803 KAR 25:260. Treatment guidelines.

RELATES TO: KRS 342.0011(13), 342.020, 342.035.

STATUTORY AUTHORITY: 342.035, 342.260, 342.265, 342.270, 342.275.

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260(1) requires the commissioner to promulgate administrative regulations necessary to carry on the work of the department and the work of administrative law judges if those administrative regulations are consistent with KRS Chapter 342 and KRS Chapter 13A. KRS 342.035(8)(a) requires the commissioner to develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers under KRS Chapter 342 and to promulgate administrative regulations to implement the developed or adopted practice parameters or evidence-based treatment guidelines. This administrative regulation adopts treatment guidelines and provides guidance to implement them. This administrative regulation does not abrogate the right, as provided in KRS 342.020, of an injured employee to choose his treating physician, or an employer to participate in a managed health care system.

Section 1. Definitions.

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

(2) "Commissioner" is defined by KRS 342.0011(9).

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

(4) "Employee" means those natural persons constituting an employee subject to the provisions of KRS Chapter 342 as defined in KRS 342.640 and the employee's legal counsel.

(5) "Employer" means those persons constituting an employer as defined in KRS 342.630, the employer's carrier, insurance carrier, self-insured group or other payment obligor, third party administrator, other person acting on behalf of the employer in a workers' compensation matter, and the employer's legal counsel.

(6) "Evidence-based medicine" means the process and use of relevant information from peer-reviewed clinical and epidemiologic research to address a clinical issue by weighing the attendant risks and benefits to determine whether proposed diagnostic or therapeutic procedures are appropriate in light of their high probability of producing the best and most favorable outcome.

(7) "Insurance carrier" is defined by KRS 342.0011(22).

(8) "Maximum medical improvement" means the point of stabilization in an employee's recovery from a work injury where substantial improvement in the human organism is no longer likely.

(9) "Medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention may reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy or serious dysfunction of any body organ or part.

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

(11) "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.

(12)

(a) "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:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration; and
3. Considered effective for the patient's illness, injury, or disease.

(b) Treatment primarily for the convenience of the patient, physician, or other healthcare provider does not constitute medical necessity.

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

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

(15) "Statement for services" is defined by 803 KAR 25:096, Section 1(5).

(16) "Treatment guidelines" or "guidelines" are the treatment guidelines developed or adopted by the commissioner pursuant to KRS 342.035(8)(a).

(17) "Utilization Review" is defined by 803 KAR 25:190, Section 1(6).

Section 2. Purpose and Adoption.

(1) The purpose of the treatment guidelines is to facilitate safe and appropriate treatment of work-related injuries and occupational diseases.

(2) The commissioner adopts the ODG treatment guidelines as published by MCG Health for use by medical providers in the treatment of work related injuries and occupational diseases. The commissioner shall review the guidelines not less than annually and update or amend this administrative regulation, if necessary, to ensure that the guidelines are consistent with the provisions of KRS 342.020 and KRS 342.035.

Section 3. Application.

(1) The treatment guidelines do not apply to treatment provided in a medical emergency.

(2) The treatment guidelines do not apply to urine drug screens. KRS 342.020(13) governs an employer's liability for urine drug screens.

(3) The treatment guidelines shall be applied in the utilization review decision-making process.

(4) Treatment designated as "Recommended" under the guidelines shall be presumed reasonable and necessary and shall not require preauthorization. This presumption shall apply to utilization review and in the resolution of medical disputes. This presumption shall be rebuttable only by clear and convincing evidence.

(5) If a medical provider seeks preauthorization for treatment designated as "Conditionally Recommended" and furnishes sound medical reasoning in support of undertaking that treatment, a medical payment obligor shall consider and address that sound medical reasoning and shall not deny preauthorization solely on the basis that conditions precedent have not been met. The failure of a medical payment obligor to comply with the time requirements in 803 KAR 25:190, Section 5(2) and (3) may result in sanctions.

(6) Treatment designated as "Not Recommended" under the guidelines or not addressed in the guidelines shall require preauthorization.

(7) The employer shall not be responsible for payment of medical treatment designated as "Not Recommended" under the guidelines or not addressed in the treatment guidelines unless it was:

(a) Provided in a medical emergency;

(b) Authorized by the medical payment obligor; or

(c) Approved through the dispute resolution process by an administrative law judge.

(8) Medical providers proposing treatment designated as "Not Recommended" under the guidelines or not addressed in the treatment guidelines shall articulate in writing sound medical reasoning for the proposed treatment, which may include:

(a) Documentation that reasonable treatment options allowable in the guidelines have been adequately trialed and failed;

(b) The clinical rationale that justifies the proposed treatment plan, including criteria that will constitute a clinically meaningful benefit; or

(c) Any other circumstances that reasonably preclude recommended or approved treatment options.

(9) Sound medical reasoning furnished by a medical provider shall be considered before preauthorization of treatment may be denied.

(10) The treatment guidelines are not intended to establish a standard for determining professional liability. The guidelines are not a standard or mandate. Exceptions to and the proper application of the guidelines require assessment of each individual course of treatment.

(11) The pharmaceutical formulary adopted in 803 KAR 25:270 shall be part of the medical treatment guidelines.

(12) Maximum medical improvement shall not preclude the provision of medical treatment necessary for the cure and relief from the effects of an injury or occupational disease if the treatment is medically necessary to maintain function at the maximum medical improvement level or to improve function following an exacerbation of the injured employee's condition.

Section 4. Preauthorization.

(1) Requests for preauthorization shall be subject to utilization review unless the medical payment obligor waives utilization review. The failure of a medical payment obligor to comply with the time requirement in 803 KAR 25:190, Section 5(2) and (3) may result in sanctions

(2) Except as modified in this Section, 803 KAR 25:190, Sections 5, 7, and 8 apply to all treatment for which preauthorization is required or requested under this administrative regulation. If the medical provider has provided sound medical reasoning for treatment, the medical payment obligor shall not deny the treatment solely on the basis that it is not designated as "Recommended" under the guidelines or not addressed in the guidelines.

(3) If the medical payment obligor denies preauthorization following utilization review, it shall issue a written notice of denial as required by 803 KAR 25:190, Section 7. 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. 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; 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 specialty as the medical provider requesting reconsideration.

(5) 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. 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. The rescheduled peer-to-peer conference shall be held no later than two (2) business days following the original conference date. 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 set out in 803 KAR 25:010, Section 22.

Section 5. Effective Dates. The treatment guidelines apply to all treatment administered on and after September 1, 2020.

(46 Ky.R. 1385, 2284, 2406; eff. 6-2-2020.)