

## KENTUCKY MEMBER APPEAL PROCESS

### Internal Appeals

A Member, the Member's Authorized Representative, or a Provider acting on behalf of the Member, may initiate an internal appeal. An appeal is a request for review of an Adverse Determination or a Coverage Denial as defined below. An internal appeal may also be initiated if We fail to make a timely utilization review determination.

**Adverse Determination** means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a Covered Person are:

- A. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
- B. Benefit coverage is therefore denied, reduced, or terminated.

**Coverage Denial** means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the Covered Person's health benefit plan.

### Initiating an Appeal

A request for an internal appeal must be submitted within sixty (60) calendar days of receipt of a denial letter and include the initial denial letter, the number of claims in question, the date(s) of service, a summary of any previous communication You have had with Us regarding this denial, and any pertinent medical information.

A Member, the Member's Authorized Representative, or a Provider may request a board eligible or certified Physician in the appropriate specialty or subspecialty area to conduct the internal appeal relating to an Adverse Determination.

Within thirty (30) days of receipt of the internal appeal request, We will send a written decision to the Member or their authorized representative, and if applicable, the Member's Provider.

An expedited appeal is deemed necessary when the Member is hospitalized, or in the opinion of the treating Provider, a review under a standard timeframe could, in the absence of immediate medical attention; result in any of the following:

- A. Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
- B. Serious impairment to bodily functions; or
- C. Serious dysfunction of a bodily organ or part.

An expedited appeal may be requested orally and followed up by an abbreviated written request by a Member, the Member's Authorized Representative or a Provider acting on behalf of a Member. An internal appeal decision will be rendered not later than (three) 3 business days after the receipt of the request for an expedited internal appeal.

Any additional pertinent information may be submitted for consideration during the internal appeal process. If You or Your Provider has new clinical information regarding Your appeal, You may provide it prior to the initiation of an External Review. BFH will then have five (5) business days from the date of receipt of the new information to render a decision based on the new information. Following that decision, You have sixty (60) calendar days to initiate an external review of an Adverse Determination.

If Our decision is to uphold a Coverage Denial, the Member, the Member's Authorized Representative, or a Provider may contact the Kentucky Department of Insurance (DOI), Health and Life Division, P.O. Box 517, Frankfort, Kentucky 40602, and request a review of Our decision. The DOI will make a determination as to whether the service should or should not be covered. If the DOI determines the disputed service should be covered, they may direct Us to either cover the service or offer external review to resolve the issue.

## External Review by an Independent Review Entity (IRE)

The Member, the Member's Authorized Representative, or a Provider acting on behalf of and with the consent of the Member may request an external review of an Adverse Determination if:

- A. The internal appeal process outlined above was completed or jointly waived by You and Us or We failed to make a timely determination or notification;
- B. The Member was covered under this Certificate on the date of service or, if a prospective denial, the Member was enrolled and eligible to receive covered benefits under this Certificate on the date the proposed service was requested; and
- C. The entire course of treatment or service would cost the Member at least one hundred dollars (\$100) if the Member had no insurance.

The request for an external review must be sent to Us within sixty (60) calendar days of receiving Our written decision rendered under the internal appeal process. As part of the request, the Member shall provide written consent authorizing the independent review entity to obtain all medical records from Us and any Provider utilized for review purposes. All medical records involved in the external review process shall be deemed confidential.

The Member will be responsible for a twenty-five dollar (\$25) filing fee to be paid to the IRE, which may be waived in case of financial hardship, or refunded if the IRE finds in favor of the Covered Person.

An external review of an "Adverse Determination" shall not be afforded if:

- A. The subject of the Member's adverse determination has previously gone through the external review process and the independent review entity found in favor of Us; and
- B. No relevant new clinical information has been submitted to Us since the independent review entity found in favor of Us.

If a dispute arises between the Plan and a Member regarding the right to an external review, the Member may file a complaint with the DOI. The DOI shall render a decision within five (5) days of receipt of the complaint.

We will be responsible for the cost of the external review. We will assign external reviews to IREs on a rotating basis such that We do not utilize the same IRE for two consecutive reviews.

The IRE will send a written decision to the Member within twenty-one (21) calendar days of receiving the request for external review. An extension of up to fourteen (14) calendar days may be allowed if the Member and BFH are in agreement.

An expedited external review process is available if the Covered Person is hospitalized or, in the opinion of the treating provider, a review under a standard timeframe could, in the absence of immediate medical attention; result in any of the following:

- A. Placing the health of the Member or, with respect to a pregnant woman, the health of the Member or her unborn child in serious jeopardy;
- B. Serious impairment to bodily functions; or
- C. Serious dysfunction of a bodily organ or part.

An expedited external review may be requested orally and followed up by an abbreviated written request. In the case of an expedited external review, the IRE will make a decision within twenty-four (24) hours from receiving all of the information required from Us. An extension of up to twenty-four (24) hours may be allowed if the Member and BFH agree.

The request for an internal appeal or an external review and any supporting documentation must be submitted to the following address: Appeals Coordinator, 651 Perimeter Drive, Suite 300, Lexington, Kentucky 40517.