

1 AN ACT relating to utilization reviews.

2 ***Be it enacted by the General Assembly of the Commonwealth of Kentucky:***

3 ➔Section 1. KRS 304.17A-600 is amended to read as follows:

4 As used in KRS 304.17A-600 to 304.17A-633:

- 5 (1) (a) "Adverse determination" means a determination by an insurer or its designee  
6 that the health care services furnished or proposed to be furnished to a covered  
7 person are:
- 8 1. Not medically necessary, as determined by the insurer, or its designee or  
9 experimental or investigational, as determined by the insurer, or its  
10 designee; and
  - 11 2. Benefit coverage is therefore denied, reduced, or terminated.
- 12 (b) "Adverse determination" does not mean a determination by an insurer or its  
13 designee that the health care services furnished or proposed to be furnished to  
14 a covered person are specifically limited or excluded in the covered person's  
15 health benefit plan;
- 16 (2) "Authorized person" means a parent, guardian, or other person authorized to act on  
17 behalf of a covered person with respect to health care decisions;
- 18 (3) "Concurrent review" means utilization review conducted during a covered person's  
19 course of treatment or hospital stay;
- 20 (4) "Covered person" means a person covered under a health benefit plan;
- 21 (5) "External review" means a review that is conducted by an independent review entity  
22 which meets specified criteria as established in KRS 304.17A-623, 304.17A-625,  
23 and 304.17A-627;
- 24 (6) "Health benefit plan" means the document evidencing and setting forth the terms  
25 and conditions of coverage of any hospital or medical expense policy or certificate;  
26 nonprofit hospital, medical-surgical, and health service corporation contract or  
27 certificate; provider sponsored integrated health delivery network policy or

1 certificate; a self-insured policy or certificate or a policy or certificate provided by a  
2 multiple employer welfare arrangement, to the extent permitted by ERISA; health  
3 maintenance organization contract; or any health benefit plan that affects the rights  
4 of a Kentucky insured and bears a reasonable relation to Kentucky, whether  
5 delivered or issued for delivery in Kentucky, and does not include policies covering  
6 only accident, credit, dental, disability income, fixed indemnity medical expense  
7 reimbursement policy, long-term care, Medicare supplement, specified disease,  
8 vision care, coverage issued as a supplement to liability insurance, insurance arising  
9 out of a workers' compensation or similar law, automobile medical-payment  
10 insurance, insurance under which benefits are payable with or without regard to  
11 fault and that is statutorily required to be contained in any liability insurance policy  
12 or equivalent self-insurance, student health insurance offered by a Kentucky-  
13 licensed insurer under written contract with a university or college whose students it  
14 proposes to insure, medical expense reimbursement policies specifically designed to  
15 fill gaps in primary coverage, coinsurance, or deductibles and provided under a  
16 separate policy, certificate, or contract, or coverage supplemental to the coverage  
17 provided under Chapter 55 of Title 10, United States Code; or limited health service  
18 benefit plans; and for purposes of KRS 304.17A-600 to 304.17A-633 includes  
19 short-term coverage policies;

20 (7) "Independent review entity" means an individual or organization certified by the  
21 department to perform external reviews under KRS 304.17A-623, 304.17A-625,  
22 and 304.17A-627;

23 (8) "Insurer" means any of the following entities authorized to issue health benefit plans  
24 as defined in subsection (6) of this section: an insurance company, health  
25 maintenance organization; self-insurer or multiple employer welfare arrangement  
26 not exempt from state regulation by ERISA; provider-sponsored integrated health  
27 delivery network; self-insured employer-organized association; nonprofit hospital,

- 1 medical-surgical, or health service corporation; or any other entity authorized to  
2 transact health insurance business in Kentucky;
- 3 (9) "Internal appeals process" means a formal process, as set forth in KRS 304.17A-  
4 617, established and maintained by the insurer, its designee, or agent whereby the  
5 covered person, an authorized person, or a provider may contest an adverse  
6 determination rendered by the insurer, its designee, or private review agent;
- 7 (10) "Nationally recognized accreditation organization" means a private nonprofit entity  
8 that sets national utilization review and internal appeal standards and conducts  
9 review of insurers, agents, or independent review entities for the purpose of  
10 accreditation or certification. Nationally recognized accreditation organizations  
11 shall include the Accreditation Association for Ambulatory Health Care  
12 (AAAHHC), the National Committee for Quality Assurance (NCQA), the American  
13 Accreditation Health Care Commission (URAC), the Joint Commission, or any  
14 other organization identified by the department;
- 15 (11) "Private review agent" or "agent" means a person or entity performing utilization  
16 review that is either affiliated with, under contract with, or acting on behalf of any  
17 insurer or other person providing or administering health benefits to citizens of this  
18 Commonwealth. "Private review agent" or "agent" does not include an independent  
19 review entity which performs external review of adverse determinations;
- 20 (12) "Prospective review" means utilization review that is conducted prior to a hospital  
21 admission or a course of treatment;
- 22 (13) "Provider" shall have the same meaning as set forth in KRS 304.17A-005;
- 23 (14) "Qualified personnel" means licensed physician, registered nurse, licensed practical  
24 nurse, medical records technician, or other licensed medical personnel who through  
25 training and experience shall render consistent decisions based on the review  
26 criteria;
- 27 (15) "Registration" means an authorization issued by the department to an insurer or a

- 1 private review agent to conduct utilization review;
- 2 (16) "Retrospective review" means utilization review that is conducted after health care  
3 services have been provided to a covered person. "Retrospective review" does not  
4 include the review of a claim that is limited to an evaluation of reimbursement  
5 levels, or adjudication of payment;
- 6 (17) (a) "Urgent care" means health care or treatment with respect to which the  
7 application of the time periods for making nonurgent determination:
- 8 1. Could seriously jeopardize the life or health of the covered person or the  
9 ability of the covered person to regain maximum function; or
- 10 2. In the opinion of a physician with knowledge of the covered person's  
11 medical condition, would subject the covered person to severe pain that  
12 cannot be adequately managed without the care or treatment that is the  
13 subject of the utilization review; and
- 14 (b) "Urgent care" shall include all requests for hospitalization and outpatient  
15 surgery;
- 16 (18) "Utilization review" means a review of the medical necessity and appropriateness of  
17 hospital resources and medical services given or proposed to be given to a covered  
18 person for purposes of determining the availability of payment. Areas of review  
19 include concurrent, prospective, and retrospective review; and
- 20 (19) "Utilization review plan" means a description of the procedures governing  
21 utilization review activities performed by an insurer or a private review agent.