1	AN ACT relating to prior authorization.
2	Be it enacted by the General Assembly of the Commonwealth of Kentucky:
3	→SECTION 1. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS
4	CREATED TO READ AS FOLLOWS:
5	(1) An insurer or its private review agent shall not require a health care provider to
6	obtain prior authorization for a particular health care service if, at the time the
7	health care service was provided, the health care provider qualified for or had an
8	exemption under subsection (2)(a) of this section, or was qualified under the
9	exemption of another health care provider in accordance with subsection (2)(b)
10	of this section, for that health care service.
11	(2) (a) A health care provider shall qualify for an exemption for a particular health
12	care service if, in the most recent evaluation period as described in
13	subsection (3) of this section, the insurer or its private review agent
14	approved not less than ninety percent (90%) of the prior authorization
15	requests submitted by the health care provider for that health care service.
16	(b) Subject to the requirements of paragraph (c) of this subsection, a health
17	care provider shall be qualified under the exemption of another health care
18	provider for a particular health care service if:
19	1. The following requirements are met:
20	a. The health care provider is an advanced practice registered
21	nurse or physician assistant;
22	b. The health care provider's collaborating or supervising
23	physician has an exemption for the health care service under
24	paragraph (a) of this subsection;
25	c. The health care service is within the scope of practice of an
26	advanced practice registered nurse or physician assistant; and
27	d. The health care provider submits the claim for the health care

1		service under the collaborating or supervising physician's
2		national provider identifier in a manner consistent with
3		applicable law; or
4		2. The health care provider is a treating provider providing a health care
5		service ordered by a health care provider with an exemption for the
6		health care service under paragraph (a) of this subsection.
7	<u>(c</u>	1. For health care services provided under paragraph (b) of this
8		subsection, the health care provider shall include the name and
9		national provider identifier of the collaborating or supervising
10		physician, or the ordering health care provider, on the claim forms for
11		the health care service.
12		2. The insurer or its private review agent may provide coding guidance to
13		health care providers submitting claim forms under subparagraph 1.
14		of this paragraph to ensure that information is appropriately captured
15		on the claim.
16		3. If the information required under subparagraph 1. of this paragraph
17		is not included on claim forms submitted for the health care service,
18		the insurer or its private review agent may treat the claim as subject to
19		an otherwise applicable prior authorization requirement.
20	(3) (a) An insurer or its private review agent shall evaluate, once every six (6)
21		months, whether a health care provider qualifies for an exemption under
22		subsection (2)(a) of this section for each health care service:
23		1. Provided by the provider during the evaluation period regardless of
24		the number of prior authorization requests submitted for the health
25		care service during the evaluation period; and
26		2. For which:
27		a. The insurer or private review agent requires prior authorization;

1		<u>ana</u>
2		b. The provider does not have an exemption under this section.
3	<u>(b</u>	An insurer or its private review agent shall not:
4		1. Include prior authorization requests that have not been finalized in its
5		evaluation under paragraph (a) of this subsection; or
6		2. Require a health care provider to request an exemption in order to
7		qualify for the exemption.
8	(4) (a	Except as provided in paragraph (b) of this subsection, not later than five
9		(5) days after conducting an evaluation under subsection (3) of this section,
0		an insurer or its private review agent shall provide a health care provider
1		with a notice, in accordance with Section 4 of this Act, that includes:
2		1. A statement:
3		a. Notifying the health care provider that the provider has been
4		granted an exemption under this section; and
5		b. Setting forth the duration of the exemption; and
6		2. A list of the health care services and plans to which the exemption
17		applies.
8	<u>(b</u>	An insurer or its private review agent may deny an exemption within five (5)
9		days after conducting an evaluation under subsection (3) of this section if
20		the insurer or private review agent provides the health care provider with
21		the following, in accordance with Section 4 of this Act:
22		1. Actual statistics and data for the relevant evaluation period;
23		2. Detailed information sufficient to demonstrate that the health care
24		provider does not meet the criteria for an exemption under subsection
25		(2)(a) of this section for the particular health care service; and
26		3. A plain language explanation of how the health care provider may
27		appeal by seeking an external review of the denial under Section 3 of

1		this Act.
2	<u>(5)</u>	If a health care provider submits a prior authorization request for a health care
3		service for which the health care provider qualifies for an exemption under
4		subsection (2)(a) of this section, the insurer or its private review agent shall
5		promptly provide the health care provider with a notice, in accordance with
6		Section 4 of this Act, that includes:
7		(a) The information required under subsection (4)(a) of this section; and
8		(b) The insurer's payment requirements.
9	<u>(6)</u>	An exemption that a health care provider qualifies for or has under subsection
0		(2)(a) of this section shall remain in effect until it is rescinded under Section 2 of
1		this Act.
2	<u>(7)</u>	When a health care provider's exemption has been denied under subsection (4)(b)
3		of this section or rescinded under Section 2 of this Act, the health care provider
4		may qualify for or have an exemption under subsection (2)(a) of this section for
5		the same health care service beginning six (6) months after the effective date of
6		the rescission or denial.
7		→SECTION 2. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS
8	CRI	EATED TO READ AS FOLLOWS:
9	<u>(1)</u>	(a) Subject to this section and except as provided in subsection (6) of Section 3
20		of this Act, an insurer or its private review agent may, during the months of
21		January and July of each year, rescind an exemption granted in accordance
22		with subsection (2)(a) of Section 1 of this Act, if the insurer or private
23		review agent:
24		1. Makes a determination, based on a retrospective review of a random
25		sample of not less than five (5) and not more than twenty (20) claims
26		submitted by the health care provider for the particular health care
27		service during the most recent evaluation period, that less than ninety

1		percent (90%) of the claims met the medical necessity criteria that
2		would have been used during the relevant evaluation period by the
3		insurer or private review agent when conducting a prior authorization
4		review for that health care service; and
5		2. Notifies the health care provider of the rescission in accordance with
6		Section 4 of this Act and paragraph (b) of this subsection.
7	<u>(b)</u>	The notification required under paragraph (a) of this subsection shall
8		include:
9		1. An identification of the health care services and plans for which the
10		exemption is being rescinded;
11		2. The date the notification was issued;
12		3. The date the rescission is effective under subsection (2)(c)2. of this
13		section;
14		4. A statement that includes:
15		a. The total number of payable claims submitted by or in
16		connection with the health care provider during the most recent
17		evaluation period that were eligible to be evaluated for the health
18		care service subject to the rescission;
19		b. Identification of each claim included in the random sample;
20		c. The insurer's or private review agent's determination of whether
21		each claim met the insurer's or private review agent's screening
22		criteria; and
23		d. For any claim determined to not have met the insurer's or
24		private review agent's screening criteria:
25		i. The principal reasons for the determination, including, if
26		applicable, a statement that the determination was based on
27		a failure to submit specified medical records;

1	ti. Ine cunical basis for the aetermination;
2	iii. A description of the screening criteria sources that were
3	used as guidelines in making the determination; and
4	iv. The professional specialty of the health care provider who
5	made the determination;
6	5. A plain language explanation of how the health care provider may
7	appeal by seeking an external review of the rescission under Section 3
8	of this Act;
9	6. A form, prescribed by the commissioner under Section 7 of this Act, to
10	be filled out by the health care provider to request an external review
11	of the rescission under Section 3 of this Act that includes:
12	a. The name, address, contact information, and national provider
13	identifier of the health care provider;
14	b. An indication of whether the health care provider is requesting
15	the independent review entity to review the same random sample
16	of claims or a different random sample of claims, as provided in
17	subsection (3)(a) of Section 3 of this Act;
18	c. The date the appeal is being requested; and
19	d. An instruction for the health care provider to:
20	i. Return the form to the insurer or private review agent
21	before the date the rescission becomes effective under
22	subsection $(2)(c)2$. of this section; and
23	ii. Include applicable medical records for any determination
24	that was based on a failure to provide medical records; and
25	7. The address and contact information for returning, by mail or
26	electronic means, the form referenced in subparagraph 6. of this
27	paragraph.

1	<u>(c)</u>	An insurer or its private review agent shall not rescind an exemption of a
2		health care provider that has less than five (5) claims subject to review
3		under paragraph (a) of this subsection.
4	(2) (a)	1. Except as provided in subparagraph 2. of this paragraph, the review
5		periods under subsection (1)(a) of this section shall be January
6		through June and July through December of each year.
7		2. If six (6) months has not elapsed since the date of the notification
8		under subsection (4)(a) or (5) of Section 1 of this Act, whichever is
9		earlier, the review period shall be extended to include the next full
10		review period set forth in subparagraph 1. of this paragraph.
11	<u>(b)</u>	An insurer or private review agent shall not include claims that have not
12		been finalized in its review under subsection (1)(a) of this section.
13	<u>(c)</u>	A rescission determination under subsection (1) of this section shall:
14		1. Be made by an individual:
15		a. Licensed to practice medicine in this state; and
16		b. When relating to a physician, who has the same or similar
17		specialty as the physician; and
18		2. Take effect:
19		a. Except as provided in subdivision b. of this subparagraph, on the
20		thirtieth day after the date the insurer or its private review agent
21		notifies the health care provider of the rescission; or
22		b. If the health care provider timely requests an external review of
23		the rescission under subsection (1)(a)1. of Section 3 of this Act,
24		on the fifth day after the date the independent review entity
25		affirms the rescission.
26	(3) If a	notice under subsection (1) of this section is sent in a manner inconsistent
27	with	the requirements of Section 4 of this Act, the notice shall be defective and

1	any exe	mption referencea in the defective notice shall remain in effect.
2	→ SECT	TION 3. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS
3	CREATED T	O READ AS FOLLOWS:
4	(1) (a) 1.	Except as provided in paragraph (b) of this subsection, a health care
5		provider may, within thirty (30) days of receiving an exemption denial
6		under Section 1 of this Act or an exemption rescission under Section 2
7		of this Act, submit a request for an external review of the rescission or
8		denial to the insurer or its private review agent. An external review
9		requested under this subparagraph shall be conducted by an
10		independent review entity.
11	<u>2.</u>	Requests for an external review under subparagraph 1. of this
12		paragraph shall be forwarded by the insurer or its private review agent
13		to the independent review entity within twenty-four (24) hours of
14		receipt by the insurer or private review agent.
15	<u>3.</u>	The department shall establish a system for each insurer or its private
16		review agent to be assigned an independent review entity for external
17		reviews conducted under subparagraph 1. of this paragraph.
18	<u>4.</u>	The system established under subparagraph 3. of this paragraph shall:
19		a. Be prospective; and
20		b. Require insurers and private review agents to utilize independent
21		review entities on a rotating basis so that an insurer or private
22		review agent does not have the same independent review entity
23		for two (2) consecutive external reviews.
24	<u>5.</u>	For purposes of the system established under subparagraph 3. of this
25		paragraph, the department shall contract with not less than two (2)
26		independent review entities.
27	(b) 1.	A health care provider may submit a request for an external review of

I		any rescission notice alleged to be sent in a manner inconsistent with
2		Section 4 of this Act. An external review requested under this
3		subparagraph shall be conducted by the department.
4		2. The commissioner shall promulgate an administrative regulation to
5		establish procedures for an external review requested under
6		subparagraph 1. of this paragraph.
7		(c) An insurer or its private review agent shall:
8		1. Not require a health care provider to engage in an internal appeal
9		before requesting an external review under this subsection; and
10		2. Provide options for a health care provider to submit a request for an
11		external review under paragraph (a)1. of this subsection by mail,
12		electronic mail, or other electronic methods.
13	<u>(2)</u>	For an external review of an exemption denial under Section 1 of this Act, the
14		independent review entity shall base its decision on the criteria established under
15		subsection (2)(a) of Section 1 of this Act.
16	<u>(3)</u>	For an external review of an exemption rescission under Section 2 of this Act by
17		an independent review entity under subsection (1)(a)1. of this section:
18		(a) A health care provider may request that the independent review entity, as
19		part of its review, consider, if available, another random sample of not less
20		than five (5) and not more than twenty (20) claims submitted to the insurer
21		or its private review agent by the health care provider during the relevant
22		evaluation period for the relevant health care service;
23		(b) The independent review entity shall base its decision on the criteria
24		established under subsection (1)(a) of Section 2 of this Act as determined by
25		the medical necessity of the following sample of claims:
26		1. The claims reviewed by the insurer or its private review agent under
27		subsection (1)(a) of Section 2 of this Act; and

1		2. If the health care provider makes a request under paragraph (a) of
2		this subsection, the additional claims submitted for review under this
3		subsection; and
4	<u>(c)</u>	In making its decision, the independent review entity shall take into account
5		all of the following:
6		1. Information submitted by the insurer or its private review agent and
7		the health care provider, including:
8		a. The relevant medical records for the claims being reviewed;
9		b. The standards, criteria, and clinical rationale used by the insurer
10		or private review agent to make its determination; and
11		c. The insurer's health plan;
12		2. Findings, studies, research, and other relevant documents of
13		government agencies and nationally recognized organizations,
14		including the National Institutes of Health, the National Cancer
15		Institute, the National Academy of Sciences, the United States Food
16		and Drug Administration, the Centers for Medicare and Medicaid
17		Services of the United States Department of Health and Human
18		Services, and the Agency for Health Care Research and Quality; and
19		3. Relevant findings in peer-reviewed medical or scientific literature,
20		published opinions of nationally recognized medical specialists, and
21		clinical guidelines adopted by relevant national medical societies.
22	(4) (a)	The independent review entity shall issue an external review decision to the
23		health care provider, insurer or its private review agent, and department not
24		later than thirty (30) days after the date the health care provider files a
25		request under subsection (1)(a)1. of this section.
26	<u>(b)</u>	The external review decision issued under this subsection shall include:
27		1. The findings for either the health care provider or the insurer or its

1	private review agent regarding each exemption under review;
2	2. The relevant provisions of the insurer's health plan and how the
3	provisions applied; and
4	3. The relevant provisions of any nationally recognized and peer-
5	reviewed medical or scientific documents used in the external review.
6	(5) If an insurer's or its private review agent's denial or rescission is overturned by
7	an independent review entity under this section, the insurer or private review
8	agent:
9	(a) Shall be bound by the decision;
10	(b) Shall not attempt to rescind the exemption reviewed by the independent
11	review entity before the end of the next evaluation period that occurs; and
12	(c) May only deny or rescind the exemption reviewed by the independent review
13	entity after the insurer or private review agent complies with this section
14	and Sections 1 and 2 of this Act.
15	(6) An insurer or its private review agent shall pay:
16	(a) For any external review requested under this section; and
17	(b) A reasonable fee determined by the Kentucky Board of Medical Licensure
18	for any copies of medical records or other documents requested from a
19	health care provider during an external review requested under this section.
20	(7) The external review process shall be confidential and shall not be subject to KRS
21	61.805 to 61.850 or KRS 61.870 to 61.884.
22	(8) (a) The insurer, private review agent, or health care provider involved in an
23	external review under subsection (1)(a)1. of this section may submit a
24	written complaint to the department regarding any independent review
25	entity's actions believed to be an inappropriate application of this section.
26	(b) 1. The department shall promptly review the complaint, and if the
27	department determines that the actions of the independent review

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1	entity were inappropriate, the department shall take corrective
2	measures, including decertification or suspension of the independent
3	review entity from further participation in external reviews.
4	2. The department's actions under subparagraph 1. of this paragraph
5	shall be subject to the powers and administrative procedures set forth
6	in this subtitle.
7	→SECTION 4. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS
8	CREATED TO READ AS FOLLOWS:
9	(1) For purposes of sending forms and notices to a health care provider under
10	Sections 1 to 7 of this Act, an insurer or its private review agent shall solicit from
11	each health care provider the provider's preferred:
12	(a) Method of contact; and
13	(b) Contact information.
14	(2) An insurer or its private review agent shall:
15	(a) Send all forms and notices required to be sent to a health care provider
16	under Sections 1 to 7 of this Act, or administrative regulations promulgated
17	pursuant thereto, in the manner designated by the health care provider
18	under subsection (1) of this section; and
19	(b) Provide a process for health care providers to update the preferences
20	designated under subsection (1) of this section.
21	→SECTION 5. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS
22	CREATED TO READ AS FOLLOWS:
23	(1) An insurer or its private review agent shall not retrospectively:
24	(a) Deny, or reduce payment to a health care provider for, a health care service
25	for which the health care provider qualified or had an exemption under
26	subsection (2)(a) of Section 1 of this Act, or qualified under the exemption
27	of another health care provider under subsection (2)(b) of Section 1 of this

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1	Act, based on medical necessity or appropriateness of care unless the health
2	care provider:
3	1. Knowingly and materially misrepresented the health care service in a
4	request for payment submitted to the insurer or private review agent
5	with the specific intent to deceive and obtain an unlawful payment
6	from the insurer or private review agent; or
7	2. Failed to substantially perform the health care service; or
8	(b) Deny a health care service on the basis of a rescission under Section 2 of
9	this Act, regardless of whether an independent review entity affirms the
10	insurer's or private review agent's determination.
11	(2) Notwithstanding any other law to the contrary, an insurer or its private review
12	agent shall not conduct a retrospective review of a health care service for which
13	the health care provider qualified or had an exemption under subsection (2)(a) of
14	Section 1 of this Act, or qualified under the exemption of another health care
15	provider under subsection (2)(b) of Section 1 of this Act, except:
16	(a) To determine if the health care provider continues to qualify for an
17	exemption; or
18	(b) When the insurer or private review agent has reasonable cause to suspect a
19	basis for denial exists under subsection (1)(a) of this section.
20	→SECTION 6. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS
21	CREATED TO READ AS FOLLOWS:
22	Nothing in Sections 1 to 7 of this Act shall be construed to:
23	(1) Authorize a health care provider to provide a health care service outside the scope
24	of the provider's applicable license; or
25	(2) Require an insurer or its private review agent to pay for a health care service
26	described in subsection (1) of this section that is performed in violation of the
27	laws of this state.

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1		→S	ECTI	ON 7. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS
2	CRE	EATE	D TO	READ AS FOLLOWS:
3	<u>For</u>	ever	y proc	cess relating to an exemption from prior authorization requirements
4	und	er Sec	ctions	1 to 7 of this Act, the commissioner shall, by administrative regulation,
5	<u>esta</u>	blish .	stando	ardized forms that shall be used by insurers and private review agents.
6		→ S	ection	8. KRS 304.17A-600 is amended to read as follows:
7	As t	ısed iı	ı KRS	304.17A-600 to 304.17A-633:
8	(1)	(a)	"Ad	verse determination" means a determination by an insurer or its designee
9			that	the health care services furnished or proposed to be furnished to a
0			cove	ered person are:
1			1.	Not medically necessary, as determined by the insurer, or its designee or
2				experimental or investigational, as determined by the insurer, or its
3				designee; and
4			2.	Benefit coverage is therefore denied, reduced, or terminated.
5		(b)	"Ad	verse determination" does not mean a determination by an insurer or its
6			desig	gnee that the health care services furnished or proposed to be furnished to
17			a co	vered person are specifically limited or excluded in the covered person's
8			heal	th benefit plan;
9	(2)	"Au	thoriz	ed person" means a parent, guardian, or other person authorized to act on
20		beha	alf of a	a covered person with respect to health care decisions;
21	(3)	"Co	ncurre	ent review" means utilization review conducted during a covered person's
22		cou	se of	treatment or hospital stay;
23	(4)	"Co	vered	person" means a person covered under a health benefit plan;
24	(5)	"Ext	ternal	review" means a review that is conducted by an independent review
25		entit	ty [wh	ich meets specified criteria as established in KRS 304.17A-623, 304.17A-
26		625,	, and 3	304.17A_627] ;

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(6)

"Health benefit plan" has the same meaning as in KRS 304.17A-005, except that for

1		purposes of KRS 304.17A-600 to 304.17A-633, the term includes short-term
2		coverage policies;
3	(7)	"Independent review entity" means an individual or organization certified by the
4		department to perform external reviews[under KRS 304.17A-623, 304.17A-625,
5		and 304.17A-627];
6	(8)	"Insurer" means any of the following entities authorized to issue health benefit
7		plans[as defined in subsection (6) of this section]:
8		(a) An insurance company; [,]
9		(b) A health maintenance organization;
10		$\underline{(c)}$ \underline{A} self-insurer or multiple employer welfare arrangement not exempt from
11		state regulation by ERISA;
12		(d) A provider-sponsored integrated health delivery network;
13		(e) A self-insured employer-organized association;
14		(f) A nonprofit hospital, medical-surgical, or health service corporation; or
15		(g) Any other entity authorized to transact health insurance business in Kentucky;
16	(9)	"Internal appeals process" means a formal process, as set forth in KRS 304.17A-
17		617, established and maintained by the insurer, its designee, or agent whereby the
18		covered person, an authorized person, or a provider may contest an adverse
19		determination rendered by the insurer, its designee, or private review agent;
20	(10)	"Nationally recognized accreditation organization":
21		(a) Means a private nonprofit entity that:
22		1. Sets national utilization review and internal appeal standards; and
23		2. Conducts review of insurers, agents, or independent review entities for
24		the purpose of accreditation or certification; and
25		(b) Shall include the Accreditation Association for Ambulatory Health Care
26		(AAAHC), the National Committee for Quality Assurance (NCQA), the
27		American Accreditation Health Care Commission (URAC), the Joint

1			Commission, or any other organization identified by the department;
2	(11)	"Priv	vate review agent" or "agent":
3		(a)	Means a person or entity performing utilization review that is either affiliated
4			with, under contract with, or acting on behalf of any insurer or other person
5			providing or administering health benefits to citizens of this Commonwealth;
6			and
7		(b)	Does not include an independent review entity <u>that</u> [which] performs external
8			<u>reviews</u> [review] of adverse determinations;
9	(12)	"Pro	spective review":
10		<u>(a)</u>	Means a utilization review that is conducted prior to the provision of health
11			care services: and[. "Prospective review" also]
12		<u>(b)</u>	Includes any insurer's or agent's requirement that a covered person or provider
13			notify the insurer or agent prior to providing a health care service, including
14			but not limited to prior authorization, step therapy protocol, preadmission
15			review, pretreatment review, utilization, and case management;
16	(13)	"Qua	alified personnel" means \underline{a} licensed physician, registered nurse, licensed
17		pract	tical nurse, medical records technician, or other licensed medical personnel
18		who	through training and experience, shall render consistent decisions based on the
19		revie	ew criteria;
20	(14)	"Reg	gistration" means an authorization issued by the department to an insurer or a
21		priva	ate review agent to conduct utilization review;
22	(15)	"Ret	rospective review":
23		(a)	Means utilization review that is conducted after health care services have been
24			provided to a covered person; and
25		(b)	Does not include the review of a claim that is limited to an evaluation of
26			reimbursement levels[,] or adjudication of payment;
27	(16)	[(a)	

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1		<u>(a)</u>	Means health care or treatment with respect to which the application of the
2			time periods for making nonurgent determination:
3			1. Could seriously jeopardize the life or health of the covered person or the
4			ability of the covered person to regain maximum function; or
5			2. In the opinion of a physician with knowledge of the covered person's
6			medical condition, would subject the covered person to severe pain that
7			cannot be adequately managed without the care or treatment that is the
8			subject of the utilization review; and[]
9		(b)	<u>Includes</u> [Urgent health care services include] all requests for hospitalization
10			and outpatient surgery;
11	(17)	<u>(a)</u>	"Utilization review" means a review of the medical necessity and
12			appropriateness of hospital resources and medical services given or proposed
13			to be given to a covered person for purposes of determining the availability of
14			payment.
15		<u>(b)</u>	Areas of review include concurrent, prospective, and retrospective review;
16			and
17	(18)	"Uti	lization review plan" means a description of the procedures governing
18		utili	zation review activities performed by an insurer or a private review agent.
19		→ S	ection 9. KRS 304.17A-605 is amended to read as follows:
20	(1)	Sect	ions 1 to 7 of this Act and KRS 304.17A-600, 304.17A-603, 304.17A-605,
21		304.	17A-607, 304.17A-609, 304.17A-611, 304.17A-613, and 304.17A-615 set
22		forth	the requirements and procedures regarding utilization review and shall apply
23		to:	
24		(a)	Any insurer or its private review agent that provides or performs utilization
25			review in connection with a health benefit plan or a limited health service
26			benefit plan; and
27		(b)	Any private review agent that performs utilization review functions on behalf

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of any person providing or administering health benefit plans or limited health

1

2		service benefit plans.
3	(2)	Where an insurer or its agent provides or performs utilization review, and in all
4		instances where internal appeals as set forth in KRS 304.17A-617 are involved, the
5		insurer or its agent shall be responsible for:
6		(a) Monitoring all utilization reviews and internal appeals carried out by or on
7		behalf of the insurer;
8		(b) Ensuring that all requirements of KRS 304.17A-600 to 304.17A-633 are met;
9		(c) Ensuring that all administrative regulations promulgated in accordance with
10		KRS 304.17A-609, 304.17A-613, and 304.17A-629 are complied with; and
11		(d) Ensuring that appropriate personnel have operational responsibility for the
12		performance of the insurer's utilization review plan.
13	(3)	A private review agent that operates solely under contract with the federal
14		government for utilization review or patients eligible for hospital services under
15		Title XVIII of the Social Security Act shall not be subject to the registration
16		requirements set forth in KRS 304.17A-607, 304.17A-609, and 304.17A-613.
17		→ Section 10. KRS 304.17A-607 is amended to read as follows:
18	(1)	An insurer or private review agent shall not provide or perform utilization reviews
19		without being registered with the department. A registered insurer or private review
20		agent shall:
21		(a) Have available the services of sufficient numbers of registered nurses,
22		medical records technicians, or similarly qualified persons supported by
23		licensed physicians with access to consultation with other appropriate
24		physicians to carry out its utilization review activities;
25		(b) Ensure that [, for any contract entered into on or after January 1, 2020,]:
26		1. For the provision of utilization review services, only licensed
27		physicians, who are of the same or similar specialty and subspecialty,

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1		when possible, as the ordering provider, shall:
2		\underline{a} .[1.] Make a utilization review decision to deny, reduce, limit, or
3		terminate a health care benefit or to deny, or reduce payment for a
4		health care service because that service is not medically necessary,
5		experimental, or investigational except:
6		\underline{i} . In the case of a health care service rendered by a chiropractor
7		or optometrist, [where] the denial shall be made respectively
8		by a chiropractor or optometrist duly licensed in Kentucky;
9		and
10		ii. As otherwise provided in subparagraph 2. of this
11		paragraph; and
12		$\underline{b.}[2.]$ Supervise qualified personnel conducting case reviews;
13		2. For the provision of utilization review services relating to prior
14		authorization, only physicians licensed in this state, who are of the
15		same or similar specialty and subspecialty as the ordering provider,
16		shall conduct the utilization review services; and
17		3. For the provision of utilization review services relating to prior
18		authorization for prescription drugs, the drug shall be the basis for the
19		prior authorization decision regardless of the dosage;
20	(c)	Have available the services of sufficient numbers of practicing physicians in
21		appropriate specialty areas to assure the adequate review of medical and
22		surgical specialty and subspecialty cases;
23	(d)	Not disclose or publish individual medical records or any other confidential
24		medical information in the performance of utilization review activities except
25		as provided in the Health Insurance Portability and Accountability Act,
26		Subtitle F, secs. 261 to 264 and 45 C.F.R. <u>Parts[secs.]</u> 160 to 164 and other
27		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 <u>not</u>[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.

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1		For purposes of this paragraph, "necessary information" is limited to:
2		a. The results of any face-to-face clinical evaluation;
3		b. Any second opinion that may be required; and
4		c. Any other information determined by the department to be
5		necessary to making a utilization review determination;
6	(j)	Provide written notice of review decisions to the covered person, authorized
7		person, and providers. The written notice may be provided in an electronic
8		format, including e-mail or facsimile, if the covered person, authorized
9		person, or provider has agreed in advance in writing to receive the notices
10		electronically. An insurer or agent that denies a step therapy exception, as
11		defined in KRS 304.17A-163, or denies coverage or reduces payment for a
12		treatment, procedure, drug that requires prior approval, or device shall include
13		in the written notice:
14		1. A statement of the specific medical and scientific reasons for denial or
15		reduction of payment or identifying that provision of the schedule of
16		benefits or exclusions that demonstrates that coverage is not available;
17		2. The medical license number and the title of the reviewer making the
18		decision;
19		3. Except for retrospective review, a description of alternative benefits,
20		services, or supplies covered by the health benefit plan, if any; and
21		4. Instructions for initiating or complying with the insurer's internal appeal
22		procedure, as set forth in KRS 304.17A-617, stating, at a minimum,
23		whether the appeal shall be in writing, and any specific filing
24		procedures, including any applicable time limitations or schedules, and
25		the position and phone number of a contact person who can provide
26		additional information;

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

1			medical and surgical and emergency room protocols, respectively, of the
2			insurer and afford other participating providers an opportunity to review and
3			comment on all of the insurer's protocols that are within the provider's legally
4			authorized scope of practice; and
5		(1)	Comply with its own policies and procedures on file with the department or, if
6			accredited or certified by a nationally recognized accrediting entity, comply
7			with the utilization review standards of that accrediting entity where they are
8			comparable and do not conflict with state law.
9	(2)	<u>(a)</u>	The insurer's or private review agent's failure to make a determination and
10			provide written notice within the time frames set forth in this section shall be
11			deemed to be a prior authorization for the health care services or benefits
12			subject to the review.
13		<u>(b)</u>	This <u>subsection</u> [provision] shall not apply where the failure to make the
14			determination or provide the notice results from circumstances which are
15			documented to be beyond the insurer's control.
16	(3)	<u>(a)</u>	An insurer or private review agent shall submit a copy of any changes to its
17			utilization review policies or procedures to the department.
18		<u>(b)</u>	No change to <u>utilization review</u> policies and procedures shall be effective or
19			used until after it has been filed with and approved by the commissioner.
20	(4)	<u>(a)</u>	A private review agent shall provide to the department the names of the
21			entities for which the private review agent is performing utilization review in
22			this state.
23		<u>(b)</u>	Notice shall be provided to the department within thirty (30) days of any
24			change.
25		→ S	ection 11. KRS 304.17A-621 is amended to read as follows:
26	The	Indep	pendent External Review Program is hereby established in the department. The
27	prog	gram s	shall provide covered persons with a formal, independent review to address

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1	disagreem	ents between the covered person and the covered person's insurer regarding an
2	adverse de	etermination made by the insurer, its designee, or a private review agent. This
3	section an	d KRS 304.17A-623 and 304.17A-625 establish requirements and procedures
4	governing	the program [external review and independent review entities].
5	→ S	ection 12. KRS 304.17A-627 is amended to read as follows:
6	(1) To b	be certified as an independent review entity under this chapter, an organization
7	shall	submit to the department an application on a form required by the department.
8	The	application shall include the following:
9	(a)	The name of each stockholder or owner of more than five percent (5%) of any
10		stock or options for an applicant;
11	(b)	The name of any holder of bonds or notes of the applicant that exceeds one
12		hundred thousand dollars (\$100,000);
13	(c)	The name and type of business of each corporation or other organization that
14		the applicant controls or with which it is affiliated and the nature and extent of
15		the affiliation or control;
16	(d)	The name and a biographical sketch of each director, officer, and executive of
17		the applicant and any entity listed under paragraph (c) of this subsection and a
18		description of any relationship the named individual has with an insurer as
19		defined in KRS 304.17A-600 or a provider of health care services;
20	(e)	The percentage of the applicant's revenues that are anticipated to be derived
21		from independent reviews;
22	(f)	A description of the minimum qualifications employed by the independent
23		review entity to select health care professionals to perform external review,
24		their areas of expertise, and the medical credentials of the health care
25		professionals currently available to perform external reviews; and

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26

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(g)

determinations.

The procedures to be used by the independent review entity in making review

1	(2)	If a	t any time there is a material change in the information included in the
2		appl	ication[,] <u>required under[provided for in]</u> subsection (1) of this section, the
3		inde	pendent review entity shall submit updated information to the department.
4	(3)	An i	ndependent review entity shall not be a subsidiary of, [or] in any way affiliated
5		with	, or owned[,] or controlled by an insurer or a trade or professional association
6		of pa	ayors.
7	(4)	An i	ndependent review entity shall not be a subsidiary of, [or] in any way affiliated
8		with	, or owned[,] or controlled by a trade or professional association of providers.
9	(5)	Heal	th care professionals who are acting as reviewers for the independent review
10		entit	y shall hold in good standing a nonrestricted license in a state of the United
11		State	es.
12	(6)	Heal	th care professionals who are acting as reviewers for the independent review
13		entit	y shall <u>:</u>
14		<u>(a)</u>	Hold a current certification by a recognized American medical specialty board
15			or other recognized health care professional boards in the area appropriate to
16			the subject of the review:[.]
17		<u>(b)</u>	Be a specialist in the treatment of the covered person's medical condition
18			under review; [,] and
19		<u>(c)</u>	Have actual clinical experience in that medical condition.
20	(7)	The	independent review entity shall:
21		<u>(a)</u>	Have a quality assurance mechanism to ensure the timeliness and quality of
22			the review: [,]
23		<u>(b)</u>	The qualifications and independence of the physician reviewer: [,] and
24		<u>(c)</u>	The confidentiality of medical records and review material.
25	(8)	Neit	her the independent review entity nor any reviewers of the entity[,] shall have

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following:

any material, professional, familial, or financial conflict of interest with any of the

1		(a)	For external reviews conducted in accordance with Section 11 of this Act
2			and KRS 304.17A-623 and 304.17A-625
3			<u>1.</u> The insurer involved in the review;
4			<u>2.[(b)]</u> Any officer, director, or management employee of the insurer;
5			3.[(e)] The provider proposing the service or treatment or any associated
6			independent practice association;
7			$\underline{4.[(d)]}$ The institution at which the service or treatment would be
8			provided;
9			5.[(e)] The development or manufacture of the principal drug, device,
10			procedure, or other therapy proposed for the covered person whose
11			treatment is under review; or
12			$\underline{6.[(f)]}$ The covered person; and
13		<u>(b)</u>	For external reviews conducted in accordance with subsection (1)(a)1. of
14			Section 3 of this Act:
15			1. The requesting health care provider;
16			2. The insurer or private review agent involved in the review;
17			3. Any officer, director, or management employee of the insurer or
18			private review agent; or
19			4. The development or manufacture of the principal drug, device,
20			procedure, or other therapy involved in the health care service that is
21			the subject of the exemption determination being reviewed.
22	(9)	As u	used in this section, "conflict of interest" shall not be interpreted to include:
23		(a)	A contract under which an academic medical center or other similar medical
24			center provides health care services to covered persons, except for academic
25			medical centers that may provide the service under review;
26		(b)	Provider affiliations which are limited to staff privileges; or
27		(c)	A specialist reviewer's relationship with an insurer as a contracting health care

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1		provider, except for a specialist reviewer proposing to provide the service
2		under review.
3	(10)	On an annual basis, the independent review entity shall report to the department the
4	fe	ollowing information:
5	(;	a) For external reviews conducted under Section 11 of this Act and KRS
6		304.17A-623 and 304.17A-625:
7		1. The number of independent review decisions in favor of covered
8		persons;
9		<u>2.[(b)]</u> The number of independent review decisions in favor of insurers;
10		$\underline{3.[(c)]}$ The average turnaround time for an independent review decision;
11		4.[(d)] The number of cases in which the independent review entity did
12		not reach a decision in the time specified in statute or administrative
13		regulation; and
14		5.[(e)] The reasons for any delay; and
15	<u>(1</u>	b) For external reviews conducted under subsection (1)(a)1. of Section 3 of
16		this Act:
17		1. The number of external review decisions in favor of health care
18		providers;
19		2. The number of external review decisions in favor of insurers and
20		private review agents;
21		3. The average turnaround time for an independent review decision;
22		4. The number of cases in which the independent review entity did not
23		reach a decision in the time specified in statute or administrative
24		regulation; and
25		5. The reasons for any delay.
26	=	Section 13. KRS 304.17A-633 is amended to read as follows:
27	<i>(1)</i> T	The commissioner shall report every six (6) months to the Interim Joint Committee

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1		on E	Banking and Insurance[,] and to the Governor on:
2		<u>(a)</u>	The state of the Independent External Review Program established under
3			Section 11 of this Act; and
4		<u>(b)</u>	The external reviews conducted under Section 3 of this Act.
5	<u>(2)</u>	The	report <u>required under subsection (1) of this section</u> shall include a summary
6		of <u>:</u>	
7		<u>(a)</u>	The number of reviews conducted:[,]
8		<u>(b)</u>	Medical specialties affected: [,] and
9		<u>(c)</u>	[a summary of]The findings and recommendations made by the independent
10			external review entity.
11		→ S	ection 14. KRS 304.17A-706 is amended to read as follows:
12	(1)	An i	nsurer may contest a clean claim only in the following instances:
13		(a)	The insurer has reasonable documented grounds to believe that the clean
14			claim involves a preexisting condition, coordination of benefits within the
15			meaning of KRS 304.18-085, or that another insurer is primarily responsible
16			for the claim;
17		(b)	The insurer will conduct a retrospective review of the services identified on
18			the claim, except that an insurer shall not contest a clean claim under this
19			paragraph based solely on a lack of prior authorization;
20		(c)	The insurer has information that the claim was submitted fraudulently; or
21		(d)	The covered person's or group's premium has not been paid.
22	(2)	(a)	If an insurer requires a provider to submit health claim attachments to the
23			claim before the claim will be paid, the insurer shall identify the specific
24			required health claim attachments in its provider manual or other document
25			that sets forth the procedure for filing claims with the insurer. The insurer
26			shall provide sixty (60) days' advance written notice of modifications to the
27			provider manual that materially change the type or content of the health claim

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1	attachments	or	other	documents	to	be	submitte	d.

(b) If a provider submits a clean claim with the required health claim attachments as specified in the provider manual or other document that sets forth the procedure for filing claims with the insurer, the insurer shall pay or deny the claim within the required claims payment time frame established in KRS 304.17A-702.

- (c) If an insurer conducts a retrospective review of a claim and requires an attachment not specified in the provider manual or other document that sets forth the procedure for filing claims, the insurer shall:
 - Notify the provider, in writing or electronically within the claims
 payment time frame established in KRS 304.17A-702, of the service that
 will be retrospectively reviewed and the specific information needed
 from the provider regarding the insurer's review of a claim;
 - Complete the retrospective review within twenty (20) business days of the insurer's receipt of the medical information described in this subsection; and
 - 3. Subject to paragraph (d) of this subsection, add interest to the amount of the claim, to be paid at a rate of twelve percent (12%) per annum, or at a rate in accordance with KRS 304.17A-730, accruing from the appropriate claim payment time frame established in KRS 304.17A-613 after the claim was received by the insurer through the date upon which the claim is paid.
- (d) If the provider fails to submit the information requested under subparagraph(c) 1. of this subsection within fifteen (15) business days from the date of the receipt of the notice, the insurer shall not be required to pay interest.
- 26 (3) (a) If a claim or portion thereof is contested by an insurer on the basis that the insurer has not received information reasonably necessary to determine

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insurer liability for the claim or portion thereof, or if the insurer contests the claim on the reasonable and documented belief that the claim involves the coordination of benefits within the meaning of KRS 304.18-085, or questions of pre-existing conditions, the insurer shall, within the applicable claims payment time frame established in KRS 304.17A-702, provide written or electronic notice to the provider, covered person, group policyholder, or other insurer, as appropriate, with an itemization of all new, never-before-provided information that is needed.

(b) The insurer shall pay or deny the claim within thirty (30) calendar days of receiving the additional information described in paragraph (a) of this subsection. If the insurer does not receive the additional information described in paragraph (a) of this subsection within fifteen (15) business days from the date of receipt of the notice set forth in paragraph (a) of this subsection, the insurer may deny the claim. Any claim denied under this paragraph may be resubmitted by the provider and any resubmitted claim shall not be denied on the basis of timeliness if the resubmitted claim is made with the timeframe for submitting claims established by the insurer beginning on the date of denial.

→ Section 15. KRS 205.536 is amended to read as follows:

- 19 (1) A Medicaid managed care organization shall have a utilization review plan, as
 20 defined in KRS 304.17A-600, that meets the requirements established in 42 C.F.R.
 21 pts. 431, 438, and 456. If the Medicaid managed care organization utilizes a private
 22 review agent, as defined in KRS 304.17A-600, the agent shall comply with all
 23 applicable requirements of KRS 304.17A-600 to 304.17A-633.
 - (2) In conducting utilization reviews for Medicaid benefits, each Medicaid managed care organization shall use the medical necessity criteria selected by the Department of Insurance pursuant to KRS 304.38-240[,] for making determinations of medical necessity and clinical appropriateness pursuant to the utilization review plan

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1		required by subsection (1) of this section.
2	(3)	To the extent consistent with the federal regulations referenced in subsection (1) of
3		this section, the Department for Medicaid Services or any managed care
4		organization contracted to provide Medicaid benefits pursuant to KRS Chapter 205
5		shall <u>:</u>
6		(a) Not require or conduct a prospective or concurrent review, as defined in KRS
7		304.17A-600, for a prescription drug:
8		<u>1.</u> [(a)] That:
9		\underline{a} .[1.] Is used in the treatment of alcohol or opioid use disorder; and
10		<u>b.[2.]</u> Contains Methadone, Buprenorphine, or Naltrexone; or
11		2.[(b)] That was approved before January 1, 2022, by the United States
12		Food and Drug Administration for the mitigation of opioid withdrawal
13		symptoms; and
14		(b) Comply with Sections 1 to 7 of this Act.
14 15		(b) Comply with Sections 1 to 7 of this Act. → Section 16. KRS 222.422 is amended to read as follows:
	(1)	
15	(1)	→ Section 16. KRS 222.422 is amended to read as follows:
15 16	(1)	→ Section 16. KRS 222.422 is amended to read as follows: As used in this section, "third-party payor" means any person required to comply
15 16 17	, ,	→ Section 16. KRS 222.422 is amended to read as follows: As used in this section, "third-party payor" means any person required to comply with KRS 304.17A-611(2) or 205.536(3)(a).
15 16 17 18	, ,	→ Section 16. KRS 222.422 is amended to read as follows: As used in this section, "third-party payor" means any person required to comply with KRS 304.17A-611(2) or 205.536(3)(a). Prior to the discharge of a patient that has received medication for addiction-
15 16 17 18 19	, ,	→ Section 16. KRS 222.422 is amended to read as follows: As used in this section, "third-party payor" means any person required to comply with KRS 304.17A-611(2) or 205.536(3)(a). Prior to the discharge of a patient that has received medication for addiction-treatment, the treating facility shall submit a written discharge plan to the patient,
15 16 17 18 19 20	, ,	→ Section 16. KRS 222.422 is amended to read as follows: As used in this section, "third-party payor" means any person required to comply with KRS 304.17A-611(2) or 205.536(3)(a). Prior to the discharge of a patient that has received medication for addiction-treatment, the treating facility shall submit a written discharge plan to the patient, and the patient's third-party payor, if any, which shall describe arrangements for
15 16 17 18 19 20 21	(2)	→ Section 16. KRS 222.422 is amended to read as follows: As used in this section, "third-party payor" means any person required to comply with KRS 304.17A-611(2) or 205.536(3)(a). Prior to the discharge of a patient that has received medication for addiction-treatment, the treating facility shall submit a written discharge plan to the patient, and the patient's third-party payor, if any, which shall describe arrangements for additional services needed following discharge.
15 16 17 18 19 20 21 22	(2)	→ Section 16. KRS 222.422 is amended to read as follows: As used in this section, "third-party payor" means any person required to comply with KRS 304.17A-611(2) or 205.536(3)(a). Prior to the discharge of a patient that has received medication for addiction-treatment, the treating facility shall submit a written discharge plan to the patient, and the patient's third-party payor, if any, which shall describe arrangements for additional services needed following discharge. → Section 17. This Act shall apply to contracts delivered, entered, renewed,
15 16 17 18 19 20 21 22 23	(2)	Section 16. KRS 222.422 is amended to read as follows: As used in this section, "third-party payor" means any person required to comply with KRS 304.17A-611(2) or 205.536(3)(a). Prior to the discharge of a patient that has received medication for addiction-treatment, the treating facility shall submit a written discharge plan to the patient, and the patient's third-party payor, if any, which shall describe arrangements for additional services needed following discharge. Section 17. This Act shall apply to contracts delivered, entered, renewed, anded, or amended on or after the effective date of this Act.

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shall, within 90 days of the effective date of this section, request the waiver or

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1 authorization, and may only delay implementation of those provisions for which a waiver

- 2 was deemed necessary until the waiver or authorization is granted.
- 3 → Section 19. Sections 1 to 17 of this Act take effect January 1, 2024.