denial of benefits.

Managed Care Program

The managed care program is a health care benefit management program. It is a cost containment benefit built upon the components of pre-certification and case management.

Pre-certification Process

Participants or their dependents with the benefit of a managed care program must have every inpatient hospital stay certified. This is a participant-driven and participant-responsible program. The participant or agent for the participant may call or have the admitting physician or hospital call to certify the stay. Medical, surgical, and psychiatric admissions must be certified prior to admission. Emergency admissions must be certified within two working days of the admission. Maternity admissions for deliveries **do not** require certification. If the newborn baby stays longer in the hospital than the mother, the newborn's continued hospital stay must be certified. Please refer to the Schedule of Benefits for the listing of services that require precertification.

Except in the case of maternity, at the time a medical, surgical, or psychiatric inpatient hospital admission **is planned** the participant or his or her dependent must let the physician know that the health care coverage includes the requirement of pre- certification. A penalty per admission as shown in the schedule of benefits will be reflected to the participant if pre-certification requirements are not followed.

Pre-certification is accomplished by telephoning a toll-free number on your I.D. card and providing the following information:

- Plan participant name
- Company name
- Patient's name and age
- Admitting physician's name, address, and phone number
- Name of hospital and address

Calls received after hours will be recorded, and the call will receive a response within one working day. In the case of emergency admissions, the call must be made within 48 hours or two working days of the emergency admission.

Concurrent Review

Inpatient care may be needed beyond the days initially certified. Days needed beyond those certified at admission must also be certified.

The pre-certification unit staff will monitor the patient's progress throughout the hospital stay to assure discharge is not delayed by inadequate planning and that each day of confinement is medically necessary and appropriate.

The pre-certification staff will contact the hospital utilization review department or the admitting physician for information if additional days are needed beyond those days initially certified. This concurrent review will continue until the patient is discharged.

Inpatient days certified at admission DO NOT determine the length of inpatient stay. Only the attending physician determines when a patient is to be discharged. The days anticipated at admission may not be needed, or an extension of inpatient days may be required. The physician determines this.

The appeal process is available for a patient's physician when a determination is made that additional days of inpatient care are not medically necessary.

Case Management Process

Case management is the process of assessing major or catastrophic illnesses and injuries and developing and coordinating a cost-effective alternative treatment plan. The process can be accomplished by utilizing current contract benefits or by proposing an exception to benefits. Additionally, case management monitors the quality of care in an appropriate place of service.

Clinical case managers, who are all registered nurses, are responsible for identifying and carefully examining as early as possible every reasonable option in the care and treatment of patients suffering from a serious illness or injury. The clinical case managers then coordinate and facilitate a smooth transition to the alternate care setting. The case management component is designed to help control the cost of treating victims of serious illnesses and injuries while monitoring for the highest quality of care.

The managed care company has the authority to modify the length of stay and to approve services which are not otherwise covered by the plan if those services are as effective as a covered service but are less costly.

Medical Claim Payment and Appeals

Pre-Service Urgent Care Claims

When a request to review an "urgent" pre-service claim is submitted, the participant will be notified of the plan's decision as soon as possible, but no more than 72 hours after the plan receives the claim (unless the participant fails to provide sufficient information to determine whether or what benefits are covered or payable under the Plan). If the treating physician classifies a claim as "urgent," the plan will do so as well.

If information to review of an "urgent" claim is incomplete, the following will occur:

- The plan will notify the participant of the deficiency and specify what information is missing. This will be done within 24 hours after receipt of the claim.
- The participant has 72 hours to provide the missing information.
- The plan will make its decision within 48 hours after the earlier of (1) when it receives all necessary information or (2) the end of the period provided for the participant to submit the information (usually 72 hours).

If a participant appeals the denial of a pre-service "urgent" claim, the plan must render a review decision as soon as possible, but no more than 24 hours after receiving the appeal.

Concurrent Care Claims

Reduction or Termination of Coverage by the Plan:

If a plan has approved an on-going course of treatment and then determines that such treatment should be reduced or terminated, the plan must notify the participant of this decision far enough in advance of the reduction or termination date to allow for an appeal and review of the decision.

However, this does not apply if the plan has been amended to reduce or end coverage for the treatment, or when the plan itself terminates.

Extensions of Treatment:

When a participant requests an extension of an on-going course of treatment beyond that which the plan has approved, the plan must do the following:

- Make a decision about the extension as soon as possible; and

- Notify the participant of the decision within 24 hours after receipt of the request, if the request was made at least 24 hours before the end of the treatment that had already been approved.

Pre-Service Benefit Claim Review for Coverage

If the plan requires that benefits for a service be predetermined prior to the service being provided, the participant or the health care provider must submit a request for that pre-service benefit claim review to the plan supervisor. A decision for a pre-service benefit determination will be made within 15 days after receipt of the request.

Extensions:

- The 15 day period may be extended for another 15 days if it is necessary because of matters beyond the plan's control, and if the plan notifies the participant of those circumstances and the expected date of the decision before the end of the first 15 day period.

- If the extension is necessary because insufficient information was submitted, the extension notice will describe the missing information and give the participant 45 days to submit such information.

Normal Post-Service Health Claims

A participant or health care provider must file a claim with the plan supervisor within the time frames set out in the plan. A claim will be considered to have been filed upon receipt by the plan supervisor. The participant will be notified within 30 days of receipt of a claim by the plan as to the benefits to be paid for that claim.

Extensions:

- The 30 day period may be extended for 15 days if it is necessary due to matters beyond the control of the plan, but the plan will notify the participant before the end of the 30 day period of those circumstances and the expected date of the decision.

- If more information is necessary to properly process the claim, a notice will be given within the 30 day period that the plan can not meet the 30 day time frame. The notice will describe the missing information and give the participant at least 45 days to provide the missing information. Upon receipt of the missing information, the claim will be processed within the later of 45 days after the

original receipt of the claim or within 15 days of receipt of the missing information.

If more information is necessary to properly process the claim and it is not received within the 45 day time frame, the claim will be denied. The claim may thereafter be re-submitted with the missing information as long as the re-filing is completed within the claim filing time limits set out in the plan.

General Conditions

The period of time within which a benefit determination is required to be made shall begin at the time the claim is filed with the plan, without regard to whether all the information necessary to make the benefit determination accompanies the filing. In the case of any extension of time to make a benefit determination which is based on a lack of submitted information necessary to determine a claim, the period for making the benefit determination shall stop running until the claimant responds to the request for additional information.

Any adverse determination shall set forth the following:

- The specific reason or reasons for the adverse determination;
- A reference to any specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the participant to make the claim payable and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits which are applicable to such procedures, including a statement of the participant's right to bring a civil action under Section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the plan will provide that criterion free of charge upon request; and
- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the plan will provide an explanation of how it made that determination free of charge upon request.

Appealing an Adverse Decision

In order to appeal an adverse decision, the plan will do the following:

- Allow a participant 180 days following receipt of a notification of an adverse benefit determination within which to file a written appeal to the plan administrator at the address found in the summary plan description;

- Allow a participant the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Provide a participant upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information which is relevant to the participant's claim for benefits;

- Provide a participant any new or additional evidence or rationale that is relied upon, considered or generated by or at the direction of the plan. The new evidence or rationale shall be provided free of charge as soon as possible, and sufficiently in advance of the time within which a final determination or appeal is required to allow the participant to respond.

- Provide for a review that takes into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

- Provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the plan who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual;

- In deciding an appeal from an adverse benefit determination that is based in whole or in part on a medical judgment, provide that the appropriate plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

- Provide that the health care professional engaged for purposes of a consultation as a part of the appeal of the benefit determination shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

- Notify the participant of the plan's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the participant's appeal, unless the plan administrator determines that special circumstances require an extension of time for processing the appeal.

Standard External Review

The Plan shall allow an external review of a benefit denial when a request for a standard external review is submitted within four months after the date of receipt of a notice of an adverse benefit determination.

The Plan will complete a preliminary review of the request within five business days following receipt of the external review request to: 1) determine if the claimant was covered by the plan at the time the claim was incurred, 2) determine if the claimant has exhausted the Plan's internal review process, if required, and 3) determine that the claimant has provided all information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will notify the covered person in writing if the request is complete. If the request is incomplete the Plan will allow the covered person to provide complete information within the later of the end of the four month period after the date of receipt of the notice of adverse benefit determination or within a 48-hour period after receipt of notification to complete the request. If the plan determines that the claim is ineligible for external review the claimant will be notified and will be given the telephone number of the Employee Benefits Security Administration (866-444-3272).

If accepted for external review the file will be assigned to an accredited independent review organization (IRO).

Upon receipt of a final external review decision the claimant will be notified of the decision. If the decision reverses in whole or in part the adverse benefit determination, the Plan will provide coverage or payment for the claim to the extent that the claim is found payable.

Expedited External Review

The Plan shall allow an "expedited external review" when he/she receives:

(a) An adverse benefits determination, if (i) the adverse benefit determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal appeal under the final regulations would seriously jeopardize the covered person's (I) life or health, or (II) ability to regain maximum function, and (ii) the covered person has filed a request for an expedited internal appeal; or

(b) A final internal adverse benefit determination, if (i) the covered person has a medical condition where the time frame completion of a standard external review would seriously jeopardize the covered person's (I) life or health, or (II) ability to regain maximum function; or (ii) the final internal adverse benefit determination concerns an admission, availability or care, continued stay, or health care item or service for which the covered person received emergency services, but has not been discharged from a facility.

Upon receipt of the request, the Plan will determine whether the request meets the reviewability requirements for standard external review. The Plan will immediately send a notice of the eligibility determination to the claimant.

Upon receipt of a final external review decision the Plan and the claimant will be notified of the decision. If the decision reverses in whole or in part the adverse benefit determination, the Plan will provide coverage or payment for the claim to the extent that the claim is found payable.

American Health Data Institute, Inc.

Title: Determination Notice

Responsibility: AHDI Management and Staff

Procedure: Notice of Determination and Presentation of Additional Information:

- Written notice of utilization review decisions will be employed for both approvals and denials.
- Written notice will be employed on each review decision for a treatment, procedure, drug that requires prior authorization or a device to the claimant (covered person, authorized person, or provider). This notice may be provided in electronic format including email or facsimile, where the covered person, authorized person or provider has agreed in advance in writing to receive such notices electronically to the extent allowed by the group health benefit plan and applicable Kentucky law.
- Providers will be given the opportunity to present additional information concerning the review to the extent allowed by the group health benefit plan and applicable Kentucky law

American Health Data Institute, Inc. (AHDI)

Determination Notices/Appeals/Coverage Denial/Federal Preemption:

AHDI does not make a determination of the denial of coverage. AHDI will review the medical aspects of a specific case, when requested by the third-party administrator (TPA) of the group health plan.

Based upon the AHDI medical review and its response to the TPA, the TPA will notify both patient/covered person and the provider in writing of the results of the coverage availability and appeal rights available under the group health plan. Contact information for the TPA is provided in the letter to the covered person/patient if any additional information is needed.

Given this, AHDI does not have in place a letter or sample template for coverage denial.

AHDI does not make a determination or address the internal claims or appeals process provided under a group health plan.

American Health Data Institute, Inc. (AHDI)

Policies & Procedures addendum (KY)

1.) 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

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.

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.

Effective May 2023

Mattie Coles

Mattie Coles, MS, RN
Nurse Manager
American Health Data Institute, Inc. (AHDI)

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.

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

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 72 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.

American Health Data Institute, Inc.

Title: Specialty Medications Review

Responsibility: AHDI Management and Staff

Procedure: Specialty Medications Reviews/Step Therapy:

- AHDI follows nationally recognized and established clinical practice review guidelines and criteria to make determinations regarding step therapy protocol and exceptions.

- When a specialty prescription medication is ordered by a physician or other prescribing practitioner (provider), AHDI will reach out to the provider to determine if any generic, lower cost or other alternative prescription medication has been or might be endorsed over the medication being prescribed.

- The AHDI Staff member will work together with the provider to determine an agreed to step therapy protocol based upon the complete specific information and documentation provided.

- If the exception request is incomplete, AHDI will notify the prescribing provider within 48 hours of the additional relevant information needed.

- Upon receipt of all necessary information to perform the exception request review, AHDI will within 48 hours:

  -grant the exception request OR
  -if the prescribing provider is averse to make a change to the medication order, the request will be forwarded to the AHDI Medical Director for review.

- If a step therapy protocol exception is not authorized, the AHDI denial of requested service policy will be followed.

- Appeal provisions are provided in the denial letter provided by the group health benefit plan's administrator. The covered person, physician or authorized person may request an appeal to the extent allowed in the group health plan document and applicable Kentucky law.

- Prior authorizations for ongoing conditions will be valid for: one year from the date the provider received the prior authorization; until the last day of coverage under the covered person's health benefit plan during a single plan year; and cover any change in dosage prescribed by the provider during the period of authorization to the extent allowed in the group health plan document and applicable Kentucky law.