KENTUCKY UTILIZATION REVIEW PROCESS

Pre-Admission, Admission or Re-Admission Review

The purpose of pre-admission, admission, or re-admission review is to determine the medical necessity of the services, performed on an elective basis, to be provided, and the appropriateness of the proposed setting. Medical Review, Inc. ("MediReview") shall base review decisions in accordance with generally accepted standards of medical practice; and clinically appropriate in terms of type, frequency, extent and duration. MediReview shall ensure consistent application of review criteria via monthly review of utilization review ("UR") decisions by the medical director.

Initial reviewers may issue approvals based upon approved criteria. If unable to approve, the request shall be referred to a licensed physician. The licensed physician can approve or deny the health care service. He/she will utilize criteria; however, the licensed physician shall also give his/her best medical opinion based upon submitted medical fact and allow the treating provider to provide additional information.

As required by SB54, MediReview shall provide a UR decision and notify the individual:

a) within five (5) days of obtaining all necessary information for "non-urgent care services";
b) within twenty-four (24) hours of obtaining all necessary information for "urgent care services";
c) where the covered person is already hospitalized, pursuant to KRS 304.17A-607 (1) (i), MediReview shall provide a review decision within twenty-four (24) hours of receipt and prior to the time when a previous authorization for hospital care will expire.

If the admission or re-admission is on an emergency basis, the admission will not be subject to pre-admission review.

MediReview, pursuant to KRS 304.17A-607(1)(h), shall provide a UR decision within twenty-four (24) hours of receipt of request for retrospective review of an emergency situation when the covered person is already hospitalized. An emergency and an elective admission are defined as follows:

a) An emergency admission is any admission required as a result of a situation which, if not treated immediately, would result in any of the following:
    i. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child, in serious injury;
    ii. Serious impairment to bodily functions; or
    iii. Serious dysfunction of a bodily organ or part.
b) An elective (non-emergency) admission is any proposed admission which, while required and appropriate, may be scheduled in advance without adversely affecting the patient's condition or the outcome of a surgical intervention.

Weekend and holiday admissions will be reviewed under an admission review protocol and conducted as required by KRS 304.17A-607(1)(i) within twenty-four (24) hours of receipt of request for authorization of treatment when the covered person is already hospitalized.

Failure to make a determination and provide written notice within the above listed time frames, pursuant to KRS 304.17A-607(2), will be deemed a prior authorization. This provision shall not apply where the failure to make a determination or provide the notice results from circumstances which are documented to be beyond MediReview's or the insurer's control.

In accordance with the Affordable Care Act (ACA), MediReview's definition of an 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) 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 UR;
b) a determination that a benefit is experimental, investigational, or not medically necessary or appropriate;
c) a determination of an individual's eligibility to participate in a plan or health insurance coverage;
d) a determination that a benefit is not a covered benefit;
e) the imposition of a preexisting condition exclusion, source-of- injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
f) 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 the time.

In accordance with KRS 304.17A-607(1)(j), MediReview shall provide written notice of all review decisions to the covered persons, authorized persons (if applicable), and all providers. In addition, the written notice shall contain: understandable language; identifying information including the covered person's name, insurance number, acute care facility name and physician name; and a brief statement concerning MediReview's function. The written notice shall be provided within seventy-two (72) hours of the date the decision was rendered. Where the covered person, authorized person or provider has agreed in advance in writing to receive such notices electronically, MediReview may provide the written notice in electronic format. If the notice is a denial of services, the denial shall include:

a) A statement of the specific medical and scientific reasons for denial or reduction of payment (coverage denials will be issued by the TPA, not MediReview);
b) The state, medical license number and the title of the reviewer making the decision;
c) Except for retrospective review, a description of alternative benefits, services or supplies covered by the health care plan, if any;
d) Instructions for initialing or complying with the internal appeal procedure, as set forth in KRS 304.17A-617, stating time frame for appeal request, method of reconsideration

request (verbal and/or written), and the position and phone number of a contact person who can provide additional information;

e) The date the decision was made and the treatment date in question;
f) Note if it is for pre-authorization.

A pre-admission, admission, or re-admission number for medical necessity and appropriateness will not be a guarantee of payment. A monitoring and validation process may be completed retrospectively. The pre-admission, admission, or re-admission decision, pursuant to KRS 304.17A-611, will not be altered unless the monitoring and validation review indicate the approval was based on fraudulent, materially inaccurate, or misrepresented information previously provided or was not covered by the benefit plan.

Penalties for noncompliance will be at the Plan Administrator's discretion in accordance with the covered person's health benefit plan.

Where the nurse reviewer cannot approve the request, it will be referred to a licensed physician, pursuant to KRS 304.17A-607(1)(b)(1). The licensed physician can approve or deny the health care service. Kentucky licensed chiropractors and optometrists will be used for chiropractic and optometry reviews.

Where an adverse determination occurs, the facility contact person will be telephonically notified of coverage denial, and in accordance with KRS 304.17A-607(1)(g) (h) (i) (j), KRS 304.17A-617(2)(e) and KRS 304.17A-545, a written denial will be issued to covered persons, authorized person (if applicable) and all providers within one (1) business day but no later than seventy-two (72) hours of the decision.

An external appeal process will be added to all denial letters for fully insured clients, non ERISA exempt plans and those ERISA exempt plans that chose to provide external review.

Coverage denials will be issued by the insurance carrier or the Plan Administrator according to the covered person's health benefit plan. MediReview will not issue coverage denials.

Pre-Authorization

The purpose of pre-authorization is to determine medical necessity of the procedure as well as the appropriateness of the proposed setting, e.g., office, outpatient surgery, or inpatient hospital stay. The requirement to obtain pre-authorization for medical services and specific procedures will be established by the private health insurer or self-insured employer health benefit plan.

MediReview shall provide a pre-authorization review decision within five (5) days of obtaining all necessary information for "non-urgent care services".

Where the pre-authorization is for a treatment, procedure, drug, or device, as required by KRS 304.17A-607(1)(h), MediReview shall provide a review decision within fifteen (15) business days of receipt of request. A one-time extension of up to fifteen (15) days is allowed if it is necessary for reasons beyond MediReview's control. Notification will be provided to the

requester of the necessity for extension prior to the expiration of the initial fifteen (15) day period. Notification will include the circumstances requiring the extension, and the date by which the insurer or MediReview expects to render a determination. The requester will be allowed forty-five (45) days from receipt of the notice in which to provide any requested information.

Failure to make a determination and provide written notice within the above listed time frames, pursuant to KRS 304.17A-607(2), will be deemed a prior authorization. This provision shall not apply where the failure to make a determination or provide the notice results from circumstances which are documented to be beyond MediReview's or the insurer's control.

MediReview's definition of an adverse determination shall be the same as defined by KRS 304.17A-600(1).

A pre-authorization number for medical necessity and appropriateness will not guarantee payment. A monitoring and validation process may be completed retrospectively. The pre-authorization decision, pursuant to KRS 304.17A-611, will not be altered unless the monitoring and validation review indicate the approval was based on fraudulent, materially inaccurate, or misrepresented information previously provided or was not a covered benefit under the plan.

Penalties for noncompliance will be at the private health insurer's or self-insured employer's plan administrator's discretion in accordance with the covered person's health benefit plan.

In accordance with KRS 304.17A-607(1)(j), MediReview shall provide written notice of all review decisions to the covered persons, authorized persons (if applicable), and all providers.

This notice will be mailed within the one (1) business day but no longer than seventy-two (72) hours after the decision. If the covered person, authorized person or provider has agreed in advance in writing, notice may be sent by e-mail or fax.

Where the nurse reviewer cannot approve the request, it will be referred to a licensed physician, pursuant to KRS 304.17A-607(1)(b)(1). The physician can approve or deny the health care service.

Where an adverse determination occurs, the facility contact person will be telephonically notified of denial, and in accordance with KRS 304.17A-607(1)(g), KRS 304.17A-617(2) (e) and KRS 304.17A-545, a written coverage denial will be issued to the attending physician, beneficiary, carrier, and acute care facility within seventy-two (72) hours of the initial request.

Concurrent Review/Continued Stay Authorization

The purpose of the concurrent review is to determine the medical necessity of continued hospital care. The inpatient facility will be responsible for contacting the nurse reviewer to request an extension beyond the pre-approved length of stay. If the beneficiary has not been discharged, then the facility shall provide criteria to justify the extension. The initial number of days

approved by a nurse reviewer will be dependent upon established criteria. MediReview shall provide concurrent review of a covered person's continued hospital stay, within twenty-four (24) hours of receipt of request and prior to the time when a previous authorization for hospital care will expire, pursuant to KRS 304.17A-607(1)(h) (i).

Where the nurse reviewer cannot approve the continued stay, it will be referred to a licensed physician, pursuant to KRS 304.17A-607(1)(b)(1). The physician can approve or deny the extended stay. If a continued stay denial is provable, the attending physician will be notified to discuss the case. If the attending physician is unavailable at that time, one (1) additional attempt will be made. On the second attempt, if the attending physician is still unavailable, the continued stay will be denied. The facility contact person will be telephonically notified, and in accordance with KRS 304.17A-607(1)(g) (h) (i) (j), KRS 304.17A-617(2) (e) and KRS 304.17A- 545, a written coverage denial will be issued to the covered person, authorized person (if applicable), and all providers within one (1) business day but no later than seventy-two (72) hours of the decision.

An external appeal process will be added to all denial letters for fully insured clients, non ERISA exempt plans, and those ERISA exempt plans that chose to provide external review.

Coverage denials will be issued by the insurance carrier or the Plan Administrator according to the covered person's health benefit plan. MediReview will not issue coverage denials.

If the covered person has been discharged prior to the continued stay request, the request will be subject to retrospective review, pursuant to KRS 304.17A-607(1)(b)(1), to determine if the continued stay was medically necessary. The review will be performed within twenty (20) business days of the receipt of requested medical information, as required by KRS 304.17A-607(1)(h) -- (see the Retrospective Review process).

Failure to make a determination within the above listed time frames, pursuant to KRS 304.17A-607(2), will be deemed an adverse determination by MediReview for purposes of initiating an internal appeal.

MediReview's definition of an adverse determination shall be the same as defined by KRS 304.17A-600(1).

In accordance with KRS 304.17A-607(1)(g), MediReview shall provide written notice of all review decisions to the covered persons, authorized persons (if applicable), and all providers.

The review for medical necessity and appropriateness will not guarantee payment. A monitoring and validation process may be completed retrospectively. The review, pursuant to KRS 304.17A-611, will not be altered unless the monitoring and validation review indicate the approval was based on fraudulent, materially inaccurate, or misrepresented information previously provided

Penalties for noncompliance will be at the private health insurer's discretion in accordance with the covered person's health benefit plan.

Retrospective Review

Retrospective review of an emergency admission will be reviewed under MediReview's admission review protocol and a determination shall be provided, as required by KRS 304.17A-607(1)(h), within twenty-four (24) hours of receipt of request.

Upon receipt of request for retrospective review for weekend and holiday admissions, the review shall be conducted under MediReview's admission review protocol. As required by KRS 304.17A-607(1)(h), MediReview shall provide a UR decision within twenty-four (24) hours of receipt of request.

Upon receipt of request for retrospective review where the concurrent/continued stay expired during the weekend or holiday, the review shall be conducted under MediReview's concurrent/continued stay protocol, and a review determination shall be provided, as required by KRS 304.17A-607(1)(h), within twenty-four (24) hours of receipt of request.

Where the insurer or MediReview has initiated a retrospective review, as required by KRS 304.17A-607(1)(h), MediReview shall provide a UR decision within thirty (30) business days of the receipt of requested medical records. An extension of up to fifteen (15) days is allowed for circumstances beyond the plan's control.

Failure to make a determination within these time frames, pursuant to KRS 304.17A-607(2), will be deemed an adverse determination by MediReview, for purposes of initiating an internal appeal.

In accordance with KRS 304.17A-607(1)(g), MediReview shall provide written notice of all review decisions to the covered persons, authorized persons (if applicable), and all providers within the thirty (30) days allowed (or greater with special circumstances as indicated above). The claimant is allowed up to forty-five (45) days from receipt of notice to provide specified information.

MediReview's definition of an adverse determination shall be the same as defined by KRS 304.17A-600(1), and in accordance with KRS 304.17A-607(1)(g), KRS 304.17A-617(2) (e) and KRS 304.17A-545, a written coverage denial will be issued to the covered person, authorized person (if applicable), and all providers.

The review for medical necessity and appropriateness will not guarantee payment. A monitoring and validation process may be completed retrospectively. The concurrent review, pursuant to KRS 304.17A-611, will not be altered unless the monitoring and validation review indicate the approval was based on fraudulent, materially inaccurate, or misrepresented information previously provided

Penalties for noncompliance will be at the private health insurer's or plan administrator's

discretion in accordance with the covered person's health benefit plan.

In accordance with KRS 304.17A-607(1), MediReview shall provide written notice of all review decisions to the covered persons, authorized persons (if applicable), and all providers within one (1) business day of the decision but no more than seventy-two (72) hours after the decision.

A description and name of the review criteria upon which UR decisions are based, including specific and separate criteria to distinguish when hospital care will be determined appropriate for inpatient status versus when the insurer/agent will approve it only for outpatient reimbursement, and policies and procedures to support the consistent application.

As required by 806 KAR 17:280 Section 4(1)(b), MediReview shall provide a description and name of the review criteria upon which UR decisions are based.

Non-Contact Denial Prohibition

No insurer shall deny or reduce payment for a service, treatment, drug or device covered under the covered person's health plan if (KRS 304.17A-615(1)):

a) During normal business hours, provider contacts insurer/PRA the day covered person is expected to be discharged in order to request review of a continued hospitalization, and a timely UR decision is not provided; or
b) Provider makes three (3) documented attempts in four (4) consecutive hour period during normal business hours to contact insurer/PRA for review of a continued hospital stay, for pre-authorization for treatment of hospitalized person or for retrospective review of an emergency admission, where the covered person remains hospitalized at the time the request is made, and insurer or PRA is not accessible. (**MediReview is not an insurer.**)

Insurer's Liability via Non-Contact

The insurer's liability to pay for covered person's hospitalization under these circumstances shall extend until insurer/PRA issues a UR decision, applicable to requests in (b) above. (This section applies only to covered health benefits. This section shall not apply if provider does not furnish information requested by insurer or PRA to make UR decisions or if actions by provider impede insurer's or PRA's ability to issue decision. (KRS 304.17A-615(2) through (5)).