

1 LABOR CABINET

2 Department of Workers' Claims

3 (Amended After Comments)

4 803 KAR 25:260 Treatment Guidelines

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

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

7 NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260(1) requires the commissioner

8 to promulgate administrative regulations necessary to carry on the work of the department and the

9 work of administrative law judges so long as those administrative regulations are consistent with

10 KRS Chapter 342 and KRS Chapter 13A. KRS 342.035 requires the commissioner to develop or

11 adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by

12 medical providers under KRS Chapter 342 and promulgate administrative regulations to

13 implement the developed or adopted treatment guidelines. This administrative regulation adopts

14 treatment guidelines and provides guidance to implement them. This administrative regulation

15 does not abrogate the right of the injured employee to choose his treating physician as

16 provided in KRS 342.020.

17 Section 1. Definitions.

18 (1) "Carrier" is defined by KRS 342.0011(6). [~~or "insurance carrier" means any~~
19 ~~insurer authorized to insure the liability of employers arising under Chapter 342 of the~~
20 ~~Kentucky Revised Statutes, an employer authorized by the commissioner to pay directly the~~
21 ~~compensation provided in Chapter 342 of the Kentucky Revised Statutes as those liabilities~~

1 ~~are incurred, a self-insured group, and any person acting on behalf of or as an agent of the~~
2 ~~insurer, self-insured employer, or self-insured group.]~~

3 (2) "Commissioner" means the commissioner charged in KRS 342.228 to administer the
4 Department of Workers' Claims and whose duties are stated in KRS 342.230.

5 (3) "Department" or "Department of Workers' Claims" means the governmental agency
6 whose responsibilities are provided in KRS 342.228.

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

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

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

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

18 **(8) [(7)]** "Maximum medical improvement" means the point of stabilization in an
19 employee's recovery from a work injury where substantial improvement in the human organism
20 is no longer likely.

1 (9) [(8)] “Medical emergency” means the sudden onset of a medical condition manifested
2 by acute symptoms of sufficient severity, including severe pain, that in the absence of immediate
3 medical attention could reasonably be expected to result in placing the patient’s health or bodily
4 functions in serious jeopardy or serious dysfunction of any body organ or part.

5 (10) “Medical payment obligor” means any employer, carrier, insurance carrier, self-
6 insurer, and any person acting on behalf of or as an agent of the employer, carrier, insurance
7 carrier, or self-insurer.

8 (11) [(9)] “Medical provider” means physicians and surgeons, psychologists, optometrists,
9 dentists, podiatrists, osteopathic and chiropractic practitioners, physician assistants, and advanced
10 practice registered nurses, acting within the scope of their license;

11 (12) [(10)] “Medically necessary” or “medical necessity” means healthcare services,
12 including medications, that a medical provider, exercising prudent clinical judgment, would
13 provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness,
14 injury, disease or its symptoms, and that are:

15 a) In accordance with generally accepted standards of medical practice; and

16 b) Clinically appropriate, in terms of type, frequency, extent, site and duration; and
17 considered effective for the patient's illness, injury or disease. Treatment primarily for the
18 convenience of the patient, physician, or other healthcare provider does not constitute medical
19 necessity.

20 (13) “Physician” is defined by KRS 342.0011(32).

1 (14) ~~[(11)]~~ "Preauthorization" means the process whereby payment for a medical service
2 or course of treatment is assured in advance by a carrier.

3 (15) ~~[(12)]~~ "Statement for services" is defined by 803 KAR 25:096 section 1 (5).

4 (16) ~~[(13)]~~ "Treatment guidelines" or "guidelines" are the treatment guidelines developed
5 or adopted by the commissioner pursuant to KRS 342.035(8)(a).

6 (17) ~~[(14)]~~ "Utilization Review" is defined by 803 KAR 25:190 section 1 (6).

7 Section 2. Purpose and Adoption.

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

10 (2) The commissioner adopts the ~~[current edition and any future published updates of~~
11 ~~the]~~ ODG treatment guidelines as ~~[currently]~~ published by MCG Health for use by medical
12 providers in the treatment of work related injuries and occupational diseases. The commissioner
13 shall review the guidelines not less than annually and update or amend this regulation, if necessary,
14 to ensure that the guidelines are consistent with the provisions of KRS 342.020 and KRS 342.035.

15 Section 3. Application.

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

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

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

1 (4) Treatment designated as “Recommended” under the guidelines shall be
2 ~~[Treatment recommended in the guidelines is]~~ presumed ~~[to be]~~ reasonable and necessary and
3 shall not require preauthorization. This presumption shall apply to utilization review and in the
4 resolution of medical disputes~~[, and]~~. This presumption shall be rebuttable only by clear and
5 convincing evidence.

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

12 (6) ~~[(5)]~~ Treatment designated as “Not Recommended” under the guidelines
13 ~~[Treatment not recommended]~~ or not addressed in the guidelines shall require preauthorization.

14 (7) ~~[(6)]~~ The employer shall not be responsible for payment of medical treatment
15 designated as “Not Recommended” under the guidelines ~~[not recommended]~~ or not addressed
16 in the treatment guidelines unless it was provided in a medical emergency; was authorized by the
17 medical payment obligor ~~[employer]~~; or was approved through the dispute resolution process by
18 an administrative law judge.

19 (8) ~~[(7)]~~ Medical providers proposing treatment designated as “Not Recommended”
20 under the guidelines ~~[not recommended]~~ or not addressed in the treatment guidelines shall
21 articulate in writing sound medical reasoning for the proposed treatment, which may include:

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

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

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

7 **(9) [(8)] Sound medical reasoning furnished by a medical provider shall be considered**
8 **before preauthorization of treatment may be denied. [Before an employer denies**
9 **preauthorization of treatment not recommended or not addressed in the treatment**
10 **guidelines, it must consider any sound medical reasoning furnished by the medical provider.]**

11 **(10) [(9)] The treatment guidelines are not intended to establish a standard for determining**
12 **professional liability. The guidelines are not a standard or mandate. Exceptions to and the**
13 **proper application of the guidelines require assessment of each individual course of**
14 **treatment.**

15 **(11) [(10)] The pharmaceutical formulary adopted in 803 KAR 25:270 shall be part of the**
16 **medical treatment guidelines.**

17 **(12) [(11)] Maximum medical improvement shall not preclude the provision of medical**
18 **treatment necessary for the cure and relief from the effects of an injury or occupational disease if**
19 **the treatment is medically necessary to maintain function at the maximum medical improvement**
20 **level or to improve function following an exacerbation of the injured employee's condition.**

21 Section 4. Preauthorization.

1 (1) Requests for preauthorization shall be subject to utilization review unless the medical
2 payment obligor ~~[employer]~~ waives utilization review. The failure of a medical payment
3 obligor to comply with the time requirements in 803 KAR 25:190 section 5 (2) and (3) may
4 result in sanctions.

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

10 (3) If the medical payment obligor ~~[carrier]~~ denies preauthorization following utilization
11 review, it shall issue a written notice of denial as required by 803 KAR 25:190 section 7. The
12 ~~[the]~~ medical provider whose recommendation for treatment is denied may request
13 reconsideration, and may require the reconsideration ~~[of the denial to]~~ include a peer-to-peer
14 conference with a second utilization review physician. The request for a peer-to-peer conference
15 shall be made by electronic communication and shall provide:

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

17 (b) A date or dates for the conference not less than five (5) business days after the date of
18 the request; and

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

1 (4) The reviewing physician participating in the [The] peer-to-peer conference must be
2 ~~[conducted by a physician]~~ of the same specialty as the medical provider requesting
3 reconsideration.

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

13 (6) ~~[Pursuant to 803 KAR 25:190 section 8(1)(c), a]~~ A written reconsideration decision
14 shall be rendered within five (5) business days of date of the peer-to-peer conference. The written
15 decision shall be entitled "FINAL UTILIZATION REVIEW DECISION."

16 (7) If a Final Utilization Review Decision is rendered denying authorization for treatment
17 before an award has been entered by or agreement approved by an administrative law judge, the
18 requesting medical provider or the injured employee may file a medical dispute pursuant to 803
19 KAR 25:012. If a Final Utilization Review Decision is rendered denying authorization for
20 treatment after an award has been entered by or agreement approved by an administrative law
21 judge, the employer shall file a medical dispute pursuant to 803 KAR 25:012.

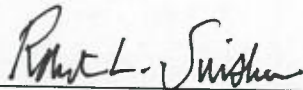
1 ~~[(8) The employer shall not be required to file a medical dispute pursuant to 803 KAR~~
2 ~~25:012, Section 1(6), to challenge a statement for services for treatment not recommended or~~
3 ~~not addressed by the guidelines when preauthorization was not requested. If the basis for~~
4 ~~denial of a statement for services is that the treatment was not recommended or not~~
5 ~~addressed in the guidelines, the insurance carrier shall provide notice to the employee and~~
6 ~~medical provider of the denial and the basis for the denial.]~~

7 (8) [(9)] Pursuant to KRS 342.285(1), a decision of an administrative law judge on a
8 medical dispute is subject to review by the workers' compensation board under the procedures set
9 out in 803 KAR 25:010 §22.

10 Section 5. Effective Dates.

11 (1) The treatment guidelines apply to all treatment administered on and after September
12 [July] 1, 2020.

This is to certify that the commissioner has reviewed and recommended this administrative regulation prior to its adoption, as required by KRS 342.260 and 342.035.



Robert L. Swisher, Commissioner
Department of Workers' Claims

1/15/20

Date

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation No.: 803 KAR 25:260

Contact person: B. Dale Hamblin, Jr.
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Phone number: (502) 782-4404

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation adopts treatment guidelines for treatment provided for the cure of and relief of a work injury or occupational disease and provides guidance for its implementation and use.

(b) The necessity of this administrative regulation: KRS 342.035(8) requires the commissioner to develop or adopt treatment guidelines and promulgate an administrative regulation to implement the treatment guidelines.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 342.035 requires the commissioner to develop or adopt treatment guidelines for the cure of and relief of a work injury or occupational disease and to promulgate an administrative regulation to implement the treatment guidelines.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: KRS 342.020 provides an employer is responsible to pay for the cure and relief from the effects of an injury or occupational disease as may reasonably be required at the time of injury and thereafter during disability or as may be required for the cure and treatment of an occupational disease. KRS 342.035 requires the commissioner to develop or adopt treatment guidelines for the cure of and relief of a work injury or occupational disease. This administrative regulation provides guidance to the employee and employer with respect to the treatment guidelines.

(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: N/A
- (b) The necessity of the amendment to this administrative regulation: N/A
- (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: All injured employees, physicians and medical providers providing services to injured workers pursuant to KRS Chapter 342, insurance carriers, self-insurance groups, self-insured employers, insured employers, and third party administrators.

(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: Physicians and medical providers are required to use the treatment guidelines adopted by the commissioner. Employers and their payment obligors will apply the treatment guidelines when reviewing and paying for treatment as required by KRS 342.020.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The cost to the payment obligors cannot be ascertained until treatment is sought and provided to the injured employee.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Injured employees are less likely to receive inappropriate treatment and more likely to receive the appropriate treatment in a more timely fashion. Employees may discover treatment is received in a more timely fashion and employers may experience a long-term reduction in medical benefit costs.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: None

(b) On a continuing basis: The cost associated with this administrative regulation is the cost of maintaining information about the treatment guidelines on the Cabinet's website.

(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 needed 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 or increase any fees.

(9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied; the regulation applies to all parties equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation No.: 803 KAR 25:260

Contact Person: B. Dale Hamblin, Jr.
dale.hamblin@ky.gov

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 agencies or departments 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, 342.260, 342.265, 342.275.

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. There should be no direct effect on expenditures.

(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? No revenue will be generated.

(c) How much will it cost to administer this program for the first year? The cost of maintaining information about the treatment guidelines on the Cabinet's website is nominal.

(d) How much will it cost to administer this program for subsequent years? Other than the cost to maintain information about the treatment guidelines on the Cabinet's website, it does not appear there will be additional costs.

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: It is possible the application of the treatment guidelines will cause treatment costs to stabilize or reduce, providing a reduction of costs to the workers' compensation system as a whole.

STATEMENT OF CONSIDERATION
RELATING to 803 KAR 25:260

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

I. The public hearing on 803 KAR 25:260, scheduled for November 21, 2019, at 10:30 a.m., at the Department of Workers' Claims, 657 Chamberlin Avenue, Frankfort, Kentucky, was held by Commissioner Robert L. Swisher. Seven (7) public comments were made at the hearing. Eight (8) written comments were received during the public comment period.

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

- (a) Eric Lamb, Lamb & Lamb, PSC
- (b) Adam Fowler, Senior Policy Analyst, Optum Workers' Comp and Auto No-Fault
- (c) Ken Eichler, Vice President of Government Affairs, MCG Health and ODG
- (d) Rosalie Faris, Occupational Managed Care Alliance
- (e) Kate Shanks, Kentucky Chamber
- (f) Lisa Anne Bickford, Director, Government Relations, Coventry
- (g) Nate Myszka, Senior Manager, State Government Affairs, Medtronic
- (h) Scott M. Brown, Legal Manager, Kentucky Employers' Mutual Insurance
- (i) Julian Roberts, President, American Association of Payers Administrators and Networks (AAPAN)
- (j) Bill Londrigan, President, Kentucky State AFL-CIO
- (k) Peter J. Naake, President, Kentucky Workers' Association
- (l) Christopher Evenson, Vice President, Kentucky Workers' Association
- (m) Stephanie Wolfinbarger, Treasurer, Kentucky Workers' Association

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

- (1) Robert L. Swisher, 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: (Disclaimer)

(a) Comment: Peter Naake - The administrative regulation should include a disclaimer that the guidelines are not rules for how a physician must treat a patient but information to assist physicians in obtaining payment for services in workers' compensation claims.

(b) Response: The administrative regulation was revised to state the guidelines are not a standard or mandate and that application of the guidelines requires assessment of each individual course of treatment.

(2) SUBJECT MATTER: (Guidelines Terminology)

(a) Comment: Peter Naake - The regulation does not use the specific treatment designations used by the guidelines; specifically, Recommended, Conditionally Recommended, and Not Recommended.

(b) Response: The administrative regulation was amended to address and reference the designations of "Recommended," "Conditionally Recommended," and "Not Recommended." The administrative regulation was further amended to make clear the designations were not necessarily dispositive; rather, sound medical reasoning must be addressed before treatment may be denied.

(3) SUBJECT MATTER: (Deference to Treating Physician)

(a) Comment: Peter Naake - The comment asserted deference should be given to the recommendation of the treating physician over mechanical recommendations of the guidelines; the guidelines should be a tool for medical providers to obtain approval and payment not a tool to more easily deny proposed medical treatment.

(b) Response: The administrative regulation was amended to make clear that all sound medical reasoning must be considered and addressed by a reviewing physician; further, the administrative regulation was amended to more clearly state the treatment guidelines are not a standard or mandate.

(4) SUBJECT MATTER: (Approval of Medical Treatment)

(a) Comment: Peter Naake - The guidelines should be used to rule out treatment with a low probability of success but should also require treatment be approved and paid through the

workers compensation system if the treating physician recommends treatment using the physician's medical judgment which considers the unique circumstances of the patient.

(b) Response: The administrative regulation was amended to make clear that all sound medical reasoning must be considered and addressed by a reviewing physician; further, the administrative regulation was amended to more clearly state the treatment guidelines are not a standard or mandate.

(5) **SUBJECT MATTER: (Authorization of Conditionally Recommended Treatment)**

(a) Comment: Peter Naake - The regulations should require authorization of the treatment recommended by the treating physician if the designation for that treatment is conditionally recommended unless it is shown the treatment fails most or all of the guidelines criteria.

(b) Response: The administrative regulation was amended to speak directly to the designations of "Recommended," "Conditionally Recommended," and "Not Recommended." The administrative regulation was further amended to make clear the designations were not necessarily dispositive; rather, all sound medical reasoning must be considered and addressed by a reviewing physician. Additionally, the administrative regulation was amended to more clearly state the treatment guidelines are not a standard or mandate but each individual course of treatment requires assessment.

(6) **SUBJECT MATTER: (The Employer Should Bear Full Cost of Medical Disputes)**

(a) Comment: Peter Naake - The Kentucky workers compensation system is unfair because of the inability of an injured employee to obtain legal representation when the issue is solely a medical expense; this inequity is created due to the employee's lack of funds to compensate an attorney. This is long been a problem and the Kentucky workers compensation system. The employer should be required to bear the full cost of medical disputes, including attorney fees and costs incurred by the employee, when the cost of litigation exceeds the cost of the medical expense being disputed.

(b) Response: The action urged by this comment is beyond the scope of this administrative regulation and KRS 342.035(8)(a), which required this administrative regulation be promulgated.

(7) **SUBJECT MATTER: (Payment for Medical Treatment)**

(a) Comment: Peter Naake - The comment asserted section 4 subsection 8 of the proposed regulation purported to relieve the employer of the obligation to pay for medical treatment, or in the alternative reopen the claim, where statement for services is "not recommended or addressed by the guidelines," and where preauthorization has not been requested. The comment asserts that this provision is contrary to KRS 342.020 and case law. Thus, the comment asserts the

proposed regulation seeks to overturn well-established state of the law and exceeds the statutory authority provided in KRS 342.035.

(b) Response: Section 4, subsection 8, of the administrative regulation has been deleted.

(8) SUBJECT MATTER: (Treatment Guidelines Will Cause Delayed or Denied Treatment)

(a) Comment: Bill Londrigan - The adoption of treatment guidelines will cause many Kentucky employees to be denied treatment or have treatment delayed, possibly causing "irremediable" harm.

(b) Response: This comment is beyond the scope of this administrative regulation. The purpose of the treatment guidelines is to expedite timely and appropriate medical care. KRS 342.035(8)(a) required the Commissioner to "develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before December 31, 2019." The process of considering and adopting treatment guidelines and the administrative framework for implementing the guidelines has been ongoing since May, 2018. This administrative regulation is a result of those discussions.

(9) SUBJECT MATTER: (Treatment Guidelines May Delay Treatment)

(a) Comment: Bill Londrigan - The comment asserted that some physicians on the Commissioner's medical advisory committee expressed concern that the treatment guidelines may delay treatment and subvert healthcare determinations of the treating physician.

(b) Response: KRS 342.035(8)(a) required the Commissioner to "develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before December 31, 2019." The process of considering and adopting treatment guidelines and the administrative framework for implementing the guidelines has been ongoing since May, 2018. This administrative regulation is a result of those discussions. The provision regarding direct peer-to-peer conferences was added to address those concerns.

(10) SUBJECT MATTER: (Cost Reduction From Use of Treatment Guidelines)

(a) Comment: Bill Londrigan - The comment asserted that the savings obtained for insurance companies by adopting treatment guidelines will be as a result of the reduction of treatment to injured employees.

(b) Response: The action urged by this comment is beyond the scope of this administrative regulation and KRS 342.035(8)(a), which required this administrative regulation be promulgated. There is no evidence to support the proposition that implementing treatment guidelines will result in a reduction of timely and appropriate medical to injured employee.

(11) SUBJECT MATTER: (Medical Dispute Issues)

(a) Comment: Bill Londrigan - The comment asserted the Department of Workers' Claims needed to hear more testimony from injured employees who have been denied treatment; there is a need for information to determine the extent of the problem with medical disputes.

(b) Response: The action urged by this comment is beyond the scope of this administrative regulation. KRS 342.035(8)(a) required the Commissioner to "develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before December 31, 2019." The process of considering and adopting treatment guidelines and the administrative framework for implementing the guidelines has been ongoing since May, 2018. A public hearing was held on November 21, 2019. Adequate opportunity has been provided to discuss the subject of this comment and to hear any concerns.

(12) SUBJECT MATTER: (Application of Treatment Guidelines)

(a) Comment: Bill Londrigan - The comment stated there will be confusion and difficulty effectively applying the treatment guidelines uniformly.

(b) Response: The action urged by this comment is beyond the scope of this administrative regulation. KRS 342.035(8)(a) required the Commissioner to "develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before December 31, 2019." The Department of Workers' Claims believes the guidelines will reduce conflict between medical providers and medical payment obligors by identifying evidence-based best medical practices. The guidelines are presented in a format that is both clear in content and simple to navigate.

(13) SUBJECT MATTER: (Treatment Guidelines Will Increase Litigation)

(a) Comment: Bill Londrigan - The comment asserted that treatment guidelines will increase the need for litigation, not reduce it.

(b) Response: KRS 342.035(8)(a) required the Commissioner to "develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before

December 31, 2019.” The process of considering and adopting treatment guidelines and the administrative framework for implementing the guidelines has been ongoing since May, 2018. This administrative regulation is a result of those discussions. The Department anticipates the treatment guidelines will ultimately reduce the number of medical disputes.

(14) **SUBJECT MATTER:** (Treatment Guidelines Will Not Return Employees to Gainful Employment)

(a) Comment: Bill Londrigan - The comment asserted the adoption of treatment guidelines will not achieve the restoration of injured employees to gainful employment.

(b) Response: The Department anticipates timely delivery of appropriate medical treatment, as a result of the treatment guidelines, will expedite the return of injured employees to gainful employment.

(15) **SUBJECT MATTER:** (There Was No Need For Treatment Guidelines)

(a) Comment: Bill Londrigan - The comment asserted the Department of Workers’ Claims already has a system to decide reasonableness and necessity of medical treatment, inferring there was no need for treatment guidelines.

(b) Response: KRS 342.035(8)(a) required the Commissioner to “develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before December 31, 2019.” The process of considering and adopting treatment guidelines and the administrative framework for implementing the guidelines has been ongoing since May, 2018. A public hearing was held on November 21, 2019. This administrative regulation is a result of those discussions. Adoption of the treatment guidelines will enhance the Department’s ability to resolve medical disputes.

(16) **SUBJECT MATTER:** (The Opioid Epidemic Was Not a Reason to Implement Treatment Guidelines)

(a) Comment: Bill Londrigan - The comment asserted the opioid epidemic was not a reason to adopt the proposed regulation because Kentucky has experienced the largest reduction in work – related injury opioid prescriptions among a group of surveyed states.

(b) Response: KRS 342.035(8)(a) required the Commissioner to “develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before December 31, 2019.” This administrative regulation is a result of that legislative mandate.

(17) **SUBJECT MATTER:** (The Administrative Regulation Did Not Create a Medical Director Position)

(a) **Comment:** Bill Londrigan - The comment opposed adoption of the proposed regulation because it did not provide for a medical director program and a staff to resolve medical treatment and prescription disputes.

(b) **Response:** The Department does not oppose the creation of a medical director position; however, the creation of that position and the establishment of the duties associated with that position are beyond the scope of this administrative regulation.

(18) **SUBJECT MATTER:** (Medical Director Position)

(a) **Comment:** Bill Londrigan - The comment requested information related to the Department of Workers' Claims or the Labor Cabinet's investigation of a possible medical director program as part of the regulation.

(b) **Response:** The Department does not oppose the creation of a medical director position; however, the creation of that position and the establishment of the duties associated with that position are beyond the scope of this administrative regulation.

(19) **SUBJECT MATTER:** (Request For Information Regarding Medical Disputed and Utilization Review)

(a) **Comment:** Bill Londrigan - The comment requested information related to medical disputes filed and utilization review denied in the last five years.

(b) **Response:** The Department is investigating whether this information is available; if so, it will be provided.

(20) **SUBJECT MATTER:** (Medical Director Position)

(a) **Comment:** Bill Londrigan - The comment asserted the Department of Workers' Claims needed a monitoring program to acquire medical director statistics which would reflect the types of treatment issues challenged, the resolution reached, and any penalties to be assessed.

(b) **Response:** The Department does not oppose the creation of a medical director position; however, the creation of that position and the establishment of the duties associated with that position are beyond the scope of this administrative regulation.

(21) **SUBJECT MATTER:** (Treatment Designations)

(a) **Comment:** Bill Londrigan - The comment asserted that treatment recommended under the guidelines is "approved." However, if the treatment is "not recommended" or "not discussed" the treatment is then "denied" under the guidelines. The comment further asserts that section 3 subsection 5 of the proposed regulation requires preauthorization regardless of the treatment or prescription, which delays treatment and prescription benefits to injured employees.

(b) Response: The administrative regulation was amended to speak directly to the designations of "Recommended," "Conditionally Recommended," and "Not Recommended." The administrative regulation was further amended to make clear the designations were not necessarily dispositive; rather, sound medical reasoning must be addressed before treatment may be denied. Requesting preauthorization of treatment designated as "Not Recommended" does not constitute denial of that treatment but means sound medical reasoning must be provided to support the treatment.

(22) **SUBJECT MATTER: (Timelines For Preauthorization Reviews and Penalties For Failing to Meet Those Timelines)**

(a) Comment: Bill Londrigan - The comment asserts the regulation fails to set strict timelines for reviews of preauthorization requests and fails to establish penalties when the timelines are not met.

(b) Response: The administrative regulation was amended to make clear the time constraints provided in existing related statutes and regulations, specifically, 803 KAR 25:190, which pertains to the utilization review process, are applicable and the failure to meet those time constraints may result in sanctions.

(23) **SUBJECT MATTER: (Creation of a Standard Form For Preauthorization)**

(a) Comment: Bill Londrigan - The comment asserted the proposed regulation did not include a standard form for preauthorization requests but should do so.

(b) Response: Many medical providers use forms which they have created; requiring these providers to use a form developed by the Department of Workers' Claims would appear to add to the provider's burden rather than reduce it. Should the development of a uniform form prove beneficial over time, this idea can be revisited. As such, the administrative regulation was not revised in response to this comment.

(24) **SUBJECT MATTER: (Timelines For Preauthorization Reviews and Penalties For Failing to Meet Those Timelines)**

(a) Comment: Bill Londrigan - The comment asserted physicians will receive delayed payment and, therefore, cease to treat injured employees because the proposed regulation does not contain strict timelines.

(b) Response: The administrative regulation was amended to make clear the time constraints provided in existing related statutes and regulations, specifically, 803 KAR 25:190, which pertains to the utilization review process, are applicable and the failure to meet those time constraints may result in sanctions.

(25) **SUBJECT MATTER: (Treatment Guidelines Create Burden on Medical Providers)**

(a) Comment: Bill Londrigan - The comment asserted the guidelines placed the burden on treatment providers to purchase access to the ODG treatment guidelines and then scour the guidelines to discover which treatment is recommended, creating "a burden to provide more."

(b) Response: The action urged by this comment is beyond the scope of this administrative regulation. KRS 342.035(8)(a) required the Commissioner to "develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before December 31, 2019." The process of considering and adopting treatment guidelines and the administrative framework for implementing the guidelines has been ongoing since May, 2018. This administrative regulation is a result of those discussions. The Department believes the treatment guidelines will ultimately reduce the burden on treatment providers.

(26) SUBJECT MATTER: (Treatment Not to Be Denied Solely Because of Guidelines Designations - Written Reasons for Denial)

(a) Comment: Bill Londrigan - The comment asserted that specific revisions be made to the proposed regulation: (a) clarify that treatment may not be denied solely based upon that treatment not being recommended or addressed in the guidelines and (B) require insurance carriers to clearly and thoroughly articulate the reason for a denial.

(b) Response: The administrative regulation was amended to make clear the guidelines could not be the basis for a denial; rather, all sound medical reasoning must be addressed before treatment may be denied. The administrative regulation was amended to make clear the written notice provisions of 803 KAR 25:190 were applicable.

(27) SUBJECT MATTER: (Who Has the Burden to File Medical Disputes)

(a) Comment: Bill Londrigan - The comment asserts that section 4 subsection 7 of the administrative regulation shifted the burden for medical disputes to injured employees, which will result in a denial or delayed of treatment.

(b) Response: This provision of the administrative regulation does not change the current state of the law regarding which party has the burden to file pre-award or post-award medical disputes.

(28) SUBJECT MATTER: (Inability of Injured Employees to Pay Attorney)

(a) Comment: Bill Londrigan - The comment asserted injured employees will not pursue formal medical disputes because they cannot afford an attorney; further, most rural counties do not have attorneys who handle workers compensation claims.

(b) Response: The comment is not germane to and is beyond the scope of this administrative regulation. KRS 342.035(8)(a) required the Commissioner to "develop or adopt

practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers . . . and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidence-based treatment guidelines on or before December 31, 2019.” The process of considering and adopting treatment guidelines and the administrative framework for implementing the guidelines has been ongoing since May, 2018. A public hearing was held on November 21, 2019. This administrative regulation is a result of those discussions.

(29) SUBJECT MATTER: (Utilization Review Without Preauthorization)

(a) Comment: Bill Londrigan - The comment asserted that section 8 of the proposed regulation relieves insurance companies of utilization review requirements if the treatment provider fails to seek preauthorization, which would then result in denial or delayed treatment.

(b) Response: It appears this comment refers to section 4, subsection 8, of the administrative regulation; this subsection has been deleted.

(30) SUBJECT MATTER: (Utilization Review Without Preauthorization)

(a) Comment: Julian Roberts - The comment supports the regulation but asserts that two business days in which to notify an employee and medical provider of a denial, as required by section 4 subsection 8 of the proposed regulation, is not sufficient time. The comment request the regulation be a revised to allow at least 10 days in which to make the notification.

(b) Response: The administrative regulation was amended to remove the subsection containing the response time.

(31) SUBJECT MATTER: (Utilization Review Without Preauthorization)

(a) Comment: Scott Brown - The comment supports the proposed regulation but requests a revision to section 4 subsection 8; specifically that a medical payment obligor be allowed 30 days in which to notify an employee and medical provider of a denial when the medical provider failed to seek preauthorization.

(b) Response: The administrative regulation was amended to remove the subsection containing the response time.

(32) SUBJECT MATTER: (Utilization Review Without Preauthorization)

(a) Comment: Adam Fowler - The comment supported the proposed regulation but requested a revision to section 4 subsection 8; specifically, the comment requested the proposed regulation be revised to allow either 10 days or 30 days in which to notify an employee and medical provider of a denial when the medical provider failed to seek preauthorization.

(b) Response: The administrative regulation was amended to remove the subsection containing the response time.

(33) **SUBJECT MATTER:** (Treatment Guidelines Updates – Treatment Not to Be Denied Solely Because of Guidelines Designations - Written Reasons for Denial)

(a) Comment: Nate Myszka - The comment supported the proposed regulation but requested the following revisions: (a) the comment sought revision to the language found in section 2 subsection 2 of the administrative regulation, which adopted the current edition in any future published updates of the ODG treatment guidelines published by MCG Health. The comment urged that a formal and regular rulemaking process occur in order to allow for public comment and to formalize consultation with the department of workers claims medical advisory committee as part of the proposed rulemaking process; (b) the comment requested a revision to section 3 subsection 8 of the administrative regulation and section 4 subsection 8 of the administrative regulation to clarify that treatment cannot be denied solely because the treatment guidelines do not recommend or address the therapy; and (c) the comment urged revision to section 4 subsections 2 and 3 of the administrative regulation to clarify that insurance carriers must articulate in writing the reasoning behind a denial.

(b) Response: The administrative regulation was amended to delete the phrase “the current edition and any future updates of” the ODG treatment guidelines. The administrative regulation was amended to make clear the guidelines cannot be the sole basis upon which treatment is denied when the treating medical provider offers sound medical reasoning in support of an exception to the guidelines; rather, all sound medical reasoning must be addressed before treatment may be denied. The administrative regulation requires the Commissioner to review the treatment guidelines not less than annually and update or amend the administrative regulation, if necessary, to ensure the guidelines are consistent with the provisions of KRS 342.020 and KRS 342.035.

(34) **SUBJECT MATTER:** (Supported Administrative Regulation as Filed)

(a) Comment: Kate Shanks - The comment supported the proposed administrative regulation as filed.

(b) Response: No revisions were made as a result of this comment.

(35) **SUBJECT MATTER:** (Conditionally Recommended)

(a) Comment: Eric Lamb - The comment sought the addition of a new section in the proposed regulation which would require authorization of treatment recommended by the treating physician if the proposed treatment was designated “Conditionally Recommended” under the guidelines and the injured employee substantially met the criteria provided in the guidelines for that treatment. The comment further requested inclusion of a definition of the term “substantially,” which would not require strict compliance with each conditionally recommended criterion; rather, it would mean substantially meeting the criteria the treating physician believed was necessary when exercising the physician’s sound medical reasoning.

(b) Response: The administrative regulation was amended to further clarify that the failure to meet all conditions precedent for a given treatment did not provide a basis upon which

treatment may be denied; rather, before treatment constituting an exception to the guidelines may be denied, all sound medical reasoning must be considered and addressed.

(36) SUBJECT MATTER: (Utilization Review Without Preauthorization)

(a) Comment: Eric Lamb - The comment requested that the first sentence of section 8 of the proposed treatment guidelines be deleted.

(b) Response: It appears this comment refers to section 4, subsection 8, of the administrative regulation; this subsection has been deleted.

(37) SUBJECT MATTER: (Medical Fee Disputes)

(a) Comment: Eric Lamb - The comment urged a new section be added to the proposed regulation which would establish circumstances under which the filing of a medical fee dispute would be considered unreasonable.

(b) Response: This comment is beyond the scope of this administrative regulation. The process for resolving medical disputes is in 803 KAR 25:012. The administrative regulation was amended to make clear administrative law judges have the authority and ability to levy sanctions when warranted by a party's behavior, including the failure to comply with time requirements.

(38) SUBJECT MATTER: (Medical Fee Disputes)

(a) Comment: Eric Lamb - The comment urged the addition of a new section which would establish when the filing of a medical fee dispute would be considered unreasonable for the purposes of KRS 342.310; specifically, (a) when there is a denial of a routine low risk procedure which is generally performed by competent physicians and which is consistent with the treatment recommended, conditionally recommended, or not addressed by the treatment guidelines; (b) when the utilization reviewer has a consistent pattern of opposing treatment which is ultimately found to be consistent with what is recommended or conditionally recommended under the treatment guidelines.

(b) Response: This comment is beyond the scope of this administrative regulation. The process for resolving medical disputes is in 803 KAR 25:012. The administrative regulation was amended to make clear administrative law judges have the authority and ability to levy sanctions when warranted by a party's behavior, including the failure to comply with time requirements.

(39) SUBJECT MATTER: (Interlocutory Relief)

(a) Comment: Eric Lamb - The comment urged that 803 KAR 25:010 section 12(2)(e) be modified so that when a request for interlocutory relief is denied, the matter is not referred to the Commissioner for reassignment of the claim to another administrative law judge for resolution of the dispute. Similarly, the comment urged that 803 KAR 25:010 section 12 (3)(a) be modified so that when a motion for interlocutory relief is filed after claim has been assigned to an

administrative law judge it should not be referred to the Commissioner for assignment to another administrative law judge for the purpose of considering the request for interlocutory relief.

(b) Response: The action urged by this comment addressed the subject of interlocutory relief and is beyond the scope of this administrative regulation and KRS 342.035(8)(a), which required this administrative regulation be promulgated. The Department of Workers' Claims is currently reviewing the possibility of revision to 803 KAR 25:010 section 12 regarding interlocutory relief.

(40) SUBJECT MATTER: (Medical Fee Disputes)

(a) Comment: Eric Lamb - The comment urged that 803 KAR 25:240 section 6 be modified to provide that records must be kept of the opinions of medical examiners and utilization reviewers, the amounts paid to those medical examiners and utilization reviewers, and the opinions provided by those medical examiners and utilization reviewers, for a period of two years. The comment would urge this data be available for consideration by an administrative law judge when ruling on whether a medical fee dispute was unreasonable and for the purpose of ruling on whether there has been an unfair claims settlement practice.

(b) Response: The action urged by this comment is beyond the scope of this administrative regulation and KRS 342.035(8)(a), which required this administrative regulation be promulgated.

(41) SUBJECT MATTER: (Purpose of Treatment Guidelines)

(a) Comment: Eric Lamb - The comment urged the Department of Workers' Claims to include a provision which would clarify it was not the Department's purpose in promulgating the medical treatment guidelines to change the burden of proof or standard of proof. Further, that the administrative law judge is not bound by the treatment practice guidelines in determining whether treatment is outside of the standard of care for the treatment of a patient in a the relevant medical community. Additionally, the comment urged inclusion of a provision stating an employer may be relieved of its obligation to pay for proposed medical treatment only if it can prove the treatment will be unproductive or outside the type of treatment generally accepted by medical professionals as reasonable in the injury employee's particular case.

(b) Response: The administrative regulation was amended to make clear that all sound medical reasoning must be considered and addressed by a reviewing physician; further, the administrative regulation was amended to more clearly state the treatment guidelines were not a standard or mandate. A provision alleged to shift the burden of proof has been deleted from the administrative regulation.

(42) SUBJECT MATTER: (Deference to Treating Physician)

(a) Comment: Eric Lamb - The comment urged a provision stating that deference should be given to the recommendation of a treating physician.

(b) Response: The administrative regulation was amended to make clear that all sound medical reasoning must be considered and addressed by a reviewing physician; further, the administrative regulation was amended to more clearly state the treatment guidelines were not a standard or mandate.

(43) SUBJECT MATTER: (Attorney Fees)

(a) Comment: Eric Lamb - The comment urged a provision that would provide attorney fee reimbursement to an injured employee when the employer's opposition to the medical treatment was unreasonable.

(b) Response: The administrative regulation was amended to make clear administrative law judges have the authority and ability to levy sanctions when warranted by a party's behavior, including the failure to comply with time requirements. Otherwise, the subject of this comment is beyond the scope of this administrative regulation.

(44) SUBJECT MATTER: (Medical Fee Disputes)

(a) Comment: Eric Lamb - The comment urged inclusion of a provision which would identify circumstances under which an employer would be presumed to be acting unreasonably in a medical fee dispute proceeding.

(b) Response: The administrative regulation was amended to make clear administrative law judges have the authority and ability to levy sanctions when warranted by a party's behavior, including the failure to comply with time requirements. Otherwise, the subject of this comment is beyond the scope of this administrative regulation. The process for resolving medical disputes is addressed in 803 KAR 25:012.

(45) SUBJECT MATTER: (Attorney Fees)

(a) Comment: Chris Evensen - The comment alleged the guidelines will be used to determine whether or not someone receives medical treatment. The comment further alleged there was an inequity in the Kentucky workers compensation system; specifically, injured employees cannot always afford attorneys. As such, the comment urged the inclusion of a provision identifying circumstances under which attorney fees would be paid.

(b) Response: The administrative regulation was amended to make clear administrative law judges have the authority and ability to levy sanctions when warranted by a party's behavior, including the failure to comply with time requirements. Otherwise, the subject of this comment is beyond the scope of this administrative regulation. The process for resolving medical disputes is addressed in 803 KAR 25:012.

(46) SUBJECT MATTER: (Supported the Administrative Regulation)

(a) Comment: Brian Allen - The comment supported the treatment guidelines and the regulation as filed. The comment asserted the treatment guidelines would be a valuable tool to guide appropriate care and make it easier for employees to navigate.

(b) Response: No revisions were made as a result of this comment.

(47) SUBJECT MATTER: (Utilization Review Without Preauthorization)

(a) Comment: Brian Allen - The comment noted that when a bill was presented for treatment already provided but for which preauthorization had not been sought, it would take longer than two days to review and respond to the billing. The comment suggested either a 10 day period or a 30 day period.

(b) Response: The administrative regulation was amended to remove the subsection containing the response time.

(48) SUBJECT MATTER: (Supported the Administrative Regulation)

(a) Comment: Rosalie Faris - The comment supported the administrative regulation as filed and, further, expressed approval that the Commissioner selected ODG as the treatment guideline. The comment stated treatment guidelines would speed up the process for approvals and allow physicians to know the steps required to receive rapid treatment approvals and payment rather than having to guess at a specific medical payment obligor's requirements for approval and payment. The comment further stated that, as a business conducting utilization review, it currently utilized ODG guidelines when reviewing treatment and payment requests under group medical insurance as well as workers compensation. Additionally, the comment stated every medical insurance carrier utilized a treatment guideline of some type; this administrative regulation ensures that all payment obligors will now use the same guideline when assessing preauthorization requests and bills.

(b) Response: No revisions were made as a result of this comment.

(49) SUBJECT MATTER: (Utilization Review Without Preauthorization)

(a) Comment: Rosalie Faris - The comment noted that when a bill was presented for payment, it meant the treatment had already been provided; thus, when a bill is presented for treatment without prior authorization for the treatment, a two day period in which to respond to the bill was unnecessarily short and was overly difficult to meet. The comment urged a revision to the administrative regulation which would allow a 10 day period during which the medical payment obligor could respond in that circumstance.

(b) Response: The administrative regulation was amended to remove the subsection containing the response time.

(50) SUBJECT MATTER: (Supported the Administrative Regulation - Utilization Review Without Preauthorization)

(a) Comment: Melissa Stevens - The comment was in support of the treatment guidelines and opined that the treatment guidelines were not meant to allow insurance carriers to deny claims and deny bills; rather, it was to allow a parameter in which to ensure that injured employees were getting appropriate care. The comment further requested a revision to allow a 10 or 30 day timeframe during which a medical payment obligor may respond to a bill presented for payment when preauthorization had not been sought for the treatment.

(b) Response: The administrative regulation was amended to remove the subsection containing the response time.

(51) SUBJECT MATTER: (Guidelines Designations)

(a) Comment: Melissa Stevens - The comment opined the designation "conditionally recommended" under the treatment guidelines simply allowed a doctor to individually tailor care for an injured employee and that employee's condition but did not constitute a basis to deny treatment, nor did the proposed administrative regulation create a circumstance which would allow the treatment guidelines be used as a basis to deny treatment.

(b) Response: The administrative regulation was amended to further clarify that the failure to meet all conditions precedent for a given treatment did not provide a basis upon which treatment may be denied; rather, before treatment may be denied, all sound medical reasoning must be addressed.

(52) SUBJECT MATTER: (Supported the Administrative Regulation)

(a) Comment: Ken Eichler -The comment was in support of the proposed administrative regulation as filed. The comment opined that the process used to develop the proposed regulation was transparent with an opportunity for all stakeholders to have a voice, to have their opinions heard, and to have those opinions seriously considered. The comment further opined that any tool can be used for good or evil. The comment stated that treatment guidelines have proven to be a tool for expediting authorization of care, expediting the delivery of care and improved outcomes for injured employees by actually decreasing obstacles to treatments; the guidelines provide a roadmap to receive authorization and treatment. The comment stated that the treatment guidelines were a tool for utilization review and authorization and not an attempt to direct the care provided by physicians; physicians are to make medical decisions regarding treatment. The comment stated that when treatment guidelines were implemented in other states there was a small learning curve but after implementation, and once individuals understand the process and procedures, it served to facilitate, expedite, and improve outcomes for injured employees.

(b) Response: No revisions were made in response to this comment.

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 1

Necessity, Form, and Conformity.

Line 14

After “. . . guidance to implement them.”, insert “This administrative regulation does not abrogate the right of the injured employee to choose his treating physician as provided in KRS 342.020.”

Page 1

Section 1. Definitions.

Line 16

After “(1) ‘Carrier’”, insert “is defined by KRS 342.0011(6).” and delete “or ‘insurance carrier’ means any insurer authorized to insure the liability of employers arising under Chapter 342 of the Kentucky Revised Statutes, an employer authorized by the commissioner to pay directly the compensation provided in Chapter 342 of the Kentucky Revised Statutes as those liabilities are incurred, a self-insured group, and any person acting on behalf of or as an agent of the insurer, self-insured employer, or self-insured group.”.

Page 2

Section 1. Definitions.

Line 8

After “the employer’s”, insert “carrier.”.

Page 2

Section 1. Definitions.

Line 15

Insert “(7) “Insurance carrier” is defined by KRS 342.0011(22).”.

Insert a new line.

Insert “**(8)**”.

Delete “(7)”.

Page 2

Section 1. Definitions.

Line 18

Insert “**(9)**”.

Delete “(8)”.

Page 3

Section 1. Definitions.

Line 1

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

Insert a new line.

Insert “**(11)**”.

Delete “(9)”.

Page 3

Section 1. Definitions.

Line 4

Insert “**(12)**”.

Delete “(10)”.

Page 3
Section 1. Definitions.
Line 13

Insert “(13) “Physician” is defined by KRS 342.0011(32).’.

Insert new line.

Insert “(14)”.

Delete “(11)”.

Page 3
Section 1. Definitions.
Line 15

Insert “(15)”.

Delete “(12)”.

Page 3
Section 1. Definitions.
Line 16

Insert “(16)”.

Delete “(13)”.

Page 3
Section 1. Definitions.
Line 18

Insert “(17)”.

Delete “(14)”.

Page 4
Section 2. Purpose and Adoption.
Line 3

After “The commissioner adopts the” delete “current edition and any future published updates of the”.

Page 4
Section 2. Purpose and Adoption.
Line 4

After “ODG treatment guidelines” insert “as” and delete “currently”.

Page 4
Section 3. Application.
Line 14

After “(4)” insert “Treatment designated as “Recommended” under the guidelines shall be” and delete “Treatment recommended in the guidelines is”.

After “presumed” delete “to be”.

After “reasonable and necessary” insert “and shall not require preauthorization”.

Page 4
Section 3. Application.
Line 15

After “in the resolution of medical disputes” delete “, and” and insert “. This presumption”.

Page 4
Section 3. Application.
Line 17

Insert “(5) If a medical provider seeks preauthorization for treatment designated as “Conditionally Recommended” and furnishes sound medical reasoning in support of undertaking that treatment, a medical payment obligor shall consider and address that”

sound medical reasoning and shall not deny preauthorization solely on the basis that conditions precedent have not been met. The failure of a medical payment obligor to comply with the time requirements in 803 KAR 25:190 section 5 (2) and (3) may result in sanctions.”.

Insert a new line.

Insert “(6)”.

Delete “(5)”.

Delete “Treatment not recommended” before “or not addressed in the guidelines”.

Insert “Treatment designated as “Not Recommended” under the guidelines before “or not addressed in the guidelines”.

Page 4
Section 3. Application.
Line 19

Insert “(7)”.

Delete “(6)”.

After “for payment of medical treatment” insert “designated as “Not Recommended” under the guidelines” and delete “not recommended”.

Page 5
Section 3. Application.
Line 1

After “was authorized by the” insert “medical payment obligor” delete “employer”.

Page 5
Section 3. Application.
Line 3

Insert “**(8)**”.

Delete “(7)”.

After “Medical providers proposing treatment” insert “**designated as “Not Recommended” under the guidelines**” and delete “not recommended”.

Page 5

Section 3. Application.

Line 12

Insert “**(9)**”.

Delete “(8)”.

Insert “**Sound medical reasoning furnished by a medical provider shall be considered before preauthorization of treatment may be denied.**” and delete “Before an employer denies preauthorization of treatment not recommended or not addressed in the treatment guidelines, it must consider any sound medical reasoning furnished by the medical provider.”.

Page 5

Section 3. Application.

Line 15

Insert “**(10)**”.

Delete “(9)”.

Page 5

Section 3. Application.

Line 16

After "professional liability." insert "**The guidelines are not a standard or mandate.**
Exceptions to and the proper application of the guidelines require assessment of each
individual course of treatment.".

Page 5
Section 3. Application.
Line 17

Insert "**(11)**".

Delete "(10)".

Page 5
Section 3. Application.
Line 19

Insert "**(12)**".

Delete "(11)".

Page 6
Section 4. Preauthorization.
Line 4

After "subject to utilization review unless the" insert "**medical payment obligor**" and
delete "employer".

Page 6
Section 4. Preauthorization.
Line 5

After "waives utilization review." insert "The failure of a medical payment obligor to comply with the time requirements in 803 KAR 25:190 section 5 (2) and (3) may result in sanctions.".

Page 6
Section 4. Preauthorization.
Line 8

After "sound medical reasoning for treatment, the" insert "medical payment obligor" and delete "employer".

Page 6
Section 4. Preauthorization.
Line 9

After "solely on the basis that it is not" insert "designated as "Recommended" under the guidelines" and delete "recommended".

Page 6
Section 4. Preauthorization.
Line 11

After "(3) If the" insert "medical payment obligor and delete "carrier".

After "following utilization review," insert "it shall issue a written notice of denial as required by 803 KAR 25:190 section 7. The" and delete "the".

After "medical provider" insert "whose recommendation for treatment is denied".

Page 6
Section 4. Preauthorization.
Line 12

After “may request reconsideration” insert “, and may require the reconsideration” and delete “of the denial to”.

After “peer-to-peer conference with a” insert “second”.

Page 7

Section 4. Preauthorization.

Line 1

After “(4)” insert “The reviewing physician participating in the” and delete “”The”.

After “peer-to-peer conference must be” delete “conducted by a physician”.

Page 7

Section 4. Preauthorization.

Line 12

After “(6)” delete “Pursuant to 803 KAR 25:190 section 8(1)(c), a” and insert “A”.

Page 7

Section 4. Preauthorization.

Line 12

After “rendered within five (5)” insert “business”.

Page 8

Section 4. Preauthorization.

Line 1

Delete “(8) The employer shall not be required to file a medical dispute pursuant to 803 KAR 25:012, Section 1(6), to challenge a statement for services for treatment not recommended or not addressed by the guidelines when preauthorization was not requested. If the basis for denial of a statement for services is that the treatment was not recommended or not addressed in the

guidelines, the insurance carrier shall provide notice to the employee and medical provider of the denial and the basis for the denial.”.

Page 8

Section 4. Preauthorization.

Line 8

Insert “(8)”.

Delete “(9)”.

Page 8

Section 4. Preauthorization.

Line 12

After “administered on or after” insert “September” and delete “July”.