803 KAR 25:110. Workers' compensation managed health care plans.

RELATES TO: 342.0011(32), 342.020, 342.035, 342.735
STATUTORY AUTHORITY: KRS 342.020(1), 342.035, 342.260(1), 342.735
NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260(1) requires the Executive Director of the Office of Workers' Claims to promulgate administrative regulations necessary to carry on the work of the office under KRS Chapter 342. KRS 342.020(3) requires a managed health care system to file with the Office a plan for the rendition of health care services for work-related injuries and occupational diseases to be approved pursuant to administrative regulations promulgated by the executive director. The purpose of this administrative regulation is to establish procedures and standards for certification of workers' compensation managed health care system health care plans pursuant to KRS 342.020.

Section 1. Definitions. (1) "Executive director" is defined by KRS 342.0011(9).
(2) "Emergency care" means:
(a) Medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to serious physical or mental disability or death; or
(b) Medical services that are immediately necessary to alleviate severe pain. "Emergency care" does not include follow-up care, except when immediate care is required to avoid serious disability or death.
(3) "Gatekeeper physician" means any qualified physician, as defined by KRS 342.0011(32), acting within the scope of his or her license who has been specifically designated by a managed health care system to provide primary care to a patient and to make referrals of patients to other providers for specialized care or diagnostic services.
(4) "Managed care plan" means a written plan describing the operations of a managed health care system.
(5) "Provider" means any person or entity licensed, certified, or registered to provide medical services.
(6) "Revocation" means the termination of a managed health care plan certificate to provide services under the Kentucky Workers' Compensation Act prior to expiration of the certificate.
(7) "Service area" means a geographic area consisting of a county or group of counties of which no county shall be subdivided.

Section 2. Certification Process. (1)(a) A managed care plan shall be certified by the executive director.
(b) A managed health care system shall apply to have a plan or plans certified by the executive director.
(c) A managed health care system may operate one (1) or more plans.
(2) An application for initial certification and renewal shall be submitted to the executive director and shall contain the following information:
(a) System identification;
1. System name and address;
2. Date and state of incorporation;
3. Name, address, and phone number of each corporate officer, director, and day-to-day plan administrator;
4. Name and address of each owner of more than five (5) percent of the stock or controlling interest in the entity;
5. Name, address, and phone number of the medical director, who shall be a doctor of medi-

cine (M.D.) or doctor of osteopathic medicine (D.O.) and who shall oversee and monitor compliance with the quality care, utilization review and credentialing provisions of the managed care plan;

6. Name, company name, address, and phone number of the case manager who shall be qualified as either a certified case manager, certified rehabilitation counselor, certified insurance rehabilitation specialist, or certified rehabilitation registered nurse who shall oversee and monitor case management provisions of the managed care plan;

7. Description of the system's organizational structure; and

(b) System qualifications;

1. Description and map of the system's service area;

2. Name, address, phone number, and specialty of all participating providers separated by county;

3. A list of those providers who shall serve as gatekeeper physicians, including an appropriate choice of the various types of physicians described in KRS 342.011(31);

4. Assurance that all licensing, registration, or certification requirements have been met and are current for the providers to practice in Kentucky (or border states wherein the provider practices) and that each participating provider shall maintain in full force and effect a professional malpractice policy with limits of no less than $500,000 for an occurrence of professional negligence;

5. A copy of the agreement that each class of medical provider shall execute to participate in the system;

6.a. A copy of the materials which the system shall provide to workers setting forth the grievance procedure and form, the requirements and restrictions of the system, the list of providers to be used by workers, and the means of accessing services and treatment within and outside of the service area.

b. The applicant shall detail the time and means by which the materials shall be delivered to employees and employers;

7. A copy of materials directed at management employees informing supervisors of the necessity of channeling injured workers to the managed care plan providers and giving immediate notice to the employer, insurance carrier, and plan of the occurrence of an injury.

Section 3. Financial Ability. (1) Each managed health care system shall demonstrate to the executive director that it has sufficient financial resources and professional expertise to perform all of the necessary functions of a managed health care system and managed care plan by the following:

(a) If the applicant has previously provided managed care or other similar medical and administrative services in the Commonwealth of Kentucky, the applicant shall provide the following:

1. A summary and description of the administrative and medical services provided; and

2. A list of representative entities for which managed care related administrative or medical services have been provided; and

(b) If the applicant has not previously provided services related to the delivery of managed care in the Commonwealth:

1. The executive director shall require, prior to certification, that the applicant post either a performance bond or cash surety deposit in an amount of $500,000 with the office of the executive director (by use of Form MC-1 or MC-2) to demonstrate sufficient financial resources to provide all of the administrative and medical services required to be performed under a managed care plan;

2. The bond or cash surety shall be released by the executive director sixty (60) days after the managed health care system demonstrates to the executive director that all of its arrangements for rendering workers' compensation managed care services in the Commonwealth have been terminated; and

3. If the managed care system demonstrates three (3) consecutive years of good performance, the executive director shall release the bond or cash surety.

(c) If the applicant has an audited financial statement addressing any of its prior operations for the preceding year, a copy of the applicant's most recent audited financial statement shall be submitted to the executive director.

Section 4. Plan Qualifications. (1) The managed health care system shall submit a copy of the managed care plan with the application, which shall comply with the requirements in this section.

(2) A plan shall provide assurance of access to quality medical services in a prompt, effective manner for employees of employers using the managed care plan.

(3) The plan shall:

(a) Offer an adequate number of health care providers including gatekeeper, specialty and subspecialty physicians, and general and specialty hospitals to afford employees reasonable choice and convenient geographic accessibility to all categories of licensed care; and

(b) Provide a complete list of the health care providers to injured employees.

(4) The employee shall choose a gatekeeper physician if it becomes apparent that continuing care is required for an injury or disease compensable under KRS Chapter 342.

(5) Employers or insurers may contract with multiple managed health care systems in order to maximize access for their employees.

(6) An employee may access providers who are not participating plan providers:

(a) For emergency care as defined in Section 1 of this administrative regulation;

(b) If the employee is referred by a gatekeeper physician outside the managed care plan for medical services;

(c) If authorized treatment is unavailable through the managed care plan; or

(d) To obtain a second opinion if a managed care plan physician recommends surgery.

(7) The plan shall have mechanisms to ensure continuity of care upon termination of contracts between the managed health care system, the employer, or participating providers.

(8) The plan shall have mechanisms for utilization review which shall prevent inappropriate, excessive, or medically unnecessary medical services and shall include:

(a)1. Treatment standards upon which utilization review decisions shall be based (including low back symptoms and injuries to the upper extremities and knees) assuring quality care in accordance with prevailing standards in the medical community of which the plan provider is a member.

2. The standards shall conform to any practice parameters or guidelines for clinical practice adopted by the executive director pursuant to KRS 342.025(8);

(b) Mechanisms requiring periodic review to determine that continued treatment of an injured employee is reasonable, appropriate, and medically necessary;

(c) Assurance that the managed health care system is conducting utilization review in accordance with the standards set forth in 803 KAR 25:190; and

(d) Adequate procedures for credentialing providers and evaluating the quality and cost effectiveness of services delivered under the plan.

(9) The plan shall have provisions for employer or carrier audit of the managed health care system's operations and the financial arrangements between the system and its providers.

(10) The plan shall have a grievance procedure meeting the requirements of Section 10 of this administrative regulation.

(11) The plan shall demonstrate effective methods of informing employees, employers, and medical providers of the services provided by the plan and requirements imposed by the plan, including a twenty-four (24) hour toll free phone number by which information may be obtained concerning plan operations, after-office-hours care, and twenty-four (24) hour access to emergency care.

(12)(a) The plan shall have a system to provide authorization numbers to medical providers and health facilities if preauthorization or continued stay review is required by the plan.

(b) The authorization numbers shall be recorded in the treatment authorization code section of the appropriate billing forms.

(13)(a) The plan shall demonstrate aggressive case management by either a certified case manager, certified rehabilitation counselor, certified insurance rehabilitation specialist, or a certified rehabilitation registered nurse to:

1. Coordinate the delivery of health services and return to work policies;
2. Promote an appropriate, prompt return to work; and
3. Facilitate communication between the employee, employer, and health care providers.

(b) The plan shall describe the circumstances under which injured employees shall be subject to case management and the services to be provided.

(14) A spreadsheet shall be mailed or emailed to the Office of Workers' Claims for entry into the Office's computer database that indicates the employers who have become associated with a managed care plan which shall include:

(a) Name and address of employer or carrier;

(b) Date of enrollment; and

(c) Date of termination, if applicable.

Section 5. Plan Certification. (1) The executive director shall notify the applicant in writing of the determination made upon the application for certification or modification thereof, within sixty (60) days of receipt of a complete application.

(2) A certificate shall be valid for a period of two (2) years and only for the service area and managed care plan or plans specified by the executive director.

(3) Upon written request made at least sixty (60) days prior to expiration of the current certificate, and demonstration of continuing compliance with the requirements of this administrative regulation the executive director shall recertify a plan for additional successive two (2) year periods.

(4) Geographical areas shall be added if the managed health care system files a supplemental application demonstrating the managed health care system's ability to serve the expanded area.

(5)(a) If an application does not meet the requirements for certification or expansion, the executive director shall notify the applicant in writing and specify those items deemed deficient.

(b) The applicant shall be granted thirty (30) days from the date of notice of the deficiency by the executive director to correct deficiencies through an amended application.

(6)(a) Certification of a managed care plan shall not be transferable.

(b) A new application for certification shall be filed if fifty (50) percent or more of the ownership or controlling interest of a system has been transferred.

Section 6. Plan Modifications. (1) A managed health care system which either implements or experiences material variations as to any matter set forth in the original application or managed care plan shall obtain approval for the modification by filing a request for modification with the executive director.

(2) Intended variations shall not be implemented until approved by the executive director.

(3) A modification outside the control of the system shall be filed with the executive director within fifteen (15) days of its occurrence.

(4)(a) Within fifteen (15) days of entering into an agreement with an employer or insurer to provide workers' compensation managed care services, the managed health care system shall submit notification thereof to the executive director.

(b) The notification shall identify the employer or employers with whom the managed health

care system has contracted and the certified managed care plan applicable to that employer.

(c) Notification shall be deemed approved unless disapproved by the executive director in writing within fifteen (15) days of filing.

(d) The system shall promptly furnish any information deemed necessary by the executive director to review the notice.

(e) If an employer or insurer terminates a contract with a managed health care system, the managed health care system shall file notification with the executive director within fifteen (15) days of the occurrence, indicating the employers for whom managed care services have been terminated and the effective date of the termination.

Section 7. Suspension or Revocation of Certification. (1) The certification of a managed care plan by the executive director may be suspended or revoked if:

(a) Service is not being provided:

1. According to the terms of the certified managed care plan;

2. In accordance with prevailing treatment standards; or

3. In accordance with treatment standards or practice parameters adopted by the executive director;

(b) The plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of KRS Chapter 342 or this administrative regulation;

(c) Any material false or misleading information is intentionally submitted by the managed health care system or participating provider to the executive director, the employer, or the insurer; or

(d) The managed health care system knowingly or negligently utilizes a health care provider whose license, registration, or certification has been suspended or revoked, or who is otherwise ineligible to provide treatment of the type rendered to an injured employee.

(2) The executive director may investigate the operations of certified managed health care systems at any time and the system and its providers shall cooperate in any investigation by the executive director.

(3)(a) If the executive director determines that grounds for termination or suspension of a managed care plan certification exists, written notice setting forth those grounds shall be mailed to the managed care system.

(b) The executive director's determination that grounds exist for termination or suspension shall be based on the following:

1. Degree of seriousness of the action taken by the managed health care plan; or

2. Number of violations of subsection (1) of this section.

(c) The system shall be granted fifteen (15) days from the date of the notice in which to file written response.

(d)Thereafter, the executive director shall render a written decision setting forth specific findings, reasons, and justifications for the action taken, which shall include termination, suspension, or conditional continuation of the certificate until deficiencies are corrected.

Section 8. Appeal of Executive Director's Action. Any managed health care system may seek review in the Franklin Circuit Court within thirty (30) days of the date of the executive director's final decision concerning its managed care plan.

Section 9. Coverage. (1) An employee of an employer for whom a managed care plan has been approved by the executive director shall obtain medical services compensable under KRS Chapter 342 from the certified managed care plan of the employer with the following conditions:

(a) For those injuries or diseases for which continuing treatment was initiated prior to the date

the managed care plan for the employer was approved, the employee may continue with its current treating physician;

(b) If an employee under continuing care changes the designation of treating physician, the employee's provider choice shall be limited to providers under the certified managed care plan and medical services thereafter shall be obtained pursuant to the managed care plan; and

(c) If initial emergency care following a compensable injury is rendered by a medical provider outside the managed health care plan, the injured worker may remain under the care of that provider so long as the provider complies with utilization review, reporting standards, and quality assurance mechanisms prescribed by the employer's managed care plan.

(2) Reimbursement of these nonplan providers shall be at the level prescribed by applicable workers' compensation fee schedules.

Section 10. Grievance Procedure. (1) Each workers' compensation managed care plan shall contain an expeditious, informal grievance procedure to resolve disputes by employees and providers relative to the rendition of medical services.

(2) A detailed description of the employee grievance procedure shall be included in informational materials provided to employees and a detailed description of the provider grievance procedure shall be included in all provider contracts.

(3) The grievance procedure shall meet the following requirements:

(a) Notice. A grievance shall be made when a written complaint or written request is delivered by the employee or provider to the managed health care system setting forth the nature of the complaint and remedial action requested.

(b) Time frame to file grievance. The employee or provider shall file a grievance within thirty (30) days of the occurrence of the event giving rise to the dispute.

(c) Resolution. The managed health care system shall render a written decision upon a grievance within thirty (30) days of receipt by the managed health care system of the grievance.

(d) Arbitration.

1. Managed care plans may provide for alternate means of dispute resolution including arbitration and mediation.

2. In that event final resolution of a grievance shall not be subject to the time constraints set forth in paragraph (c) of this subsection.

3. In all cases involving urgent treatment issues, resolution mechanisms shall include procedures to expedite those issues and prevent undue delay.

(4) Record of grievance proceedings. The managed health care system shall maintain records for two (2) years of each formal grievance which shall include the following:

(a) A description of the grievance;

(b) The employee's name and address;

(c) Names and addresses of the health care providers relevant to the grievance;

(d) The managed health care system's and employer's name and address; and

(e) A description of the managed health care system's findings, conclusions, and disposition of the grievance.

(5) Appeal.

(a) An employee or provider dissatisfied with the managed health care system's resolution of a grievance may apply for review by an administrative law judge by filing a request for resolution within thirty (30) days of the date of the system's final decision.

(b) Upon review by an administrative law judge the movant shall be required to prove that the system's final decision is unreasonable or otherwise fails to conform with KRS Chapter 342.

Section 11. Reporting. Each managed health care system having a certified managed care plan

shall submit:

(1) An annual report to the executive director on or before April 15 containing the following information for the previous year:

(a) Number of employees treated by the managed care plan;

(b) Number of employers and employees covered by the managed care plan; and

(c) Number of grievances filed, and summary of action;

(2) On or before April 15 and October 15 of each year, a copy of the provider directory of participating medical providers shall be provided to the executive director.

Section 12. Treatment Plans. (1) Those sections of 803 KAR 25:096 concerning treatment plans shall, to the extent possible, apply to managed care plans.

(2) Each managed health care system shall retain treatment plans and make them available to the employee, employer, Special Fund, Uninsured Employers' Fund, administrative law judges, or attorneys representing any of the parties, upon request.

Section 13. Provider Verification. (1) Each employer which provides medical services through a managed care plan shall provide to the injured employee a written certification of workers' compensation managed care coverage as soon as practicable following notice of a compensable injury or disease requiring continuing medical services.

(2) The verification shall contain the following information:

(a) Employer name, address, and phone number;

(b) Name and telephone number of the managed health care system to be contacted; and

(c) Employee name and Social Security number.

(3) Possession of the verification shall not be construed as authorization for medical service or payment.

Section 14. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Form MC-1, Managed Care System Depository Agreement" (November 1994); and

(b) "Form MC-2, Managed Care System Bond Form" (November 1994).

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Worker's Claims, 657 Chamberlin Avenue, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (21 Ky.R. 1604; Am. 1886; eff. 2-9-95; 27 Ky.R. 1890; eff. 3-19-2001; 34 Ky.R. 639; 1423; eff. 1-4-2008.)