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Emily B Caudill
REGULATIONS COMPILER

1 EDUCATION AND LABOR CABINET

2 Department of Workers' Claims

3 (Amended After Comments)

4 803 KAR 25:195. Utilization review, Appeal of Utilization Review Decisions, and Medical Bill
5 Audit

6 RELATES TO: KRS Chapter 342

7 STATUTORY AUTHORITY: KRS 342.035(5) and (6), 342.260

8 NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 provides that the
9 Commissioner of the Department of Workers' Claims shall promulgate administrative regulations
10 necessary to carry on the work of the Department of Workers' Claims, and the commissioner may
11 promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342.
12 KRS 342.035(5) requires the commissioner to promulgate administrative regulations governing
13 medical provider utilization review activities conducted by an insurance carrier, group self-insurer
14 or self-insured employer pursuant to KRS Chapter 342. KRS 342.035(5) provides the
15 commissioner of the Department of Workers' Claims shall promulgate administrative regulations
16 that require each insurance carrier, group self-insurer and individual self-insured employer to
17 certify to the commissioner the program it has adopted to insure compliance with the medical fee
18 schedule provisions of KRS 342.035(1) and (4). KRS 342.035(8) requires the commissioner to
19 adopt or develop a pharmaceutical formulary and treatment guidelines; utilization review assists

1 in the proper implementation of the pharmaceutical formulary and treatment guidelines. This
2 administrative regulation ensures [insures] that insurance carriers, group self-insurers, and
3 individual self-insured employers implement a utilization review and medical bill audit
4 program.

5 Section 1. Definitions. (1) "Business day" means any day except Saturday, Sunday
6 or any day which is a legal holiday.

7 (2) "Calendar day" means all days in a month, including Saturday, Sunday and any
8 day which is a legal holiday.

9 (3) "Carrier" is defined by KRS 342.0011(6).

10 (4) "Commissioner" is defined by KRS 342.0011(9).

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

14 (6) "Department" is defined by KRS 342.0011(8).

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

17 (8) "Medically necessary" or "medical necessity" means healthcare services,
18 including medications, that a medical provider, exercising prudent clinical judgment, would
19 provide to a patient for the purpose of preventing, evaluating, diagnosing or treating, an
20 illness, injury, disease or its symptoms, and that are:

21 1. In accordance with generally accepted standards of medical practice;

1 2. Clinically appropriate, in terms of type, frequency, extent site and duration; and

2 3. Considered effective for the patient's illness, injury, or disease.

3 (9) "Medical payment obligor" means any **self-insured** employer, carrier, insurance
4 carrier, self-insurer, or any person acting on behalf of or as an agent of the **self-insured**
5 employer, carrier, insurance carrier, or self-insurer.

6 (10) "Medical provider" means physicians and surgeons, psychologists, optometrists,
7 dentists, podiatrists, osteopathic and chiropractic practitioners, physician assistants, and
8 advanced practice registered nurses, acting within the scope of their license

9 (11) "Physician" is defined by KRS 342.0011(32).

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

12 (13) **"Same medical specialty" means a branch of medical practice focused**
13 **regularly and routinely on a defined group of patients, diseases, skills, body part, or**
14 **type of injury and performed by a physician with the same or similar qualifications.**

15 (14) [(13)] "Utilization review" means a review of the medical necessity and
16 appropriateness of medical care and services for purposes of recommending payments for a
17 compensable injury or disease.

18 (15) [(14)] "Utilization review and medical bill audit plan" means the written plan
19 submitted to the commissioner by each medical payment obligor describing the procedures
20 governing utilization review and medical bill audit activities.

1 **(16)** [(15)] "Vendor" means a person or entity which implements a utilization review
2 and medical bill audit program for purposes of offering those services to carriers.

3 Section 2. Utilization Review and Medical Bill Audit Program. (1) The utilization
4 review program shall assure that:

5 (a) A utilization reviewer has the education, training, and experience, necessary
6 to evaluate clinical issues and services for medical necessity and appropriateness [is
7 appropriately qualified];

8 (b) Treatment rendered to an injured worker is medically necessary and appropriate;
9 and

10 (c) Necessary medical services are not withheld or unreasonably delayed.

11 (2) The medical bill audit program shall assure that:

12 (a) A statement or payment for medical goods and services and charges for a
13 deposition, report, or photocopy comply with KRS Chapter 342 and 803 KAR Chapter 25;

14 (b) A medical bill auditor has the education, training, or experience, necessary to
15 evaluate medical bills and statements [is appropriately qualified] and

16 (c) A statement for medical services is not disputed without reasonable grounds.

17 Section 3. Utilization Review and Medical Bill Audit Plan Approval. (1) A medical
18 payment obligor shall fully implement and maintain a utilization review and medical bill
19 audit program.

20 (2) A medical payment obligor shall provide to the commissioner a written plan
21 describing the utilization review and medical bill audit program. The commissioner shall

1 approve each utilization review and medical bill audit plan which complies with the
2 requirements of this administrative regulation and KRS Chapter 342.

3 (3) A vendor shall submit to the commissioner for approval a written plan describing
4 the utilization review and medical bill audit program. Upon approval, the vendor shall receive
5 written notice from the commissioner.

6 (4) A medical payment obligor who contracts with an approved vendor for utilization
7 review or medical bill audit services shall notify the commissioner of the contractual
8 arrangement. The contractual arrangement may provide for separate utilization review and
9 medical bill audit vendors.

10 (5) A plan shall be approved for a period of four (4) years.

11 (a) At least ninety (90) calendar days prior to the expiration of the period of approval,
12 a medical payment obligor or its approved vendor shall apply for renewal of the approval.

13 (b) During the term of an approved plan, the commissioner shall be notified as soon
14 as practicable of a material change in the approved plan or a change in the selection of a
15 vendor.

16 (6) A medical payment obligor or its utilization review vendor [~~carrier who~~
17 ~~contracts with an approved vendor for utilization review services~~] shall provide annually to
18 the commissioner summaries of the number of utilization reviews conducted, [~~utilization~~
19 ~~reviews waived in accordance with KRS 342.035(5)(e)~~], utilization reviews resulting in an
20 approval, and utilization reviews resulting in a denial, peer-to-peer conferences requested,
21 peer-to-peer conferences that resulted in approval of the requested treatment, and peer-
22 to-peer conferences that resulted in denial of the requested treatment.

1 **(a) The medical payment obligor or its utilization review vendor shall email the**
2 **summaries in a Microsoft Excel spreadsheet with rows labeled for each summary**
3 **category to LaborEDI@ky.gov.**

4 **(b) The summaries shall only include data gathered from the medical payment**
5 **obligor's most recent complete fiscal year that ended on or before March 31 of the year**
6 **in which the summaries are due. The summaries** ~~[The annual report of the approved~~
7 ~~vendor]~~ shall be filed with the commissioner no later than **September 1 each year** ~~[August~~
8 ~~1 for the preceding year, including any fiscal year ending on or before June 30].~~

9 **(c) If a utilization review vendor provides utilization review services for more**
10 **than one medical payment obligor, the utilization review vendor shall submit a separate**
11 **spreadsheet for each medical payment obligor.**

12 **(d) If a utilization review or a peer-to-peer conference results in a portion of the**
13 **treatment being approved and a portion of the treatment being denied, the result shall**
14 **be reported as both an approval and a denial for reporting purposes.**

15 Section 4. Utilization Review and Medical Bill Audit Written Plan Requirements. The
16 written utilization review and medical bill audit plan submitted to the commissioner shall
17 include the following elements:

18 (1) A description of the process, policies and procedures for making decisions;

19 (2) A statement that medical treatment guidelines adopted by the commissioner
20 pursuant to KRS 342.035 (8)(a) shall be incorporated in the plan as the standard for utilization
21 review medical decision making;

1 (3) A description of the criteria by which claims, medical services and medical bills
2 shall be selected for review;

3 (4) A description of the:

4 (a) Qualifications of internal and consulting personnel who shall conduct utilization
5 review and medical bill audit; and

6 (b) The manner in which the personnel shall be involved in the review process;

7 (5) A description of the process to assure that a treatment plan shall be obtained for
8 review by qualified medical personnel if a treatment plan is required by 803 KAR 25:096;

9 (6) A description of the process to assure that a physician shall be designated by each
10 injured employee as required under 803 KAR 25:096 or 803 KAR 25:110;

11 (7) A description of the process for rendering and promptly notifying the medical
12 provider and employee of the initial utilization review decision;

13 (8) A description of the reconsideration process within the structure of the utilization
14 review and medical bill audit program;

15 (9) An assurance that a database shall be maintained, which shall:

16 (a) Record:

17 1. Each instance of utilization review;

18 2. Each instance of medical bill audit;

19 3. The name of the reviewer;

20 4. The extent of the review;

- 1 5. The conclusions of the reviewer; and
- 2 6. The action, if any, taken as the result of the review;
- 3 (b) Be maintained for a period of at least two (2) years; and
- 4 (c) Be subject to audit by the commissioner, or his agent, pursuant to KRS
- 5 342.035(5)(b); and
- 6 (10) A description of the policies and procedures that shall be implemented to protect
- 7 the confidentiality of patient information.

8 Section 5. Claim Selection Criteria. (1) Unless the medical payment obligor, in good

9 faith, denies the claim as noncompensable or waives utilization review pursuant to KRS

10 342.035 (5)(c), medical services reasonably related or asserted to be related to the claim shall

11 be subject to utilization review if:

- 12 (a) A medical provider requests preauthorization of a medical treatment or procedure;
- 13 (b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR
- 14 25:096 treatment plan is received;
- 15 (c) The total medical costs cumulatively exceed \$3000;
- 16 (d) The total lost work days cumulatively exceed thirty (30) days; or
- 17 (e) An administrative law judge orders a review.

18 (2) Utilization review shall commence when the medical payment obligor has notice

19 that a claims selection criteria has been met. The medical payment obligor may waive

20 utilization review pursuant to KRS 342.035(5)(c) within two (2) business days of notice that

21 a claims selection criteria has been met **unless additional information is required, in which**

1 case, utilization review shall be waived within two (2) business days following receipt of
2 the requested information.

3 (a) The following requirements shall apply if preauthorization has been requested and
4 utilization review has not been waived by the medical payment obligor:

5 1. The initial utilization review decision shall be communicated to the medical
6 provider and employee within two (2) business days of the initiation of the utilization review
7 process, unless additional information is required. If additional information is required, a
8 single request shall be made within two (2) additional business days.

9 2. The requested information shall be submitted by the medical provider within ten
10 (10) business days.

11 3. The initial utilization review decision shall be rendered and communicated within
12 two (2) business days following receipt of the requested information.

13 (b) The following requirements shall apply if retrospective utilization review occurs:

14 1. The initial utilization review decision shall be communicated to the medical
15 provider and employee within seven (7) business [~~ten (10) calendar~~] days of the initiation of
16 the utilization review process, unless additional information is required. If additional
17 information is required, a single request shall be made within two (2) additional business
18 days.

19 2. The requested information shall be submitted by the medical provider within ten
20 (10) business days.

1 3. The initial utilization review decision shall be rendered within two (2) business
2 days following receipt of the requested information.

3 (3) A medical provider may request an expedited utilization review determination for
4 proposed medical treatment or services, the lack of which could reasonably be expected to
5 lead to serious physical or mental disability or death. The expedited utilization review
6 determination shall be rendered and communicated within twenty-four (24) hours following
7 a request for expedited review.

8 (4) Initiation of utilization review shall toll the thirty (30) day period for challenging
9 or paying medical expenses pursuant to KRS 342.020(4). The thirty (30) day period for
10 paying medical expenses shall commence on the date of the final utilization review decision.

11 (5) Each medical bill audit shall be initiated within **five (5) business** [~~seven (7)~~
12 ~~calendar~~] days of receipt to assure:

13 (a) Compliance with applicable fee schedules, in accordance with 803 KAR Chapter
14 25;

15 (b) Accuracy; and

16 (c) That a physician has been designated in accordance with 803 KAR 25:096 **or 803**
17 **KAR 25:110.**

18 (6) A medical bill audit shall not toll the thirty (30) day period for challenging or
19 paying medical expenses pursuant to KRS 342.020(4).

20 Section 6. Utilization Review and Medical Bill Audit Personnel Qualifications. (1)

21 Utilization review personnel shall have education, training, and experience necessary for

1 evaluating the clinical issues and services under review. The following professionals shall
2 issue an initial utilization review approval:

3 (a) A physician;

4 (b) A registered nurse;

5 (c) A licensed practical nurse;

6 (d) A medical records technician; or

7 (e) Other personnel whose training and experience qualify them to issue decisions on
8 medical necessity or appropriateness, including a medical doctor, surgeon, psychologist,
9 optometrist, dentist, podiatrist, and osteopathic practitioner, acting within the scope of
10 the license or licenses required by the jurisdiction in which they are employed.

11 (2) Utilization review personnel shall hold the license required by the United
12 States' jurisdiction in which they are employed.

13 (3) A physician shall supervise utilization review personnel.

14 (4) A physician shall authorize and ratify any utilization review denial.

15 (5) [(2)] Only a physician may issue an initial utilization review denial. A physician
16 shall supervise utilization review personnel in making utilization review recommendations.
17 Personnel shall hold the license required by the jurisdiction in which they are employed.

18 (6) [(3)] Personnel conducting a medical bill audit shall have the education, training
19 or experience necessary for evaluating medical bills and statements.

20 Section 7. Written Notice of Denial. (1) Following initial review, a written notice of
21 denial shall:

1 (a) Be issued to both the medical provider and the employee in a timely manner but
2 no more than **two (2) business days after initiation of the utilization review process unless**
3 **additional information was required, in which case, the written notice of denial shall be**
4 **issued no later than two (2) business days after the initial utilization review decision** [~~ten~~
5 (~~10~~) calendar days from the initiation of the utilization review process];

6 (b) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and

7 (c) Contain:

8 1. A statement of the medical reasons for denial;

9 2. The name, state of licensure and medical license number of the reviewer; and

10 3. An explanation of utilization review reconsideration rights.

11 (2) Payment for medical services shall not be denied on the basis of lack of
12 information absent documentation of a good faith effort to obtain the necessary information.

13 Section 8. Reconsideration. (1) A reconsideration process to appeal an initial decision
14 shall be provided within the structure of utilization review.

15 (a) A request for reconsideration of the initial utilization review decision shall be
16 made by an aggrieved party within **ten (10) business** [~~fourteen (14) calendar~~] days of receipt
17 of a written notice of denial.

18 (b) Reconsideration of the initial utilization review decision shall be conducted by a
19 different reviewer of **the same medical specialty** [~~at least the same qualifications~~] as the
20 medical provider whose treatment is being reconsidered.

1 (c) A written reconsideration decision shall be rendered within seven (7) business
2 ~~[ten (10) calendar]~~ days of receipt of a request for reconsideration unless a peer-to-peer
3 conference is requested, in which case, the written reconsideration decision shall be
4 rendered within five (5) business days after the day on which the peer-to-peer
5 conference was held. The written decision shall be clearly entitled "UTILIZATION
6 REVIEW - RECONSIDERATION DECISION". If the reconsideration decision is made by
7 an appropriate specialist or subspecialist, the written decision shall further be entitled
8 "FINAL UTILIZATION REVIEW DECISION".

9 (d) Those portions of the medical record that are relevant to the reconsideration, if
10 authorized by the patient and in accordance with state or federal law, shall be considered and
11 providers shall be given the opportunity to present additional information.

12 ~~[(2)(a) If a utilization review denial is upheld upon reconsideration and a board~~
13 ~~eligible or certified physician in the appropriate specialty or subspecialty area, or a~~
14 ~~chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095 has not previously~~
15 ~~reviewed the matter, an aggrieved party may request further review by:~~

16 1. A board eligible or certified physician in the appropriate specialty or subspecialty;

17 or

18 2. A chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.

19 ~~(b) A written decision shall be rendered within seven (7) business [ten (10) calendar]~~
20 ~~days of the request for specialty reconsideration. The specialty decision shall be clearly~~
21 ~~entitled "FINAL UTILIZATION REVIEW DECISION".]~~

1 **(2)** ~~[(3)]~~ A reconsideration process to appeal an initial decision shall be provided
2 within the structure of medical bill audit.

3 (a) A request for reconsideration of the medical bill audit decision shall be made by
4 an aggrieved party within **ten (10) business** ~~[fourteen-(14)-calendar]~~ days of receipt of that
5 decision.

6 (b) Reconsideration shall be conducted by a different reviewer of at least the same
7 qualifications as the initial reviewer.

8 (c) A written decision shall be rendered within **seven (7) business** ~~[ten-(10)-calendar]~~
9 days of receipt of a request for reconsideration. The written decision shall be clearly entitled
10 "MEDICAL BILL AUDIT RECONSIDERATION DECISION".

11 (d) A request for reconsideration of the medical bill audit decision shall not toll the
12 thirty (30) day period for challenging or paying medical expenses pursuant to KRS
13 342.020(1).

14 Section 9. Peer-to-Peer Conference. (1) If the medical payment obligor denies
15 preauthorization following utilization review, it shall issue a written notice of denial as
16 required in Section 7 of this administrative regulation. The medical provider whose
17 recommendation for treatment is denied may request reconsideration and may require the
18 reconsideration include a peer-to-peer conference with a second utilization review physician.
19 The request for a peer-to-peer conference shall be made by electronic communication and
20 shall provide:

21 (a) A telephone number for the reviewing physician to call;

1 (b) A date or dates for the conference not less than five (5) business days after the
2 date of the request **unless the peer-to-peer conference request stems from a denial issued**
3 **pursuant to 803 KAR 25:270, in which case, a date or dates not less than two (2) business**
4 **days after the date of the request. In either case, the parties may by agreement hold the**
5 **conference in a shorter time period;** and

6 (c) A one (1)-hour period during the date or dates specified during which the
7 requesting medical provider, or a designee, will be available to participate in the conference
8 between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time), Monday through Friday.

9 (4) The reviewing physician participating in the peer-to-peer conference shall be of
10 the same **medical** specialty as the medical provider requesting reconsideration.

11 (5) Failure of the reviewing physician to participate during the date and time specified
12 shall result in the approval of the request for preauthorization and approval of the
13 recommended treatment unless good cause exists for the failure to participate. In the event of
14 good cause for failure to participate in the peer-to-peer conference, the reviewing physician
15 shall contact the requesting medical provider to reschedule the peer-to-peer conference. The
16 rescheduled peer-to-peer conference shall be held no later than two (2) business days
17 following the original conference date. Failure of the requesting medical provider or its
18 designee to participate in the peer-to-peer conference during the time he or she specified
19 availability may result in denial of the request for reconsideration.

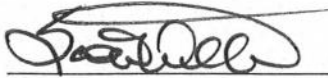
20 (6) A written reconsideration decision shall be rendered within five (5) business days
21 of date of the peer-to-peer conference. The written decision shall be entitled "FINAL
22 UTILIZATION REVIEW DECISION."

23 (7) If a Final Utilization Review Decision is rendered denying authorization for
24 treatment before an award has been entered by or agreement approved by an administrative

1 law judge, the requesting medical provider or the injured employee may file a medical dispute
2 pursuant to 803 KAR 25:012. If a Final Utilization Review Decision is rendered denying
3 authorization for treatment after an award has been entered by or agreement approved by an
4 administrative law judge, the employer shall file a medical dispute pursuant to 803 KAR
5 25:012.

6 (8) Pursuant to KRS 342.285(1), a decision of an administrative law judge on a
7 medical dispute is subject to review by the workers' compensation board under the
8 procedures set out in 803 KAR 25:010, Section 22.

This is to certify the Commissioner has reviewed and recommended this administrative regulation prior to its adoption, as required by KRS 342.260, 342.270 and 342.285.



Scott Wilhoit, Commissioner
Department of Workers' Claims

Date 8/11/2022

CONTACT PERSON:

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REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation: 803 KAR 25:195

Contact person: B. Dale Hamblin, Jr.

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation governs medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to KRS Chapter 342.
 - (b) The necessity of this administrative regulation: KRS 342.035(5)(c) requires the commissioner to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to KRS Chapter 342.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 342.020 makes employers and their payment obligors responsible for payment of reasonable and necessary medical treatment for the cure and relief of work-place injuries and occupational diseases. Utilization review assists employers and employees in determining whether medical treatment is reasonable and necessary. Additionally, KRS 342.020(7)(f) requires employers with a managed care system to establish procedures for utilization review of medical services to assure that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee. This regulation provides guidance to stakeholders regarding the requirements of a utilization review program and its implementation.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides guidance to stakeholders regarding the requirements of a statutorily required utilization review program and its implementation.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This is an amendment to new administrative regulation.
 - (b) The necessity of the amendment to this administrative regulation: To respond to stakeholder comments.
 - (c) How the amendment conforms to the content of the authorizing statutes: N/A
 - (d) How the amendment will assist in the effective administration of the statutes: N/A
- (3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Insurance carriers, self-insured groups, self-insured employers, and injured employees.

- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Insurance carriers, self-insured groups, and self-insured employers will be required to have a system of utilization review to assess the reasonableness and necessity of medical treatment. Entities utilizing a managed care organization must include utilization review as part of that program. Employees will receive appropriate medical treatment in a timely manner.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Costs are expected to remain consistent with current costs.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Employers, medical payment obligors, and employees may be assured that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, is cost ineffective, and not harmful to the employee.
- (5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
- (a) Initially: No additional costs are associated with implementation.
 - (b) On a continuing basis: No additional continuing costs.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department of Workers' Claims normal budget is the source of funding.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary to implement this administrative regulation.
- (8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any new fees or directly or indirectly increase any fees.
- (9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied because the utilization review procedure applies to all parties equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation No. 803 KAR 25:195
Contact Person: B. Dale Hamblin, Jr.
Phone number: (502) 782-4404

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department of Workers' Claims and all parts of government with employees.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 342.020, 342.035, and 342.260.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No revenue will be generated.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No new administrative costs will be required.

(d) How much will it cost to administer this program for subsequent years? No new administrative costs will be required.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

There is no fiscal impact on state or local government because the activities associated with the administrative regulation are currently performed by those entities; however, the same cannot be said absent this administrative regulation.

STATEMENT OF CONSIDERATION
RELATING to 803 KAR 25:195

Labor Cabinet, Department of Workers' Claims
(Amended After Comments)

I. The public hearing on 803 KAR 25:021, scheduled for June 23, 2022, at 10:00 a.m., at the Department of Workers' Claims, Mayo-Underwood Building, 3rd Floor, 500 Mero Street, Frankfort, Kentucky, was held by Commissioner Scott C. Wilhoit. Eight (8) written comments were received during the public comment period and two (2) persons commented during the public hearing.

II. The following persons were noted as attendees or offered comment:

(a) Rosalie Faris, Occupational Managed Care Alliance

(b) Ed O'Daniel, American Property Casualty Insurance Association, Liberty Mutual Insurance Co.

(c) Joyce Young, Bluegrass Health Network

(d) Suzanne Remfry, Bluegrass Health Network

(e) Brandy Howard, Bluegrass Health Network

(f) Kerry Reynolds, Corvel

(g) Denise Weissrock, Corvel

(h) Robert L. Swisher, Attorney, KEMI

(i) Kenneth A. Stoller, American Property Casualty Insurance Association

(j) Mark Treesh, Insurance Institute of Kentucky

(k) Jody Townsend, State Auto Insurance Companies

(l) Kara Larson, Medata, Inc.

(m) Lisa Anne Bickford, enlyte, Mitchell/Genex/Coventry

(n) Bill Londrigan, Kentucky State AFL-CIO

(o) Thomas Ferreri, Ferreri Partners PLLC

(p) Elizabeth Filtz, Sentry Insurance

(q) Kristal Garrison, Liberty Mutual Insurance

III. The following persons from the administrative body were present at the hearing or responded to comments:

(1) Scott Wilhoit, Commissioner, Department of Workers' Claims

(2) B. Dale Hamblin, Jr., Assistant General Counsel, Workers' Claims Legal Division

IV. Summary of Comments and Responses

(1) SUBJECT MATTER: Utilization review and Medical Bill Audit Plan.

(a) Comment: Ed O'Daniel – The collection of data regarding the number of utilization reviews waived in accordance with KRS 342.035(5)(c) is overly broad and would create

inefficiencies for carriers, self-insured employers, and claims administrators, across the industry. Further, there is no appreciable benefit to injured employees.

The following made a similar comment:

1. Rosalie Faris, Occupational Managed Care Alliance, Inc.,
2. Kristyl Garrison, Liberty Mutual Insurance Co.,
3. Robert L. Swisher, Attorney, Kentucky Employers' Mutual Insurance,
4. Kenneth Stoller, American Property Casualty Insurance Association,
5. Mark Treesh, Insurance Institute of Kentucky,
6. Jody Townsend, State Auto.

(b) Response: The administrative regulation was amended to remove the requirement that insurance carriers, self-insured employers, and self-insured groups must report utilization reviews waived pursuant to KRS 342.035(5)(c).

(2) SUBJECT MATTER: Time requirements.

(a) Comment: Rosalie Faris - There would be less overall confusion if time references were all made to "business days" rather than "calendar days."

The following made a similar comment:

1. Bill Londrigan
2. Lisa Anne Bickford

(b) Response: The administrative regulation was amended to use "business days" in place of "calendar days" where possible.

(3) SUBJECT MATTER: Claim Selection Criteria.

(a) Comment: Rosalie Faris – The comment stated there was confusion regarding the current utilization review selection criteria. Does the claimant have to be off work for thirty (30) days and have medical costs in excess of \$3,000 or is one of the listed criteria enough to require utilization review? The comment agreed that prior authorization alone should be sufficient to require utilization review. It was suggested that the criteria be updated to look at the invasive nature of the procedure rather than a dollar amount because the current dollar amount was very low in relation to the current cost of medical treatment.

The following made a similar comment:

1. Lisa Anne Bickford.

(b) Response: While the Department agrees some of the selection criteria may need updated and is willing to entertain that possibility at a future date, without additional data the Department is unwilling to change the criteria at this time; there is a history of stakeholders understanding the use of the current utilization review selection criteria. No amendment was made in response to this comment.

(4) SUBJECT MATTER: Claim Selection Criteria and Written Notice of Denial.

(a) Comment: Rosalie Faris – The comment stated there was a contradiction between Section 5(2)(a), which allows 14 business days (up to 20 calendar days), and Section 7 which allows no more than ten (10) calendar days.

(b) Response; The administrative regulation was amended to state the time periods using business days rather than calendar days; additional language was added to make the time periods match.

(5) SUBJECT MATTER: Reconsideration.

(a) Comment: Rosalie Faris - Providers frequently want to submit additional information and neither Section 8(1)(c) nor Section 8(2)(b) provides a process to allow this.

(b) Response: The administrative regulation was amended to allow for the insertion of a peer-to-peer conference in the stated time sequence; there is no prohibition against a treating physician supplying additional written documentation during the peer-to-peer process.

(6) SUBJECT MATTER: Peer-to-peer conference.

(a) Comment: Rosalie Faris – The comment stated that the use of the term “same specialty” was too vague.

(b) Response: The administrative regulation was amended to use the term “same medical specialty” and provide a definition of “same medical specialty.”

(7) SUBJECT MATTER: Peer-to-peer conference.

(a) Comment: Rosalie Faris - Section 9(6) does not include an option to allow for submission of additional information.

(b) Response: There is no prohibition against a treating physician supplying additional written documentation during the peer-to-peer process and that process provides a five (5) day period following the peer-to-peer conference before the final utilization review decision must be rendered. No amendment was made in response to this comment.

(8) SUBJECT MATTER: Reconsideration.

(a) Comment: Rosalie Faris - Neither section 8(1)(c)'s nor section 8(2)(b)'s timeframes are possible with the inclusion of a peer-to-peer conference.

(b) Response: The administrative regulation was amended to allow for the inclusion of a peer-to-peer conference.

(9) SUBJECT MATTER: Utilization Review and Medical Bill Audit Plan Approval.

(a) Comment: Rosalie Faris – The comment questioned whether the medical payment obligor or the utilization review vendor for the medical payment obligor was required to provide to the commissioner the summaries of information requested in section 3(6).

The following made a similar comment:

1. Robert L. Swisher, Attorney, Kentucky Employers' Mutual Insurance,

(b) Response: The administrative regulation was amended to remove a specific summary request and to make clear the medical payment obligor or its utilization review vendor is

provide the summaries to the commissioner; the medical payment obligor and utilization review vendor may determine between them which will provide the summaries.

(10) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Robert L. Swisher – The comment stated section 4 did not address gatekeeper physicians required under the managed care regulation.

(b) Response: The administrative regulation was amended so that subsection (6) now reads “[a] description of the process to assure that a physician shall be designated by each injured employee as required under 803 KAR 25:096 or 803 KAR 25:110.”

(11) SUBJECT MATTER: Claim Selection Criteria.

(a) Comment: Robert L. Swisher – The comment interprets section 5(2) to preclude the ability to waive UR after acquiring and considering records or other information acquired after the initial two (2) day period and states that such a limitation is counter-productive and may delay medical treatment. Further, limiting the ability to waive utilization review runs contrary to the policy of encouraging the expeditious delivery of medical benefits.

The following made a similar comment:

1. Lisa Anne Bickford.

(b) Response: Section 5(2) states the medical payment obligor may waive utilization review; the direction is permissive, not mandatory. A medical payment obligor is not

precluded from approving treatment at any time. As such, the administrative regulation was not amended in response to this comment.

(12) SUBJECT MATTER: Claim Selection Criteria.

(a) Comment: Robert L. Swisher – The comment stated Section 5(5)(c) failed to address the gatekeeper physicians required under the managed care regulation.

(b) Response: The administrative regulation was amended so that section 5(5)(c) states “[t]hat a physician has been designated in accordance with 803 KAR 25:096 or 803 KAR 25:110.”

(13) SUBJECT MATTER: Reconsideration.

(a) Comment: Robert L. Swisher – The comment stated that the use of the term “qualifications” was ambiguous and should be harmonized with Section 9(4).

(b) Response: The administrative regulation was amended to use the term “same medical specialty” and provide a definition of “same medical specialty.”

(14) SUBJECT MATTER: Reconsideration.

(a) Comment: Robert L. Swisher – The comment stated Section 8(2)(a) was unnecessary and duplicative because of the amendment to Section 8(1)(b).

(b) Response: The administrative regulation was amended to delete section 8(2)(a).

(15) SUBJECT MATTER: Peer-to-peer conference.

(a) Comment: Kara Larson – The comment stated the timeline in Section 9(1)(b) does not match the peer-to-peer timeframe provisions in 803 KAR 25:270 Section 4(3)(b) and subsection (6) and that differing timeframes may cause confusion and create potential delays.

(b) Response: The administrative amendment was amended to meet the time provisions provided in 803 Kar 25:270, Section 4(3)(b).

(16) SUBJECT MATTER: Peer-to-peer conference.

(a) Comment: Lisa Anne Bickford – The comment stated that parties to a peer-to-peer conference were unable to hold a peer-to-peer conference earlier than five (5) days if both parties agree to the earlier timeframe.

(b) Response: The administrative regulation was amended to make clear the parties can agree to hold the peer-to-peer conference earlier than five (5) days if both parties agree to the earlier timeframe.

(17) SUBJECT MATTER: Utilization Review and Medical Bill Audit Program.

(a) Comment: Bill Londrigan – The comment requested the Department publish data on its website pertaining to the number of utilization reviews conducted, reconsideration appeals, peer-to-peer reviews, and the success or failure rate of utilization review.

(b) Response: The Department agrees it is important to publish this data and will do so on its website once the data is gathered and available; however, the Department understands its statutory duties and obligations to include the authority to do so without the necessity of

an administrative regulation. As such, the administrative regulation was not amended in response to this comment.

(18) SUBJECT MATTER: Utilization Review and Medical Bill Audit Program.

(a) Comment: Bill Londrigan – The comment requested the following categories of annual data reporting be added to Section 3(6): the number of appeals of initial utilization reviews, the number of actual peer-to-peer reviews commenced and conducted, the number of peer-to-peer reviews resulting in approval or denial, and the number of initial utilization review denials of treatment where the treatment was later approved by an appeal, peer-to-peer, or ALJ decision.

(b) Response: The administrative regulation was amended to include summaries of the specified data with the exception of the number of initial utilization review denials of treatment where the treatment was later approved by an appeal, peer-to-peer, or ALJ decision because other factors outside of utilization review may have played a role in the ultimate outcome, thereby skewing the data.

(19) SUBJECT MATTER: Utilization Review and Medical Bill Audit Program.

(a) Comment: Bill Londrigan – The comment requested the regulation be amended to add a medical advisory committee to advise the Commissioner on the medical aspects of various programs administered by the Department of Worker's Claims. The comment stated the members of the medical advisory committee should include the deputy commissioner and representatives for employers, employees, labor unions, insurance, self-insured employers,

occupational medicine specialists, doctors of chiropractic, local health departments, orthopedic specialists, neurosurgeons, psychiatrists, psychologists, pain management rehabilitation specialists, pain management specialists, physical therapists, primary care physicians, emergency medicine physicians and pharmacists. The comment further stated the medical advisory committee should provide the Commissioner with a report concerning the medical aspects of the various programs no less than annually.

(b) Response: The Department agrees a medical advisory committee to advise the Commissioner on medical aspects of the various programs administered by the Department would be beneficial; however, the Department believes amending the proposed administrative regulation to require the formation of medical advisory committee is premature at the current time. As such, the administrative regulation was not amended in response to this comment.

(20) SUBJECT MATTER: Utilization Review and Medical Bill Audit Personnel Qualifications.

(a) Comment: Robert L. Swisher – The comment requested Section 6(1)(e) of the proposed administrative regulation be amended to state that an initial utilization review approval may be issued by other personnel whose training and experience qualify them to issue decisions on medical necessity or appropriateness, including, but not limited to, a medical doctor, surgeon, psychologist, optometrist, dentist, podiatrist, and osteopathic practitioner, acting within the scope of their licenses required by the jurisdiction in which they are employed.

(b) Response: The administrative regulation was amended to include the specified categories.

(21) SUBJECT MATTER: Utilization Review and Medical Bill Audit Personnel Qualifications.

(a) Comment: Robert L. Swisher – The comment requested Section 6(2) of the proposed administrative regulation be amended to state that an initial utilization review denial may be issued by only a medical doctor, surgeon, psychologist, optometrist, dentist, podiatrist, and osteopathic practitioner, acting within the scope of their license required by the jurisdiction in which they are employed.

(b) Response: The department is mindful of the potential impact of Toler v. Oldham County Fiscal Court, 2021-SC-0356-WC, on utilization review; however having a physician authorize and ratify any utilization review denial allows the physician to act as a gatekeeper to ensure treatment and medications are properly assessed before a denial is issued. The administrative regulation was amended to require a physician, as defined by KRS 342.0011(32), to authorize and ratify an initial utilization review denial.

(22) SUBJECT MATTER: Utilization Review and Medical Bill Audit Personnel Qualifications.

(a) Comment: Thomas L. Ferreri. – The comment reacted to the potential impact of the Toler v. Oldham County Fiscal Court, 2021-SC-0356-WC, decision on utilization review. In the decisions, the Supreme Court held a medical doctor not licensed in Kentucky was not a

“physician” as defined in KRS 342.0011(32). The comment argued the Commissioner had the authority to redefine “physician” for the purpose of utilization review and requested the proposed administrative regulation be amended to do so. The comment further stated that the failure to redefine “physician” for the purpose of utilization review to include a physician licensed both inside and outside of Kentucky would create delays in the utilization review process and clog the utilization review system.

(b) Response: The department is mindful of the potential impact of Toler v. Oldham County Fiscal Court, 2021-SC-0356-WC, on utilization review; however having a physician authorize and ratify any utilization review denial allows the physician to act as a gatekeeper to ensure treatment and medications are properly assessed before a denial is issued. The administrative regulation was amended to require a physician, as defined by KRS 342.0011(32), to authorize and ratify an initial utilization review denial.

(23) SUBJECT MATTER: Utilization Review and Medical Bill Audit Plan Approval.

(a) Comment: Kenneth A. Stoller – The comment stated the annual report filing date in Section 3(6) be set later than August 1 because carrier fiscal years end on or near June 30.

(b) Response: The administrative regulation was amended to make clear that a full fiscal year of data gathering is to occur before the reporting of summaries is required. The administrative regulation was further amended to make clear that a the medical payment obligor’s fiscal year must conclude prior to March 31 of the year in which the summary is due and that the summary is not due until September 1.

(24) SUBJECT MATTER: Utilization Review and Medical Bill Audit Plan Approval.

(a) Comment: Kenneth A. Stoller – The comment stated the proposed administrative regulation should be amended to delay implementation of the reporting requirement until 2023 to prevent partial-year data reports from the effective date of the emergency regulation.

(b) Response: The administrative regulation was amended to make clear that a full fiscal year of data gathering is to occur before the reporting of summaries is required. The administrative regulation was further amended to make clear that the medical payment obligor's fiscal year must conclude prior to March 31 of the year in which the summary is due and that the summary is not due until September 1.

(25) SUBJECT MATTER: Utilization Review and Medical Bill Audit Plan Approval.

(a) Comment: Kenneth A. Stoller – The comment requested the proposed administrative regulation be amended to allay concerns that carriers will be required to perform time-consuming manual claim file review for the requested data points beyond UR waivers; for example, how would a carrier report a partial denial of 10 of 20 requested physical therapy session?

(b) Response: The administrative regulation was amended to make clear that where proposed treatment is partially approved and partially denied will count as both approval and a denial for reporting purposes.

(26) SUBJECT MATTER: Utilization Review and Medical Bill Audit Plan Approval.

(a) Comment: Elizabeth Filtz – The comment requested confirmation or answers for the following regarding Section 3(6): (1) Do carriers licensed for multiple underwriting companies file one comprehensive, or individual annual report for all? (2) If a carrier acts as a TPA for a self-insured employer, who reports the data, the carrier or the self-insured employer? Further, if the carrier is the proper reporting entity, is the data included with the Carrier's company data or does it need to remain separate for each self-insured entity? (3) Will the adoption of this emergency rule require amendments to current certified filing plans? (4) Confirm that the annual reporting period is July 1-June 30 of preceding year and due date is August 1 of the reporting year.

(b) Response: The administrative regulation was amended to allow a medical payment obligor or its utilization review vendor to file the summary with the commissioner. When an entity provides utilization review services for more than one medical payment obligor, a separate summary is required for each medical payment obligor. The administrative regulation was further amended to make clear that the medical payment obligor's fiscal year must conclude prior to March 31 of the year in which the summary is due and that the summary is not due until September 1.

(27) SUBJECT MATTER: Utilization Review and Medical Bill Audit Plan Approval.

(a) Comment: Lisa Anne Bickford - The comment requested the proposed administrative regulation be amended to clarify Section 3(6) with respect to the annual reporting timeframes for: (a) submission of information and how to do so; (b) the development of a standardized form and format for submitting the data; (c) the due date for the first submitted report; (d) and the timeframe to be included in the first report.

(b) Response: : The administrative regulation was amended to make clear that a full fiscal year of data gathering is to occur before the reporting of summaries is required. The administrative regulation was further amended to make clear that the medical payment obligor's fiscal year must conclude prior to March 31 of the year in which the summary is due and that the summary is not due until September 1. The administrative regulation was also amended to clarify the format in which to submit the summaries and the method by which the summary is to be reported to the Department.

(28) SUBJECT MATTER:

(a) Comment: Lisa Anne Bickford - The comment requested the proposed administrative regulation be amended to strike Section 5(1)(c) and (d). The comment understood those provisions to speak to retrospective determinations whereas KRS 342.035(5)(c) appeared to speak only to prospective utilization review. As a consequence, these provisions may have created an inadvertent conflict. Also, 803 KAR 25:260 and 25:270 define the objective benchmarks by which medical treatment regimen should be gauged. As such, the retrospective provisions within the proposed administrative regulation should be struck.

(b) Response: The Department does not understand the provisions in Section 5(1)(c) and (d) to apply in an ongoing manner; in other words, once either of those criteria are reached, further medical services reasonably related or asserted to be related to the claim must be submitted to utilization review. As such, the Department does believe those provisions create a conflict with KRS 342.035(5)(c). No amendment was made in response to this comment.

(28) SUBJECT MATTER: Peer-to-Per Conference.

(a) Comment: Lisa Anne Bickford - The comment requested the proposed administrative regulation be amended to clarify the mechanism for automatic approval of proposed treatment when a reviewing physician fails to participate in a peer-to-peer conference during the date and time specified. Additionally, who makes that determination?

(b) Response: KRS 342.325 provides that any question arising under KRS Chapter 342 that is not settled by agreement of the parties is to be determined by an administrative law judge. Therefore, if the parties do not agree that the reviewing physician failed to participate in the peer-to-peer conference during the date and time specified, the matter would be determined by an administrative law judge. No amendment was made in response to this comment.

(29) SUBJECT MATTER: Peer-to-Per Conference.

(a) Comment: Lisa Anne Bickford - The comment requested the proposed administrative regulation be amended to clarify who determines that “good cause” existed to excuse the reviewing physician for a failure to participate in a peer-to-peer conference during the date and time specified.

(b) Response: KRS 342.325 provides that any question arising under KRS Chapter 342 that is not settled by agreement of the parties is to be determined by an administrative law judge. Therefore, if the parties do not agree that “good cause” existed to excuse the reviewing physician for a failure to participate in a peer-to-peer conference, the matter would be determined by an administrative law judge. No amendment was made in response to this comment.

(30) SUBJECT MATTER: Peer-to-Peer Conference.

(a) Comment: Lisa Anne Bickford - The comment requested the proposed administrative regulation be amended to clarify the way in which a utilization review vendor could prove a peer-to-peer conference took place when the requesting treatment provider denies the conference occurred?

(b) Response: KRS 342.325 provides that any question arising under KRS Chapter 342 that is not settled by agreement of the parties is to be determined by an administrative law judge. Therefore, if the parties do not agree that a peer-to-peer conference took place, the matter would be determined by an administrative law judge. No amendment was made in response to this comment.

V. SUMMARY OF STATEMENT OF CONSIDERATION AND ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The public hearing on this administrative regulation was held as scheduled. In addition, written comments were received. The Department of Workers' Claims responded to the comments and amends the administrative regulation as follows:

Page 2

Necessity, Function, and Conformity

Line 2

After "administrative regulation" insert "ensures" and delete "insures".

Page 3

Section 1. Definitions.

Line 2

After “means any” insert “self-insured”.

Page 3

Section 1. Definitions.

Line 3

After “as an agent of the” insert “self-insured”

Page 3

Section 1. Definitions.

Line 11

After “(13)” insert ““Same medical specialty” means a branch of medical practice focused regularly and routinely on a defined group of patients, diseases, skills, body part, or type of injury and performed by a physician with the same or similar qualifications.” and insert a new line and insert “(14)” on the new line.

Page 3

Section 1. Definitions.

Line 14

Before “(14)” insert “(15)” and delete “(14)”.

Page 3

Section 1. Definitions.

Line 17

Before “(15)” insert “(16)” and delete “(15)”.

Page 3

Section 3. Utilization Review and Medical Bill Audit Program.

Line 21

After “A utilization reviewer” insert “**has the education, training, and experience, necessary to evaluate clinical issues and services for medical necessity and appropriateness**” and delete “is appropriately qualified”.

Page 4

Section 3. Utilization Review and Medical Bill Audit Program.

Line 6

After “A medical bill auditor” insert “**has the education, training, or experience, necessary to evaluate medical bills and statements**” and delete “is appropriately qualified”.

Page 5

Section 3. Utilization Review and Medical Bill Audit Plan Approval.

Line 6

After “(6) A” insert “**medical payment obligor or its utilization review vendor**” and delete “[carrier who contracts with an approved vendor for utilization review services]”.

Page 5

Section 3. Utilization Review and Medical Bill Audit Plan Approval.

Line 8

Delete “utilization reviews waived in accordance with KRS 342.035(5)(c)”.

Page 5

Section 3. Utilization Review and Medical Bill Audit Plan Approval.

Line 9

After “resulting in a denial” insert “**, peer-to-peer conferences requested, peer-to-peer conferences that resulted in approval of the requested treatment, and peer-to-peer conferences that resulted in denial of the requested treatment.**”

(a) The medical payment obligor or its utilization review vendor shall email the summaries in a Microsoft Excel spreadsheet with rows labeled for each summary category to LaborEDI@ky.gov.

(b) The summaries shall only include data gathered from the medical payment obligor's most recent complete fiscal year that ended on or before March 31 of the year in which the summaries are due. The summaries delete "The annual report of the approved vendor".

Page 5

Section 3. Utilization Review and Medical Bill Audit Plan Approval.

Line 10

After "shall be filed with the commissioner no later than" insert "**September 1 each year**" and delete "August 1 for the preceding year, including any fiscal year ending on or before June 30".

Page 5

Section 3. Utilization Review and Medical Bill Audit Plan Approval.

Line 12

Before "Section 4. Utilization Review and Medical Bill Audit Written Plan Requirements" insert these new paragraphs to subsection (6):

"(c) If a utilization review vendor provides utilization review services for more than one medical payment obligor, the utilization review vendor shall submit a separate spreadsheet for each medical payment obligor.

(d) If a utilization review or a peer-to-peer conference results in a portion of the treatment being approved and a portion of the treatment being denied, the result shall be reported as both an approval and a denial for reporting purposes."

Page 6

Section 4. Utilization Review and Medical Bill Audit Written Plan Requirements.

Line 7

After "required under 803 KAR 25:096" insert "**or 803 KAR 25:110**".

Page 7

Section 5. Claim Selection Criteria.

Line 19

After “selection criteria has been met” insert “**unless additional information is required, in which case, utilization review shall be waived within two (2) business days following receipt of the requested information**”.

Page 8

Section 5. Claim Selection Criteria.

Line 11

After “and employee within” insert “**seven (7) business**” and delete “ten (10) calendar”.

Page 9

Section 5. Claim Selection Criteria.

Line 6

After “medical bill audit shall be initiated within” insert “**five (5) business**” and delete “seven (7) calendar”.

Page 9

Section 5. Claim Selection Criteria.

Line 10

After “in accordance with 803 KAR 25:096” insert “**or 803 KAR 25:110**”.

Page 10

Section 6. Utilization review and Medical Bill Audit Personnel Qualifications.

Line 2

After “medical necessity or appropriateness” insert “**, including a medical doctor, surgeon, psychologist, optometrist, dentist, podiatrist, and osteopathic practitioner, acting within**”.

the scope of the license or licenses required by the jurisdiction in which they are employed.

(2) Utilization review personnel shall hold the license required by the United States' jurisdiction in which they are employed.

(3) A physician shall supervise utilization review personnel.

(4) A physician shall authorize and ratify any utilization review denial".

Page 10

Section 6. Utilization review and Medical Bill Audit Personnel Qualifications.

Line 3

Before "(2)" insert "(5)" and delete "(2)".

Page 10

Section 6. Utilization review and Medical Bill Audit Personnel Qualifications.

Line 6

Before "(3)" insert "(6)" and delete "(3)".

Page 10

Section 7. Written Notice of Denial.

Line 11

After "more than" insert "two (2) business days after initiation of the utilization review process unless additional information was required, in which case, the written notice of denial shall be issued no later than two (2) business days after the initial utilization review decision" and delete "ten (10) calendar days from the initiation of the utilization review process".

Page 11

Section 8. Reconsideration.

Line 2

After “an aggrieved party within” insert “**ten (10) business**” and delete “fourteen (14) calendar”.

Page 11

Section 8. Reconsideration.

Line 4

After “different reviewer of” insert “**the same medical specialty**” and delete “at least the same qualifications”.

Page 11

Section 8. Reconsideration.

Line 6

After “shall be rendered within” insert “**seven (7) business**” and delete “ten (10) calendar”.

Page 11

Section 8. Reconsideration.

Line 7

After “a request for reconsideration” insert “**unless a peer-to-peer conference is requested, in which case, the written reconsideration decision shall be rendered within five (5) business days after the day on which the peer-to-peer conference was held**”.

Page 11

Section 8. Reconsideration.

Line 14

Delete subsection (2) in its entirety.

Page 12

Section 8. Reconsideration.

Line 4

Before “(3)” insert “**(2)**” and delete “(3)”.

Page 12

Section 8. Reconsideration.

Line 7

After “aggrieved party within” insert “**ten (10) business**” and delete “fourteen (14) calendar”.

Page 12

Section 8. Reconsideration.

Line 10

After “shall be rendered within” insert “**seven (7) business**” and delete “ten (10) calendar”.

Page 13

Section 9. Peer-to-Peer Conference.

Line 2

After “the request” insert “**unless the peer-to-peer conference request stems from a denial issued pursuant to 803 KAR 25:270, in which case, a date or dates not less than two (2) business days after the date of the request. In either case, the parties may by agreement hold the conference in a shorter time period**”.

Page 13

Section 9. Peer-to-Peer Conference.

Line 7

After “same” insert “**medical**”.

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MEMORANDUM

TO: Dale Hamblin., Assistant General Counsel, Workers' Claims Legal Division, Education and Labor Cabinet

FROM: Emily Caudill, Regulations Compiler

RE: Amended After Comments – 803 KAR 025:195.

DATE: August 12, 2022

A copy of the Amended After Comments regulation listed above along with the required Statement of Consideration are enclosed for your files.

This administrative regulation will be reviewed by the Administrative Regulation Review Subcommittee at its **September 2022** meeting. Please notify the proper person(s) of this meeting.

If you have questions, please contact us at RegsCompiler@LRC.ky.gov or (502) 564-8100.

Enclosure