POINT C STANDARD OPERATING PROCEDURE

TITLE:	Appeal Timeframes SOP	**INCEPTION DATE:**	**2/11/2026**
AUTHORITY:	Compliance/Clinical Operations	**REVISION DATE:**	
POLICY NUMBER:	**OP 2.0**	**RETIREMENT DATE:**	
URAC SUBSTANDARDS			

1. Purpose

The purpose of this Standard Operating Procedure (SOP) is to define the Kentucky-specific operational workflows and processes required for compliant Appeals activities performed by Point C in accordance with KRS 304.17A-600 through 304.17A-619, 29 CFR 2560.503-1, and the Kentucky Department of Insurance Utilization Review Registration Application requirements.

2. Scope

Applies to all internal appeals across pre-service, post-service, and concurrent/continued care determinations, including expedited (urgent) appeals. Governs intake, routing to independent peer review (IRO), determinations, notifications, and records.

3. DEFINITIONS

Appeal: A request to review an adverse/non-certification determination.

Expedited (Urgent) Appeal: Appeal where standard timeframes could jeopardize the member's health or ability to regain maximum function.

Adverse Benefit Determination (ABD): Denial, reduction, termination, or failure to provide or pay a benefit, including medical necessity and coverage denials.

Peer Reviewer: Licensed, independent clinician (via URAC-accredited IRO) rendering the appeal determination, not involved in the initial decision.

4. ROLES AND RESPONSIBILITIES

Appeals Intake Coordinator: Receives and date/time-stamps appeals; identifies level (urgent vs. standard) and category (pre-service, post-service, concurrent); ensures complete documentation.

UR Nurse / Appeals Reviewer: Verifies completeness, prepares case packet, submits to IRO portal, monitors deadlines, retrieves IRO decision, and issues notifications; processes claims adjustments as applicable.

URAC-Accredited Independent Review Organization (IRO): Provides independent physician review; physician is credentialed, board-certified/eligible, within scope, not involved in the initial decision, and free of conflict or outcome-based incentives.

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Compliance / Clinical Operations: Oversight and accountability for timeliness, notification content, and adherence to URAC/ERISA/state standards.

5. SUBMITTING AN APPEAL

5.0 Submitting an Appeal

1. How to file an appeal:
   Your appeal must be received in written form.
   Complete an Appeal form, make a copy and send the original to:
   Point C Health
   Appeals Division
   PO Box 25307
   Overland Park, KS 66225
   For questions call Customer Service: (872) 265-4701

2. Urgent Appeal:
   If your situation meets the definition of “urgent” under the law, your review will generally be conducted with in 72 hours. Generally an “urgent situation” is one in which your health may be in serious jeopardy or, in the opinion of your doctor, you may experience pain that cannot be adequately controlled while you wait for a decision of your appeal.

3. Who can Appeal:
   You or someone you name to act on your behalf (authorized representative) may file an appeal

4. Is additional information allowed?
   Yes, you may supply additional information. All pertinent information should be submitted with your appeal form.

5. Kentucky Additional Rights:

   If your coverage denial is upheld after completion of the internal appeal process, you maybe eligible to request an external review through the Kentucky Department of Insurance’s

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Independent External Review Program. Eternal review is conducted by an independent review entity assigned by the Department. You, or an authorized representative, or your provider (with your consent) may request an external review. You must submit request in writing within 60 days of receiving a final determination letter.

For instruction and required forms, contact:
Kentucky Department of Insurance
Division of Consumer Protection
Phone: (800) 595-6053
Website: https://insurance.ky.gov

6. OPERATIONAL PROCEDURE

5.1 Intake & Logging

1. Receive appeal via mail or fax from member, authorized representative, or provider. Date/time-stamp receipt (appeal clock starts on this date).
2. Classify the request as Urgent/Expedited (if delay may jeopardize life/health/function) or Standard, and as Pre-Service, Post-Service, or Concurrent Care.
3. Create case in appeals system; label with unique identifier (e.g., LastName, FirstName, MemberID, RequestType, DateReceived).

5.2 Completeness Check & Information Request

1. If documentation is incomplete, contact the requester (call or fax) and attempt every 3–4 business days until complete.
2. After 3 attempts, issue a Lack-of-Information notice. Document all attempts and correspondence.

5.3 IRO Submission & Review

1. Link all records to the denied authorization and submit the appeal to the IRO via web portal.
2. IRO conducts independent physician peer review (not involved in the initial decision; appropriate specialty/scope) and signs an attestation; no outcome-based incentives.

5.4 Determination & Notifications

1. Once the IRO posts the determination, retrieve it, verify the outcome, and file to the case record.

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2. Issue notifications to the member and provider within required timeframes (verbal/voicemail when required, followed by written notice).
3. Process claims adjustments if applicable.

5.5 Level II (If Applicable)

When multiple internal appeal levels are used, a Level II review is performed by a different independent physician peer reviewer. The combined internal appeal process may not exceed 60 calendar days from the initial appeal to the final internal adverse benefit determination (ACA §2719).

7. TIMEFRAMES FOR APPEAL DETERMINAITONS

6.1 Urgent (Expedited) Appeals

Determination as soon as possible, consistent with medical urgency, not later than 72 hours.

Event	Timeframe
Notification to claimant of insufficient information or failure to follow filing procedures	24 hours
Response window for claimant to supply information	48 hours
Benefit determination after claimant response	48 hours
Notification to claimant of claim determination (urgent appeal)	72 hours

6.2 Concurrent Care Claims Event

	Timeframe
Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination to allow appeal
Notification to claimant of rescission	30 days

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Determination on appeal of urgent claims (filed >24 hours before termination)	24 hours
Notification of adverse benefit determination on appeal (non-urgent)	As soon as feasible, but not more than 30 days

6.3 Pre-Service Claims Event

	Timeframe
Notification of adverse benefit determination	15 calendar days
Extension due to matters beyond the control of the plan	15 calendar days
Notification of insufficient information on the claim	15 days
Response by claimant after insufficient information notice	45 days
Notification (oral/written) of failure to follow plan's filing procedures	5 days
Notification of adverse benefit determination on appeal	30 days

6.4 Post-Service Claims Event

	Timeframe
Notification of adverse benefit determination	30 days
Extension due to matters beyond the control of the plan	15 days
Extension due to insufficient information on the claim	15 days
Response by claimant after insufficient information notice	45 days

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Notification of adverse benefit determination on appeal	60 days

8. WRITTEN NOTICE STANDARDS

- Specific reasons for the decision.
- References to plan provisions and/or clinical/medical necessity guidelines; provide copies of internal rules/guidelines upon request at no charge.
- Description of appeal procedures and time limits; for ERISA plans, the right to bring a civil action under ERISA §502 after final internal denial, if applicable.
- Statement of the claimant's right to access, free of charge, all documents, records, and information relevant to the claim.
- Verbal or voicemail notification to the member and attending physician/facility when required, followed by written notice.
- Notification of availability and instructions for initiating a peer-to-peer conversation, if one has not previously occurred.

9. KENTUCKY STATE SPECIFIC REQUIREMENTS

- Internal appeal timeframes: Standard 30 calendar days; Expedited (urgent) 72 hours or sooner if medical exigencies require.
- Reviewer qualifications: licensed physicians not involved in initial denial; board-eligible/board-certified; (sub)specialty-matched upon request; multiple IREs used on rotation.
- Continued coverage during internal appeals (ACA §2719 preemption): maintain ongoing treatment; advance notice before reduction/termination; allow simultaneous expedited external review for urgent or ongoing care.
- Appeals deemed exhausted if plan fails to comply (subject to de minimis exception with written explanation within 10 calendar days upon request).
- Recordkeeping: maintain appeal records (reason; dates received, reviewed, decided; outcome; reviewer credentials) for 5 years.
- Coverage denials & DOI: respond within 10 business days to DOI review requests; DOI may direct coverage or immediate external review if medical issue must be evaluated.
- External review: filing window 4 months from final internal decision; expedited external review completed within 24 hours of IRE receiving required info (up to 72 hours by agreement); standard external review

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completed within 21 days of receiving all required info (up to 45 days with permitted extension); member filing fee $25 (annual cap $75; waiver/refund for hardship or overturned decision).

10. POLICY HISTORY

Policy Number	Author	Description of Change & Reason	Approval Date	Distribution Date
OP 2.0	Jennifer Sweeney	Initial SOP Drafted	2/11/2026	

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