803 KAR 25:190. Utilization review and medical bill audit.

RELATES TO: KRS Chapter 342

STATUTORY AUTHORITY: KRS 342.035(5), 342.260

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 provides that the Executive Director of the Office of Workers' Claims shall promulgate administrative regulations necessary to carry on the work of the Office of Workers' Claims, and the executive director may promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342. KRS 342.035(5) provides that the Executive Director of the 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 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 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. This administrative regulation insures that insurance carriers, group self-insurers, and individual self-insured employers implement a utilization review and audit program.

Section 1. Definitions.

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

(2) "Executive Director" is defined by KRS 342.0011(9).

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

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

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

(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.

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

(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. 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 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 executive director a written plan describing the utilization review and medical bill audit program. The 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 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 executive director.

(4) A carrier who contracts with an approved vendor for utilization review or medical bill audit services shall notify the 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) 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 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 4. Utilization Review and Medical Bill Audit Written Plan Requirements. The written utilization review and medical bill audit plan submitted to the 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 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 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 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) 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 working days.

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

3. The initial utilization review decision shall be rendered within two (2) 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) 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 working days.

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

3. The initial utilization review decision shall be rendered within two (2) 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) 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 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 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) 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 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) 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) 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) 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) 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) 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).

(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.)