May 28, 2021

VIA EMAIL: Dale.Hamblin@ky.gov

B. Dale Hamblin, Jr.
Assistant General Counsel Department of Workers' Claims
Mayo-Underwood Building
3rd Floor 500 Mero Street
Frankfort, Kentucky 40601

Re: 803 KAR 25:190. Utilization review -- Medical Bill Audit -- Medical Director -- Appeal of Utilization Review Decisions.

Dear Mr. Hamblin:

On behalf of the Association of Claims Professionals (ACP), we are writing to comment upon the recently proposed rulemaking related to utilization review and appeals in the workers' compensation program (803 KAR 25:190). ACP and its members are concerned the proposed rule may incentivize frivolous appeals, preempt existing internal appeals processes, and add duplicate regulations on carriers and self-insured employers. There is also a concern regarding how some of the terms in the proposed rule may be defined. We urge the Department to address these concerns prior to finalizing the rule and thank the department for its time an attention to our concerns.

About ACP

ACP was formed in 2002 as the only national association representing the interests of independent claims professionals. ACP members employ thousands of claims specialists and other professionals across the country and in Kentucky and handle millions of property and casualty, workers' compensation, disability, and other liability claims annually. Membership is comprised of independent claims adjusters and third-party administrator organizations, many of whom handle claims administration responsibilities for Kentucky insureds and their carriers. ACP member companies employ dozens of adjusters in the Commonwealth.

Section 17. Appeals of Utilization Review

Most concerns that ACP and its members have regarding the proposed rulemaking involve Section 17, which details the appeals process for utilization review and share our comments on three issues: (1) potential for frivolous appeals; (2) lack of definition for "reasonable basis"; and (3) preemption of internal appeals.

1. Potential for Frivolous Appeals

The regulations fail to address what happens in situations where claimants or their physicians file non-meritorious or frivolous appeals under Section 17 of the proposed regulations. More specifically, the proposal requires the "medical payment obligor," the carriers and self-insured employers, to pay a $400 fee for each appeal by a claimant or physician of a utilization review denial within 15 calendar days of the appeal. If the "medical payment obligor" does not pay the $400 or does not meet the 15-day deadline, the presumption will be that "the denial was in error and the medical director should find accordingly." This requires the obligor to pay for the costs of every appeal, irrespective of whether the appeal had merit or was frivolously or maliciously filed by a disgruntled claimant. We object to the payment of any fee, and particularly payment of fees in non-meritorious appeals by claimants or their physicians. Further, we also object to the proposal that a "medical payment obligor" which does not pay the fee or misses the deadline could also be exposed to an "assessment of a civil penalty."

One member of ACP reviewed the number of UR decision appeals by claimants in a recent one-month period prior to the release of the rule found and identified 187 denials that would qualify under the proposed rule. This would mean the company would be obligated to pay $75,000 in fees for a single month simply to defend itself against claimant appeals. This sheer cost of fees to defend against appeals creates an outsized incentive for the "medical payment obligor" to not contest appeals, even when the appeal has no merit. In an effort to avoid the cost of defending appropriately denied medical treatment based on accepted evidence-based medical treatment guidelines adopted by the Commonwealth as the standard for making medical necessity determinations, the "medical payment obligor" may decide to forego the cost containment measures adopted by the Commonwealth and authorize all treatment regardless of whether it is consistent with medical treatment guidelines. This could be detrimental to Kentucky injured workers as inappropriate medical treatment can cause life-time disability, and in turn increase claim cost for Kentucky employers.

Moreover, while the rule provides this significant burden for the "medical payment obligor," there are no corresponding disincentives for the injured worker, treating provider or attorney to file an appeal. As such, the proposed rule incentivizes the "medical payment obligor" to avoid an appeal, and at the same time it increases the incentive for the injured worker, treating provider and attorney to appeal in the first instance. The injured worker, treating provider and attorney, facing no penalty or cost at all, are incentivized to appeal *every and any* adverse determination. This will inevitably increase the number of appeals, including both appropriate and frivolous appeals, and costs to insurers and self-insured, having nothing to do with the merits. Since there is nothing in the rule to stop or limit the filing of frivolous appeals, not only does this put the "medical payment obligor" in a position of having to deal with unnecessary appeals that could be avoided, it also puts the commonwealth's medical director in a similar position. We anticipate the inevitable backlog for the medical director.

Given the asymmetry of the incentives created by this proposal we urge the Department to reconsider the proposed rule, and re-design the appeal process in a new proposal. We suggest a greater focus on balancing the incentives and limiting frivolous appeals. One such approach would be to create a definition of frivolous appeals and create an incentive against pursuing appeals that meet that definition. ACP and its members offer our help to the Commonwealth in the creation and definition of such a policy if it decides to pursue this approach.

2. Lack of Definition for "Reasonable Basis"

Proposed new Section 17 also requires the "medical payment obligor" to cover the "employee's or physician's costs of the appeal, including reasonable attorney's fees" in cases where the medical director determines "there was no reasonable basis upon which to deny the treatment, recommended treatment, or prescribed medication, or that the medical payment obligor failed to follow the required utilization review procedure." However, Section 1 of the proposed rule, which defines the terms in the rule, does not include a definition for "reasonable basis." Thus, under the proposed rule a "medical payment obligor" must meet a standard which is not defined in the rule and if they do not meet that undefined standard they can be held financially responsible for cost that might reach into the tens of thousands of dollars. This lack of clarity is a concern for ACP and its members.

Additionally, there is confusion about what the Commonwealth is attempting to identify with the use of the phrase "no reasonable basis." The sentence in the proposed rule states that the "medical payment obligator" is responsible for the aforementioned costs and fees when there is "no reasonable basis" for the denial "or" if "the medical payment obligor failed to follow the required utilization review procedure" when it denied the appeal. This implies that there might be a circumstance in which a "medical payment obligor" is acting within the "required utilization review procedure" and denied a claim. The "no reasonable basis" standard is particularly confusing given that the Commonwealth already requires the "utilization review procedure" used by the "medical payment obligor" to be based upon an evidence-based medical treatment guideline. Stated differently, a "medical payment obligor" cannot deny a claim based on an evidence-based medical treatment guideline but also have "no reasonable basis" for denying the claim. If there is no way for that to occur, meaning that by meeting the existing evidence-based medical treatment guidelines the "medical payer obligor" has met the "reasonable basis" standard, then this section of regulation is inappropriately ambiguous and duplicative of existing regulation. ACP urges that this provision (Section 17 Part h) be removed.

3. Preemption of Internal Appeals

Section 17 also permits appeals to proceed prior to the treating provider or claimant completing the internal appeal process. Multiple other states (for example, Texas) have recognized that allowing the internal appeal process to be completed is beneficial to all parties, including the claimant and the Department. Allowing these denials to work their way through the internal appeals process results in fewer state level appeals being filed, an additional opportunity for the

treating provider to have a peer to peer discussion with the peer reviewer, and for those claimants who have their appeals resolved during the internal review it is quicker than waiting for the commonwealth to resolve them. We urge the Commonwealth to amend the regulation to require the internal appeal process be exhausted before an external appeal can be filed.

Additionally, a significant portion of denials can be resolved through peer to peer discussion or by obtaining the appropriate medical records that have been requested but not received by the "medical payer obligor." Allowing these appeals to be handled internally will remove many of the simple straight forward appeals that are based on a lack of information and not an underlying disagreement. This can reduce the potential for these appeals to take up the time of the Commonwealth and avoid a potential backlog.

Thus, we urge the Department to include in the final rule language that allows the commonwealth appeals process to start only once the internal appeal process has had a chance to be completed.

Section 11. Utilization Review and Medical Bill Audit Plan Approval.

In addition to the concerns above regarding section 17 of the proposed rule ACP and its members have concerns regarding the audit plan approval outlined in section 11 of the rule. This provision would require the "medical payer obligator" to submit for review and approval to the state a written plan describing utilization review and bill review audit programs every four years. ACP is concerned that this approach is duplicative of existing rules that apply to agents.

Utilization review and bill review agents are already licensed and approved by the Commonwealth of Kentucky to perform these services. Therefore, it would be redundant for the Commonwealth to require one set of regulation on the agents and a similar regulatory structure on the entity that employs those agents. Additionally, there are existing reporting requirements on the carrier for every instance of utilization review and bill review audit over a 2-year period. That existing review includes outcomes. Thus, this provision of the rule appears to be redundant and ACP suggests it be removed.

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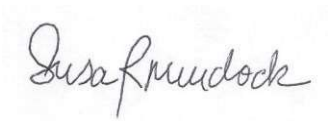
We appreciate the opportunity to provide comments and participate in the rulemaking process. Please let us know if you have any further questions or comments about the above. Please also

feel free to contact me at susan@murdockinc.com if you have any questions about our comments.

Sincerely,



Susan R. Murdock Executive Director
Association of Claims Professionals
1700 Pennsylvania Avenue, Suite 200
Washington, DC 20006
Phone: 202.626.2941
www.claimsprofession.org