AN ACT relating to reimbursement for pharmacist services.

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

➔SECTION 1. A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Insurer" means any insurer, self-insurer, self-insured plan, or self-insured group not exempt by federal law from regulation under the insurance laws of this state; and

(b) "Practice of pharmacy" has the same meaning as in KRS 315.010.

(2) For policies, plans, or contracts issued or renewed on or after the effective date of this Act, an insurer, or a third-party administrator for such insurer, shall not deny reimbursement to a pharmacist for a service or procedure, or reimburse a pharmacist for a service or procedure at a rate less than that provided to other nonphysician practitioners, if the service or procedure:

(a) Is within the scope of the practice of pharmacy;

(b) Would otherwise be covered under the policy, plan, or contract if the service or procedure were provided by a:

1. Physician;

2. Advanced practice registered nurse; or

3. Physician assistant; and

(c) Is performed by the pharmacist in strict compliance with laws and administrative regulations related to the pharmacist's license.

(3) This section shall not be construed to limit coverage otherwise required or provided under a policy, plan, or contract, or under any other law.

➔Section 2. KRS 304.14-135 is amended to read as follows:

(1) The commissioner shall prescribe the following uniform health insurance claim forms which shall be used by all insurers transacting health insurance in this state

and by all state agencies that require health insurance claim forms for their records as the sole instrument for reimbursement:

(a) The uniform health insurance claim form for an institutional provider shall consist of the UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Billing Committee;

(b) The uniform health insurance claim form for a dentist shall consist of a data set and form approved by the American Dental Association;

(c) The uniform health insurance claim form for all other health care providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee; and

(d) A clean claim for pharmacists shall consist of***:***

1. ***For prescription drug claims,*** a universal claim form ***and*** ~~[or]~~ data set approved by the National Council ***for*** ~~[on]~~ Prescription Drug ***Programs*** ~~[Program]~~***; and***

2. For all other claims for services or procedures that are within the scope of the practice of pharmacy, as defined in KRS 315.010, a 1500 Health Insurance Claim Form or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claim Committee.

(2) An insurer shall not require a provider to:

(a) Use a claim form that is different than the uniform claim form for the provider type as set out in subsection (1) of this section;

(b) Modify the uniform claims form or its content; or

(c) Submit additional claims forms.

➔Section 3. KRS 304.17A-300 is amended to read as follows:

(1) A provider-sponsored integrated health delivery network may be created by health care providers for the purpose of providing health care services.

(2) No person shall in this Commonwealth be, act as, or hold itself out as a provider-sponsored integrated health delivery network unless it holds a certificate of filing from the commissioner. Each provider-sponsored integrated health delivery network that seeks to offer services shall first be certified by the department.

(3) To qualify as a provider-sponsored integrated health delivery network, an applicant shall submit information acceptable to the department to satisfactorily demonstrate that the provider-sponsored integrated health delivery network:

(a) Is licensed and in good standing with the licensure boards for participating providers;

(b) Has demonstrated the capacity to administer the health plans it is offering;

(c) Has the ability, experience, and structure to arrange for the appropriate level and type of health care services;

(d) Has the ability, policies, and procedures to conduct utilization management activities;

(e) Has the ability to achieve, monitor, and evaluate the quality and cost effectiveness of care provided by its provider network;

(f) Is financially solvent;

(g) Has the ability to assure enrollees adequate access to providers, including geographic availability and adequate numbers and types;

(h) Has the ability and procedures to monitor access to its provider network;

(i) Has a satisfactory grievance procedure and the ability to respond to enrollees' inquiries and complaints;

(j) Does not limit the participation of any health care provider in its provider network in another provider network;

(k) Has the ability and policies that allow patients to receive care in the most

appropriate, least restrictive setting;

(l) Does not discriminate in enrolling members;

(m) Participates in coordination of benefits;

(n) Uses standardized electronic claims and billing processes and formats;~~[and]~~

(o) Discloses to the cooperative reimbursement arrangements with providers***; and***

(p) Complies with Section 1 of this Act.

(4) Fees for the following services shall be paid to the commissioner by every provider-sponsored integrated health delivery network, and the fees shall be the same as those for insurers as specified in Subtitle 4 of this chapter:

(a) For filing an application for a certificate of filing or amendment thereto;

(b) For filing an annual statement; and

(c) For other services deemed necessary by the commissioner.

(5) Provider-sponsored integrated health delivery networks shall be subject to the provisions of this subtitle, and to the following provisions of this chapter, to the extent applicable and not in conflict with the expressed provisions of this subtitle:

(a) Subtitle 1 -- Scope of Code;

(b) Subtitle 2 -- Commissioner of the Department of Insurance;

(c) Subtitle 3 -- Authorization of Insurers and General Requirements;

(d) Subtitle 4 -- Fees and Taxes;

(e) Subtitle 5 -- Kinds of Insurance--Limits of Risk--Reinsurance;

(f) Subtitle 6 -- Assets and Liabilities;

(g) Subtitle 7 -- Investments;

(h) Subtitle 8 -- Administration of Deposits;

(i) Subtitle 9 -- Agents, Consultants, Solicitors, and Adjusters;

(j) Subtitle 12 -- Trade Practices and Frauds;

(k) Subtitle 14 -- KRS 304.14-120 to 304.14-130 and 304.14-500 to 304.14-560;

(l) Subtitle 25 -- Continuity of Management;

(m) Subtitle 33 -- Insurers Rehabilitation and Liquidation;

(n) Subtitle 37 -- Insurance Holding Company Systems; and

(o) Subtitle 99 -- Penalties.

➔Section 4. KRS 304.17A-844 is amended to read as follows:

(1) After a hearing or upon agreement by the self-insured employer-organized association group, the commissioner may suspend or revoke the certificate of filing of a self-insured employer-organized association group, impose a civil penalty of up to five thousand dollars ($5,000) per violation on a self-insured employer-organized association group, or both, for:

(a) Violations of KRS 304.17A-800 to 304.17A-844 ***and Section 1 of this Act*** or administrative regulations promulgated thereunder;

(b) Obtaining a certificate of filing by unfair or deceptive means;

(c) Operating in a financially hazardous manner;

(d) Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a member, an employee of a member, or a person otherwise entitled thereto by the group or its administrator; or

(e) Unfair or deceptive business practices.

(2) The commissioner, in his or her discretion and without advance notice or a hearing thereon, may suspend or revoke the certificate of filing of any self-insured employer-organized association group upon the commencement of the following proceedings:

(a) Receivership;

(b) Conservatorship;

(c) Rehabilitation; or

(d) Other delinquency proceedings.

➔Section 5. KRS 304.17B-011 is amended to read as follows:

(1) The Office of Health Data and Analytics shall select a third-party administrator, through the state competitive bidding process, to administer Kentucky Access. The third-party administrator shall be an administrator licensed by the department. The office shall consider criteria in selecting a third-party administrator that shall include, but not be limited to, the following:

(a) A third-party administrator's proven ability to demonstrate performance of the operations of an insurer to include the following: enrollee enrollment, eligibility determination, provider enrollment and credentialing, utilization management, quality improvement, drug utilization review, premium billing and collection, claims payment, and data reporting;

(b) The total cost to administer Kentucky Access;

(c) A third-party administrator's proven ability to demonstrate that Kentucky Access shall be administered in a cost-efficient manner;

(d) A third-party administrator's proven ability to demonstrate experience in two (2) or more states administering a risk pool for a minimum of a three (3) year period; and

(e) A third-party administrator's financial condition and stability.

(2) The office may contract with the third-party administrator for a period of four (4) years with an option for a two (2) year extension as approved by the office on a year-by-year contract basis. At least one (1) year prior to the expiration of the third-party administrator's contract, the office may solicit third-party administrators, including the current third-party administrator, to submit bids to serve as the third-party administrator for the succeeding four (4) year period.

(3) In addition to any duties and obligations set forth in the contract with the third-party administrator, the third-party administrator shall:

(a) Develop and establish policies and procedures for enrollee enrollment, eligibility determination, provider enrollment and credentialing, utilization

management, case management, disease management, quality improvement, drug utilization review, premium billing and collection, data reporting, and other responsibilities determined by the office;

(b) Develop and establish policies and procedures for paying the agent referral fee under KRS 304.17B-001 to 304.17B-031;

(c) Develop and establish policies and procedures to ensure timely and efficient payment of claims to include, but not limited to, the following:

1. Develop and provide a claims billing manual to health care providers enrolled in Kentucky Access that includes information relating to the proper billing of a claim and the types of claim forms to use;

2. Payment of all claims in accordance with the provisions of this chapter and ***Section 1 of this Act and*** the administrative regulations promulgated thereunder; and

3. Notification to an enrollee through an explanation of benefits if a claim is denied or if there is enrollee financial responsibility of a paid claim for deductible or coinsurance amounts;

(d) Issue denial letters under KRS 304.17A-540 for denial of preauthorization and precertification requests for medical necessity and medical appropriateness determinations;

(e) Submit information to the office and the department under KRS 304.17A-330;

(f) Submit reports to the office regarding the operation and financial condition of Kentucky Access. The frequency, content, and form of the reports shall be determined by the office;

(g) Submit an annual report to the office three (3) months after the end of each calendar year. The annual report shall include:

1. Earned premium;

2. Administrative expenses;

3. Incurred losses for the year;

4. Paid losses for the year;

5. Number of enrollees enrolled in Kentucky Access by category of eligibility; and

6. Any other information requested by the office; and

(h) Be subject to examination by the office under Subtitles 2 and 3 of this chapter.

(4) The third-party administrator shall be paid for necessary and reasonable expenses, as provided in the contract between the office and the third-party administrator.

➔SECTION 6. A NEW SECTION OF SUBTITLE 32 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

Corporations subject to this subtitle shall comply with Section 1 of this Act.

➔Section 7. KRS 18A.225 is amended to read as follows:

(1) (a) The term "employee" for purposes of this section means:

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan

established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;

2. Any certified or classified employee of a local board of education;

3. Any elected member of a local board of education;

4. Any person who is a present or future recipient of a retirement allowance from the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, the Judicial Retirement Plan, or the Kentucky Community and Technical College System's optional retirement plan authorized by KRS 161.567, except that a person who is receiving a retirement allowance and who is age sixty-five (65) or older shall not be included, with the exception of persons covered under KRS 61.702(4)(c), unless he or she is actively employed pursuant to subparagraph 1. of this paragraph; and

5. Any eligible dependents and beneficiaries of participating employees and retirees who are entitled to participate in the state-sponsored health insurance program;

(b) The term "health benefit plan" for the purposes of this section means a health benefit plan as defined in KRS 304.17A-005;

(c) The term "insurer" for the purposes of this section means an insurer as defined in KRS 304.17A-005; and

(d) The term "managed care plan" for the purposes of this section means a managed care plan as defined in KRS 304.17A-500.

(2) (a) The secretary of the Finance and Administration Cabinet, upon the recommendation of the secretary of the Personnel Cabinet, shall procure, in

compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090, from one (1) or more insurers authorized to do business in this state, a group health benefit plan that may include but not be limited to health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), and exclusive provider organization (EPO) benefit plans encompassing all or any class or classes of employees. With the exception of employers governed by the provisions of KRS Chapters 16, 18A, and 151B, all employers of any class of employees or former employees shall enter into a contract with the Personnel Cabinet prior to including that group in the state health insurance group. The contracts shall include but not be limited to designating the entity responsible for filing any federal forms, adoption of policies required for proper plan administration, acceptance of the contractual provisions with health insurance carriers or third-party administrators, and adoption of the payment and reimbursement methods necessary for efficient administration of the health insurance program. Health insurance coverage provided to state employees under this section shall, at a minimum, contain the same benefits as provided under Kentucky Kare Standard as of January 1, 1994, and shall include a mail-order drug option as provided in subsection (13) of this section. All employees and other persons for whom the health care coverage is provided or made available shall annually be given an option to elect health care coverage through a self-funded plan offered by the Commonwealth or, if a self-funded plan is not available, from a list of coverage options determined by the competitive bid process under the provisions of KRS 45A.080, 45A.085, and 45A.090 and made available during annual open enrollment.

(b) The policy or policies shall be approved by the commissioner of insurance and may contain the provisions the commissioner of insurance approves, whether

or not otherwise permitted by the insurance laws.

(c) Any carrier bidding to offer health care coverage to employees shall agree to provide coverage to all members of the state group, including active employees and retirees and their eligible covered dependents and beneficiaries, within the county or counties specified in its bid. Except as provided in subsection (20) of this section, any carrier bidding to offer health care coverage to employees shall also agree to rate all employees as a single entity, except for those retirees whose former employers insure their active employees outside the state-sponsored health insurance program.

(d) Any carrier bidding to offer health care coverage to employees shall agree to provide enrollment, claims, and utilization data to the Commonwealth in a format specified by the Personnel Cabinet with the understanding that the data shall be owned by the Commonwealth; to provide data in an electronic form and within a time frame specified by the Personnel Cabinet; and to be subject to penalties for noncompliance with data reporting requirements as specified by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions to protect the confidentiality of each individual employee; however, confidentiality assertions shall not relieve a carrier from the requirement of providing stipulated data to the Commonwealth.

(e) The Personnel Cabinet shall develop the necessary techniques and capabilities for timely analysis of data received from carriers and, to the extent possible, provide in the request-for-proposal specifics relating to data requirements, electronic reporting, and penalties for noncompliance. The Commonwealth shall own the enrollment, claims, and utilization data provided by each carrier and shall develop methods to protect the confidentiality of the individual. The Personnel Cabinet shall include in the October annual report submitted pursuant to the provisions of KRS 18A.226 to the Governor, the General

Assembly, and the Chief Justice of the Supreme Court, an analysis of the financial stability of the program, which shall include but not be limited to loss ratios, methods of risk adjustment, measurements of carrier quality of service, prescription coverage and cost management, and statutorily required mandates. If state self-insurance was available as a carrier option, the report also shall provide a detailed financial analysis of the self-insurance fund including but not limited to loss ratios, reserves, and reinsurance agreements.

(f) If any agency participating in the state-sponsored employee health insurance program for its active employees terminates participation and there is a state appropriation for the employer's contribution for active employees' health insurance coverage, then neither the agency nor the employees shall receive the state-funded contribution after termination from the state-sponsored employee health insurance program.

(g) Any funds in flexible spending accounts that remain after all reimbursements have been processed shall be transferred to the credit of the state-sponsored health insurance plan's appropriation account.

(h) Each entity participating in the state-sponsored health insurance program shall provide an amount at least equal to the state contribution rate for the employer portion of the health insurance premium. For any participating entity that used the state payroll system, the employer contribution amount shall be equal to but not greater than the state contribution rate.

(3) The premiums may be paid by the policyholder:

(a) Wholly from funds contributed by the employee, by payroll deduction or otherwise;

(b) Wholly from funds contributed by any department, board, agency, public postsecondary education institution, or branch of state, city, urban-county, charter county, county, or consolidated local government; or

(c) Partly from each, except that any premium due for health care coverage or dental coverage, if any, in excess of the premium amount contributed by any department, board, agency, postsecondary education institution, or branch of state, city, urban-county, charter county, county, or consolidated local government for any other health care coverage shall be paid by the employee.

(4) If an employee moves his place of residence or employment out of the service area of an insurer offering a managed health care plan, under which he has elected coverage, into either the service area of another managed health care plan or into an area of the Commonwealth not within a managed health care plan service area, the employee shall be given an option, at the time of the move or transfer, to change his or her coverage to another health benefit plan.

(5) No payment of premium by any department, board, agency, public postsecondary educational institution, or branch of state, city, urban-county, charter county, county, or consolidated local government shall constitute compensation to an insured employee for the purposes of any statute fixing or limiting the compensation of such an employee. Any premium or other expense incurred by any department, board, agency, public postsecondary educational institution, or branch of state, city, urban-county, charter county, county, or consolidated local government shall be considered a proper cost of administration.

(6) The policy or policies may contain the provisions with respect to the class or classes of employees covered, amounts of insurance or coverage for designated classes or groups of employees, policy options, terms of eligibility, and continuation of insurance or coverage after retirement.

(7) Group rates under this section shall be made available to the disabled child of an employee regardless of the child's age if the entire premium for the disabled child's coverage is paid by the state employee. A child shall be considered disabled if he has been determined to be eligible for federal Social Security disability benefits.

(8) The health care contract or contracts for employees shall be entered into for a period of not less than one (1) year.

(9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or his designee regarding the state-sponsored health insurance program for employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the seven (7) Supreme Court districts, two (2) members representing retirees under age sixty-five (65), one (1) member representing local health departments, two (2) members representing the Kentucky Teachers' Retirement System, and three (3) members at large. The secretary shall also appoint two (2) members from a list of five (5) names submitted by the Kentucky Education Association, two (2) members from a list of five (5) names submitted by the largest state employee organization of nonschool state employees, two (2) members from a list of five (5) names submitted by the Kentucky Association of Counties, two (2) members from a list of five (5) names submitted by the Kentucky League of Cities, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The advisory committee shall be appointed in January of each year and shall meet quarterly.

(10) Notwithstanding any other provision of law to the contrary, the policy or policies provided to employees pursuant to this section shall not provide coverage for obtaining or performing an abortion, nor shall any state funds be used for the purpose of obtaining or performing an abortion on behalf of employees or their dependents.

(11) Interruption of an established treatment regime with maintenance drugs shall be

grounds for an insured to appeal a formulary change through the established appeal procedures approved by the Department of Insurance, if the physician supervising the treatment certifies that the change is not in the best interests of the patient.

(12) Any employee who is eligible for and elects to participate in the state health insurance program as a retiree, or the spouse or beneficiary of a retiree, under any one (1) of the state-sponsored retirement systems shall not be eligible to receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a retiree and an active employee spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year.

(13) (a) The policies of health insurance coverage procured under subsection (2) of this section shall include a mail-order drug option for maintenance drugs for state employees. Maintenance drugs may be dispensed by mail order in accordance with Kentucky law.

(b) A health insurer shall not discriminate against any retail pharmacy located within the geographic coverage area of the health benefit plan and that meets the terms and conditions for participation established by the insurer, including price, dispensing fee, and copay requirements of a mail-order option. The retail pharmacy shall not be required to dispense by mail.

(c) The mail-order option shall not permit the dispensing of a controlled substance classified in Schedule II.

(14) The policy or policies provided to state employees or their dependents pursuant to this section shall provide coverage for obtaining a hearing aid and acquiring hearing aid-related services for insured individuals under eighteen (18) years of age, subject to a cap of one thousand four hundred dollars ($1,400) every thirty-six (36) months pursuant to KRS 304.17A-132.

(15) Any policy provided to state employees or their dependents pursuant to this section shall provide coverage for the diagnosis and treatment of autism spectrum disorders consistent with KRS 304.17A-142.

(16) Any policy provided to state employees or their dependents pursuant to this section shall provide coverage for obtaining amino acid-based elemental formula pursuant to KRS 304.17A-258.

(17) If a state employee's residence and place of employment are in the same county, and if the hospital located within that county does not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a contiguous county that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

(18) If a state employee's residence and place of employment are each located in counties in which the hospitals do not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a county contiguous to the county of residence that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

(19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and in the best interests of the state group to allow any carrier bidding to offer health care coverage under this section to submit bids that may vary county by county or by larger geographic areas.

(20) Notwithstanding any other provision of this section, the bid for proposals for health insurance coverage for calendar year 2004 shall include a bid scenario that reflects the statewide rating structure provided in calendar year 2003 and a bid scenario that

allows for a regional rating structure that allows carriers to submit bids that may vary by region for a given product offering as described in this subsection:

(a) The regional rating bid scenario shall not include a request for bid on a statewide option;

(b) The Personnel Cabinet shall divide the state into geographical regions which shall be the same as the partnership regions designated by the Department for Medicaid Services for purposes of the Kentucky Health Care Partnership Program established pursuant to 907 KAR 1:705;

(c) The request for proposal shall require a carrier's bid to include every county within the region or regions for which the bid is submitted and include but not be restricted to a preferred provider organization (PPO) option;

(d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the carrier all of the counties included in its bid within the region. If the Personnel Cabinet deems the bids submitted in accordance with this subsection to be in the best interests of state employees in a region, the cabinet may award the contract for that region to no more than two (2) carriers; and

(e) Nothing in this subsection shall prohibit the Personnel Cabinet from including other requirements or criteria in the request for proposal.

(21) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 12, 2006, to public employees pursuant to this section which provides coverage for services rendered by a physician or osteopath duly licensed under KRS Chapter 311 that are within the scope of practice of an optometrist duly licensed under the provisions of KRS Chapter 320 shall provide the same payment of coverage to optometrists as allowed for those services rendered by physicians or osteopaths.

(22) Any fully insured health benefit plan or self-insured plan issued or renewed on or after ***the effective date of this Act***~~[July 12, 2006]~~, to public employees pursuant to

this section shall comply with***:***

(a) Section 1 of this Act;

(b) ~~[the provisions of]~~KRS 304.17A-270 and 304.17A-525***;***

(c) KRS 304.17A-600 to 304.17A-633;

(d) KRS 205.593;

(e) KRS 304.17A-700 to 304.17A-730;

(f) KRS 304.14-135;

(g) KRS 304.17A-580 and 304.17A-641;

(h) KRS 304.99-123;

(i) KRS 304.17A-138; and

(j) Administrative regulations promulgated pursuant to statutes listed in this subsection.

~~[(23) Any fully insured health benefit plan or self- insured plan issued or renewed on or after July 12, 2006, to public employees shall comply with KRS 304.17A-600 to 304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to 304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641 pertaining to emergency medical care, KRS 304.99-123, and any administrative regulations promulgated thereunder.~~

~~(24) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 1, 2019, to public employees pursuant to this section shall comply with KRS 304.17A-138.]~~

➔Section 8. KRS 342.020 is amended to read as follows:

(1) In addition to all other compensation provided in this chapter, the employer shall pay for the cure and relief from the effects of an injury or occupational disease the medical, surgical, and hospital treatment, including nursing, medical, and surgical supplies and appliances, as may reasonably be required at the time of the injury and

thereafter for the length of time set forth in this section, or as may be required for the cure and treatment of an occupational disease.

(2) In claims resulting in an award of permanent total disability or resulting from an injury described in subsection (9) of this section, the employer's obligation to pay the benefits specified in this section shall continue for so long as the employee is disabled regardless of the duration of the employee's income benefits.

(3) (a) In all permanent partial disability claims not involving an injury described in subsection (9) of this section, the employer's obligation to pay the benefits specified in this section shall continue for seven hundred eighty (780) weeks from the date of injury or date of last exposure.

(b) In all permanent partial disability claims not involving an injury described in subsection (9) of this section, the commissioner shall, in writing, advise the employee of the right to file an application for the continuation of benefits as described in this section. This notice shall be made to the employee seven hundred fifty-four (754) weeks from the date of injury or last exposure.

(c) An employee shall receive a continuation of benefits as described in this section for additional time beyond the period provided in paragraph (a) of this subsection as long as continued medical treatment is reasonably necessary and related to the work injury or occupational disease if:

1. An application is filed within seventy-five (75) days prior to the termination of the seven hundred eighty (780) week period;
2. The employee demonstrates that continued medical treatment is reasonably necessary and related to the work injury or occupational disease; and
3. An administrative law judge determines and orders that continued benefits are reasonably necessary and related to the work injury or occupational disease for additional time beyond the original seven

hundred eighty (780) week period provided in paragraph (a) of this subsection.

(d) If the administrative law judge determines that medical benefits are not reasonably necessary or not related to the work injury or occupational disease, or if an employee fails to make proper application for continued benefits within the time period provided in paragraph (c) of this subsection, any future medical treatment shall be deemed to be unrelated to the work injury and the employer's obligation to pay medical benefits shall cease permanently.

(4) In the absence of designation of a managed health care system by the employer, the employee may select medical providers to treat his injury or occupational disease. Even if the employer has designated a managed health care system, the injured employee may elect to continue treating with a physician who provided emergency medical care or treatment to the employee. The employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services. The commissioner shall promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled. The provider of medical services shall submit the statement for services within forty-five (45) days of the day treatment is initiated and every forty-five (45) days thereafter, if appropriate, as long as medical services are rendered. Except as provided in subsection (7) of this section, in no event shall a medical fee exceed the limitations of an adopted medical fee schedule or other limitations contained in KRS 342.035, whichever is lower. The commissioner may promulgate administrative regulations establishing the form and content of a statement for services and procedures by which disputes relative to the necessity, effectiveness, frequency, and cost of services may be resolved.

(5) Notwithstanding any provision of the Kentucky Revised Statutes to the contrary,

medical services and treatment provided under this chapter shall not be subject to copayments or deductibles.

(6) Employers may provide medical services through a managed health care system. The managed health care system shall file with the Department of Workers' Claims a plan for the rendition of health care services for work-related injuries and occupational diseases to be approved by the commissioner pursuant to administrative regulations promulgated by the commissioner.

(7) All managed health care systems rendering medical services under this chapter shall include the following features in plans for workers' compensation medical care:

(a) Copayments or deductibles shall not be required for medical services rendered in connection with a work-related injury or occupational disease;

(b) The employee shall be allowed choice of provider within the plan;

(c) The managed health care system shall provide an informal procedure for the expeditious resolution of disputes concerning rendition of medical services;

(d) The employee shall be allowed to obtain a second opinion, at the employer's expense, from an outside physician if a managed health care system physician recommends surgery;

(e) The employee may obtain medical services from providers outside the managed health care system, at the employer's expense, when treatment is unavailable through the managed health care system;

(f) The managed health care system shall establish procedures for utilization review of medical services to assure that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee; and

(g) Statements for services shall be audited regularly to assure that charges are not

duplicated and do not exceed those authorized in the applicable fee schedules.

(h) A schedule of fees for all medical services to be provided under this chapter which shall not be subject to the limitations on medical fees contained in this chapter.

(i) Restrictions on provider selection imposed by a managed health care system authorized by this chapter shall not apply to emergency medical care.

(8) Except for emergency medical care, medical services rendered pursuant to this chapter shall be under the supervision of a single treating physician or physicians' group having the authority to make referrals, as reasonably necessary, to appropriate facilities and specialists. The employee may change his designated physician one (1) time and thereafter shall show reasonable cause in order to change physicians.

(9) When a compensable injury or occupational disease results in the amputation or partial amputation of an arm, hand, leg, or foot, or the loss of hearing, or the enucleation of an eye or loss of teeth, or permanent total or permanent partial paralysis, the employer shall pay for, in addition to the other medical, surgical, and hospital treatment enumerated in subsection (1) and this subsection, a modern artificial member and, where required, proper braces as may reasonably be required at the time of the injury and thereafter during disability.

(10) Upon motion of the employer, with sufficient notice to the employee for a response to be filed, if it is shown to the satisfaction of the administrative law judge by affidavits or testimony that, because of the physician selected by the employee to treat the injury or disease, or because of the hospital selected by the employee in which treatment is being rendered, that the employee is not receiving proper medical treatment and the recovery is being substantially affected or delayed; or that the funds for medical expenses are being spent without reasonable benefit to the employee; or that because of the physician selected by the employee or because of the type of medical treatment being received by the employee that the employer will

substantially be prejudiced in any compensation proceedings resulting from the employee's injury or disease; then the administrative law judge may allow the employer to select a physician to treat the employee and the hospital or hospitals in which the employee is treated for the injury or disease. No action shall be brought against any employer subject to this chapter by any person to recover damages for malpractice or improper treatment received by any employee from any physician, hospital, or attendant thereof.

(11) An employee who reports an injury alleged to be work-related or files an application for adjustment of a claim shall execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding any other provision in the Kentucky Revised Statutes, any physician, psychiatrist, chiropractor, podiatrist, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer, special fund, uninsured employers' fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation.

(12) When a provider of medical services or treatment, required by this chapter, makes referrals for medical services or treatment by this chapter, to a provider or entity in which the provider making the referral has an investment interest, the referring provider shall disclose that investment interest to the employee, the commissioner, and the employer's insurer or the party responsible for paying for the medical services or treatment, within thirty (30) days from the date the referral was made.

(13) (a) Except as provided in paragraphs (b) and (c) of this subsection, the employer, insurer, or payment obligor shall not be liable for urine drug screenings of patients in excess of:

1. One (1) per year for a patient considered to be low-risk;
2. Two (2) per year for a patient considered to be moderate-risk; and
3. Four (4) per year for patients considered to be high-risk;

based upon the screening performed by the treating medical provider and other pertinent factors.

(b) The employer, insurer, or payment obligor may be liable for urine drug screening at each office visit for patients that have exhibited aberrant behavior documented by multiple lost prescriptions, multiple requests for early refills of prescriptions, multiple providers prescribing or dispensing opioids or opioid substitutes as evidenced by the electronic monitoring system established in KRS 218A.202 or a similar system, unauthorized dosage escalation, or apparent intoxication.

(c) The employer, insurer, or payment obligor may request additional urine drug screenings which shall not count toward the maximum number of drug screenings enumerated in paragraph (a) of this subsection.

(d) The commissioner shall promulgate administrative regulations related to urine drug screenings as part of the practice parameters or treatment guidelines required under KRS 342.035.

(14) (a) As used in this subsection, "practice of pharmacy" has the same meaning as in KRS 315.010.

(b) In addition to all other compensation that may be reimbursed to a pharmacist under this chapter, the employer, insurer, or payment obligor shall be liable for the reimbursement of a pharmacist for a service or procedure, and shall not reimburse a pharmacist for a service or procedure at a rate less than that provided to other nonphysician practitioners, if the service or procedure:

1. Is within the scope of the practice of pharmacy;

2. Would otherwise be compensable under this chapter if the service or procedure were provided by a:

a. Physician;

b. Advanced practice registered nurse; or

c. Physician assistant; and

3. Is performed by the pharmacist in strict compliance with laws and administrative regulations related to the pharmacist's license.