304.17A-607 Duties of insurer or private review agent performing utilization reviews -- Requirement for registration -- Consequences of insurer's failure to make timely utilization review determination -- Requirement that insurer or private review agent submit changes to the department -- Requirement that private review agent provide timely notice of entities for whom it is providing review. (Effective until January 1, 2023)

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the department. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that, for any contract entered into on or after January 1, 2020, for the provision of utilization review services, only licensed physicians, who are of the same or similar specialty and subspecialty, when possible, as the ordering provider, shall:

1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264 and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section and administrative

regulations promulgated in accordance with KRS 304.17A-609;

(h) Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review, or as otherwise provided in this subtitle, provide a utilization review decision in accordance with the timeframes in paragraph (i) of this subsection and 29 C.F.R. Part 2560, including written notice of the decision;

(i) 1. Render a utilization review decision concerning urgent health care services, and notify the covered person, authorized person, or provider of that decision no later than twenty-four (24) hours after obtaining all necessary information to make the utilization review decision; and

2. If the insurer or agent requires a utilization review decision of nonurgent health care services, render a utilization review decision and notify the covered person, authorized person, or provider of the decision within five (5) days of obtaining all necessary information to make the utilization review decision.

For purposes of this paragraph, "necessary information" is limited to:

a. The results of any face-to-face clinical evaluation;

b. Any second opinion that may be required; and

c. Any other information determined by the department to be necessary to making a utilization review determination;

(j) Provide written notice of review decisions to the covered person, authorized person, and providers. The written notice may be provided in an electronic format, including e-mail or facsimile, if the covered person, authorized person, or provider has agreed in advance in writing to receive the notices electronically. An insurer or agent that denies step therapy, as defined in KRS 304.17A-163, overrides or denies coverage or reduces payment for a treatment, procedure, drug that requires prior approval, or device shall include in the written notice:

1. A statement of the specific medical and scientific reasons for denial or reduction of payment or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;

2. The medical license number and the title of the reviewer making the decision;

3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, and any specific filing procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information;

(k) Afford participating physicians an opportunity to review and comment on all

medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and

(l) Comply with its own policies and procedures on file with the department or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law.

(2) The insurer's or private review agent's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be a prior authorization for the health care services or benefits subject to the review. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the department. No change to policies and procedures shall be effective or used until after it has been filed with and approved by the commissioner.

(4) A private review agent shall provide to the department the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

Effective: January 1, 2020

History: Amended 2019 Ky. Acts ch. 190, sec. 9, effective January 1, 2020. -- Amended 2010 Ky. Acts ch. 24, sec. 1236, effective July 15, 2010. -- Amended 2004 Ky. Acts ch. 59, sec. 12, effective July 13, 2004. -- Amended 2002 Ky. Acts ch. 181, sec. 5, effective July 15, 2002. -- Amended 2001 Ky. Acts ch. 145, sec. 2, effective June 21, 2001. -- Created 2000 Ky. Acts ch. 262, sec. 4, effective July 14, 2000.