Compiler's Note: Voided by 2022 RS SB 65.

LABOR CABINET

Department of Workers' Claims

(Amended at ARRS Committee)

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~~[Executive director]~~" 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" ***is defined by KRS 342.0011(8) [~~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" ***means healthcare services, including medications, that a medical provider, exercising prudent clinical judgment, would***

provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration; and

(c) Considered effective for the patient's illness, injury, or disease. [~~is defined in 803 KAR 25:260(12)~~] .

(10) "Medical provider" ***means physicians and surgeons, psychologists, optometrists, dentists, podiatrists, osteopathic and chiropractic practitioners, physician assistants, and advanced practice registered nurses, acting within the scope of their license [~~is defined in 803 KAR 25:260 Section 1(11)~~]*** .

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

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

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

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

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

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

Section 2. Implementation.

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

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

Section 3. 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 ***803 KAR Chapter 25~~[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. ~~[Section 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. ~~[Section 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 ***for making*** ~~***[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. ~~[Section 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 $3,000;

(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 ***submitted~~[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 ***submitted~~[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***, in accordance with 803 KAR Chapter 25***;

(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. ~~[Section 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. ***The following professionals shall issue an initial utilization review approval:***

(a) A physician***; ~~[,]~~***

(b) A registered nurse***; ~~[,]~~***

(c) A licensed practical nurse***; ~~[,]~~***

(d) A medical records technician***; ~~[,]~~*** or

(e) Other personnel ***whose~~[,]~~[who through]*** training and experience ***qualify them~~[is qualified]~~*** to issue decisions on medical necessity or appropriateness ***~~[, shall issue the initial utilization review approval]~~***.

(2) ***Only*** a physician ***may~~[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. ~~[Section 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. ~~[Section 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 ***comply ~~[complies]~~*** with KRS Chapter 342 and ***803 KAR Chapter 25 ~~[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 ***utilization [~~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. ***These [~~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 ***for making [~~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 ***:***

(a) Qualifications of internal and consulting personnel who shall conduct utilization review and medical bill audit ***;*** and

(b) 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 ***$3,000*** ***[~~$1000~~]*** ; or

(d) The total lost work days cumulatively exceed ***thirty (30)*** ***[~~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 ***the [~~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 ***, in accordance with 803 KAR Chapter 25*** .

(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 **, and the employee's attorney if represented,** 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 ***submitted [~~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 **, and the employee's attorney if represented,** 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 ***submitted [~~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 ***, in accordance with 803 KAR Chapter 25*** ;

(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) ***Only*** a physician ***may [~~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, the employee's attorney if represented, 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, the employee's attorney if represented, 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) Within the department there shall be a medical director. The medical director shall be a licensed physician in good standing with the Kentucky Board of Medical Licensure.

(2) The Secretary shall appoint the medical director, upon consultation with the Commissioner to a term of four (4) years. A medical director may serve more than one (1) term of four (4) years.

(3) If a vacancy occurs during a four (4) year term, the secretary shall appoint a licensed physician in good standing with the Kentucky Board of Medical Licensure as medical director for the unexpired term. Nothing in this administrative regulation shall prevent the Secretary from appointing a licensed physician in good standing with the Kentucky Board of Medical Licensure to fill an unexpired term and to serve a subsequent term.

(4) After consultation with the Commissioner, the Secretary may remove the medical director for good cause, the grounds for which shall be expressed in writing.

(5) The medical director shall:

(a) Process appeals of utilization review decisions pursuant to this administrative 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.

(6) If the treatment is outside of the medical director's certification or specialty, the medical director may seek the assistance of other physicians with the appropriate certification or specialty to assist or perform any tasks outlined within this administrative regulation; the other physicians shall not be the physician whose treatment or recommended treatment is under review or the physicians who issued or upheld the utilization review denial.

(7)

~~*[(1)]*~~ ~~*[After consultation with the Commissioner, the]*~~ ~~[The]~~ ~~*[Secretary shall appoint a medical director to:]*~~

~~*[(a)]*~~ ~~*[process appeals of utilization review decisions and medical bill audit decisions rendered pursuant to this administrative 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, if]*~~ ~~*[when]*~~ ~~*[appropriate, seek the assistance of other physicians to assist or perform any tasks outlined within this administrative regulation. If]*~~ ~~*[When]*~~ ~~*[the treatment under appeal is chiropractic treatment, the medical director shall seek the assistance of a chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.]*~~

~~*[(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:

1. Deputy commissioner ~~*; [,]*~~ and

2. A representative for *:*

a. Employers ***; [,]***
b. Employees ***; [,]***
c. Labor unions ***; [,]***
d. Insurance ***; [,]***
e. Self-insured ***employers; [,]***
f. Occupational medicine ***; [,]***
g. Chiropractic ***; [,]***
h. Orthopedics ***; [,]***
i. Neurosurgery ***; [,]*** ,
j. Psychiatry [psychiatric] ; [,]
k. Pain management rehabilitation ***; [,]***
l. Pain management ***; [,]***
m. Emergency medicine ***; [,]***
n. Hospitals, [a hospital representative] ; [,] and
o. Pharmacies [a pharmacy representative] .

(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)*** ***[forty-five (45)]*** ~~[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 ***upon request and*** 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 ***$200*** ***[$400.00]*** for each appeal submitted to the medical director. The fee shall be paid by the medical payment obligor no later than ***twenty-one (21) [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 ***. This failure shall [and]*** be construed as an admission by the employer that the denial was in error ***,*** and the medical director ***shall [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)

(a) The appeal shall be dismissed if, within five (5) calendar days of the appeal to the medical director, the medical payment obligor ***provides [may cause the appeal to be dismissed by providing]*** notice ***of dismissal*** to ***the:***

1. Medical director ***; [,]***

2. Medical provider whose treatment, recommended treatment, or prescribed medication is being denied ***; [,]*** and

3. Employee.

(b) With ***this [~~such a~~]*** dismissal, the medical payment obligor shall authorize the payment of the questioned services pursuant to the appropriate fee schedule ***, in accordance with 803 KAR Chapter 25*** . If ***the [~~such~~]*** dismissal occurs, ***a [~~no~~]*** fee as required by this ***administrative*** regulation shall ***not*** 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 ***in keeping with the treatment guidelines and pharmaceutical formulary created or adopted by the commissioner*** .

(b) ***The medical director shall consider the opinion of the medical provider whose treatment, recommended treatment, or prescribed medication is being denied.***

(c) 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. **Necessary information shall be considered missing until the medical director has obtained:**

1. All of the records reviewed by the physician that issued the utilization review denial; and

2. All medical treatment records from the date of the injury or for the two year period preceding the date of the utilization review, whichever is shorter, for the injury or occupational disease giving rise to the treatment, recommended treatment, or prescribed medication for which the utilization review denial was issued.

(d) **Within seven (7) calendar days from receipt of the appeal, the [~~The~~]** medical director shall set a date on which all relevant information shall be due to the medical director.

(e) 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.

(f) 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.

(g) 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.

(h) **No later than two (2) days after the medical director has made a determination, the [~~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 employee's attorney if represented** ***; [~~,~~]*** 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~~] .**

(i) ***If [~~Additionally, upon a determination by~~]*** the medical director ***determines*** 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, ***then*** the medical director shall request ***the commissioner or the administrative law judge to impose the appropriate penalties, fines, or [~~that~~]*** sanctions ***[~~be imposed~~]*** on the medical payment obligor by directing ***that*** 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 these~~] [~~aforementioned~~] [~~sanctions is within the discretion of the~~***

~~commissioner or administrative law judge to whom the request for sanctions was addressed.]~~

(j) 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 ***thirty (30)*** ***~~[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.

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

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

(3) 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".

(4) 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).

~~[(5)] [Any party may appeal the "MEDICAL BILL AUDIT RECONSIDERATION DECISION" to the medical director pursuant to Section 17 of this regulation.]~~

Section 19. This administrative regulation was found deficient by the Administrative Regulation Review Subcommittee on November 9, 2021.

(22 Ky.R. 303; 740; eff. 9-19-1995; 23 Ky.R. 1459; 2181; 2489; eff. 12-13-1996; 24 Ky.R. 1771; 2124; 2686; eff. 6-15-1998; 27 Ky.R. 1893; eff. 3-19-2001; TAm eff. 8-9-2007; 47 Ky.R. 2116; 48 Ky.R. 435; 1753; eff. 3-1-2022; Made unenforceable by SB 65 2022 RS, eff. 4-14-2022.)

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