

**LABOR CABINET**  
**Department of Workers' Claims**  
**(Amendment)**

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

RELATES TO: KRS Chapter 342

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

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 provides that the Commissioner [~~Executive Director~~] of the Department [~~Office~~] of Workers' Claims shall promulgate administrative regulations necessary to carry on the work of the Department [~~Office~~] of Workers' Claims, and the commissioner [~~executive director~~] may promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342. KRS 342.035(5) provides that the commissioner [~~Executive Director~~] of the Department [~~Office~~] of Workers' Claims shall promulgate administrative regulations that require each insurance carrier, group self-insurer and individual self-insured employer to certify to the commissioner [~~executive director~~] the program it has adopted to insure compliance with the medical fee schedule provisions of KRS 342.035(1) and (4). KRS 342.035(5) also requires the commissioner [~~executive director~~] to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, group self-insurer or self-insured employer pursuant to KRS Chapter 342. KRS 342.035(6) allows the commissioner to promulgate regulations incorporating managed care or other concepts intended to reduce costs or to speed the delivery of payment of medical services to employees receiving medical and related benefits under KRS Chapter 342. This administrative regulation insures that insurance carriers, group self-insurers, and individual self-insured employers implement a utilization review and audit program and establishes a medical director to speed the delivery of payment of medical services to employees receiving medical and related benefits under this chapter. This administrative regulation does not abrogate the right, as provided in KRS 342.020, of an injured employee to choose his treating physician, or an employer to participate in a managed health care system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (a) A utilization reviewer is appropriately qualified;
- (b) Treatment rendered to an injured worker is medically necessary and appropriate; and
- (c) Necessary medical services are not withheld or unreasonably delayed.

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

- (a) A statement or payment for medical goods and services and charges for a deposition, report, or photocopy complies with KRS Chapter 342 and applicable administrative regulations;
- (b) A medical bill auditor is appropriately qualified; and
- (c) A statement for medical services is not disputed without reasonable grounds.

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

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

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

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

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

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

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

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

- (1) A description of the process, policies and procedures whereby decisions shall be made;
- (2) A description of the specific criteria utilized in the decision making process, including a description of the specific medical guidelines used as the resource to confirm the medical diagnosis and to provide consistent criteria and practice standards against which care quality and related costs are measured;
- (3) A description of the criteria by which claims, medical services and medical bills shall be selected for review;
- (4) A description of the qualifications of internal and consulting personnel who shall conduct utilization review and medical bill audit and the manner in which the personnel shall be involved in the review process;
- (5) A description of the process to assure that a treatment plan shall be obtained for review by qualified medical personnel if a treatment plan is required by 803 KAR 25:096;
- (6) A description of the process to assure that a physician shall be designated by each injured employee as required under 803 KAR 25:096;
- (7) A description of the process for rendering and promptly notifying the medical provider and employee of the initial utilization review decision;
- (8) A description of the reconsideration process within the structure of the utilization review and medical bill audit program;
- (9) An assurance that a database shall be maintained, which shall:
  - (a) Record:
    1. Each instance of utilization review;
    2. Each instance of medical bill audit;
    3. The name of the reviewer;
    4. The extent of the review;
    5. The conclusions of the reviewer; and
    6. The action, if any, taken as the result of the review;
  - (b) Be maintained for a period of at least two (2) years; and
  - (c) Be subject to audit by the commissioner [~~executive director~~], or his agent, pursuant to KRS 342.035(5)(b);
- (10) An assurance that a toll free line shall be provided for an employee or medical provider to contact the utilization reviewer. The reviewer or a representative of the reviewer shall be reasonably accessible to an interested party at least five (5) days per week, forty (40) hours per week during normal business hours;
- (11) A description of the policies and procedures that shall be implemented to protect the confidentiality of patient information; and
- (12) An assurance that medical treatment guidelines adopted by the commissioner pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the standard for utilization review medical decision making. [~~An assurance that the acute low back pain practice parameter adopted by the executive director pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the standard for evaluating an applicable low back claim. Additional medical guidelines which may be adopted by the executive director pursuant to KRS 342.035(8)(a) shall be incorporated in a utilization review plan.~~]

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

- (a) A medical provider requests preauthorization of a medical treatment or procedure;
  - (b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan is received;
  - (c) The total medical costs cumulatively exceed \$3000;
  - (d) The total lost work days cumulatively exceed thirty (30) days; or
  - (e) An arbitrator or administrative law judge orders a review.
- (2) If applicable, utilization review shall commence when the carrier has notice that a claims selection criteria has been met.

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

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

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

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

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

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

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

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

(3) A medical provider may request an expedited utilization review determination for proposed medical treatment or services, the lack of which could reasonably be expected to lead to serious physical or mental disability or death. The expedited utilization review determination shall be provided within twenty-four (24) hours following a request for expedited review.

(4) Initiation of utilization review shall toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1). The thirty (30) day period shall commence on the date of the final utilization review decision.

(5) Each medical bill audit shall be initiated within seven (7) calendar days of receipt to assure:

(a) Compliance with applicable fee schedules;

(b) Accuracy; and

(c) That a physician has been designated in accordance with 803 KAR 25:096.

(6) A medical bill audit shall not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1).

Section 7 [6]. Utilization Review and Medical Bill Audit Personnel Qualifications. (1) Utilization review personnel shall have education, training, and experience necessary for evaluating the clinical issues and services under review. A physician, registered nurse, licensed practical nurse, medical records technician or other personnel, who through training and experience is

qualified to issue decisions on medical necessity or appropriateness, shall issue the initial utilization review approval.

(2) A physician shall issue an initial utilization review denial. A physician shall supervise utilization review personnel in making utilization review recommendations. Personnel shall hold the license required by the jurisdiction in which they are employed.

(3) Personnel conducting a medical bill audit shall have the education, training or experience necessary for evaluating medical bills and statements.

Section 8 [7]. Written Notice of Denial. (1) Following initial review, a written notice of denial shall:

(a) Be issued to both the medical provider and the employee in a timely manner but no more than ten (10) calendar days from the initiation of the utilization review process;

(b) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and

(c) Contain:

1. A statement of the medical reasons for denial;

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

3. An explanation of utilization review reconsideration rights.

(2) Payment for medical services shall not be denied on the basis of lack of information absent documentation of a good faith effort to obtain the necessary information.

Section 9 [8]. Reconsideration. (1) A reconsideration process to appeal an initial decision shall be provided within the structure of utilization review.

(a) A request for reconsideration of the initial utilization review decision shall be made by an aggrieved party within fourteen (14) calendar days of receipt of a written notice of denial.

(b) Reconsideration of the initial utilization review decision shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer.

(c) A written reconsideration decision shall be rendered within ten (10) calendar days of receipt of a request for reconsideration. The written decision shall be clearly entitled "UTILIZATION REVIEW - RECONSIDERATION DECISION". If the reconsideration decision is made by an appropriate specialist or subspecialist, the written decision shall further be entitled "FINAL UTILIZATION REVIEW DECISION".

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

(2)(a) If a utilization review denial is upheld upon reconsideration and a board eligible or certified physician in the appropriate specialty or subspecialty area, or a chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095 has not previously reviewed the matter, an aggrieved party may request further review by:

1. A board eligible or certified physician in the appropriate specialty or subspecialty; or

2. A chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.

(b) A written decision shall be rendered within ten (10) calendar days of the request for specialty reconsideration. The specialty decision shall be clearly entitled "FINAL UTILIZATION REVIEW DECISION".

(3) A reconsideration process to appeal an initial decision shall be provided within the structure of medical bill audit.

(a) A request for reconsideration of the medical bill audit decision shall be made by an aggrieved party within fourteen (14) calendar days of receipt of that decision.

(b) Reconsideration shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer.

(c) A written decision shall be rendered within ten (10) calendar days of receipt of a request for reconsideration. The written decision shall be clearly entitled "MEDICAL BILL AUDIT RECONSIDERATION DECISION".

(d) A request for reconsideration of the medical bill audit decision shall not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1).

Section 10. Utilization Review and Medical Bill Audit Program. (1) The utilization review program shall assure that:

(a) A utilization reviewer is appropriately qualified;

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

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

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

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

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

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

Section 11. Utilization Review and Medical Bill Audit Plan Approval. (1) A carrier shall fully implement and maintain a utilization review and medical bill audit program.

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

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

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

(5) A plan shall be approved for a period of four (4) years.

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

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

(6) A carrier, who contracts with an approved vendor for utilization review services, shall provide annually to the commissioner summaries of the number of utilizations reviews, waivers per KRS 342.035(5)(c), utilization review approvals for treatment, utilization review denials for treatment and appeals to the medical director. Such annual reports of the approved vendor shall be filed with the Department by August 1 for the preceding fiscal year ending June 30.

Section 12. Utilization Review and Medical Bill Audit Written Plan Requirements. The written utilization review and medical bill audit plan submitted to the commissioner shall include the following elements:

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

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

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

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

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

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

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

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

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

(a) Record:

1. Each instance of utilization review;

2. Each instance of medical bill audit;

3. The name of the reviewer;

4. The extent of the review;

5. The conclusions of the reviewer; and

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

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

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

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

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

(12) An assurance that medical treatment guidelines adopted by the commissioner pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the standard for utilization review medical decision making.

### Section 13. Claim Selection Criteria and Process.

(1) Unless the medical payment obligor, in good faith, denies the claim as noncompensable or waives utilization review pursuant to KRS 342.035(5)(c), medical services reasonably related or asserted to be related to the claim shall be subject to utilization review if:

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

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

(c) The total medical costs cumulatively exceed \$1,000; or

(d) The total lost work days cumulatively exceed fifteen (15) days.

(2) Utilization review shall commence when the medical payment obligor has notice that a claims selection criteria has been met. The medical payment obligor may waive utilization review pursuant to KRS 342.035(5)(c) within two (2) business days of such notice. Failure by the medical payment obligor to waive and communicate its waiver to the employee and medical provider or initiate its utilization review process within two (2) business days shall result in the medical payment obligor paying for the subject medical services pursuant to the appropriate fee schedules.

(a) The following requirements shall apply if preauthorization has been requested and utilization review has not been waived:

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

2. The requested information shall be tendered by the medical provider within five (5) business days.

3. The utilization review decision shall be rendered and communicated within two (2) business days following receipt of the requested information.

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

1. The utilization review decision shall be rendered and communicated to the medical provider and employee within five (5) business days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional business days.

2. The requested information shall be tendered by the medical provider within five (5) business days.

3. The utilization review decision shall be rendered and communicated within two (2) business days following receipt of the requested information.

(3) A medical provider may request an expedited utilization review determination for proposed medical treatment or services, the lack of which could reasonably be expected to lead to serious physical or mental disability or death. The expedited utilization review determination shall be rendered and communicated within twenty-four (24) hours following a request for expedited review.

(4) Initiation of utilization review shall toll the thirty (30) day period for paying medical expenses pursuant to KRS 342.020(4). The thirty (30) day period for paying medical expenses shall commence on the date of the utilization review decision.

(5) Each medical bill audit shall be initiated within seven (7) calendar days of receipt to assure:

(a) Compliance with applicable fee schedules;

(b) Accuracy; and

(c) That a physician has been designated in accordance with 803 KAR 25:096.

(6) A medical bill audit shall not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(4).

#### Section 14. Utilization Review and Medical Bill Audit Personnel Qualifications.

(1) Utilization review personnel shall have education, training, and experience necessary for evaluating the clinical issues and services under review. A physician, registered nurse, licensed practical nurse, medical records technician or other personnel, who through training and experience is qualified to issue decisions on medical necessity or appropriateness, shall issue the initial utilization review approval.

(2) A physician shall issue an initial utilization review denial. A physician shall supervise utilization review personnel in making utilization review recommendations. Personnel shall hold the license required by the jurisdiction in which they are employed.

(3) Personnel conducting a medical bill audit shall have the education, training or experience necessary for evaluating medical bills and statements.

#### Section 15. Written Notice of Denial.

(1) Following utilization review, a written notice of denial shall:



(a) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and

(b) Contain:

1. A statement of the medical reasons for denial;

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

3. An explanation of utilization appeal rights with instructions on how to proceed with an appeal.

(2) The Department shall develop and provide a form on its website that a medical payment obligor may use to comply with Section 15 (1) above.

(3) A copy of the written notice of denial along with the mailing address, telephone number, and, if known, the email address of the employee and medical provider whose treatment, recommended treatment, or prescribed medication is being denied shall be sent by electronic mail to the medical director on the same day that the notice of denial is rendered and communicated to that medical provider and employee. The medical director shall then immediately notify the employee and that medical provider of the actions required to appeal the utilization review denial at no cost to the employee.

(4) Payment for medical services shall not be denied on the basis of lack of information absent documentation of a good faith effort to obtain the necessary information.

#### Section 16. Medical Director.

(1) The Secretary shall appoint a medical director to:

(a) Process appeals of utilization review decisions and medical bill audit decisions rendered pursuant to this regulation, and

(b) At least annually, review and advise the commissioner and the Secretary on the effectiveness of the Medical Fee Schedule for Physicians, the Treatment Guidelines and the Pharmaceutical Formulary in reducing costs and speeding the delivery of medical services to employees receiving medical benefits under KRS Chapter 342.

(2) The medical director shall be a Kentucky licensed physician in good standing with the Kentucky Board of Medical Licensure.

(3) The medical director may, when appropriate, seek the assistance of other physicians to assist or perform any tasks outlined within this regulation.

(4) The medical director shall chair a Workers' Compensation Medical Advisory Committee to provide advice on issues related to the medical treatment of injured workers. The medical director may request the committee to advise on the medical aspects of the Department's various programs in advancing the goal of ensuring that all injured employees receive superior quality and cost efficient treatment to facilitate recovery from injury and a swift, safe return to the workforce.

(a) In addition to the medical director serving as chair, the commissioner shall serve on the Workers' Compensation Medical Advisory Committee and may appoint the following to the Workers' Compensation Medical Advisory Committee: deputy commissioner, and a representative for employers, employees, labor unions, insurance, self-insured, occupational medicine, chiropractic, orthopedics, neurosurgery, psychiatric, pain management rehabilitation, pain management, emergency medicine and pharmacy.

(b) No less than annually, the Workers' Compensation Medical Advisory Committee shall provide the commissioner and Secretary with a report concerning the activity, effectiveness and impact of the medical director and the utilization review programs on the delivery of payment of medical services to injured employees.

#### Section 17. Appeals of Utilization Review Decisions.

(1) Upon receipt of a written notice of denial of treatment subject to utilization review, the employee or medical provider whose treatment, recommended treatment, or prescribed medication, is being denied may appeal the utilization review decision to the medical director.

(2) The employee or medical provider whose treatment, recommended treatment, or prescribed medication is being denied shall have thirty (30) calendar days from receipt of the written notice of denial to appeal the utilization review decision to the medical director. The medical director may extend the time to appeal for good cause.

(3) Failure to appeal to the medical director shall result in the utilization review decision having preclusive effect as to the reasonableness and necessity of the treatment.

(4) An appeal to the medical director shall toll the thirty (30) day period for paying medical expenses pursuant to KRS 342.020(4). The thirty (30) day period to pay the approved medical expenses shall commence on the date of the medical director's written determination or the date on which the parties reach agreement regarding disputed treatment.

(5) The Department shall charge a fee of \$400.00 for each appeal submitted to the medical director. The fee shall be paid by the medical payment obligor no later than fifteen (15) calendar days following the date of the appeal to the medical director. Failure to pay the fee shall constitute a failure to complete a necessary step in the administrative review process and be construed as an admission by the employer that the denial was in error and the medical director should find accordingly. Failure to pay the fee may also result in assessment of a civil penalty pursuant to KRS 342.990(7)(e).

(6) Within five (5) calendar days of the appeal to the medical director, the medical payment obligor may cause the appeal to be dismissed by providing notice to the medical director, medical provider whose treatment, recommended treatment, or prescribed medication is being denied and employee. With such a dismissal, the medical payment obligor shall authorize the payment of the questioned services pursuant to the appropriate fee schedule. If such dismissal occurs, no fee as required by this regulation shall be due, or if paid, the fee shall be refunded to the medical payment obligor.

(7) Upon receipt of an appeal request by an employee or medical provider whose treatment or recommended treatment is being denied:

(a) The medical director shall conduct the utilization review appeal.

(b) The medical director may contact the medical provider whose treatment, recommended treatment, or prescribed medication is being denied for the purpose of obtaining any necessary missing information.

(c) The medical director shall set a date on which all relevant information shall be due to the medical director.

(d) The medical director shall determine the medical necessity of the treatment, recommended treatment, or prescribed medication within fourteen (14) calendar days after receipt of all necessary information by the medical director.

(e) Upon determination that any or all of the treatment, recommended treatment, or prescribed medication is reasonable and necessary, the medical director shall plainly state the reasons for each approval in a written determination.

(f) Upon determination that any or all of the treatment, recommended treatment, or prescribed medication is not reasonable and necessary, the medical director shall plainly state the reasons for each denial in a written determination.

(g) The medical director shall transmit the written determination to the medical provider whose treatment, recommended treatment, or prescribed medication, is being denied, the employee, the employer and the medical payment obligor by facsimile, electronic mail or the United States Postal Service within fourteen (14) calendar days after receipt of all necessary information by the medical director.

(h) Additionally, upon a determination by the medical director that there was no reasonable basis upon which to deny the treatment, recommended treatment, or prescribed medication, or that the medical payment obligor failed to follow the required utilization review procedure, the medical director shall request that sanctions be imposed on the medical payment obligor by directing the employee's or physician's costs of the appeal, including reasonable attorney's fees, be paid by the medical payment obligor. Whether or not to impose the aforementioned sanctions is within the discretion of the commissioner or administrative law judge to whom the request for sanctions was addressed.

(i) If at any time during the appeal with the medical director, the medical payment obligor raises work relatedness, causation or non-compensability issues, the parties shall be advised by the medical director that resolution of these issues requires a filing of an application for adjustment of claim or Form 112, Medical Dispute, whichever is appropriate. The medical director, however, shall continue with the appeal and issue a written determination of the reasonableness and necessity of the proposed medical treatment consistent with this regulation.

(8) A determination by the medical director of the reasonableness and necessity of the treatment, recommended treatment, or prescribed medication shall remain effective for six (6) months from the date of the written determination of the medical director, unless a change in condition is shown by objective medical findings.

(9) If the medical director's determination is to approve the medical treatment, the medical payment obligor shall pay for the treatment, recommended treatment, or prescribed medication within the thirty (30) day time period set forth in KRS 342.020(4) unless a Form 112, Medical Dispute, is timely filed.

(10) If a party disagrees with the medical director's written determination, the aggrieved party may file a Form 112, Medical Dispute, and proceed in accordance with 803 KAR 25:012.

(11) The filing of a Form 112, Medical Dispute, shall toll the thirty (30) day period for paying medical expenses pursuant to KRS 342.020(4) until such time as the reasonableness and necessity of the proposed medical treatment is decided by an administrative law judge.

(12) Failure to file a Form 112, Medical Dispute, within fourteen (14) calendar days shall result in the written determination of the medical director having preclusive effect as to the reasonableness and necessity of the treatment that is the subject of the medical director's determination.

Section 18. Reconsideration and Appeals of Medical Bill Audit Decisions. A reconsideration process to appeal an initial decision shall be provided within the structure of medical bill audit.

(a) A request for reconsideration of the medical bill audit decision shall be made by an aggrieved party within fourteen (14) calendar days of receipt of that decision.

(b) Reconsideration shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer.

(c) A written decision shall be rendered within ten (10) calendar days of receipt of a request for reconsideration. The written decision shall be clearly entitled "MEDICAL BILL AUDIT-RECONSIDERATION DECISION".

(d) A request for reconsideration of the medical bill audit decision shall not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1).

(e) Any party may appeal the "MEDICAL BILL AUDIT RECONSIDERATION DECISION" to the medical director pursuant to Section 17 of this regulation.

ROBERT L. SWISHER, Commissioner

APPROVED BY AGENCY: February 18, 2021

FILED WITH LRC: February 18, 2021 at 2:38 p.m.

**PUBLIC HEARING AND PUBLIC COMMENT PERIOD:** A public hearing on this administrative regulation shall be held on May 27, 2021, at 10:00 a.m. (EDT) by video teleconference pursuant to KRS 61.800, et seq. In keeping with KRS 13A.270, individuals interested in attending or being heard at this hearing shall notify this agency in writing of their intent to attend no later than five (5) workdays prior to the hearing along with contact information. Upon notification of intent to attend, individuals will be provided information necessary to attend the video teleconference. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted through May 31, 2021. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person

**CONTACT PERSON:** B. Dale Hamblin, Jr., Assistant General Counsel, Department of Workers' Claims, Mayo-Underwood Building, 3rd Floor, 500 Mero Street, Frankfort, Kentucky 40601, phone (502) 782-4404, fax (502) 564-0681, email Dale.Hamblin@ky.gov.

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: B. Dale Hamblin, Jr.

(1) Provide a brief summary of:

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

(b) The necessity of this administrative regulation: To provide guidance to insurance carriers, group self-insurers, and individual self-insured employers with respect to utilization review, medical billing, and appeals to the medical director.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 342.260 provides that the Commissioner of the Department of Workers' Claims shall promulgate administrative regulations necessary to carry on the work of the Department of Workers' Claims, and the commissioner may promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342. KRS 342.035(5) provides that the commissioner of the Department of Workers' Claims shall promulgate administrative regulations that require each insurance carrier, group self-insurer and individual self-insured employer to certify to the commissioner the program it has adopted to insure compliance with the medical fee schedule provisions of KRS 342.035(1) and (4). KRS 342.035(5) also requires the commissioner to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, group self-insurer or self-insured employer pursuant to KRS Chapter 342. KRS 342.035(6) allows the commissioner to promulgate regulations incorporating managed care or other concepts intended to reduce costs or to speed the delivery of payment of medical services to employees receiving medical and related benefits under KRS Chapter 342.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation helps to ensure timely benefits to em-

ployees through the use of utilization review. If the employee or medical provider disagrees with a utilization review decision, they are afforded the opportunity for a review by a neutral third party, the medical director. Because the medical director will be the one to decide appealed medical disputes, the resolution of appeals will be more consistent and the delivery of medical benefits more efficient.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This amendment adds a new position and amends the method by which utilization review appeals are adjudicated.

(b) The necessity of the amendment to this administrative regulation: The medical director will more effectively assist the department in fulfilling its medical-related responsibilities. Further, the amendment to this administrative regulation creates a medical advisory committee, which includes stakeholders from the various medical disciplines, to provide input on medical matters.

(c) How the amendment conforms to the content of the authorizing statutes: The commissioner is required to promulgate administrative regulations necessary to govern the medical provider utilization review activities conducted by insurance carriers, self-insured groups, and self-insured employers. The amendment to this administrative regulation adds a person with medical expertise to help assure injured employees receive timely and appropriate medical benefits.

(d) How the amendment will assist in the effective administration of the statutes: The addition of a medical director will help streamline medical decisions and help assure injured employees receive reasonable and necessary medical treatment in a timely fashion.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Insurance carriers, self-insured groups, and self-insured employers.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: The amendment to the administrative regulation directs the path taken by a utilization review appeal when appealed to the medical director.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The medical payment obligor will pay \$400 for each appeal taken to the medical director.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Payment obligors will no longer be required to perform an in-house review of the requested medical treatment, which required the hiring of an independent physician to perform the review. The employee and medical provider will be afforded an independent review of requested medical treatment.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: \$350,000.

(b) On a continuing basis: \$350,000 per year.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department of Workers' Claims normal budget is the source of funding.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The Department anticipates the fees will offset implementation costs.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does establish a fee.

(9) TIERING: Is tiering applied? Tiering is not applied; the administrative regulation applies equally.

## FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Those governmental agencies constituting a medical payment obligor for the purpose of workers' compensation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 342.035(5) and (6), 342.260.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. Without knowing the number of utilization review appeals that will occur, it is impossible to estimate the effect on expenditures.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? It is anticipated that approximately \$400,000 will be generated.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? It is anticipated that approximately \$400,000 will be generated in subsequent years.

(c) How much will it cost to administer this program for the first year? Approximately \$350,000.

(d) How much will it cost to administer this program for subsequent years? Approximately \$350,000 per year.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation: It is anticipated that the costs to administer the medical director appeal process will be offset by the fees generated so that the overall impact will be revenue neutral.