304.17A-603 Application of KRS 304.17A-600 to 304.17A-633 -- Written procedures for coverage and utilization review determinations to be accessible on insurers' Web sites -- Preauthorization review requirements for insurers.

(1) KRS 304.17A-600 to 304.17A-633 shall apply to any insurer that covers citizens of the Commonwealth under a health benefit plan.

(2) An insurer shall maintain written procedures for:

(a) Determining whether a requested service, treatment, drug, or device is covered under the terms of a covered person's health benefit plan;

(b) Making utilization review determinations; and

(c) Notifying covered persons, authorized persons, and providers acting on behalf of covered persons of its determinations.

(3) An insurer shall make the written procedures required by this section readily accessible on its Web site to covered persons, authorized persons, and providers.

(4) (a) If an insurer requires preauthorization to be obtained for a service to be covered, the insurer shall maintain information on its publicly accessible Web site about the list of services and codes for which preauthorization is required. The Web site shall indicate, for each service required to be preauthorized:

1. When preauthorization was required, including the effective date or dates and the termination date or dates, if applicable;

2. The date the requirement was listed on the insurer's Web site; and

3. Where applicable, the date that preauthorization was removed.

(b) An insurer shall maintain a complete list of services for which preauthorization is required, including for all services where preauthorization is performed by an entity under contract with the insurer.

(c) An insurer shall not deny a claim for failure to obtain preauthorization if the preauthorization requirement was not in effect on the date of service on the claim.

(5) Except as otherwise provided in this subtitle, prior authorization shall not be required for births or the inception of neonatal intensive care services and notification shall not be required as a condition of payment.

(6) Unless otherwise specified by the provider's contract, an insurer shall not deem as incidental or deny supplies that are routinely used as part of a procedure when:

(a) An associated procedure has been preauthorized; or

(b) Preauthorization for the procedure is not required.

Effective: January 1, 2020

History: Amended 2019 Ky. Acts ch. 190, sec. 8, effective January 1, 2020. -- Created 2000 Ky. Acts ch. 262, sec. 2, effective July 14, 2000.