CHAPTER 145

(HB 174)

AN ACT relating to insurance.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF KRS 304.14-600 TO 304.14-625 IS CREATED TO READ AS FOLLOWS:

(1) Any long term care policy, issued on or after the effective date of this Act, which provides coverage for assisted living benefits shall cover services received in any assisted living community which:

(a) Meets the requirements of KRS 194A.700 to 194A.729 and any administrative regulations promulgated under KRS 194A.700 to 194A.729; and

(b) Meets any additional requirements of an assisted living community set forth in the long term care policy approved by the commissioner.

(2) Any long term care policy, issued on or after the effective date of this Act, which provides coverage for adult day care services shall cover services received in any adult day care facility which:

(a) Meets the requirements of KRS 205.950 or 216B.0443 and any administrative regulations promulgated under KRS 205.950 or 216B.0443; and

(b) Meets any additional requirements of an adult day care center set forth in the long term care policy approved by the commissioner.

Section 2. KRS 304.17A-607 is amended to read as follows:

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the department. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that only licensed physicians shall:

1. Make a 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, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264

and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Be available twenty-four (24) hours a day, seven (7) days a week to conduct:

1. Preadmission review of an emergency admission, if preauthorization is required for emergency admissions or use of an emergency room;

2. Preauthorization of weekend admissions to a hospital, or to review services delivered on the weekend or after normal business hours, if the covered person is subject to preauthorization on weekends or after normal business hours; and

3. Review of a patient's continued hospitalization, if a prior authorization will expire on a weekend;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section and administrative regulations promulgated in accordance with KRS 304.17A-609;

(h) Provide a utilization review decision:

1. Within twenty-four (24) hours of a request for:

a. Preadmission review of a hospital admission, unless additional information is needed;

b. Preauthorization of treatment when the covered person is already hospitalized; or

c. Retrospective review of an emergency hospital admission;

2. Within two (2) business days of a receipt of a request for preauthorization for a treatment, procedure, drug, or device;

3. Within twenty-four (24) hours of receipt of a request for review of a covered person's continued hospital stay and prior to the time when a previous authorization for hospital care will expire; and

4. Within twenty (20) business days of the receipt of requested medical information when the insurer or private review agent has initiated a retrospective review;

(i) Provide written notice of review decisions to the covered person, authorized person, and providers. An insurer or agent that denies coverage or reduces payment for a treatment, procedure, drug, or device shall include in the written notice:

1. A statement of the specific medical and scientific reasons for denial or reduction of payment;

2. The name, state of licensure, medical license number, and the title of the reviewer making the decision;

3. A description of~~[other]~~ alternative ***benefits***~~[treatments]~~, services, or supplies covered by the health benefit plan; and

4. Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, time limitations, or schedules for filing appeals, and the name and phone number of a contact person who can provide additional information;

(j) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and

(k) Comply with its own policies and procedures on file with the department.

(2) The insurer's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be an adverse determination by the insurer for the purpose of initiating an internal appeal as set forth in KRS 304.17A-617. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the department. No change to policies and procedures shall be effective until thirty (30) days after it has been filed with and approved by the commissioner.

(4) A private review agent shall provide to the department the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

Section 3. KRS 304.17A-617 is amended to read as follows:

(1) Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer shall disclose the availability of the internal review process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements set forth in KRS 304.17A-607(1)(i). For purposes of this section "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. Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for review by the department.

(2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person. The internal appeals process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse determinations made under utilization review and of coverage denials, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review. At a minimum, these procedures shall include the following:

(a) Insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal;

(b) Insurers or their designees shall render a decision not later than three (3) business days after the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. 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;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of a bodily organ or part;

(c) Internal appeal of an adverse determination shall only be conducted by a licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(d) Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers given the opportunity to present additional information;

(e) To facilitate expeditious handling of an appeal of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for a covered person shall provide the person undertaking an appeal with a denial letter that shall include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;

2. The name, state of licensure, medical license number, and the title of the person making the decision;

3. A description of~~[other]~~ alternative ***benefits***~~[treatments]~~, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating an internal appeal of the adverse determination, or filing a request for review with the department where a coverage denial is upheld by the insurer on internal appeal.

(3) The department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers. For purposes of this subsection "coverage denials" shall not include an adverse determination as defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

(a) On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the department shall notify the insurer which issued the

denial of the request for review and shall call for the insurer to respond to the department regarding the request for review within five (5) days receipt of notice to the insurer;

(b) Within five (5) days of receiving the notice of the request for review from the department, the insurer shall provide to the department the following information:

1. Confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person on the date of service under a health benefit plan issued by the insurer;

2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process under this section; and

3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available;

(c) In addition to the information described in paragraph (b) of this subsection, the insurer and the covered person, authorized person, or provider shall provide to the department any information requested by the department that is germane to its review;

(d) On the receipt of the information described in paragraphs (b) and (c) of this subsection, unless the department is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's health benefit plan. If the department determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review under KRS 304.17A-621, 304.17A-623, and 304.17A-625, where the conditions precedent to the review are present. If the department notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review.

Approved March 20, 2001