CHAPTER 181

(SB 38)

AN ACT relating to health insurance.

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

Section 1. KRS 304.17-3163 is amended to read as follows:

(1) All insurers issuing individual health insurance policies in this Commonwealth providing coverage on an expense-incurred basis shall make available and offer to the purchaser coverage for:

(a) ***The following, if an insurer provides medical and surgical benefits with respect to mastectomy, in a manner determined in consultation with the attending physician and the covered person, and subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the coverage:***

1. All stages of breast reconstruction surgery ***of the breast on which a mastectomy has been performed***~~[following a mastectomy that resulted from breast cancer if the insurer also covers mastectomies]~~;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

(b) Diagnosis and treatment of endometriosis and endometritis if the insurer also covers hysterectomies; and

(c) Bone density testing for women age thirty-five (35) ***years*** and older, as indicated by the health-care provider, in accordance with standard medical practice, to obtain baseline data for the purpose of early detection of osteoporosis.

(2) No insurer under this section shall offer ***medical and surgical benefits with respect to a mastectomy***~~[coverage for mastectomies]~~ that requires the procedure to be performed on an outpatient basis.

(3) An insurer shall provide written notice to a covered person of the availability of medical and surgical benefits with respect to a mastectomy upon enrollment and annually thereafter.

(4) An insurer shall not:

(a) Deny eligibility, or continued eligibility, to an individual to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of 42 U.S.C. sec. 300gg-52; and

(b) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives to an attending provider, to induce the provider to provide care to an individual in a manner inconsistent with 42 U.S.C. sec. 300gg-52.

Section 2. KRS 304.17A-134 is amended to read as follows:

(1) A health benefit plan~~[issued or renewed on or after July 15, 1996,]~~ shall make available and offer to the purchaser coverage for:

(a) ***The following, if a health benefit plan provides medical and surgical benefits with respect to mastectomy, in a manner determined in consultation with the attending physician and the covered person, and subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the coverage:***

1. ***All stages of*** breast reconstruction surgery ***of the breast on which the mastectomy has been performed***~~[following a mastectomy that resulted from breast cancer if the insurer also covers mastectomies]~~;

2. ***Surgery and reconstruction of the other breast to produce a symmetrical appearance; and***

3. ***Prostheses and physical complications of all stages of mastectomy, including lymphedemas;***

(b) Diagnosis and treatment of endometriosis and endometritis if the ***health benefit plan***~~[insurer]~~ also covers hysterectomies; and

(c) Bone density testing for women age thirty-five (35) ***years*** and older, as indicated by the health-care provider, in accordance with standard medical practice, to obtain baseline data for the purpose of early detection of osteoporosis.

(2) No health benefit plan under this section shall offer ***medical and surgical benefits with respect to a mastectomy***~~[coverage for mastectomies]~~ that requires the procedure be performed on an outpatient basis.

(3) A health benefit plan shall provide written notice to a covered person of the availability of medical and surgical benefits with respect to a mastectomy upon enrollment and annually thereafter.

(4) A health benefit plan shall not:

(a) Deny eligibility, or continued eligibility, to an individual to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of 42 U.S.C. sec. 300gg-52; and

(b) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives to an attending provider, to induce the provider to provide care to an individual in a manner inconsistent with 42 U.S.C. sec. 300gg-52.

Section 3. KRS 304.17A-527 is amended to read as follows:

(1) A managed care plan as defined in KRS 304.17A-500 shall file with the commissioner sample copies of any agreements it enters into with providers for the provision of health care services. The commissioner shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements ***and contracts entered into or renewed after the effective date of this Act*** shall include the following:

(a) A hold harmless clause that states that the provider may not, under any circumstance, including:

1. Nonpayment of moneys due the providers by the managed care plan,

2. Insolvency of the managed care plan, or

3. Breach of the agreement,

bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services;

(b) A continuity of care clause that states that if an agreement between the provider and the managed care plan is terminated for any reason, other than a quality of care issue or fraud, the provider shall continue to provide services and reimburse the provider in accordance with the agreement until the subscriber, dependent of the subscriber, or the enrollee is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy;

(c) A survivorship clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the provider and the managed care plan;~~[and]~~

(d) ***A clause stating that, upon request, the insurer shall provide the provider with specific fees for requested codes applicable to the compensation that the provider will receive under the contract with the insurer within thirty (30) days of the date of such request; and***

(e) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide ***their licensed*** health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan ***where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services,*** the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

(2) An insurer that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the commissioner. The insurer shall also file the following information regarding the risk-sharing arrangement:

(a) The number of enrollees affected by the risk-sharing arrangement;

(b) The health care services to be provided to an enrollee under the risk-sharing arrangement;

(c) The nature of the financial risk to be shared between the insurer and entity or provider, including, but not limited to, the method of compensation;

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated administrative functions; and

(e) The insurer's oversight and compliance plan regarding the standards and method of review.

(3) Nothing in this section shall be construed as requiring an insurer to submit the actual financial information agreed to between the insurer and the entity or provider. The

commissioner shall have access to a specific risk sharing arrangement with an entity or provider upon request to the insurer. Financial information obtained by the department shall be considered to be a trade secret and shall not be subject to KRS 61.872 to 61.884.

Section 4. KRS 304.17A-600 is amended to read as follows:

As used in KRS 304.17A-600 to 304.17A-633:

(1) (a) "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:

1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and

2. Benefit coverage is therefore denied, reduced, or terminated.

(b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions;

(3) "Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay;

(4) "Covered person" means a person covered under a health benefit plan;

(5) "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(6) "Health benefit plan" means the document evidencing and setting forth the terms and conditions of coverage of any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network policy or certificate; a self-insured policy or certificate or a policy or certificate provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; ***or limited health service benefit plans;*** and for purposes of KRS 304.17A-600 to 304.17A-633 includes short-term coverage policies***;***~~[.]~~

(7) "Independent review entity" means an individual or organization certified by the department to perform external reviews under KRS 304.17A-623, 304.17A-625, and 304.17A-627[. An independent review entity which is accredited by the National Commission on Quality Assurance, the American Accreditation Health Care Commission, or another nationally recognized accreditation organization as identified by the department shall be deemed certified by the department];

(8) "Insurer" means any of the following entities authorized to issue health benefit plans as defined in subsection (6) of this section: an insurance company, health maintenance ***organization***[origination]; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association; nonprofit hospital, medical-surgical, or health service corporation; or any other entity authorized to transact health insurance business in Kentucky;

(9) "Internal appeals process" means a formal process, as set forth in KRS 304.17A-617, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent;

(10) ***"Nationally recognized accreditation organization" means a private nonprofit entity that sets national utilization review and internal appeal standards and conducts review of insurers, agents, or independent review entities for the purpose of accreditation or certification. Nationally recognized accreditation organizations shall include the National Committee for Quality Assurance (NCQA), the American Accreditation Health Care Commission (URAC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any other organization identified by the department;***

(11) "Private review agent" or "agent" means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth. "Private review agent" or "agent" does not include an independent review entity which performs external review of adverse determinations;

(12)[(11)] "Prospective review" means utilization review that is conducted prior to a hospital admission or a course of treatment;

(13)[(12)] "Provider" shall have the same meaning as set forth in KRS 304.17A-005;

(14)[(13)] "Qualified personnel" means licensed physician, registered nurse, licensed practical nurse, medical records technician, or other licensed medical personnel who through training and experience shall render consistent decisions based on the review criteria***;***[.]

(15)[(14)] "Registration" means an authorization issued by the department to an insurer or a private review agent to conduct utilization review***;***[.]

(16)[(15)] "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person. "Retrospective review" does not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment;

(17)[(16)] "Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person

for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review***; and***[~~.~~]

(18)[~~(17)~~] "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

Section 5. 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) ***Where an insurer, its agent, or private review agent provides or performs utilization review,*** be available ***to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays***[~~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 ***within the timeframes listed in this paragraph that will be followed by written notice of the decision within one (1) business day of the date the decision is rendered. A written notice in electronic format, including E-mail or facsimile, may suffice for this purpose where the covered person, authorized person, or provider has agreed in advance in writing to receive such notices electronically and shall include the required elements of subsection (j) of this section***:

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 ***, unless there is a documented need for additional information***; ***and***

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 a utilization review decision 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;***

(j) 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 alternative benefits, services, or supplies covered by the health benefit plan***, if any***; 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, ***and any specific filing procedures, including any applicable*** time limitations, or schedules~~[for filing appeals]~~, and the

position[name] and phone number of a contact person who can provide additional information;

(k)[(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

(l)[(k)] Comply with its own policies and procedures on file with the department ***or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law***.

(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 ***or used*** 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 6. KRS 304.17A-609 is amended to read as follows:

The department shall promulgate emergency administrative regulations regarding utilization review and internal ***appeal***[review], including the specification of information required of insurers and private review agents which shall, at a minimum, include:

(1) A utilization review plan ***that contains all***[that includes] information utilized for conducting preadmission, admission, readmission review, preauthorization, continued stay authorization, and retrospective review ***and which***[that], for each type of review, includes:

(a) Utilization review policies and procedures to evaluate proposed or delivered medical services;

(b) Time frames for review;

(c) A written summary describing the review process and required forms;

(d) Documentation ***that actively practicing providers with appropriate qualifications are involved in the development or adoption*** of[qualifications of personnel who developed the specific] utilization review ***criteria***[procedures] relating to specialty and subspecialty areas;

(e) Descriptions and names of review criteria upon which utilization review decisions are based; and

(f) Additional standards, if any, for the consideration of special circumstances.

(2) The type and qualifications of the personnel either employed or under contract to perform utilization review;

(3) Assurance that a toll-free line will be provided that covered persons, authorized persons, and providers may use to contact the insurer or private review agent;

(4) The policies and procedures to ensure that a representative of the insurer or private review agent shall be reasonably accessible to covered persons, authorized persons, and providers at least forty (40) hours per week during normal business hours;

(5) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(6) A copy of the materials designed to inform covered persons, authorized persons, and providers of the toll-free number and the requirements of the utilization review plan;

(7) A list of the entities for which the private review agent is performing utilization review in this state; and

(8) Evidence of compliance or the ability to comply with the requirements and procedures established regarding utilization review and the administrative regulations promulgated thereunder.

(9) In lieu of disclosing information specified in subsection (1) of this section, an insurer or private review agent may submit to the department evidence of accreditation or certification, if any, with a nationally recognized accreditation organization that oversees the information described in subsections (1) to (8) of this section, provided that the department may still require the information in subsection (8) of this section or other information to demonstrate compliance with the requirements of this section and Sections 4, 5, 7, 8, 9, and 10 of this Act not covered by the standards of the nationally recognized accreditation organization, as well as basic information necessary for the department to contact the insurer or private review agent. Nothing in this subsection shall be construed to prohibit or in any way limit the department's authority to require the submission of information specified in subsections (1) to (8) of this section or any other information the department deems necessary for purposes of investigating a complaint that the insurer or private review agent is not in compliance with KRS 304.17A-600 to 304.17A-633.

Section 7. KRS 304.17A-613 is amended to read as follows:

(1) The department shall, through the promulgation of emergency administrative regulations, develop a process:

(a) For the review of applications for registration of insurers or private review agents seeking to conduct utilization reviews;

(b) For the review of applications for insurers or private review agents seeking registration renewal to continue as a utilization review entity;

(c) Ensuring that no registration shall be approved unless the commissioner has documentation or findings that all applicants seeking registration or renewal to conduct utilization review are in compliance with the requirements and procedures established regarding utilization review, and as to renewals, have complied with KRS 304.17A-600 to 304.17A-633 and administrative regulations promulgated to enforce and to administer KRS 304.17A-600 to 304.17A-633; and

(d) Establishing fees for applications and renewals in an amount sufficient to pay the administrative costs of the program and any other costs associated with carrying out the provisions of KRS 304.17A-600, 304.17A-603, 304.17A-605, 304.17A-607, 304.17A-609, 304.17A-611, 304.17A-613, and 304.17A-615.

(2) The registration issued in accordance with this section expires on the second anniversary of the effective date unless it is renewed.

(3) The registration issued under this section is not transferable.

(4) The commissioner may revoke or suspend the utilization review registration of any insurer or private review agent who does not comply with the requirements and procedures established regarding utilization review or any administrative regulations promulgated thereunder.

(5) The department shall establish reporting requirements to:

(a) Evaluate the effectiveness of insurers and private review agents; and

(b) Determine if the utilization review plans are in compliance with the requirements and procedures established regarding utilization review and applicable administrative regulations.

(6) Upon request of any provider, authorized person, or covered person whose care is subject to review, the department shall provide copies of policies or procedures of any insurer or private review agent that has been issued a registration by the department to conduct review in this state.

(7) Notwithstanding any provision to the contrary, an insurer or private review agent registered and in good standing under the provisions of KRS 211.461 to 211.466, prior to July 14, 2000, shall be deemed in compliance with requirements and procedures established in KRS 304.17A-600 to 304.17A-633 regarding utilization review and registered accordingly.

(8) Upon receipt of written complaints from covered persons, authorized persons, or providers stating that an insurer or a private review agent has failed to perform a review in accordance with the utilization review plan or the requirements and procedures established regarding utilization review, or administrative regulations promulgated thereunder, the commissioner shall:

(a) Send a copy of the complaint to the insurer or the private review agent within ten (10) days of receipt of the complaint, and require that any written reply be sent to the commissioner within ten (10) days; and

(b) Review the complaint and any written reply received from the insurer or private review agent within the time frames set forth in paragraph (a) of this subsection and make a recommendation to the insurer or private review agent and the covered person, authorized person, or provider.

(9) The commissioner shall consider complaints before issuing or renewing any registration or renewal of a registration to an insurer or a private review agent.

(10) Notwithstanding any provision in this section to the contrary, the department shall accept accreditation or certification by a nationally recognized accreditation organization as sufficient documentation or finding for purposes of subsections (1) and (5) of this section that the insurer or private review agent meets the application requirements for registration or renewal. Insurers or private review agents accredited or certified by a

nationally recognized accreditation organization shall be deemed compliant with the utilization review and internal appeals requirements of this section and Sections 4, 5, 6, 8, 9, and 10 of this Act and administrative regulations to the extent the standards of such nationally recognized accreditation organization sufficiently meet these requirements. The department shall have a simplified process in administrative regulations for insurers and private review agents to register using accreditation or certification and shall limit any additional documentation only for demonstrating compliance with requirements in this section and Sections 4, 5, 6, 8, 9, and 10 of this Act not met by the standards of a nationally recognized accreditation organization.

Section 8. 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 ***Section 5(1)(j) of this Act***~~[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 ***internal appeal***~~[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 ***receipt of*** 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) ***In addition to any previous notice required under Section 5(1)(j) of this Act, and*** to facilitate expeditious handling of ***a request for external review***~~[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 ***covered*** person***, authorized person, or provider acting on behalf of the covered person***~~[undertaking an appeal]~~ with ***an internal appeal determination***~~[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 alternative benefits, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating an ***external review of an***~~[internal appeal of the]~~ adverse determination, or filing a request for review with the department ***if***~~[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 ***of*** 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 ***on the date the service was sought or denied***;

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.

(e) An insurer shall be required to cover the treatment, service, drug, or device that was denied or provide notification of the right to external review in accordance with paragraph (d) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer.

(f) If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed thirty (30) days, or provide the covered person the opportunity for external review.

Section 9. KRS 304.17A-623 is amended to read as follows:

(1) Every insurer shall have an external review process to be utilized by the insurer or its designee, consistent with this section and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer, its designee, or agent shall disclose the availability of the external review process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial as set forth in ***Section 5(1)(j) of this Act***~~[KRS 304.17A-607(1)(i)]~~ and ***in the denial letter required in KRS*** 304.17A-617(1) and (2)(e). 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.

(2) A covered person, an authorized person, or a provider acting on behalf of and with the consent of the covered person, may request an external review of an adverse determination rendered by an insurer, its designee, or agent.

(3) The insurer shall provide for an external review of an adverse determination if the following criteria are met:

(a) The insurer, its designee, or agent has rendered an adverse determination;

(b) The covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2). The insurer and the covered person may however, jointly agree to waive the internal appeal requirement;

(c) The covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and

(d) The entire course of treatment or service will cost the covered person at least one hundred dollars ($100) if ***the***~~[not]~~ covered ***person had no insurance***~~[by the insurer]~~.

(4) The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within sixty (60) days, except as set forth in KRS 304.17A-619(1), of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process. As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

(5) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the independent review entity and which may be waived if the independent review entity determines that the fee creates a financial hardship on the covered person. The fee shall be refunded if the independent review entity finds in favor of the covered person.

(6) A covered person shall not be afforded an external review of an adverse determination if:

(a) The subject of the covered person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and

(b) No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

(7) The department shall establish a system for each insurer to be assigned an independent review entity for external reviews. The system established by the department shall be prospective and shall require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two (2) consecutive external reviews. The department shall contract with no less than two (2) independent review entities.

(8) (a) If a dispute arises between an insurer and a covered person regarding the covered person's right to an external review, the covered person may file a complaint with the department. Within five (5) days of receipt of the complaint, the department shall render a decision and may direct the insurer to submit the dispute to an independent review entity for an external review if it finds:

1. The dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and

2. All of the requirements of subsection (3) of this section have been met.

(b) The complaint process established in this section shall be separate and distinct from, and shall in no way limit other grievance or complaint processes available to consumers under other provisions of the KRS or duly promulgated administrative regulations. This complaint process shall not limit, alter, or supplant the mechanisms for appealing coverage denials established in KRS 304.17A-617.

(9) The external review process shall be confidential and shall not be subject to KRS 61.805 to 61.850 and KRS 61.870 to 61.884.

(10) External reviews shall be conducted in an expedited manner by the independent review entity if the covered person is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame 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 her unborn child in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of a bodily organ or part.

(11) Requests for expedited external review, shall be forwarded by the insurer to the independent review entity within twenty-four (24) hours of receipt by the insurer.

(12) For expedited external review, a determination shall be made by the independent review entity within twenty-four (24) hours from the~~[date of its]~~ receipt of ***all information required***~~[notice of the adverse determination]~~ from the insurer. An extension of up to twenty-four (24) hours may be allowed if the covered person and the insurer or its designee agree. The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication, that the adverse determination has been assigned to an independent review entity for expedited review.

(13) External reviews which are not expedited shall be conducted by the independent review entity and a determination made within twenty-one (21) calendar days of receipt of the request for external review. An extension of up to fourteen (14) calendar days may be allowed if the covered person and the insurer are in agreement.

Section 10. KRS 304.17A-625 is amended to read as follows:

(1) In making its decision, an independent review entity conducting the external review shall take into account all of the following:

(a) Information submitted by the insurer, the covered person, the authorized person, and the covered person's provider, including the following:

1. The covered person's medical records;

2. The standards, criteria, and clinical rationale used by the insurer to make its decision; and

3. The insurer's health benefit plan.

(b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health, or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, and the United States Food and Drug Administration, the ***Centers for Medicare & Medicaid Services***~~[Health Care Financing Administration]~~ of the United States Department of Health and Human Services, and the Agency for Health Care Research and ***Quality***~~[Policy]~~; and

(c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical specialists, and clinical guidelines adopted by relevant national medical societies.

(2) The independent review entity shall base its decision on the information submitted under subsection (1) of this section. In making its decision, the independent review entity shall consider safety, appropriateness, and cost effectiveness.

(3) The insurer shall provide any coverage determined by the independent review entity to be medically necessary. The independent review entity shall not be permitted to allow coverage for services specifically limited or excluded by the insurer in its health benefit plan. The decision shall apply only to the individual covered person's external review.

(4) Nothing in this section shall be construed as requiring an insurer to provide coverage for out of network services, procedures, or tests, except as set forth in KRS 304.17A-515(1)(c) and 304.17A-550.

(5) The insurer shall be responsible for the cost of the external review.

(6) The independent review entity shall provide to the covered person, treating provider, insurer, and the department a decision which shall include:

(a) The findings for either the insurer or covered person regarding each issue under review;

(b) The proposed service, treatment, drug, device, or supply for which the review was performed;

(c) The relevant provisions in the insurer's health benefit plan and how applied; and

(d) The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

(7) The decision of the independent review entity shall not be made solely for the convenience of the insurer, the covered person, or the provider.

(8) Consistent with the rules of evidence, a written decision prepared by an independent review entity shall be admissible in any civil action related to the adverse determination. The independent review entity's decision shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

(9) The decision of the independent review entity shall be binding on the insurer with respect to that covered person. Failure of the insurer to provide coverage as required by the independent review entity shall:

(a) Be a violation of the insurance code of a nature sufficient to warrant the commissioner revoking or suspending the insurer's license or certificate of authority; and

(b) Constitute an unfair claims settlement practice as set forth in KRS 304.12-230.

(10) Failure to provide coverage as required by the independent review entity shall also subject the insurer to the provisions of KRS 304.99-010 and 304.99-020 and require the insurer to pay the claim that was the subject of the external review, without need for the covered person or authorized person to further establish a right as to the payment amount. Reasonable attorney fees associated with the actions of the insured necessary to collect amounts owed the covered person shall be assessed against and borne by the insurer.

(11) ***The insurer shall implement the decision of the independent review entity whether the covered person has disenrolled or remains enrolled with the insurer.***

(12) If the covered person has been disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was previously denied by the insurer, its agent, or designee and later approved by the independent review entity for a period not to exceed thirty (30) days.

(13) Within thirty (30) days of the decision in favor of the covered person by the independent review entity, the insurer shall provide written notification to the department that the decision has been implemented in accordance with this section.

(14) An independent review entity and any medical specialist the entity utilizes in conducting an external review shall not be liable in damages in a civil action for injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review. This subsection does not grant immunity from civil liability or professional disciplinary action to an independent review entity or medical specialist for an action that is outside the scope of authority granted in KRS 304.17A-621, 304.17A-623, and 304.17A-625.

(15)[~~(12)~~] Nothing in KRS 304.17A-600 to 304.17A-633 shall be construed to create a cause of action against any of the following:

(a) An employer that provides health care benefits to employees through a health benefit plan;

(b) A medical expert, private review agent, or independent review entity that participates in the utilization review, internal appeal, or external review addressed in KRS 304.17A-600 to 304.17A-633; or

(c) An insurer or provider acting in good faith and in accordance with any finding, conclusion, or determination of an Independent Review Entity acting within the scope of authority set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625.

(16)[~~(13)~~] The covered person, insurer, or provider in the external review may submit written complaints to the department regarding any independent review entity's actions believed to be an inappropriate application of the requirements set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625. The department shall promptly review the complaint, and if the department determines that the actions of the independent review entity were inappropriate, the department shall take corrective measures, including decertification or suspension of the independent review entity from further participation in external reviews. The department's actions shall be subject to the powers and administrative procedures set forth in subtitle 17A of KRS Chapter 304.

Section 11. KRS 304.17A-700 is amended to read as follows:

As used in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.

(1) "Adjudicate" means an insurer pays, contests, or denies a clean claim;

(2) "Claims payment time frame" means the time period prescribed under KRS 304.17A-702 following receipt of a clean claim from a provider at the address published by the insurer, whether it is the address of the insurer or a delegated claims processor, within which an insurer is required to pay, contest, or deny a health care claim;

(3) "Clean claim" means a properly completed billing instrument, paper or electronic, ***including the required health claim attachments, submitted in the following applicable form***[~~that~~

~~does not involve coordination of benefits for third-party liability, pre-existing condition investigations, or subrogation]~~.

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
2. Entries stated as mandatory by the NUBC; and
3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

(b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.

(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

(4) "Commissioner" means the commissioner of the Department of Insurance;

(5) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services;

(6) "Department" means the Department of Insurance;

(7) "Electronic" or "electronically" means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(8) "Health benefit plan" has the same meaning as provided in KRS 304.17A-005;

(9) "Health care provider" or "provider" ***means a provider licensed in Kentucky as defined***~~[has the same meaning provided]~~ in KRS 304.17A-005 and, for the purposes of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 only, shall include physical therapists licensed under KRS Chapter 327***, psychologists licensed under KRS Chapter 319, and social workers licensed under KRS Chapter 335***. Nothing contained in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall be construed to include physical therapists***, psychologists, and social workers*** as a health care provider or provider under KRS 304.17A-005;

(10) "Health claim ***attachments***~~[attachment]~~" means ***medical***~~[additional]~~ information from a covered person's medical record~~[to the basic claim form]~~ required by the insurer ***containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to KRS 304.17A-720***;

(11) "Institutional provider" means a health care facility licensed under KRS Chapter 216B;

(12) "Insurer" has the same meaning provided in KRS 304.17A-005;

(13) "Kentucky Uniform Billing Committee (KUBC)" means the committee of health care providers, governmental payors, and commercial insurers established as a local arm of

NUBC to implement the bill requirements of the NUBC and to prescribe any additional billing requirements unique to Kentucky insurers;

(14) "National Uniform Billing Committee (NUBC)" means the national committee of health care providers, governmental payors, and commercial insurers that develops the national uniform billing requirements for institutional providers as referenced in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, sec. 300gg et seq.;

(15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person; and

(16) "Utilization review" has the same meaning as provided in ***subsection (17) of Section 4 of this Act***~~[KRS 211.461]~~.

Section 12. KRS 304.17A-702 is amended to read as follows:

(1) Except for claims involving organ transplants, each insurer shall reimburse a provider for a clean claim or send a written or an electronic notice denying or contesting the claim within thirty (30) calendar days from the date that the claim is received by the insurer or any entity that administers or processes claims on behalf of the insurer. Clean claims involving organ transplants shall be paid, denied, or contested within sixty (60) calendar days from the date that the claim is received by the insurer or any entity that administers or processes claims on behalf of the ***insurer***~~[insurers]~~.

(2) Within the applicable claims payment time frame, an insurer shall:

(a) Pay the total amount of the claim in accordance with any contract between the insurer and the provider;

(b) Pay the portion of the claim that is not in dispute and notify the provider, in writing or electronically, of the reasons the remaining portion of the claim will not be paid; or

(c) Notify the provider, in writing or electronically, of the reasons no part of the claim will be paid.

Section 13. KRS 304.17A-704 is amended to read as follows:

(1) (a) Within forty-eight (48) hours of receiving an original or corrected claim submitted electronically, an insurer, its agent, or designee shall acknowledge the date of receipt of the claim by an electronic transmission to the provider, its billing agent, or designee that submitted the claim; and

(b) Within twenty (20) calendar days of receipt of an original or corrected claim submitted by mail or other nonelectronic means, an insurer***, its agent, or designee*** shall acknowledge the date of receipt of the claim ***to the provider, its billing agent, or designee that submitted the claim***.

1. For claims containing all necessary information and having no errors, the insurer shall make available confirmation of receipt of the claim to the provider, ***its*** billing agent, or designee that submitted the claim. Acknowledgment may be in writing or the insurer***, its agent, or designee*** may list the claim and the date it was received on a file that can be accessed electronically by the provider***, its agent, or designee***.

2. Claims that contain errors or lack necessary information shall be acknowledged by an electronic transmission or in writing to the provider, ***its*** billing agent, or designee that submitted the claim.

(2) ***At the time of acknowledgment under paragraph (a) or (b) of subsection (1) of this section,*** an insurer***, its agent, or designee,*** shall notify the provider, ***its billing agent, or designee that submitted the claim,*** in writing or electronically,~~[at the time that receipt of a claim is acknowledged,]~~ of all information that is missing ***from the billing instrument, any errors in the billing instrument, or of any other circumstances***~~[or in error]~~ which preclude it from being a clean claim.

(3) When an insurer***, its agent, or designee*** has notified a provider***, its billing agent, or designee that submitted the claim,*** that a claim contains errors, upon receipt of a corrected ***clean*** claim the insurer shall ***adjudicate***~~[pay]~~ the corrected ***clean*** claim within the applicable claims payment time frame for a clean claim established in KRS 304.17A-702.

(4) By January 1, 2001, an insurer shall have in place a mechanism to inform providers of the status of a claim either through:

(a) Notation on the remittance; or

(b) By allowing providers to check claim status electronically at any time following submission of the claim to the insurer.

Section 14. KRS 304.17A-706 is amended to read as follows:

(1) An insurer may ***contest***~~[delay payment by contesting]~~ a clean claim only in the following instances:

(a) The insurer has ***reasonable documented grounds to believe that the clean claim involves a preexisting condition, coordination of benefits within the meaning of KRS 304.18-085, or***~~[information]~~ that another insurer is primarily responsible for the claim;

(b) The insurer will conduct a retrospective review of the services identified on the claim;

(c) The insurer has information that the claim was submitted fraudulently; or

(d) The covered person's or group's premium has not been paid.

(2)~~[An insurer shall pay any uncontested portion of a claim and provide written or electronic notification to the provider of the contested amount within the applicable claims payment time frame established in KRS 304.17A-702.~~

~~(3)]~~ (a) If an insurer~~[routinely]~~ requires a provider to submit ***health claim*** attachments to the claim~~[containing additional medical information summarizing the diagnosis, the treatment, or services rendered to the covered person]~~ before the claim will be paid, the insurer shall identify the specific~~[routinely]~~ required~~[information]~~ ***health claim attachments*** in its provider manual or other document that sets forth the procedure for filing claims with the insurer. The insurer shall provide sixty (60) days' advance written notice of modifications to the provider manual that materially change the type or content of the ***health claim*** attachments ***or other documents*** to be submitted.

(b) If a provider submits a clean claim with the required ***health claim*** attachments as specified in the provider manual or other document that sets forth the procedure for

filing claims with the insurer, the insurer shall pay or deny the claim within the required claims payment time frame established in KRS 304.17A-702.

(c) If an insurer conducts a retrospective review of a claim and requires an attachment not specified in the provider manual or other document that sets forth the procedure for filing claims, the insurer shall:

1. Notify the provider, in writing or electronically within the claims payment time frame established in KRS 304.17A-702, of the service that will be retrospectively reviewed and the specific information needed from the provider regarding the insurer's review of a claim;

2. Complete the retrospective review within twenty (20) business days of the insurer's receipt of the medical information described in this subsection; and

3. ***Subject to paragraph (d) of this subsection,*** add interest to the amount of the claim, to be paid at a rate of twelve percent (12%) per annum, or at a rate in accordance with KRS 304.17A-730, accruing from the ***appropriate claim payment time frame established in Section 7 of this Act***[~~thirty-first day~~] after the claim was received by the insurer through the date upon which the claim is paid.

(d) If the provider fails to submit the information requested under subparagraph (c) 1. of this subsection within fifteen (15) business days from the date of the receipt of the notice, the insurer shall not be required to pay interest.

(***3***)[~~(4)~~] (a) If a claim or portion thereof is contested by an insurer on the basis that the insurer has not received information reasonably necessary to determine insurer liability for the claim or portion thereof, ***or if the insurer contests the claim on the reasonable and documented belief that the claim involves the coordination of benefits within the meaning of KRS 304.18-085, or questions of pre-existing conditions,*** the insurer shall, within the applicable claims payment time frame established in KRS 304.17A-702, provide written or electronic notice to the provider, covered person, ***group policyholder,*** or ***other*** insurer, as appropriate, with an itemization of all new, never-before-provided information that is needed.

(b) The insurer shall pay or deny the claim within thirty (30) calendar days of receiving the additional information described in paragraph (a) of this subsection. ***If the insurer does not receive the additional information described in paragraph (a) of this subsection within fifteen (15) business days from the date of receipt of the notice set forth in paragraph (a) of this subsection, the insurer may deny the claim. Any claim denied under this paragraph may be resubmitted by the provider and any resubmitted claim shall not be denied on the basis of timeliness if the resubmitted claim is made with the timeframe for submitting claims established by the insurer beginning on the date of denial.***

Section 15. KRS 304.17A-714 is amended to read as follows:

(1) Except for overpayments which are a result of an error in the payment rate or method, an insurer that determines that a provider was overpaid shall, within twenty-four (24) months from the date that the insurer paid the claim, provide written or electronic notice to the provider of the amount of the overpayment, the covered person's name, patient identification number, date of service to which the overpayment applies, insurer reference

number for the claim, and the basis for determining that an overpayment exists. Electronic notice includes E-mail or facsimile where the provider agreed in advance in writing to receive such notices. The insurer shall either:

(a) Request a refund from the provider; or

(b) Indicate on the notice that, within thirty (30) calendar days from the postmark date or electronic delivery date of the insurer's notice, if the insurer does not receive a notice of provider dispute in accordance with subsection (2) of this section, the amount of the overpayment will be recouped from future payments.

(2) If a provider disagrees with the amount of the overpayment, the provider shall within thirty (30) calendar days from the postmark date or the electronic delivery date of the insurer's written notice dispute the amount of the overpayment by submitting additional information to the insurer.

(3) If a provider files a dispute in accordance with subsection (2) of this section, no recoupment shall be made until the dispute is resolved. If a provider does not dispute the amount of the overpayment and does not provide a refund as required in subsection (2) of this section, the insurer may recoup the amount due from future payments.

(4) All disputes submitted by providers pursuant to subsection (2) of this section shall be processed in accordance and completed within thirty (30) days with the insurer's provider appeals process.

(5) An insurer may recover an overpayment resulting from an error in the payment rate or method by requesting a refund from the provider or making a recoupment of the overpayment from the provider, subject to the provisions of subsection (6) of this section. A provider may dispute such recoupment in accordance with the provisions contained in KRS 304.17A-708.

(6) If an insurer chooses to collect an overpayment made to a provider through a recoupment against future provider payments, the insurer shall, within twenty-four (24) months from the date that the insurer paid the claim, ***and at the actual time of recoupment*** give the provider written ***or electronic*** documentation that specifies:

(a)~~[(1)]~~ The amount of the recoupment;

(b)~~[(2)]~~ The covered person's name to whom the recoupment applies;

(c)~~[(3)]~~ Patient identification number; and

(d)~~[(4)]~~ Date of service.

Section 16. KRS 304.17A-722 is amended to read as follows:

(1) No later than ninety (90) days following ***the effective date of this Act***~~[July 14, 2000]~~, the department shall promulgate administrative regulations requiring all insurers to report information ***on a calendar quarter basis***~~[, according to timetables prescribed by the department but no less than annually,]~~ on prompt payment of claims ***to providers, as defined in Section 11 of this Act, that shall be limited to***~~[that shall include]~~ the following:

(a) ***The number of clean claims received by the insurer, its agent, or designee during the reporting period***~~[Percentage of clean claims paid within the claims payment time frame]~~;

(b) ***The percentage of clean claims received by the insurer, its agent, or designee that were:***

1. Adjudicated within the claims payment timeframe;

2. Adjudicated within one (1) to thirty (30) days from the end of the claims payment timeframe;

3. Adjudicated within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe;

4. Adjudicated within sixty-one (61) to ninety (90) days from the end of the claims payment timeframe;

5. Adjudicated more than ninety (90) days from the end of the claims payment timeframe; and

6. Not yet adjudicated;~~[Percentage of clean claims paid after the claims payment time frame and the number of days for hospitals, physicians, and all other providers, excluding pharmacies, within which the claims were finally adjudicated, reporting them in thirty-one (31) to sixty (60) day, sixty-one (61) to ninety (90) day, and more than ninety (90) day intervals; and]~~

(c) ***The percentage of clean claims received during the reporting quarter that were paid and not denied or contested:***

1. Within the claims payment timeframe;

2. Within one (1) to thirty (30) days from the end of the claims payment timeframe;

3. Within thirty-one (31) to sixty (60) days from the end of the claims payment timeframe;

4. Within sixty (60) to ninety (90) days from the end of the claims payment timeframe;

5. More than ninety (90) days from the end of the claims payment timeframe; and

6. Not yet paid;

(d) Amount of interest paid***; and***

(e) For clean claims received during the reporting quarter that were not denied or contested, the percentage of the total dollar amount of those claims that were paid within the claims payment timeframe.

(2) ***Data required in subsection (1) of this section shall be reported for hospitals, physicians, and all other providers, excluding pharmacies.***

(3) Insurers shall submit information required in subsection (1) of this section to the department no later than one hundred eighty (180) days following the close of the reporting quarter.

(4) The department shall, as part of the market conduct survey of each insurer, audit the insurer to determine compliance with KRS 304.17A-700 to 304.17A-730 and KRS 304.14-135 and 304.99-123. Findings shall be made available to the public upon request.

(5)[~~(3)~~] The commissioner shall annually present to the Interim Joint Committee on Banking and Insurance and to the Governor a report on the payment practices of insurers and compliance with the provisions of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 and the commissioner's enforcement activities, including the number of complaints received and those acted upon by the department.

Section 17. KRS 304.17A-730 is amended to read as follows:

(1) An insurer that fails to pay, deny, or settle a clean claim in accordance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall pay interest according to the following schedule on the amount of the claim that remains unpaid:

(a) For claims that are paid between ***one (1) and thirty (30)***[~~thirty-one (31) and sixty (60)~~] days from the date that ***payment was due under Section 12 of this Act***[~~the claim was received by the insurer or any entity that administers or processes claims on behalf of the insurer~~], interest at a rate of twelve percent (12%) per annum shall accrue from the date payment was due under KRS 304.17A-702;

(b) For claims that are paid between ***thirty-one (31) and sixty (60)***[~~sixty-one (61) days and ninety (90)~~] days from the date that ***payment was due under Section 12 of this Act***[~~the claim was received by the insurer or any entity that administers or processes claims on behalf of the insurer~~], interest at a rate of eighteen percent (18%) per annum shall accrue from the date payment was due under KRS 304.17A-702; and

(c) For claims that are paid more than ***sixty (60)***[~~ninety (90)~~] days from the date ***payment was due under Section 12 of this Act***[~~that the claim was received by the insurer or any entity that administers or processes claims on behalf of the insurer~~], interest at a rate of twenty-one percent (21%) per annum shall accrue from the date that payment was due under KRS 304.17A-702.

(2) When paying a claim after the time required by KRS 304.17A-702, the insurer shall add the interest payable to the amount of the unpaid claim without the necessity for any claim for that interest to be made by the provider filing the original claim. The interest obligation otherwise imposed by this section shall not apply if the failure to pay, deny, or settle a claim is due to, or results from, in whole or in part, acts or events beyond the control of the insurer, including but not limited to, acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbance, riot, or complete or partial disruptions of facilities.

Section 18. KRS 304.99-123 is amended to read as follows:

(1) In addition to any other penalty or remedy authorized by law, the department may assess the following fines for noncompliance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123:

(a) A fine of one thousand dollars ($1,000) per day or ten percent (10%) of the unpaid claim amount, whichever is greater, for each day that a clean claim remains unpaid in violation of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.

(b) Except for the late payment of claims under subsection (2) of this section, a fine of up to ten thousand dollars ($10,000) where the commissioner determines that an insurer has willfully and knowingly violated KRS 304.17A-700 to 304.17A-730 and KRS

205.593, 304.14-135, and 304.99-123 or has a pattern of repeated violations of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.

(2) For purposes of paragraph (a) of subsection (1) of this section, an insurer is in compliance when***:***

(a) Ninety-five percent (95%) of the clean claims ***received by the insurer, its agent, or designee***[~~paid~~] during each calendar quarter, excluding pharmaceutical claims ***were adjudicated within the claims payment timeframes in accordance with Section 12 of this Act; and***

(b) At least ninety percent (90%) of the total dollar amount for clean claims received by the insurer, its agent, or designee during each calendar quarter, excluding pharmaceutical claims, that were not denied or contested, were paid within the claims payment timeframes established in Section 12 of this Act[~~, were paid within thirty (30) days and the total dollar amount paid within thirty (30) days, excluding the amount paid for pharmaceutical claims, equaled at least ninety percent (90%) of the total dollar amount paid for clean claims during that calendar quarter~~].

Section 19. KRS 304.18-0983 is amended to read as follows:

(1) All insurers issuing group or blanket health insurance policies and certificates in this Commonwealth providing coverage on an expense-incurred basis shall make available and offer to the purchaser coverage for:

(a) ***The following, if an insurer provides medical and surgical benefits with respect to a mastectomy, in a manner determined in consultation with the attending physician and the covered person, and subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the coverage:***

1. All stages of breast reconstruction surgery ***of the breast on which the mastectomy has been performed***[~~following a mastectomy that resulted from breast cancer if the insurer also covers mastectomies~~];

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

(b) Diagnosis and treatment of endometriosis and endometritis if the insurer also covers hysterectomies; and

(c) Bone density testing for women age thirty-five (35) ***years*** and older, as indicated by the health-care provider, in accordance with standard medical practice, to obtain baseline data for the purpose of early detection of osteoporosis.

(2) No insurer under this section shall offer ***medical and surgical benefits with respect to a mastectomy***[~~coverage for mastectomies~~] which requires the procedure be performed on an outpatient basis.

(3) An insurer shall provide written notice to a covered person of the availability of medical and surgical benefits with respect to a mastectomy upon enrollment and annually thereafter.

(4) An insurer shall not:

(a) Deny eligibility, or continued eligibility, to an individual to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of 42 U.S.C. sec. 300gg-6; and

(b) Penalize or otherwise reduce or limit the reimbursement of an attending provider or provide incentives to an attending provider, to induce the provider to provide care to an individual in a manner inconsistent with 42 U.S.C. sec. 300gg-6.

Section 20. KRS 304.32-1593 is amended to read as follows:

(1) All nonprofit hospital, medical-surgical, dental, and health service corporations issuing contracts in this Commonwealth providing hospital, medical, or surgical expense benefits shall make available and offer to the purchaser coverage for:

(a) ***The following, if medical and surgical benefits with respect to a mastectomy are covered, in a manner determined in consultation with the attending physician and the covered person, and subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the coverage:***

1. All stages of breast reconstruction surgery ***of the breast on which the mastectomy has been performed***~~[following a mastectomy that resulted from breast cancer if the insurer also covers mastectomies]~~;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

(b) Diagnosis and treatment of endometriosis and endometritis if the insurer also covers hysterectomies; and

(c) Bone density testing for women age thirty-five (35) ***years*** and older, as indicated by the health-care provider, in accordance with standard medical practice, to obtain baseline data for the purpose of early detection of osteoporosis.

(2) No insurer under this section shall offer ***medical and surgical benefits with respect to a mastectomy***~~[coverage for mastectomies]~~ that requires the procedure be performed on an outpatient basis.

(3) An insurer shall provide written notice to a covered person of the availability of medical and surgical benefits with respect to a mastectomy upon enrollment and annually thereafter.

(4) An insurer shall not:

(a) Deny eligibility, or continued eligibility, to an individual to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of 42 U.S.C. secs. 300gg-6 and 300gg-52; and

(b) Penalize or otherwise reduce or limit the reimbursement of an attending provider or provide incentives to an attending provider, to induce the provider to provide care to an individual in a manner inconsistent with 42 U.S.C. secs. 300gg-6 and 300gg-52.

Section 21. KRS 304.38-1934 is amended to read as follows:

(1) Health maintenance organizations issuing contracts in this Commonwealth that provide hospital, medical, or surgical expense benefits shall make available and offer to the purchaser coverage for:

(a) ***The following, if a health maintenance organization provides medical and surgical benefits with respect to a mastectomy, in a manner determined in consultation with the attending physician and the covered person, and subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the coverage:***

1. ***All stages of*** breast reconstruction surgery ***of the breast on which the mastectomy has been performed***[~~following a mastectomy that resulted from breast cancer if the insurer also covers mastectomies~~];

2. ***Surgery and reconstruction of the other breast to produce a symmetrical appearance; and***

3. ***Prostheses and physical complications of all stages of mastectomy, including lymphedemas;***

(b) Diagnosis and treatment of endometriosis if the ***health maintenance organization***[~~insurer~~] also covers hysterectomies; and

(c) Bone density testing for women age thirty-five (35) ***years*** and older, as indicated by the health-care provider, in accordance with standard medical practice, to obtain baseline data for the purpose of early detection of osteoporosis.

(2) No ***health maintenance organization***[~~insurer~~] under this section shall offer ***medical and surgical benefits with respect to mastectomy***[~~coverage for mastectomies~~] that requires the procedure be performed on an outpatient basis.

(3) A health maintenance organization shall provide written notice to a covered person of the availability of medical and surgical benefits with respect to a mastectomy upon enrollment and annually thereafter.

(4) A health maintenance organization shall not:

(a) Deny eligibility, or continued eligibility, to an individual to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of 42 U.S.C. secs. 300gg-6 and 300gg-52; and

(b) Penalize or otherwise reduce or limit the reimbursement of an attending provider or provide incentives to an attending provider, to induce the provider to provide care to an individual in a manner inconsistent with 42 U.S.C. secs. 300gg-6 and 300gg-52.

Section 22. KRS 304.32-320 is amended to read as follows:

Any private employer doing business in this state who provides for his employees on a self-insured basis hospital or surgical benefits shall notify the Department of Insurance of the existence of the program within sixty (60) days of June 17, 1978. Any employer doing business in this state who implements for his employees on a self-insured basis a plan for providing hospital or surgical benefits shall notify the Department of Insurance not less than thirty (30) days prior to implementing such plan***, and shall include in the notice the name of any outside third party administrator. Any change in third party administrators shall be reported to the Department of Insurance within thirty (30) days of the change. The Department of Insurance shall make this information available upon request***.

Section 23. The following KRS section is repealed:

304.17A-350 Payment and contest of claims -- Circumstances under which insurer may delay payment or require additional information from provider.

Approved April 2, 2002