LABOR CABINET
Department of Workers' Claims
(Amended at ARRS Committee)

803 KAR 25:195. Utilization review, appeal of utilization review decisions, and medical bill audit.

RELATES TO: KRS Chapter 342
STATUTORY AUTHORITY: KRS 342.035(5), (6), 342.260
NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 requires the Commissioner of the Department of Workers' Claims to 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) 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(5) requires the Commissioner of the Department of Workers' Claims to 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 established to ensure compliance with the medical fee schedule provisions of KRS 342.035(1) and (4). KRS 342.035(8) requires the commissioner to establish or develop a pharmaceutical formulary and treatment guidelines. This administrative regulation establishes provisions to ensure that insurance carriers, group self-insurers, and individual self-insured employers implement a utilization review and medical bill audit program.

Section 1. Definitions.

(1) "Business day" means any day except Saturday, Sunday, or any day that 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) "Commissioner" is defined by KRS 342.0011(9).

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

(6) "Department" is defined by KRS 342.0011(8).

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

(8) "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.

(9) "Medical payment obligor" means any self-insured employer, carrier, insurance carrier, self-insurer, or any person acting on behalf of or as an agent of the self-insured employer, carrier, insurance carrier, or self-insurer.

(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

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

(12) "Preauthorization" means a process whereby payment for a medical service or course of treatment is assured in advance by a carrier.

(13) "Same medical specialty" means a branch of medical practice focused regularly and routinely on a defined group of patients, diseases, skills, body parts, or types of injury and performed by a physician with the same or similar qualifications.

(14) "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) "Utilization review and medical bill audit plan" means the written plan submitted to the commissioner by each medical payment obligor describing the procedures governing utilization review and medical bill audit activities.

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

Section 2. Utilization Review and Medical Bill Audit Program.

(1) The utilization review program shall assure that:

(a) A utilization reviewer has the education, training, and experience, necessary to evaluate clinical issues and services for medical necessity and appropriateness;

(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 with KRS Chapter 342 and 803 KAR Chapter 25;

(b) A medical bill auditor has the education, training, or experience, necessary to evaluate medical bills and statements; and

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

Section 3. Utilization Review and Medical Bill Audit Plan Approval.

(1) A medical payment obligor shall fully implement and maintain a utilization review and medical bill audit program.

(2) A medical payment obligor 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 if the plan 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 medical payment obligor 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 medical payment obligor 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 medical payment obligor or its utilization review vendor shall provide annually to the commissioner summaries of the number of utilization reviews conducted, utilization

reviews resulting in an approval, and utilization reviews resulting in a denial, peer-to-peer conferences requested, peer-to-peer conferences that resulted in approval of the requested treatment, and peer-to-peer conferences that resulted in denial of the requested treatment.

(a) The medical payment obligor or its utilization review vendor shall email the summaries in the Microsoft Excel spreadsheet with rows labeled for each summary category to LaborEDI@ky.gov.

(b) The summaries shall only include data gathered from the medical payment obligor's most recent complete fiscal year that ended on or before March 31 of the year in which the summaries are due. The summaries shall be filed with the commissioner no later than September 1 each year.

(c) If a utilization review vendor provides utilization review services for more than one (1) medical payment obligor, the utilization review vendor shall submit a separate spreadsheet for each medical payment obligor.

(d) If a utilization review or a peer-to-peer conference results in a portion of the treatment being approved and a portion of the treatment being denied, the result shall be reported as both an approval and a denial for reporting purposes.

Section 4. Utilization Review and Medical Bill Audit Written Plan Requirements. The written utilization review and medical bill audit plan submitted to the commissioner shall include:

(1) A description of the process, policies, and procedures for making decisions;

(2) A statement 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;

(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 or 803 KAR 25:110;

(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 the commissioner's agent, pursuant to KRS 342.035(5)(b); and

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

Section 5. Claim Selection Criteria.

(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 $3000;

(d) The total lost work days cumulatively exceed thirty (30) days; or

(e) An administrative law judge orders a review.

(2) Utilization review shall commence once 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 notice that a claims selection criteria has been met unless additional information is required, in which case, utilization review shall be waived within two (2) business days following receipt of the requested information.

(a) The following requirements shall apply if preauthorization has been requested and utilization review has not been waived by the medical payment obligor:

1. The initial utilization review decision shall be 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, a single request shall be made within two (2) additional business days;

2. The requested information shall be submitted by the medical provider within ten (10) business days; and

3. The initial 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 initial utilization review decision shall be communicated to the medical provider and employee within seven (7) business days of the initiation of the utilization review process, unless additional information is required. If additional information is required, a single request shall be made within two (2) additional business days;

2. The requested information shall be submitted by the medical provider within ten (10) business days; and

3. The initial utilization review decision shall be rendered 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 challenging or 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 final utilization review decision.

(5) Each medical bill audit shall be initiated within five (5) business 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 or 803 KAR 25:110.

(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 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 training and experience qualify them to issue decisions on medical necessity or appropriateness, including a medical doctor, surgeon, psychologist, optometrist, dentist, podiatrist, and osteopathic practitioner, acting within the scope of the license or licenses required by the jurisdiction in which they are employed.

(2) Utilization review personnel shall hold the license required by the United States' jurisdiction in which they are employed.

(3) A physician shall supervise utilization review personnel.

(4) A physician shall authorize and ratify any utilization review denial.

(5) Only a physician may 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.

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

Section 7. Written Notice of Denial.

(1) Following initial review of a request for preauthorization, 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 two (2) business days after initiation of the utilization review process unless additional information was required, in which case, the written notice of denial shall be issued no later than two (2) business days after the initial utilization review decision;

(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 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 ten (10) business 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 the same medical specialty as the medical provider whose treatment is being reconsidered.

(c) A written reconsideration decision shall be rendered within seven (7) business days of receipt of a request for reconsideration unless a peer-to-peer conference is requested, in which case, the written reconsideration decision shall be rendered within five (5) business days after the day on which the peer-to-peer conference was held. 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 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 ten (10) business 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 seven (7) business 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 9. Peer-to-peer Conference.

(1) If the medical payment obligor denies preauthorization following utilization review, it shall issue a written notice of denial as required in Section 7 of this administrative regulation.

(2) The medical provider whose recommendation for treatment is denied may request reconsideration and may require the reconsideration include a peer-to-peer conference with a second utilization review physician.

(3) The request for a peer-to-peer conference shall be made by electronic communication and shall provide:

(a) A telephone number for the reviewing physician to call;

(b) A date or dates for the conference not less than five (5) business days after the date of the request unless the peer-to-peer conference request stems from a denial issued pursuant to 803 KAR 25:270, in which case, a date or dates not less than two (2) business days after the date of the request. In either case, the parties may by agreement hold the conference in a shorter time period; and

(c) A one (1)-hour period during the date or dates specified during which the requesting medical provider, or a designee, will be available to participate in the conference between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time), Monday through Friday.

(4) The reviewing physician participating in the peer-to-peer conference shall be of the same medical specialty as the medical provider requesting reconsideration.

(5)

(a)

1. Failure of the reviewing physician to participate during the date and time specified shall result in the approval of the request for preauthorization and approval of the recommended treatment unless good cause exists for the failure to participate.

2. In the event of good cause for failure to participate in the peer-to-peer conference, the reviewing physician shall contact the requesting medical provider to reschedule the peer-to-peer conference.

(b) The rescheduled peer-to-peer conference shall be held no later than two (2) business days following the original conference date.

(c) Failure of the requesting medical provider or its designee to participate in the peer-to-peer conference during the time he or she specified availability may result in denial of the request for reconsideration.

(6) A written reconsideration decision shall be rendered within five (5) business days of date of the peer-to-peer conference. The written decision shall be entitled "FINAL UTILIZATION REVIEW DECISION."

(7) If a Final Utilization Review Decision is rendered denying authorization for treatment before an award has been entered by or agreement approved by an administrative law judge, the requesting medical provider or the injured employee may file a medical dispute pursuant to 803 KAR 25:012. If a Final Utilization Review Decision is rendered denying authorization for treatment after an award has been entered by or agreement approved by an administrative law judge, the employer shall file a medical dispute pursuant to 803 KAR 25:012.

(8) Pursuant to KRS 342.285(1), a decision of an administrative law judge on a medical dispute is subject to review by the workers' compensation board under the procedures established in 803 KAR 25:010, Section 22.

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