KENTUCKY MEDICAL FEE DISPUTES QUICK-REFERENCE

PROCEDURE

Medical expense disputes involve issues before, during and after litigation. Those issues concern whether treatment is reasonable, necessary or related to the work injury. Medical expense disputes must be resolved by the filing of a Form 112, regardless of the nature of the dispute, within 30 days from receipt of a completed statement of services or a request from preauthorization for either denying or paying a medical bill (unless utilization review has been initiated). 803 KAR 25:012 SECTION 1 and 803 KAR 25:096. A single Form 112 may encompass both past and future contested treatment of the same nature or for the same condition if specifically stated. You do not need to file identical Form 112's concerning the same subject matter if an ALJ has ruled upon both the past expenses and the necessity of future expenses. When an ALJ Order encompasses future treatment, the medical provider is precluded from tendering future statements for services encompassed by the ALJ Order. Any party aggrieved by the ALJ decision on a medical fee dispute may appeal the decision to the Board. Also, the Movant is "subject to" sanctions for filing a medical fee dispute prior to the exhaustion of any required utilization review or medical bill audit procedure.

WHAT IS THE TIME FRAME FOR PAYING MEDICAL EXPENSES?

There is a 30 day window to pay medical expenses; however, this period of time can be tolled with the UR process and in other circumstances as outlined below. The medical provider must submit medical bills within 45 days of the date of service or these bills may not be compensable. However, the employer must file a Form 112 (and a motion to reopen if this dispute arises after settlement or award) if it wants to deny payment.

WHAT MUST BE FILED WITH A FORM 112?

A Form 112 must include the following: (a) Copies of all the disputed medical bills, (b) supporting affidavits, IME/ expert opinion; (c) and any final utilization report. Depending on the stage of litigation, if any, the following shall be required: in all pre-litigated claims the original Form 112 must be sent to the Commissioner, who shall serve the parties; if a Form 101 has been filed, then the original Form 112 is sent to the Commissioner and copies of the Form 112 are sent to the employee and medical provider with a Motion to Join the relevant/ applicable medical providers. Finally, in a post litigated claim, once again the original Form 112 needs to be sent to the Commissioner and copies of the Form 112 are sent to the medical provider and employee along with a Motion to Reopen and a Motion to Join the Medical Providers.

WHO HAS THE BURDEN OF PROOF IN A MEDICAL FEE DISPUTE?

In pre-litigated claims, the employee has the burden of proof; however, the employer may file a Form 112. In a litigated claim, the employer may have the burden of proof and should file a Form 112. In a post litigated claim, the employer has the burden of proof and must file a medical fee dispute or Form 112.

WHAT IS A COMPLETED STATEMENT FOR SERVICES?

For a non-pharmaceutical bill for an office visit or treatment, a completed HCFA 1500 and for hospital treatment, a completed Form UB-92; Copies of legible treatment notes must also be submitted along with the supporting documentation. For a pharmaceutical bill, there is no particular form, but the following information must be provided: (a) identity of the prescribed medication; (b) the number of units prescribed; (c) the date of the prescription; (d) name of the prescribing physician. Lastly with any expenses the injured worker must submit a Form 114.

CAN AN EMPLOYEE DOCTOR SHOP?

803 KAR 25:096 concerns Selection of Physicians, Treatment Plans, and Statement for Medical Services. With the exception of emergency care, all treatment from work-related injuries must be rendered under the coordination of a single physician selected by the employee. The designated physician shall have sole authority to make a referral to a treatment facility or to a specialist. At the employee's discretion, a second physician may be designated as the treating physician, without receipt of the carrier's authorization. However, after two physicians have been selected, the employee must then receive written consent from either the carrier or ALJ before treating as a gatekeeper with a third or additional physician. The carrier cannot unreasonably withhold such consent. You need to forward an employee a Form 113 if the work-related injury 1) causes the employee to miss work or 2) causes the need for continuing medical care. Thus, there is no need to forward an employee a Form 113 if the injury results in no lost time, and is not expected to require continuing medical treatment beyond a one-time only emergency room visit. If an employee or physician fails to complete a Form 113, there is no responsibility to make payment or compensation.

ARE THERE INSTANCES WHERE THE 30 DAY WINDOW TO PAY MEDICAL EXPENSES ARE EXTENDED?

The 30 window to either deny or pay submitted bills is tolled when: (a) A complete statement for services is not received; (b) The medical provider fails to respond to a request for information; (c) The physician fails to provide a treatment plan; (d) The UR and/or appeals process has not been completed; (e) Failure to complete a Form 113 by an employee or physician.

WHEN IS A TREATMENT PLAN REQUIRED?

A physician shall prepare a treatment plan if: (a) Long term medical care is required; (b) An elective surgical procedure, resident work hardening program is required; (c) Medical rehabilitation program or pain management is required; (d) The employee has received treatment with passive modalities for a period exceeding 60 days; (e) An elective surgical procedure or placement into a resident work-hardening, pain management, or medical rehabilitation program is recommended.

The designated physician shall provide copy of a treatment plan seven days in advance of an elective surgical procedure or placement into pain management and in all other cases, within 15 days following a request by the employer/ carrier.

WHAT ARE THE MOST FREQUENT REASONS FOR DENYING MEDICAL BILLS?

1. The bills are not submitted timely (45 days);
2. Failed to submit a completed statement for services;
3. UR;
4. Bills in excess of the fee schedule;
5. Peer review.

FREQUENTLY ASKED QUESTIONS

WHAT IS UTILIZATION REVIEW?

UR means review of the medical necessity and appropriateness of medical care and services for purposes of recommending payments for a compensable injury or disease. 803 KAR 25:190.

WHAT ARE THE TRIGGERS FOR UTILIZATION REVIEW?

1. The medical provider requests pre-authorization;
2. Notification of a surgical procedure;
3. The total medical costs cumulatively exceed $3,000.00;
4. The total lost work days cumulatively exceed 30 days;
5. An arbitrator or ALJ orders the UR.

WHAT IS PEER REVIEW?

This term is neither defined in the statute or the regulations. The two main processes by which medical treatment for injured workers are challenged are 1) reasonableness and necessity and (2) causation. UR covers reasonableness and necessity and therefore by the implication the term PEER REVIEW refers to challenging medical bills on the basis of a lack of connection between treatment and the work injury.

WHAT TRIGGERS PEER REVIEW?

It can commence with a statement for services or a pre-authorization request. Also, whenever there are red flags on questions of whether there is a relationship between treatment and the work injury there is a trigger. Examples frequently involve employees with a compensable cervical claim subsequently seeking treatment in the thoracic, low back or shoulder areas or one with CTS seeking treatment for shoulder and neck complaints. Another classic example is when there is a major gap in treatment. On many occasions, there is a mixed question of reasonableness and causation. When that arises, it is advisable to seek both a UR and a peer review determination or an IME.

HOW LONG DO I HAVE TO DO A UR/PEER REVIEW

The simple answer here is immediately. UR shall commence when the carrier has notice that a claims selection criteria has been met. 803 KAR 25:190 Section 5. As stated above there is a 30 day window to either deny or be obligated to pay a medical bill. The UR process has to be performed within this timeframe, but the 30 day window is tolled by the UR process. If pre-certification has been requested the UR decision must be 'communicated' to the medical provider and employee within 2 working days of the initiation of the UR process, unless additional information is required at which time the requested information must be given within 10 working days of the request. 803 KAR 25:190 Section 5. For Peer Review, if an IME is needed, it should be completed within the 30 day window of the trigger.

CAN UTILIZATION REVIEW AND PEER REVIEW BE APPEALED?

An aggrieved party can request an appeal of the original UR opinion with 14 days of a receipt of the written notice of denial. 803 KAR 25:190 Section 8. This reconsideration must be performed by a different reviewer of at least the same qualifications. A written decision must be rendered within 10 days upon a receipt of the request for appeal. If upon appeal the original UR report was upheld an aggrieved party then can request a board eligible or certified physician in the appropriate specialty to review the UR decisions if such a physician has not already reviewed the matter. This includes chiropractic review. A decision has to be rendered within ten days. The best advice here is upon appeal to have a specialist issue the second UR report so that this third step can be eliminated. There is no appeal of a peer review determination.

WHEN IS AN IME NEEDED?

An IME is usually performed after either the UR or Peer Review process as a way to further solidify a denial of a medical procedure or medications. Common examples that might trigger the need for an IME include:

1. COMPLEX CAUSATION ISSUES;
2. THE INJURED WORKER DEVELOPS OTHER MEDICAL CONDITIONS;
3. LONG TERM NARCOTIC MEDICATIONS OR CHIROPRACTIC CARE;

Remember there is a 30 day window to dispute a medical bill or to offer a formal denial. The best use of an IME is after a UR denial has been issued and a Medical Fee Dispute (Form 112) has been filed within the 30 day window to toll the 30 day payment requirement. This will allow more time for the medical records to be collected and sent to the IME physician to facilitate a more detailed and comprehensive IME report that will carry more credibility.

CAN SANCTIONS BE ASSESSED BY AN ALJ?

The ALJ "may" award costs and attorney fees against the offending party if there is a determination that the medical fee dispute has been "brought, prosecuted, or defended without reasonable grounds". Further, the ALJ "shall" assess sanctions when the carrier "challenges bills without reasonable medical or factual foundation" or when the medical provider "without reasonable foundation, submits bills for non-work-related conditions."

*This Quick Guide is intended for general informational purposes only and is not meant to replace legal counsel. We urge you to consult an attorney for any issue regarding applicability or interpretation of any provision of the Kentucky Workers' Compensation Act. This is not intended to be a complete summary of Kentucky's law.