CHAPTER 9

(SB 10)

AN ACT relating to strokes.

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

➔Section 1. KRS 216B.0425 is amended to read as follows:

(1) Except as otherwise provided, for purposes of this section:

(a) "Acute care hospital" means a licensed facility providing inpatient and outpatient medical or surgical services to an individual that seeks care and treatment, regardless of the individual's ability to pay for services, on an immediate and emergent basis through an established emergency department and a continuous treatment basis on its premises for more than twenty-four (24) hours; and

(b) "Primary stroke center certification***,*** " ***"acute stroke ready hospital certification," and "comprehensive stroke center certification" mean***~~[means]~~ certification for acute care hospitals issued by the Joint Commission***, the American Heart Association,***~~[on Accreditation of Healthcare Organizations (JCAHO)]~~ or another cabinet-approved nationally recognized organization that provides disease-specific certification for stroke care, that:

1. Complies with census-based national standards and safety goals;

2. Effectively uses evidence-based clinical practice guidelines to manage and optimize care; and

3. Uses an organized approach to measure performance.

(2) The secretary of the Cabinet for Health and Family Services shall designate as a primary stroke center any acute care hospital which has received ***an acute stroke ready hospital certification, a comprehensive stroke center certification, or*** a primary stroke center certification.

(3) The secretary shall suspend or revoke an acute care hospital's designation as ***an acute stroke ready hospital, a comprehensive stroke center, or*** a primary stroke center if certification is withdrawn by ***the Joint Commission, the American Heart Association,***~~[JCAHO]~~ or another cabinet-approved certifying organization.

(4) (a) The cabinet shall maintain a list of certified acute stroke ready hospitals, comprehensive stroke centers, and primary stroke centers and post the list on its Web site. The cabinet shall provide the list and periodic updates to the Kentucky Board of Emergency Medical Services.

(b) The Kentucky Board of Emergency Medical Services shall share the list with each local emergency medical services provider at least annually, and as new centers and hospitals are designated and certified.

➔Section 2. KRS 311A.180 is amended to read as follows:

(1) Each emergency medical services medical director for an ambulance service, or other emergency medical services provider, shall submit***:***

(a) His or her protocols, ***including the pre-hospital care protocols related to the assessment, treatment, and transport of stroke patients;***

(b) His or her standing orders***;***~~[,]~~ and

(c) Similar medical control documents to the board for approval prior to placing the document in use.

(2) The medical advisor for the board shall review each document submitted to ascertain if it is in accordance with accepted standards of medical care and in accordance with the provisions of this chapter and administrative regulations promulgated thereunder. If the protocol, standing order, or other medical control document clearly violates the accepted standards of medical care, this chapter, or an administrative regulation, the medical advisor shall notify the emergency medical services medical director of the exact violation and recommend a correction thereof.

(3) Following review of protocol, standing order, and medical control documents and giving the emergency medical services medical director who submitted the documents an opportunity to review the medical advisor's comments, the medical advisor shall submit the documents together with his or her comments to the board for approval or disapproval.

(4) The board shall approve, disapprove, or approve with modifications protocol, standing order, and medical control documents submitted by the emergency medical services medical director at its next regular or special meeting following the submission of the documents.

(5) If a protocol, standing order, or other medical control document is disapproved by the board, the emergency medical services medical director who submitted it may appeal the decision to the Franklin Circuit Court. If the decision of the board is appealed to the Franklin Circuit Court, the board shall bear the burden of proving that the protocol, standing order, or other medical control document violates the accepted standards of medical care, or an administrative regulation.

(6) The board shall, by administrative regulation, specify a schedule for submission and prompt review and decision making with regard to protocols, standing orders, and medical control documents submitted to the board.

➔Section 3. KRS 216.2929 is amended to read as follows:

(1) (a) The Cabinet for Health and Family Services shall make available on its Web site information on charges for health-care services at least annually in understandable language with sufficient explanation to allow consumers to draw meaningful comparisons between every hospital and ambulatory facility, differentiated by payor if relevant, and for other provider groups as relevant data becomes available.

(b) Any charge information compiled and reported by the cabinet shall include the median charge and other percentiles to describe the typical charges for all of the patients treated by a provider and the total number of patients represented by all charges, and shall be risk-adjusted according to recommendations of the Health Services Data Advisory Committee.

(c) The report shall clearly identify the sources of data used in the report and explain limitations of the data and why differences between provider charges may be misleading. Every provider that is specifically identified in any report shall be given thirty (30) days to verify the accuracy of its data prior to public release and shall be afforded the opportunity to submit comments on its data that shall be included on the Web site and as part of any printed report of the data.

(d) The cabinet shall only provide linkages to organizations that publicly report comparative-charge data for Kentucky providers using data for all patients treated regardless of payor source, which may be adjusted for outliers, is risk-adjusted, and meets the requirements of paragraph (c) of this subsection.

(2) (a) The cabinet shall make information available on its Web site at least annually describing quality and outcome measures in understandable language with sufficient explanations to allow consumers to draw meaningful comparisons between every hospital and ambulatory facility in the Commonwealth and other provider groups as relevant data becomes available.

(b) 1. The cabinet shall utilize only national quality indicators that have been endorsed and adopted by the Agency for Healthcare Research and Quality, the National Quality Forum, or the Centers for Medicare and Medicaid Services; or

2. The cabinet shall provide linkages only to the following organizations that publicly report quality and outcome measures on Kentucky providers:

a. The Centers for Medicare and Medicaid Services;

b. The Agency for Healthcare Research and Quality;

c. The Joint Commission~~[on the Accreditation of Health Care Organizations]~~; and

d. Other organizations that publicly report relevant outcome data for Kentucky providers as determined by the Health Services Data Advisory Committee.

(c) The cabinet shall utilize or refer the general public to only those nationally endorsed quality indicators that are based upon current scientific evidence or relevant national professional consensus and have definitions and calculation methods openly available to the general public at no charge.

(3) Any report the cabinet disseminates or refers the public to shall:

(a) Not include data for a provider whose caseload of patients is insufficient to make the data a reliable indicator of the provider's performance;

(b) Meet the requirements of subsection (1)(c) of this section;

(c) Clearly identify the sources of data used in the report and explain the analytical methods used in preparing the data included in the report; and

(d) Explain any limitations of the data and how the data should be used by consumers.

(4) The cabinet shall at least annually, on or before October 1, submit a report on the operations and activities of the cabinet under KRS 216.2920 to 216.2929 during the preceding fiscal year, including a copy of each study or report required or authorized under KRS 216.2920 to 216.2929 and any recommendations relating thereto.

(5) The cabinet shall report at least biennially, no later than October 1 of each odd-numbered year, on matters pertaining to comparative health-care charges, quality, and outcomes, the effectiveness of its activities relating to educating consumers and containing health-care costs, and any recommendations regarding its data collection and dissemination activities.

(6) The cabinet shall report at least biennially, no later than October 1 of each odd-numbered year, on the special health needs of the minority population in the Commonwealth as compared to the population in the Commonwealth as compared to the population at large. The report shall contain an overview of the health status of minority Kentuckians, shall identify the diseases and conditions experienced at disproportionate mortality and morbidity rates within the minority population, and shall make recommendations to meet the identified health needs of the minority population.

(7) The reports required under subsections (4), (5), and (6) of this section shall be submitted to the Interim Joint Committees on Appropriations and Revenue and Health and Welfare and to the Governor.

➔Section 4. KRS 216B.185 is amended to read as follows:

(1) The Office of the Inspector General shall accept accreditation by the Joint Commission~~[on Accreditation of Healthcare Organizations]~~ or another nationally recognized accrediting organization with comparable standards and survey processes, that has been approved by the United States Centers on Medicare and Medicaid Services, as evidence that a hospital demonstrates compliance with all licensure requirements under this chapter. An annual on-site licensing inspection of a hospital shall not be conducted if the Office of the Inspector General receives from the hospital:

(a) A copy of the accreditation report within thirty (30) days of the initial accreditation and all subsequent reports; or

(b) Documentation from a hospital that holds full accreditation from an approved accrediting organization on or before July 15, 2002.

(2) Nothing in this section shall prevent the Office of the Inspector General from making licensing validation inspections and investigations as it deems necessary related to any complaints. The cabinet shall promulgate the necessary administrative regulations to implement the licensing validation process. Any administrative regulations shall reflect the validation procedures for accredited hospitals participating in the Medicare program.

(3) A hospital shall pay any licensing fees required by the cabinet in order to maintain a license.

(4) A new hospital shall not be exempt from the on-site inspection until meeting the requirements of subsection (1) of this section and administrative regulations promulgated under KRS 216B.040, 216B.042, and 216B.105 for acute, critical access, psychiatric, and rehabilitation facility requirements.

(5) Before beginning construction for the erection of a new building, the alteration of an existing building, or a change in facilities for a hospital, the hospital shall submit plans to the Office of Inspector General for approval.

(6) To the extent possible, the cabinet shall consider all national standards when promulgating administrative regulations for hospital licensure.

➔Section 5. KRS 216B.455 is amended to read as follows:

(1) A certificate of need shall be required for all Level I psychiatric residential treatment facilities. The application for a certificate of need shall include formal written agreements of cooperation that identify the nature and extent of the proposed working relationship between the proposed Level I psychiatric residential treatment facility and each of the following agencies, organizations, or facilities located in the service area of the proposed facility:

(a) Regional interagency council for children with emotional disability or severe emotional disability as

defined in KRS 200.509;

(b) Department for Community Based Services;

(c) Local school districts;

(d) At least one (1) psychiatric hospital; and

(e) Any other agency, organization, or facility deemed appropriate by the cabinet.

(2) Notwithstanding provisions for granting of a nonsubstantive review of a certificate of need application under KRS 216B.095, the cabinet shall review and approve the nonsubstantive review of an application seeking to increase the number of beds as permitted by KRS 216B.450 if the application is submitted by an eight (8) bed or sixteen (16) bed Level I psychiatric residential treatment facility licensed and operating or holding an approved certificate of need on July 13, 2004. The cabinet shall base its approval of expanded beds upon the Level I psychiatric residential treatment facility's ability to meet standards designed by the cabinet to provide stability of care. The standards shall be promulgated by the cabinet in an administrative regulation in accordance with KRS Chapter 13A. An application under this subsection shall not be subject to any moratorium relating to certificate of need.

(3) All Level I psychiatric residential treatment facilities shall comply with the licensure requirements as set forth in KRS 216B.105.

(4) All Level I psychiatric residential treatment facilities shall be certified by the Joint Commission~~[on Accreditation of Healthcare Organizations]~~, ~~[or]~~the Council on Accreditation of Services for Families and Children, or any other accrediting body with comparable standards that is recognized by the state.

(5) A Level I psychiatric residential treatment facility shall not be located in or on the grounds of a psychiatric hospital. More than one (1) freestanding Level I psychiatric residential treatment facility may be located on the same campus that is not in or on the grounds of a psychiatric hospital.

(6) The total number of Level I psychiatric residential treatment facility beds shall not exceed three hundred and fifteen (315) beds statewide.

(7) (a) The Cabinet for Health and Family Services shall investigate the need for specialty foster care and post-treatment services for persons discharged from Level I and Level II psychiatric residential treatment facilities.

(b) The cabinet shall report to the Governor and the Legislative Research Commission by August 1, 2011, detailing information on specialty foster care and post-treatment services for persons discharged from Level I and Level II psychiatric residential treatment facilities.

➔Section 6. KRS 216B.457 is amended to read as follows:

(1) A certificate of need shall be required for all Level II psychiatric residential treatment facilities. The need criteria for the establishment of Level II psychiatric residential treatment facilities shall be in the state health plan.

(2) An application for a certificate of need for Level II psychiatric residential treatment facilities shall not exceed fifty (50) beds. Level II facility beds may be located in a separate part of a psychiatric hospital, a separate part of an acute care hospital, or a Level I psychiatric residential treatment facility if the Level II beds are located on a separate floor, in a separate wing, or in a separate building. A Level II facility shall not refuse to admit a patient who meets the medical necessity criteria and facility criteria for Level II facility services. Nothing in this section and KRS 216B.450 and 216B.455 shall be interpreted to prevent a psychiatric residential treatment facility from operating both a Level I psychiatric residential treatment facility and a Level II psychiatric residential treatment facility.

(3) The application for a Level II psychiatric residential treatment facility certificate of need shall include formal written agreements of cooperation that identify the nature and extent of the proposed working relationship between the proposed Level II psychiatric residential treatment facility and each of the following agencies, organizations, or entities located in the service area of the proposed facility:

(a) Regional interagency council for children with emotional disability or severe emotional disability created under KRS 200.509;

(b) Community board for mental health or individuals with an intellectual disability established under KRS 210.380;

(c) Department for Community Based Services;

(d) Local school districts;

(e) At least one (1) psychiatric hospital; and

(f) Any other agency, organization, or entity deemed appropriate by the cabinet.

(4) The application for a certificate of need shall include:

(a) The specific number of beds proposed for each age group and the specific, specialized program to be offered;

(b) An inventory of current services in the proposed service area; and

(c) Clear admission and discharge criteria, including age, sex, and other limitations.

(5) All Level II psychiatric residential treatment facilities shall comply with the licensure requirements as set forth in KRS 216B.105.

(6) All Level II psychiatric residential treatment facilities shall be certified by the Joint Commission~~[on Accreditation of Healthcare Organizations]~~, ~~[or]~~the Council on Accreditation of Services for Families and Children, or any other accrediting body with comparable standards that are recognized by the Centers for Medicare and Medicaid Services.

(7) A Level II psychiatric residential treatment facility shall be under the clinical supervision of a qualified mental health professional with training or experience in mental health treatment of children and youth.

(8) Treatment services shall be provided by qualified mental health professionals or qualified mental health personnel. Individual staff who will provide educational programs shall meet the employment standards outlined by the Kentucky Board of Education and the Education Professional Standards Board.

(9) A Level II psychiatric residential treatment facility shall meet the following requirements with regard to professional staff:

(a) A licensed psychiatrist, who is board-eligible or board-certified as a child or adult psychiatrist, shall be employed or contracted to meet the treatment needs of the residents and the functions that shall be performed by a psychiatrist;

(b) If a Level II psychiatric residential treatment facility has residents ages twelve (12) and under, the licensed psychiatrist shall be a board-eligible or board-certified child psychiatrist; and

(c) The licensed psychiatrist shall be present in the facility to provide professional services to the facility's residents at least weekly.

(10) A Level II psychiatric residential treatment facility shall:

(a) Prepare a written staffing plan that is tailored to meet the needs of the specific population of children and youth that will be admitted to the facility based on the facility's admission criteria. The written staffing plan shall include but not be limited to the following:

1. Specification of the direct care per-patient staffing ratio that the facility shall adhere to during waking hours and during sleeping hours;

2. Delineation of the number of direct care staff per patient, including the types of staff and the mix and qualifications of qualified mental health professionals and qualified mental health personnel, that shall provide direct care and will comprise the facility's per-patient staffing ratio;

3. Specification of appropriate qualifications for individuals included in the per-patient staffing ratio by job description, education, training, and experience;

4. Provision for ensuring compliance with its written staffing plan, and specification of the circumstances under which the facility may deviate from the per-patient staffing ratio due to patient emergencies, changes in patient acuity, or changes in patient census; and

5. Provision for submission of the written staffing plan to the cabinet for approval as part of the facility's application for initial licensure.

No initial license to operate as a Level II psychiatric residential treatment facility shall be granted until the cabinet has approved the facility's written staffing plan. Once a facility is licensed, it shall comply

with its approved written staffing plan and, if the facility desires to change its approved per-patient staffing ratio, it shall submit a revised plan and have the plan approved by the cabinet prior to implementation of the change;

(b) Require full-time professional and direct care staff to meet the continuing education requirements of their profession or be provided with forty (40) hours per year of in-service training; and

(c) Develop and implement a training plan for all staff that includes but is not limited to the following:

1. Behavior-management procedures and techniques;
2. Physical-management procedures and techniques;
3. First aid;
4. Cardiopulmonary resuscitation;
5. Infection-control procedures;
6. Child and adolescent growth and development;
7. Training specific to the specialized nature of the facility;
8. Emergency and safety procedures; and
9. Detection and reporting of child abuse and neglect.

(11) A Level II psychiatric residential treatment facility shall require a criminal records check to be completed on all employees and volunteers. The employment or volunteer services of an individual shall be governed by KRS 17.165, with regard to a criminal records check. A new criminal records check shall be completed at least every two (2) years on each employee or volunteer.

(12) (a) Any employee or volunteer who has committed or is charged with the commission of a violent offense as specified in KRS 439.3401, a sex crime specified in KRS 17.500, or a criminal offense against a victim who is a minor as specified in KRS 17.500 shall be immediately removed from contact with a child within the residential treatment center until the employee or volunteer is cleared of the charge.

(b) An employee or volunteer under indictment, legally charged with felonious conduct, or subject to a cabinet investigation shall be immediately removed from contact with a child.

(c) The employee or volunteer shall not be allowed to work with the child until a prevention plan has been written and approved by the cabinet, the person is cleared of the charge, or a cabinet investigation reveals an unsubstantiated finding, if the charge resulted from an allegation of child abuse, neglect, or exploitation.

(d) Each employee or volunteer shall submit to a check of the central registry. An individual listed on the central registry shall not be a volunteer at or be employed by a Level II psychiatric residential treatment facility.

(e) Any employee or volunteer removed from contact with a child pursuant to this subsection may, at the discretion of the employer, be terminated, reassigned to a position involving no contact with a child, or placed on administrative leave with pay during the pendency of the investigation or proceeding.

(13) An initial treatment plan of care shall be developed and implemented for each resident, and the plan of care shall be based on initial history and ongoing assessment of the resident's needs and strengths, with an emphasis on active treatment, transition planning, and after-care services, and shall be completed within seventy-two (72) hours of admission.

(14) A comprehensive treatment plan of care shall be developed and implemented for each resident, and the plan of care shall be based on initial history and ongoing assessment of the resident's needs and strengths, with an emphasis on active treatment, transition planning, and after-care services, and shall be completed within ten (10) calendar days of admission.

(15) A review of the treatment plan of care shall occur at least every thirty (30) days following the first ten (10) days of treatment and shall include the following documentation:

(a) Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;

(b) An assessment of progress toward each treatment goal and objective with revisions as indicated; and

(c) A statement of justification for the level of services needed, including suitability for treatment in a less-restrictive environment and continued services.

(16) A Level II psychiatric residential treatment facility shall provide or arrange for the provision of qualified dental, medical, nursing, and pharmaceutical care for residents. The resident's parent, guardian, legal custodian, or conservator may choose a professional for nonemergency services.

(17) A Level II psychiatric residential treatment facility shall ensure that opportunities are provided for recreational activities that are appropriate and adapted to the needs, interests, and ages of the residents.

(18) A Level II psychiatric residential treatment facility shall assist residents in the independent exercise of health, hygiene, and grooming practices.

(19) A Level II psychiatric residential treatment facility shall assist each resident in securing an adequate allowance of personally owned, individualized, clean, and seasonal clothes that are the correct size.

(20) A Level II psychiatric residential treatment facility shall assist, educate, and encourage each resident in the use of dental, physical, or prosthetic appliances or devices and visual or hearing aids.

(21) The cabinet shall promulgate administrative regulations that include but are not limited to the following:

(a) Establishing requirements for tuberculosis skin testing for staff of a Level II psychiatric residential treatment facility;

(b) Ensuring that accurate, timely, and complete resident assessments are conducted for each resident of a Level II psychiatric residential treatment facility;

(c) Ensuring that accurate, timely, and complete documentation of the implementation of a resident's treatment plan of care occurs for each resident of a Level II psychiatric residential treatment facility;

(d) Ensuring that an accurate, timely, and complete individual record is maintained for each resident of a Level II psychiatric residential treatment facility;

(e) Ensuring that an accurate, timely, and complete physical examination is conducted for each resident of a Level II psychiatric residential treatment facility;

(f) Ensuring accurate, timely, and complete access to emergency services is available for each resident of a Level II psychiatric residential treatment facility; and

(g) Ensuring that there is accurate, timely, and complete administration of medications for each resident of a Level II psychiatric residential treatment facility.

(22) The cabinet shall, within ninety (90) days of July 15, 2010, promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and KRS 216B.450 and 216B.455. When promulgating the administrative regulations, the cabinet shall not consider only staffing ratios when evaluating the written staffing plan of an applicant, but shall consider the applicant's overall ability to provide for the needs of patients.

(23) The cabinet shall report, no later than August 1 of each year, to the Interim Joint Committee on Health and Welfare regarding the implementation of this section and KRS 216B.450 and 216B.455. The report shall include but not be limited to information relating to resident outcomes, such as lengths of stay in the facility, locations residents were discharged to, and whether residents were readmitted to a Level II psychiatric residential treatment facility within a twelve (12) month period.

➔Section 7. 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;

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

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

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

(16) "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) (a) "Urgent care" means health care or treatment with respect to which the application of the time periods for making nonurgent determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

(b) "Urgent care" shall include all requests for hospitalization and outpatient surgery;

(18) "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

(19) "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

➔Section 8. KRS 304.18-130 is amended to read as follows:

(1) Except as otherwise expressly provided herein, no contract providing major medical or outpatient care benefits, issued pursuant to Subtitles 18, 32, and 38 of KRS Chapter 304, shall be sold or offered for sale in the Commonwealth of Kentucky unless such contract offers the master policyholder the option to purchase in new contracts the minimum benefits for treatment of alcoholism as specified in KRS 304.18-140.

(2) Coverage for treatment shall be divided into three (3) distinct phases:

(a) Emergency detoxification treatment;

(b) Residential treatment; and

(c) Outpatient treatment.

Such contracts shall contain a stipulation that no payment shall be made by the carrier to the provider except upon completion of the phase of program of treatment by the patient, under the guidance and direction of a physician licensed to practice in the Commonwealth or a professional, designated by such physician, who is a recognized staff member of a treatment facility licensed by the department or accredited by the Joint Commission~~[on the Accreditation of Hospitals]~~.

(3) Disability and accident income benefits and basic health care contracts that do not provide major medical or outpatient care are excluded from KRS 304.18-130 to 304.18-180.

➔Section 9. KRS 304.18-140 is amended to read as follows:

Group contracts providing major medical or outpatient care benefits issued pursuant to KRS 304.18-130 for treatment of alcoholism shall require:

(1) That the patient be under the supervision of a physician licensed to practice in the Commonwealth or a professional designated by such physician, and who is a recognized staff member of a treatment facility licensed by the department or accredited by the Joint Commission~~[on the Accreditation of Hospitals]~~;

(2) That the patient receive appropriate emergency detoxification treatment, residential treatment and outpatient treatment at facilities licensed by the department or accredited by the Joint Commission~~[on the Accreditation of Hospitals]~~, for alcoholism treatment; and

(3) That the following minimum benefits per patient be provided:

(a) Emergency detoxification - 3 days, $40 per day

(b) Residential treatment - 10 days, $50 per day

(c) Outpatient treatment - 10 visits, $10 per visit.

➔Section 10. KRS 304.18-160 is amended to read as follows:

Treatment for alcoholism in acute care hospitals licensed by the Commonwealth or accredited by the Joint

Commission~~[on Accreditation of Hospitals]~~ shall be treated by all health care carriers as any other disease entity covered by their contracts.

Signed by Governor March 19, 2015.