LABOR CABINET

Department of Workers' Claims

(Amended After Comments)

803 KAR 25:190. Utilization review -- Medical Bill Audit -- Medical Director -- Appeal of Utilization Review Decisions.

RELATES TO: KRS Chapter 342

STATUTORY AUTHORITY: KRS 342.035(5) and (6), 342.260

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 provides that the Commissioner [~~Executive Director~~] of the Department [~~Office~~] of Workers' Claims shall promulgate administrative regulations necessary to carry on the work of the Department [~~Office~~] of Workers' Claims, and the commissioner [~~executive director~~] may promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342. KRS 342.035(5) provides that the commissioner [~~Executive Director~~] of the Department [~~Office~~] of Workers' Claims shall promulgate administrative regulations that require each insurance carrier, group self-insurer and individual self-insured employer to certify to the commissioner [~~executive director~~] the program it has adopted to insure compliance with the medical fee schedule provisions of KRS 342.035(1) and (4). KRS 342.035(5) also requires the commissioner [~~executive director~~] to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, group self-insurer or self-insured employer pursuant to KRS Chapter 342.

KRS 342.035(6) allows the commissioner to promulgate regulations incorporating managed care or other concepts intended to reduce costs or to speed the delivery of payment of medical services to employees receiving medical and related benefits under KRS Chapter 342. This administrative regulation insures that insurance carriers, group self-insurers, and individual self-insured employers implement a utilization review and audit program and establishes a medical director to speed the delivery of payment of medical services to employees receiving medical and related benefits under this chapter. This administrative regulation does not abrogate the right, as provided in KRS 342.020, of an injured employee to choose his treating physician, or an employer to participate in a managed health care system.

Section 1. Definitions. (1) "Business day" means any day except Saturday, Sunday or any day which is a legal holiday.

(2) "Calendar day" means all days in a month, including Saturday, Sunday and any day which is a legal holiday.

(3) "Carrier" is defined by KRS 342.0011(6).

(4) [~~(2)~~] "Commissioner" is defined by KRS 342.0011(9).

(5) [~~(3)~~] "Denial" means a determination by the utilization reviewer that the medical treatment, proposed treatment, service, or medication [~~or service~~] under review is not medically necessary or appropriate and, therefore, payment is not recommended.

(6) "Department" means the Kentucky Department of Workers' Claims.

(7) [~~(4)~~] "Medical bill audit" means the review of medical bills for services which have been provided to assure compliance with adopted fee schedules.

(8) "Medical Director" means the Medical Director of the Department of Workers' Claims appointed by the Secretary.

(9) "Medically necessary" or "medical necessity" is defined in 803 KAR 25:260(12).

(10). "Medical provider" is defined in 803 KAR 25:260 Section 1(11).

(11) "Physician" is defined by KRS 342.0011(32).

(12) [~~(5)~~] "Preauthorization" is defined in 803 KAR 25:260(14). means a process whereby payment for a medical service or course of treatment is assured in advance by a carrier.

(13) "Secretary" means the Secretary of the Kentucky Labor Cabinet.

(14) [~~(6)~~] "Utilization review" means a review of the medical necessity and appropriateness of medical care and services for purposes of recommending payments for a compensable injury or disease.

(15) [~~(7)~~] "Utilization review and medical bill audit plan" means the written plan submitted to the commissioner [executive director] by each carrier describing the procedures governing utilization review and medical bill audit activities.

(16) [~~(8)~~] "Vendor" means a person or entity which implements a utilization review and medical bill audit program for purposes of offering those services to carriers.

Section 2. Implementation. (1) The requirements established in Sections 3 through 9 of this administrative regulation shall apply to all utilization reviews and medical bill audits conducted before **June [~~January~~]** 1, 2022.

(2) The requirements established in Sections 10 through 18 of this administrative regulation shall apply to all utilization reviews and medical bill audits conducted on or after **June [~~January~~]** 1, 2022.

Section 3 [~~2~~]. Utilization Review and Medical Bill Audit Program. (1) The utilization review program shall assure that:

(a) A utilization reviewer is appropriately qualified;

(b) Treatment rendered to an injured worker is medically necessary and appropriate; and

(c) Necessary medical services are not withheld or unreasonably delayed.

(2) The medical bill audit program shall assure that:

(a) A statement or payment for medical goods and services and charges for a deposition, report, or photocopy complies with KRS Chapter 342 and applicable administrative regulations;

(b) A medical bill auditor is appropriately qualified; and

(c) A statement for medical services is not disputed without reasonable grounds.

Section 4 [~~3~~]. Utilization Review and Medical Bill Audit Plan Approval. (1) A carrier shall fully implement and maintain a utilization review and medical bill audit program.

(2) A carrier shall provide to the commissioner [~~executive director~~] a written plan describing the utilization re-view and medical bill audit program. The commissioner [~~executive director~~] shall approve each utilization review and medical bill audit plan which complies with the requirements of this administrative regulation and KRS Chapter 342.

(3) A vendor shall submit to the commissioner [~~executive director~~] for approval a written plan describing the utilization review and medical bill audit program. Upon approval, the vendor shall receive written notice from the commissioner [~~executive director~~].

(4) A carrier who contracts with an approved vendor for utilization review or medical bill audit services shall notify the commissioner [~~executive director~~] of the contractual arrangement. The contractual arrangement may provide for separate utilization review and medical bill audit vendors.

(5) A plan shall be approved for a period of four (4) years [~~, or until December 31, 2000, whichever is later~~].

(a) At least ninety (90) calendar days prior to the expiration of the period of approval, a carrier or its approved vendor shall apply for renewal of the approval.

(b) During the term of an approved plan, the commissioner [~~executive director~~] shall be notified as soon as practicable of a material change in the approved plan or a change in the selection of a vendor.

Section 5 [4]. Utilization Review and Medical Bill Audit Written Plan Requirements. The written utilization review and medical bill audit plan submitted to the commissioner [~~executive director~~] shall include the following elements:

(1) A description of the process, policies and procedures whereby decisions shall be made;

(2) A description of the specific criteria utilized in the decision making process, including a description of the specific medical guidelines used as the resource to confirm the medical diagnosis and to provide consistent criteria and practice standards against which care quality and related costs are measured;

(3) A description of the criteria by which claims, medical services and medical bills shall be selected for review;

(4) A description of the qualifications of internal and consulting personnel who shall conduct utilization review and medical bill audit and the manner in which the personnel shall be involved in the review process;

(5) A description of the process to assure that a treatment plan shall be obtained for review by qualified medical personnel if a treatment plan is required by 803 KAR 25:096;

(6) A description of the process to assure that a physician shall be designated by each injured employee as required under 803 KAR 25:096;

(7) A description of the process for rendering and promptly notifying the medical provider and employee of the initial utilization review decision;

(8) A description of the reconsideration process within the structure of the utilization review and medical bill audit program;

(9) An assurance that a database shall be maintained, which shall:

(a) Record:

1. Each instance of utilization review;

2. Each instance of medical bill audit;

3. The name of the reviewer;

4. The extent of the review;

5. The conclusions of the reviewer; and

6. The action, if any, taken as the result of the review;

(b) Be maintained for a period of at least two (2) years; and

(c) Be subject to audit by the commissioner [~~executive director~~], or his agent, pursuant to KRS 342.035(5)(b);

(10) An assurance that a toll free line shall be provided for an employee or medical provider to contact the utilization reviewer. The reviewer or a representative of the reviewer shall be reasonably accessible to an interested party at least five (5) days per week, forty (40) hours per week during normal business hours;

(11) A description of the policies and procedures that shall be implemented to protect the confidentiality of patient information; and

(12) An assurance that medical treatment guidelines adopted by the commissioner pursuant to KRS 342.035 (8)(a) shall be incorporated in the plan as the standard for utilization review medical decision making. ~~[An assurance that the acute low back pain practice parameter adopted by the executive director pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the standard for evaluating an applicable low back claim. Additional medical guidelines which may be adopted by the executive director pursuant to KRS 342.035(8)(a) shall be incorporated in a utilization review plan.]~~

Section 6 [~~5~~]. Claim Selection Criteria. (1) Unless the carrier, in good faith, denies the claim as noncompensable, medical services reasonably related to the claim shall be subject to utilization review if:

(a) A medical provider requests preauthorization of a medical treatment or procedure;

(b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan is received;

(c) The total medical costs cumulatively exceed $3000;

(d) The total lost work days cumulatively exceed thirty (30) days; or

(e) An arbitrator or administrative law judge orders a review.

(2) If applicable, utilization review shall commence when the carrier has notice that a claims selection criteria has been met.

(a) The following requirements shall apply if preauthorization has been requested:

1. The initial utilization review decision shall be communicated to the medical provider and employee within two (2) business [~~working~~] days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional business [~~working~~] days.

2. The requested information shall be tendered by the medical provider within ten (10) business [~~working~~] days.

3. The initial utilization review decision shall be rendered within two (2) business [~~working~~] days following receipt of the requested information.

(b) The following requirements shall apply if retrospective utilization review occurs:

1. The initial utilization review decision shall be communicated to the medical provider and employee within ten (10) calendar days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional business [~~working~~] days.

2. The requested information shall be tendered by the medical provider within ten (10) business [~~working~~] days.