Approved:
Date: 3-12-02

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Sandy Praeger at 9:30 a.m. on February 26, 2002 in Room 234 N of the Capitol.

All members were present except:

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Ken Wilke, Office of the Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Others attending: See attached list.

**Overview of Utilization Review Statutes and Regulations**

Dr. Bill Wolff, Kansas Legislative Research Department, briefed the Committee on utilization review statutes, regulations and information compiled by the Kansas Insurance Department. (Attachment 1)

During Committee discussion on the utilization review process, representatives from the Kansas Insurance Department, Richard Huncker and Julie Gonzales, contributed to the discussion on information related to the Utilization Review Advisory Committee. It was noted there currently are 167 utilization review organizations certified in the state that have URAC accreditation. Larry Pitman, Kansas Foundation for Medical Care and a member of URAC, explained the screened criteria and appeal process used for utilization review. The Chair requested the Utilization Review Advisory Committee convene and review the recommendations that had been made and report back to Committee or recommend an interim study on the process.

**Discussion and Action on SB 586 - Long-term Care Insurance - restrictions on elimination period**

During Committee discussion on **SB 586** the Chair called the Committee's attention to the need to amend a drafting error on page 1, line 25 of the bill, so that "100" would read "365" days. Senator Teichman made a motion to change "100" to "365" days on page 1, line 25 of the bill, and that the Committee recommend **SB 586 as amended** favorable for passage, seconded by Senator Barnett. The motion carried.

**Discussion and Action on SB 420 - Health care provider insurance availability act; certain health care providers**

Senator Feleciano called the Committee's attention to a letter from J. Greg Kite dated February 22, 2002, that was delivered to each Committee member at their statehouse office regarding **SB 420**.

Senator Feleciano made a motion that the Committee recommend **SB 420** favorable for passage, seconded by Senator Steineger. The motion failed.

Senator Feleciano and Senator Steineger requested their "Yes" vote be recorded.

**Approval of Committee Minutes**

Senator Teichman made a motion to approve the Committee minutes of February 19, 20, 21, 2002, seconded by Senator Steineger. The motion carried.

**Adjournment**

The meeting was adjourned at 10:30 a.m.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

SENATE FINANCIAL INSTITUTIONS & INSURANCE
COMMITTEE GUEST LIST

DATE: 2-26-02

| NAME | REPRESENTING |
| --- | --- |
| Rob Neises | |
| Don Andersen | Raney-Neises Family |
| Julie Stell | Kansas Ins. Dept. |
| Larry W. Pitman | KFMC |
| Rich Huncker | Ks. Ins. Dept |
| Bill Sneed | HIAA |
| Kevin Davis | Am. Family Ins. |
| Rich Guthrie | Health Midwest |
| Linda DeCoursey | KS Ins Dept |
| Chip Wheelen | KAOM |
| Larry Buening | Bd of Healing Arts. |
| Bill Henry | Ks. Credit Union Assn. |
| Ron Hein | Wesley Medical Center |
| Larry Magill | KAIA |
| John Peterson | Ks Hospital Assn |
| Jerry Slaughter | KMS |
| Chris Collins | KMS |
| Ronnie Ann Power | KAAP |
| Cheryl Dillard | Mid America Health |
| Lee Wright | Farmers Ins |
| Barb Conant | KTLA |

Article 22a – UTILIZATION REVIEW (History: 1994)

K.S.A. 40-22a01. Utilization review organization act.

K.S.A. 40-22a02.
Purpose: The legislature finds that in order to promote delivery of quality health care services in a cost effective manner, it is necessary to encourage greater coordination between health care providers and those agencies performing utilization review of health care services. Effective standards for utilization review activities will protect patients while reducing administrative costs associated with the review and approval of health care services provided to patients.

K.S.A. 40-22a03.
Definitions: Commissioner, utilization review, utilization review organization, health care provider.

K.S.A. 40-22a04.
Rules and Regs: Commissioner shall adopted rules and regs, with the advise of the advisory committee, establishing standards governing the conduct of the UR activities performed in this state or affecting residents of this state by UROs (unless granted exemption under 40-22a06.)
Certificate: No URO may conduct utilization review services without obtaining a certificate from the commissioner. Certificates that are issued cost $100, and remain effective until suspended, surrendered or revoked and subject to continuation fee of $50.
Conditions: Commissioner shall not issue a certificate until the applicant:

- Files formal application required by Commissioner and has been executed under oath by the CEO of the applicant.
- Files a certified copy of its charter or articles of incorporation and bylaws if any
- States location of office(s) of RUO where review affecting residents or health care providers of this state will be principally performed.
- Provides summary of qualification and experience of persons performing UR.
- Makes payment of fee
- Provides any other information or documentation required by commissioner.

Suspension/revocation: The Commissioner may, with the advice of the advisory committee, may suspend or revoke the certificate or any exemption from the certificate requirements upon determination that the interests of Kansas insureds are not being properly served under such certificate or exemption. Action of such can only be taken after a hearing conducted in accordance of KAPA.

K.S.A. 40-22a05. Advisory committee.

- Purpose: Created to assist the commissioner in the adoption of rules and regs to implement the provisions of this act. The advisory committee is attached to the Insurance Department and all administrative functions of the committee shall be under the direction and supervision of the commissioner.
- Commissioner appoints 13 members. Commissioner is chair (or designee); one public member; four URO representatives; seven representatives of health care providers (one shall be a representative of a Kansas hospital, two shall be persons licensed to practice medicine and surgery in Kansas.

Senate Financial Inst. & Insurance
Date: 2-26-02
Attachment No. 1

- Terms are for three years, except staggered at initial setup.
- Within available appropriations, advisory committee members shall be paid subsistence allowances, mileage and other expenses as provided for in the statutes KSA 75-3223.

Before adopting rules and regs, the commissioner with the advice of the advisory committee shall:

- Establish UR standards which provide for uniformity in the procedures for interaction between UROs and health care providers, payors and consumers of health care
- Establish procedures that prevent unnecessary and inappropriate disruption to the health care delivery system.
- Efficient process for certification of UROs
- Specify kinds of insurance or types of insurance products to which the standards apply and the scope of application.

Act does **not** apply to:

- Workers Comp
- Reviews conducted by any insurance company, HMO, prepaid service plan, group funded self-insured plan or similar entity solely for the purpose of determining compliance with specific terms and conditions of an insurance policy, agreement or contract as part of the normal claims process;
- Medical programs operated by SRS.

K.S.A. 40-22a06 Certificate not required

No certificate shall be required for utilization review activities conducted by or on behalf of:

- Agency of federal government
- Person, agency or URO acting on behalf of federal government
- Federally qualified HMO authorized to transact business in Kansas which is administering a quality assurance program and performing UROs for its own members.
- Person employed or used by a URO authorized to perform UR in Kansas, including nurses and other providers. Exemption shall NOT apply to individual persons performing utilization review activities in conjunction with any insurance contract or health benefit plan in a contractual relationship with an HMO, group funded self-insurance plan or insurance company.
- Health benefit plan that is self-insured and qualified under ERISA.
- Hospitals, home health agencies clinics. Private health care provider offices or any other authorized health care facility or entity conducting in-house UR unless such is the purpose of approving or denying payment for hospital or medical services;
- URO conducting UR ONLY with respect to mental health, chemical dependency, chiropractic, optometric, podiatric, dental or other health care service(s) other than the practice of medical/surgical until UR standards governing treatment or service are incorporated in rules and regs.

Those URO accredited by and adhering to national utilization review standards approved by the American accreditation health care commission or other utilization review orgs that the advisory committee may recommend and the commissioner approves do not have to provide:
Charter, or articles of incorporation and bylaws, location of offices of URO, summary of qualifications or experience of persons performing UR, pay the $100 fee, and provide other info requested by commissioner.

KSA 40-22a07. Unlawful act; penalties.

- No person or URO can perform UR activities in this state except in accordance with this act.
- No URO or individual performing UR reviews may agree to be compensated contingent upon frequency of denials, costs avoided by denial or other results adverse to the needs of the patient as determined by the attending health care provider.
- When the commissioner has reason to believe this act has been violated or any rules and regs, the commissioner may conduct hearing (KAPA) and may
  - Issue and serve order for such organization to cease and desist for engaging in violations.
  - Suspend or revoke certificate
  - Assess a monetary penalty of not less than $500 and not more than $1,000
  - Apply any combination of above by written order.

KSA 40-22a08. Examination; expenses

- Commissioner, whenever deems it to be prudent, may visit and examine the affairs of any URO to determine if the URO is in compliance of the act and rules and regs.
- Any person or entity examined pays the reasonable and proper charges incurred for such examination.

KSA 40-22a09. Written procedures for UR; patient info confidential

Each URO shall have written procedures for assuring that the patient-specific information obtained during the process will be:

- Kept confidential applicable with fed and state laws
- Used solely for the purposes of UR, qualify assurance, discharge planning and catastrophic case management.

KSA 40-22a10. Patient information not subject to discovery or subpoena.

Not subject to discovery or subpoena or other means of legal compulsion for their release to any person or entity;

Shall not be admissible in judicial or administrative proceeding other than disciplinary proceeding by state board of healing arts or other agency regulating health care providers.

KSA 40-22a11. The commissioner shall adopt necessary rules and regs, not inconsistent with this act, for implementing the provisions of this act.

KSA 40-22a12. Provisions of this act are declared to be severable.

(d) An insurer writing life insurance, disability income insurance or long-term care insurance coverage that obtains information under paragraphs (1) or (2) of subsection (b), shall not:

(1) Use the information contrary to paragraphs (3) or (4) of subsection (b) in writing a type of insurance coverage other than life for the individual or a member of the individual's family; or

(2) provide for rates or any other aspect of coverage that is not reasonably related to the risk involved.

**History:** L. 1997, ch. 190, § 14; July 1.

### Article 22a.—UTILIZATION REVIEW

**40-22a01. Utilization review organization act.** This act shall be known and may be cited as the utilization review organization act.

**History:** L. 1994, ch. 238, § 1; July 1.

**40-22a02. Same; purpose.** The legislature finds that in order to promote the delivery of quality health care services in a cost effective manner, it is necessary to encourage greater coordination between health care providers and those agencies performing utilization review of health care services. Effective standards for utilization review activities will protect patients while reducing administrative costs associated with the review and approval of health care services provided to patients.

**History:** L. 1994, ch. 238, § 2; July 1.

**40-22a03. Same; definitions.** For the purposes of this act:

(a) "Commissioner" means the commissioner of insurance.

(b) "Utilization review" means the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedures and facilities.

(c) "Utilization review organization" means any entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

(d) "Health care provider" means a licensed medical care facility, a licensed health maintenance organization, or a person licensed or registered to engage in an occupation which renders health care services.

**History:** L. 1994, ch. 238, § 3; July 1.

**40-22a04. Same; standards; rules and regulations; certificate; conditions; annual fee; suspension or revocation of certificate.** (a) The commissioner shall adopt rules and regulations, with the advice of the advisory committee created by K.S.A. 40-22a05, establishing standards governing the conduct of utilization review activities performed in this state or affecting residents of this state by utilization review organizations. Unless granted an exemption under K.S.A. 40-22a06, no utilization review organization may conduct utilization review services in this state or affecting residents of this state on or after May 1, 1995, without first obtaining a certificate from the commissioner.

(b) The commissioner shall not issue a certificate to a utilization review organization until the applicant:

(1) Files a formal application for certification in such form and detail as required by the commissioner and such application has been executed under oath by the chief executive officer of the applicant;

(2) files with the commissioner a certified copy of its charter or articles of incorporation and bylaws, if any;

(3) states the location of the office or offices of the utilization review organization where utilization review affecting residents or health care providers of this state will be principally performed;

(4) provides a summary of the qualifications and experience of persons performing utilization review affecting the persons and at the locations identified pursuant to paragraph (3);

(5) makes payment of a certification fee of $100 to the commission; and

(6) provides such other information or documentation as the commissioner requires.

(c) Certificates issued by the commissioner pursuant to this act shall remain effective until suspended, surrendered or revoked subject to payment of an annual continuation fee of $50.

(d) The commissioner with the advice of the advisory committee may suspend or revoke the certificate or any exemption from certification requirements upon determination that the interests of Kansas insureds are not being properly served under such certificate or exemption. Any such action shall be taken only after a hearing conducted in accordance with the provisions of the Kansas administrative procedure act.

**History:** L. 1994, ch. 238, § 4; July 1.

**40-22a05. Same; advisory committee; membership; rules and regulations; act not**



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**applicable to certain reviews and programs.** (a) There is hereby created an advisory committee which shall assist the commissioner in the adoption of rules and regulations to implement the provisions of this act. The advisory committee shall consist of 13 persons appointed by the commissioner as follows:

(1) The commissioner, or the designee of the commissioner, who shall be the chairperson;

(2) one member appointed from the public at large;

(3) four members who are representatives of utilization review organizations; and

(4) seven members who are representatives of health care providers, one of which shall be a representative of a Kansas hospital, and two of which shall be persons licensed to practice medicine and surgery in Kansas.

(b) Members of the advisory committee shall be appointed for a term of three years, except that the first term of office of two members representing utilization review organizations and two members representing health care providers shall be for a term of two years, and the first term for two members representing health care providers and one member representing utilization review organizations shall be for a term of one year.

(c) The advisory committee shall be attached to the insurance department, and all administrative functions of the advisory committee shall be under the direction and supervision of the commissioner. Within available appropriations therefor, members of the advisory committee shall be paid subsistence allowances, mileage and other expenses as provided in subsection (e) of K.S.A. 75-3223 and amendments thereto.

(d) Before adopting rules and regulations to carry out the provisions of this act, the commissioner with the advice of the advisory committee shall:

(1) Establish utilization review standards which provide for uniformity in the procedures for interaction between utilization review organizations and health care providers, payors and consumers of health care;

(2) establish utilization review procedures that prevent unnecessary and inappropriate disruption to the health care delivery system;

(3) strive to achieve an efficient process for the certification of utilization review organizations; and

(4) specify the kinds of insurance or types of insurance products to which the standards apply and the scope of such application.

(e) This act shall not apply to:

(1) Utilization review of health care services provided to patients under the authority of the Kansas workers compensation act (K.S.A. 44-501 *et seq.*, and amendments thereto);

(2) reviews conducted by any insurance company, health maintenance organization, prepaid service plan, group-funded self-insured plan or similar entity solely for the purpose of determining compliance with the specific terms and conditions of an insurance policy, agreement or contract as a part of the normal claim settlement process; or

(3) any medical programs operated by the secretary of social and rehabilitation services or any entity to the extent it is acting under contract with the secretary.

**History:** L. 1994, ch. 238, § 5; July 1.

**40-22a06. Same; certificate not required for certain review activities; certain provisions not applicable to certain organizations.** (a) No certificate shall be required for utilization review activities conducted by or on behalf of:

(1) An agency of the federal government;

(2) a person, agency or utilization review organization acting on behalf of the federal government, but only to the extent such person, agency or organization is providing services under federal regulation;

(3) a federally qualified health maintenance organization authorized to transact business in Kansas which is administering a quality assurance program and performing utilization review activities for its own members as required by 42 U.S.C. 300e(c)(8) and 42 U.S.C. 300e(c)(6) respectively;

(4) a person employed or used by a utilization review organization authorized to perform utilization review in Kansas, including, but not limited to, individual nurses and other health care providers. This exemption shall not apply with respect to individual persons performing utilization review activities in conjunction with any insurance contract or health benefit plan pursuant to a direct contractual relationship with a health maintenance organization, group-funded self-insurance plan or insurance company;



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(5) a health benefit plan that is self-insured and qualified under the federal employee retirement income security act of 1974 as amended;

(6) hospitals, home health agencies, clinics, private health care provider offices or any other authorized health care facility or entity conducting general, in-house utilization review unless such review is for the purpose of approving or denying payment for hospital or medical services in a particular case; or

(7) utilization review organizations conducting utilization review only with respect to mental health, chemical dependency, chiropractic, optometric, podiatric, dental or any other health care service or services other than the practice of medicine and surgery, until utilization review standards governing such treatment or service are incorporated in rules and regulations adopted pursuant to K.S.A. 40-22a04, and amendments thereto.

(b) The provisions of K.S.A. 40-22a04 (b)(2), (3), (4), (5), (6) and subsection (c), and amendments thereto, shall not apply to:

(1) Utilization review organizations accredited by and adhering to the national utilization review standards approved by the American accreditation health care commission; or

(2) such other utilization review organizations as the advisory committee may recommend and the commissioner approves.

**History:** L. 1994, ch. 238, § 6; L. 1998, ch. 14, § 1; July 1.

**40-22a07. Same; unlawful acts; penalties.** (a) (1) It is unlawful for any person or utilization review organization to perform utilization review activities in this state except in accordance with this act.

(2) No utilization review organization nor any individual performing utilization review activities may agree to be compensated or receive compensation which is contingent in any way upon frequency of certification denials, costs avoided by denial or reduction in payment of claims or other results which may be adverse to the needs of the patient as determined by the attending health care provider.

(b) When the commissioner has reason to believe a utilization review organization subject to this act has been or is engaged in any conduct which violates this act or any rules and regulations adopted pursuant to K.S.A. 40-22a11, the commissioner, after a hearing conducted in accordance with the Kansas administrative procedure act, may:

(1) Issue and cause to be served upon the utilization review organization an order requiring such organization to cease and desist from engaging in such violations;

(2) suspend or revoke the utilization review organization's certificate to perform utilization review affecting residents of this state;

(3) assess a monetary penalty of not less than $500 and not more than $1,000 for each violation; or

(4) apply any combination of the above provisions as the commissioner, by written order, deems appropriate.

**History:** L. 1994, ch. 238, § 7; July 1.

**40-22a08. Same; examination by commissioner; expenses.** Whenever the insurance commissioner deems it to be prudent for the benefit of the insureds, health care providers or insurers, the commissioner or any person designated by the commissioner may visit and examine the affairs of any utilization review organization to determine if the organization is in compliance with this act or rules and regulations adopted under this act or orders issued by the commissioner pursuant to such act or rules and regulations.

Any person or entity examined pursuant to the provisions of this section shall pay the reasonable and proper charges incurred for such examination, including the actual expenses of the insurance commissioner or the expenses and compensation of the commissioner's authorized representative and the expenses and compensation of assistants and examiners employed therein.

**History:** L. 1994, ch. 238, § 8; July 1.

**40-22a09. Same; written procedures for utilization review; patient information confidential.** Each utilization review organization shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

(a) Kept confidential in accordance with applicable federal and state laws; and

(b) used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management.

**History:** L. 1994, ch. 238, § 9; July 1.

**40-22a10. Same; patient information not subject to discovery or subpoena.** Any records, charts or other information exchanged be-



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tween a health care provider or patient and a utilization review organization shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity and shall not be admissible in evidence in any judicial or administrative proceeding other than a disciplinary proceeding by the state board of healing arts or other agency of the state which regulates health care providers.

**History:** L. 1994, ch. 238, § 10; July 1.

**40-22a11. Same; rules and regulations.** The commissioner shall adopt necessary rules and regulations, not inconsistent with this act, for implementing the provisions of this act.

**History:** L. 1994, ch. 238, § 11; July 1.

**40-22a12. Same; severability.** If any provision or clause of this act or application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this act that can be given effect without the invalid provision or application. To this end, the provisions of this act are declared to be severable.

**History:** L. 1994, ch. 238, § 12; July 1.

**40-22a13. External review of adverse health care decisions; definitions.** On and after January 1, 2000, for the purposes of K.S.A. 40-22a13 through 40-22a16 and amendments thereto:

(a) "Adverse decision" means a utilization review determination by a third-party administrator, a health insurance plan, an insurer or a health care provider acting on behalf of an insured that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational and, (1) if the requested service is provided in a manner that leaves the insured with a financial obligation to the provider or providers of such services, or (2) the adverse decision is the reason for the insured not receiving the requested services.

(b) "Emergency medical condition" means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy.

(c) "External review organization" means an entity that conducts independent external reviews of adverse decisions pursuant to a contract with the commissioner. Such entity shall have experience serving as the external quality review organization in health programs administered by the state of Kansas, or be a nationally accredited external review organization which utilizes health care providers actively engaged in the practice of their profession in the state of Kansas who are qualified and credentialed with respect to the health care service review. In the event no Kansas providers are qualified and credentialed with respect to the review of any case, the external review organization shall have the discretion to employ health care providers who actively engage in such health care provider's practice outside the state of Kansas.

(d) "Health insurance plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans.

(e) "Insured" means the beneficiary of any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, municipal group funded pool, and the self-funded coverage established by the state of Kansas, or any hospital or medical expense, health, hospital or medical service corporation contract or a plan provided by a municipal group-funded pool.

(f) "Insurer" means any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, provider sponsored organizations, municipal group-funded pool and the self-funded coverage established by the state of Kansas for its employees.

**History:** L. 1999, ch. 162, § 6; July 1.

**40-22a14. Same; exceptions; review procedure; confidentiality.** On and after January 1, 2000:

(a) The provisions of K.S.A. 40-22a13 through 40-22a16 and amendments thereto shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-227, and amend-



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(6) provides such other information or documentation as the commissioner requires.

(c) Certificates issued by the commissioner pursuant to this act shall remain effective until suspended, surrendered or revoked subject to payment of an annual continuation fee of $50.

(d) The commissioner with the advice of the advisory committee may suspend or revoke the certificate or any exemption from certification requirements upon determination that the interests of Kansas insureds are not being properly served under such certificate or exemption. Any such action shall be taken only after a hearing conducted in accordance with the provisions of the Kansas administrative procedure act.

**History.**—L. 1994, ch. 238, § 4.

### § 40-22a05. Advisory committee

(a) There is hereby created an advisory committee which shall assist the commissioner in the adoption of rules and regulations to implement the provisions of this act. The advisory committee shall consist of 13 persons appointed by the commissioner as follows:

(1) The commissioner, or the designee of the commissioner, who shall be the chairperson;

(2) one member appointed from the public at large;

(3) four members who are representatives of utilization review organizations; and

(4) seven members who are representatives of health care providers, one of which shall be a representative of a Kansas hospital, and two of which shall be persons licensed to practice medicine and surgery in Kansas.

(b) Members of the advisory committee shall be appointed for a term of three years, except that the first term of office of two members representing utilization review organizations and two members representing health care providers shall be for a term of two years, and the first term for two members representing health care providers and one member representing utilization review organizations shall be for a term of one year.

(c) The advisory committee shall be attached to the insurance department, and all administrative functions of the advisory committee shall





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be under the direction and supervision of the commissioner. Within available appropriations therefor, members of the advisory committee shall be paid subsistence allowances, mileage and other expenses as provided in subsection (e) of K.S.A. 75-3223 and amendments thereto.

(d) Before adopting rules and regulations to carry out the provisions of this act, the commissioner with the advice of the advisory committee shall:

(1) Establish utilization review standards which provide for uniformity in the procedures for interaction between utilization review organizations and health care providers, payors and consumers of health care;

(2) establish utilization review procedures that prevent unnecessary and inappropriate disruption to the health care delivery system;

(3) strive to achieve an efficient process for the certification of utilization review organizations; and

(4) specify the kinds of insurance or types of insurance products to which the standards apply and the scope of such application.

(e) This act shall not apply to:

(1) Utilization review of health care services provided to patients under the authority of the Kansas workers compensation act (K.S.A. 44-501 et seq., and amendments thereto);

(2) reviews conducted by any insurance company, health maintenance organization, prepaid service plan, group-funded self-insured plan or similar entity solely for the purpose of determining compliance with the specific terms and conditions of an insurance policy, agreement or contract as a part of the normal claim settlement process; or

(3) any medical programs operated by the secretary of social and rehabilitation services or any entity to the extent it is acting under contract with the secretary.

**History.**—L. 1994, ch. 238, § 5.

## § 40-22a06. Exemptions

(a) No certificate shall be required for utilization review activities conducted by or on behalf of:

(1) An agency of the federal government;





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# UTILIZATION REVIEW ORGANIZATION ADVISORY COMMITTEE

Chairperson: Insurance Commissioner or designee
Rich Huncker, Kansas Insurance Department

| | YEAR TERM EXPIRES |
|---|---|
| **One public at large:** | |
| Nancy Hiebert, Lawrence (public at large) | July 1, 2001 - June 30, 2004 |
| **Four representatives of URO's:** | |
| David J. Magill, Health Management Strategies International, Topeka (URO) | July 1, 1999 - June 30, 2002 |
| Dr. Jill Sumfest, Preferred Plus of KS, Inc., Wichita (URO) | July 1, 2001 - June 30, 2004 |
| Larry Pitman, Kansas Foundation for Medical Care, Topeka (URO) | July 1, 2001 - June 30, 2004 |
| Tom Johnson, Blue Cross/Blue Shield of Kansas, Topeka (URO) | July 1, 1999 - June 30, 2002 |
| **Seven representatives of health care providers (including one hospital and two licensed to practice medicine and surgery in Kansas):** | |
| Nancy Castellucci, Neosho Memorial (provider-hospital) | July 1, 1999 - June 30, 2002 |
| Dr. Ted Daugherty, Topeka (provider-physician) | July 1, 1999 - June 30, 2002 |
| Dr. Sanford Pomerantz, Kansas Psychiatric Society, Topeka (provider-psychiatrist) | July 1, 2000 - June 30, 2003 |
| William Albott, Ph.D, Topeka (provider-psychologist) | July 1, 2000 - June 30, 2003 |
| Dr. Brad Swanson, Winfield (provider-chiropractor) | July 1, 2001 - June 30, 2004 |
| Kelly D. Douglas, DDS, MS, Topeka (provider-dentist) | July 1, 2000 - June 30, 2003 |
| Mike Metro, Kansas State Nurses Assn., Salina (provider-nurse) | July 1, 2000 - June 30, 2003 |

Members serve a three-year term.

I/users/admin/word/boards/uro/urogov
8/01

Kathleen Sebelius
Commissioner of Insurance
**Kansas Insurance Department**

**MEMORANDUM**

TO: Members of Utilization Review Organization Advisory Committee

FROM: Richard G. Huncker, CIE
Accident and Health Supervisor

SUBJECT: October 22, 1998 Meeting

DATE: October 26, 1998

Enclosed you will find a copy of the minutes from the Advisory Committee meeting and the changes to the regulations that resulted from the meeting. Please review the minutes and the proposed regulation. If you have any changes to either the minutes or the language contained within the regulations please put your revisions in writing along with the basis for the change.

Once we receive your input we will start the process of adopting this regulation. Your response to this matter within ten days of receipt of this information would be greatly appreciated.

If you should have any questions regarding this matter please do not hesitate to contact Julie Gonzales or myself at (785) 296-7850.

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420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
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Consumer Assistance Hotline
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TO: Members of Utilization Review Organization Advisory Committee

FROM: Richard G. Huncker, CIE
Accident and Health Supervisor

SUBJECT: October 22, 1998 Meeting

DATE: October 26, 1998

A meeting of the Utilization Review Organization Advisory Committee was held on Thursday, October 22, 1998. The meeting was conducted at the Insurance Department in the third floor conference room. Along with the minutes from the meeting is attached a list of those who participated in the meeting and a copy of the agenda.

The meeting was called to order at 1:30pm. It began with the introduction of two new members, Nancy Castellucci, who is with Neosho Memorial Regional Medical Center and Clark Grimes who is our public representative.

Richard Huncker reviewed the history of the statute and regulation. As of the date of the Advisory Committee meeting we have issued approximately 206 certificates for utilization review.

Rich also asked how the committee members felt about the regulations and statute in terms of if they were helpful. Mike Metro stated that there were a lot less problems on the whole. They still see some problems with national companies going through mergers.

Nancy Castellucci has had problems with the criteria not being provided to them. They were recently fined $259 for a late review. A listing of the criteria that each utilization review organization uses would be helpful. Dr. Larry Stout added that many URO's use whichever criteria their consultant uses. David Magill added that the problems they have encountered have been very minimal. Tom Johnson added that when criteria are published it is a sort of "cookbook" medicine. Larry Pitman added that the criteria is only a tool. Dr. Ted Daughety indicated that publishing criteria did not impact appeals.

Larry Pitman brought to the discussion a concern with the definition of "Health Care Provider" being changed to "Attending Physician". The committee agreed as a whole to revert back to the old language and make no change to the definition of "Health Care Provider."

Nancy Castellucci suggested that the definition of "Health Professional" should state "an individual who: (1) has undergone formal training in a health care field; and (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field. The language that had been (3) was deleted.

Larry Pitman raised a question regarding the importance of the definition of "Review of Service Request". Tom Johnson stated that the definition was more of a benefit determination and did not really relate to utilization review activities. The committee decided that the definition was not necessary and it was deleted.

Larry Pitman also pointed out that the URAC 3.0 standards includes a definition for written notification which was not incorporated into our regulation. The definition will be added.

The language contained in K.A.R. 40-4-41b(a)(2) was changed to state: "Routinely request copies of clinical records on all patients reviewed. During prospective and concurrent review copies of clinical records shall only be required when a difficulty develops in certifying the necessity or appropriateness of the admission or extension of stay, frequency or duration of service. In those cases, only the necessary or pertinent sections of the record shall be required." The language "or length of anticipated inability to return to work" was deleted. Tom Johnson suggested that that language would pertain more to workers compensation.

It was then discussed that for purposes of consistency all references to "health care provider" that had been stricken through would be changed back.

Tom Johnson suggested that language be added to K.A.R. 40-4-41d(b) to say that "All the time limits apply in the absence of a contractual agreement." K.A.R. 40-4-41d(9)(b) will be changed to say "For services provided by a physician, M.D. or D.O. the reviewing physician must be board certified by:" K.A.R. 40-4-41d(c) will be changed to say "for non M.D., D.O, or physician be in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate;"

K.A.R. 40-4-41e (b)(4) will be changed to say "require initial clinical reviewers to be supported by a medical director or clinical director." K.A.R. 40-4-41e(c)(4)(b) will be deleted.

Nancy Castellucci wanted to leave the language "general type of criteria used by the review agent" in K.A.R. 40-4-41g(e)(1). The committee agreed that this would be appropriate. It was also discussed that the word "requirements" should be left after the word "management".

There were concerns brought up with regard to K.A.R. 40-4-41h regarding confidentiality and members were advised that the department will be looking into this further.

Mike Metro expressed concerns with subcontracting. He suggested that all subcontracted entities be certified to conduct utilization review activities. We will look at creating some language to accomplish this.

October 22, 1998 Advisory Committee Meeting

Members Involved:

Clark Grimes
Nancy Castellucci
Mike Metro
Larry W. Pitman
Dr. Larry E Stout
David Magill
Dr. Ted Doughety
Tom Johnson
Dr. Robert Sinnett
Richard Huncker

Others:

Becky Sanders (Legal Division- Kansas Insurance Department)
Julie Gonzales (Policy Examiner- Kansas Insurance Department)

TO: Members of Utilization Review Organization Advisory Committee

FROM: Julie Gonzales

SUBJECT: December 14, 2000 Meeting

DATE: December 27, 2000

A meeting of the Utilization Review Organization Advisory Committee was held on Thursday, December 14, 2000. The meeting was conducted at the Kansas Insurance Department in the third floor conference room.

Richard Huncker began the meeting with some general background information regarding the utilization review regulations.

Julie Gonzales provided an update on the number of certified utilization review organizations in Kansas. There are currently 227 certified utilization review organizations. 180 of those have URAC accreditation and the other 47 have completed the formal application process. A list of certified utilization review organization has been included with these minutes.

Richard Huncker went through the composition of the committee. K.S.A. 40-22a05 spells out the membership requirements for the committee. It is a thirteen-member committee comprised of the commissioner's designee, one public member, four utilization review organizations and seven providers. He also stated that the department had no controversies to report. He asked the committee members if there were any issues they would like to discuss. Committee members voiced no concerns about existing utilization review activities.

Introductions were made at this time. Those present at the meeting included: Dr. William Albott (new committee member), Dr. Ted Daughety, Larry Pitman, Rebecca Sanders, Richard Huncker and Julie Gonzales.

Richard Huncker indicated that the primary purpose for the meeting was to complete the process of updating the existing regulations in an effort to make them more uniform with URAC's standards. If URAC revises its standards in 2001, Julie will advise the advisory committee.

Rebecca Sanders stated that several of the changes to the proposed regulations are grammatical in nature. She also stated that the revision process is currently in the public comment period. She indicated that the Joint Committee on Rules and Regulations had several recommended changes that are not incorporated at this time. (See memo of 12/07/00 included with these minutes).

The committee discussed each of the Joint Committee on Rules and Regulations concerns as follows:

- **K.A.R. 40-4-41(c)(32)**
  The Joint Committee recommended striking the word "general" from the definition of principal reason.

  Dr. Albott suggested that "general" doesn't really add anything. The committee agreed and "general" will be stricken.

- **K.A.R. 40-4-41(c)(36)**
  The Joint Committee recommends using the defined term "written notification" to allow other means of written or electronic means of communicating a reconsideration request.

Dr. Albott suggested adding "or written notification" after "by telephone" since written notification is defined in K.A.R. 40-4-41(c)(47) to mean correspondence transmitted by mail, facsimile, or electronic medium. The committee agreed and the change will be made.

Julie Gonzales added that Clark Grimes, who was not able to attend the meting due to inclement weather, had called and suggested that the regulations include a definition of nurse practitioner.

Larry Pitman stated that nurse practitioners work under the auspices of licensed physicians and can do nothing without the written order of a physician.

Richard Huncker added that the definition of "provider" includes nurse practitioners now. No change was made.

Larry Pitman asked if K.A.R. 40-4-41(c)(19)(A)(i) should include chiropractic and dental.

Dr. Daughety asked if chiropractic services are separated anywhere else.

Richard Huncker stated that the definition generally encompasses the whole gamete of health care coverages that are included in an accident and health policy. He also said that he knew of nothing in our laws that specifically identifies chiropractic.

Dr. Daughety asked if it could be presumed that dental or chiropractic would be excluded.

Richard Huncker pointed out that those services are not excluded in K.A.R. 40-4-41(c)(19)(B) so they would be included.

Rebecca Sanders indicated that Mr. Huncker's statement would be a correct legal interpretation. The committee agreed that since they are not excluded there was no change required.

Dr. Albott suggested that K.A.R. 40-4-41(c)(21)(B) be revised by striking "holds an associate or higher degree in a health care field". The committee agreed and the change will be made.

Rebecca Sanders stated that the Joint Committee on Rules and Regulations wanted a better definition of "Scripted Clinical Screening" in K.A.R. 40- 4-41(c)(38)(A).

Larry Pitman stated that Scripted Clinical Screening is a tool by which trained review personnel can evaluate care being provided and if the scripted criteria are met the services are authorized. If the criteria are not met it is referred on to a health care professional.

Rebecca Sanders stated that the Joint Committee recommended using "working day" in K.A.R. 40-4-41d(a)(2). The committee had no problem with the change.

The Joint Committee also had a concern with K.A.R. 40-4-41d(b). The committee decided to add "written notification" to address their concerns.

The public hearing for the updated regulations is scheduled for January 12, 2001 at 10:00am at the Kansas Insurance Department. Rebecca Sanders stated that public comments could be submitted to her attention in writing via the mail or email prior to the public hearing. Also, the Joint Committee had concerns with our Economic Impact Statement (see memo of December 13, 2000). They need to have dollar amounts as to how much it will cost standard utilization review organizations to comply with the proposed changes. If anyone has any information regarding these costs they should let her know. She will contact some of the standard utilization review organizations for feedback on what would be required for them to comply.

Larry Pitman asked if K.A.R. 40-4-41d(9)(B) should be board certified or board eligible.

Dr. Daughety said that the American Board of Medical Specialties no longer uses the term "board eligible".

Dr. Albott suggested striking "preestablished" from K.A.R. 40-4-41f(a)(2).

Dr. Albott stated that the definition also says promotes objective and systematic monitoring so it doesn't open the door for just anybody to develop criteria.

Richard Huncker stated that we will make the changes and strike preestablished since the committee was okay with that change.

Dr. Albott had a major concern with K.A.R. 40-4-41g and its definition of normal business day. He would like to see it extended to be 6am to 8pm. As a provider who frequently sees patients at early and late hours 9-4pm is a narrow window.

Richard Huncker said that he could understand the problem but thought that this would cause a big economic impact.

Dr. Daughety suggested the removal of "standard" from central time since sometimes it is "daylight savings" time.

Richard Huncker stated that we would make that change. He then asked Dr. Albott how serious he was with the hours of operations issue. Dr. Albott said that he wasn't terribly serious. His concern is that when we define it as 9-4pm that this is organization friendly but not provider friendly so what it does is cause an economic impact on every provider.

Dr. Daughety added that 9-4pm is stated as a minimum.

Julie Gonzales will contact URAC on this point to see if they have considered any changes to their hours of operation requirements.

Julie Gonzales stated that Nancy Castellucci (unable to attend due to weather) has a concern with the fact that she calls an 800 number and then ends up calling a regular phone number and is charged for the call. Julie will contact Nancy for more information and name of any specific utilization review organizations that are doing this.

Richard Huncker said that a utilization review organization could lose its certification through a hearing process and monetary penalties could be involved.

Julie Gonzales brought up the NCQA issue. NCQA wishes to be recognized like URAC in Kansas as an accrediting entity for utilization review organizations. See handout included with these minutes.

Richard Huncker asked if we would have to change the law.

Rebecca Sanders stated that K.S.A. 40-22a06 would allow for it if the advisory committee recommended NCQA and the commissioner approved it.

Julie Gonzales said that NCQA is supposed to be providing a side-by-side comparison of their program and URAC's program.

Dr. Albott said the "differences" might be the key.

Larry Pitman suggested that we also ask to see the marketing material that NCQA will be using.

STATE OF KANSAS

BEN F. BARRETT
DIRECTOR
WILLIAM G. WOLFF
ASSOCIATE DIRECTOR
ALAN D. CONROY
CHIEF FISCAL ANALYST

STAFF
LEGISLATIVE COORDINATING COUNCIL
INTERIM COMMITTEES
STANDING COMMITTEES
LEGISLATIVE INQUIRIES

# THE LEGISLATIVE RESEARCH DEPARTMENT

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December 7, 2000

Kathleen Sebelius, Commissioner
Kansas Insurance Department
420 SW 9th Street
Building Mail

Dear Commissioner Sebelius:

At its meeting on December 6, 2000, the Joint Committee on Administrative Rules and Regulations reviewed for public comment rules and regulations concerning utilization review organizations. After discussion, the Committee expressed the following comments.

- KAR 40-4-41 In subsection (c) paragraph (32), strike the word "general." In paragraph (36) use the defined term "written notification" to allow other means of written or electronic means of communicating a reconsideration request (see the language in KAR 40-4-41d (a)(5)). And, in paragraph (38)(A) develop a better definition of the term "Scripted clinical screening."

- KAR 40-4-41d. In subsection (a)(2), clarify the wording that access must be provided within one business day. .. (a)(6), is "working day" meant to be the same as "business day."

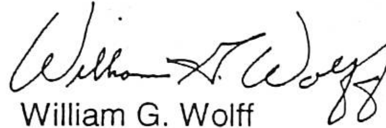
  In subsection (b), would the definition of the term "written notification" also be applicable for standard appeals.

- Economic Impact. The Department has used nearly identical language to express the economic impact of the regulations. However, there is nothing in that language that provides the actual or estimated costs of the proposed regulations. Revise the economic impact statement to provide more specific cost data.

Please make these comments a part of the public record on these regulations. The Committee will review the regulations which the agency ultimately adopts and reserves any

expression of legislative concern to that review. To assist in that final review, please inform the Joint Committee in writing, at the time the rules and regulations are adopted and filed with the Secretary of State of any and all changes which have been made following the public hearing.

Sincerely,



William G. Wolff
Associate Director

WGW/aem

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KANSAS INSURANCE DEPARTMENT
420 S.W. NINTH STREET
TOPEKA, KANSAS 66612

# Memo

**To: Members of the Utilization Review Advisory Committee**

**From:** Rebecca A. Sanders
Staff Attorney

**Date:** 12/13/00

**Re: Revised Utilization Review Regulations**

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The Kansas Legislature has requested that the Kansas Insurance Department attempt to quantify the economic impact that these regulations will have on utilization review organizations, insurance companies and consumers. In an attempt to provide the best information and estimate that we can to the legislature we need your assistance. You have all been given copies of the amended regulations. The following is my summary of these amended regulations and proposed regulations. If you would please review this summary and the regulations and provide me with an estimate if you can, of the economic impact of these revised and proposed regulations will have on your organization and the clients you serve including insurance companies and consumers by January 8, 2001.

If the particular regulation will have an economic impact please say so. If the change results in reduced costs please provide an estimate in terms of money the best that you can. The same applies if these changes are going to result in increased costs. I certainly appreciate any assistance that you can give. If you have any questions after today's meeting feel free to contact me by telephone, at 785-296-6664 or by e-mail bsanders@ins.wpo.state.ks.us.

The following is my summary of the revisions and the proposed regulations:

K.A.R. 40-4-41 is the definition regulation and the proposed revisions add 29 new definitions.

K.A.R. 40-4-41b has minor changes but the revisions do put a limitation of what information should be considered in reviews.

K.A.R. 40-4-41c has revisions that require reviewers to discuss noncertifcation decisions with providers or consumers if requested, provide clinical rationale in written notices and discuss if requested and inform providers or consumers of the appeal procedures.

K.A.R. 40-4-41d is the regulation that sets out required appeal procedures. The revisions set out what training or qualifications a reviewer shall have.

K.A.R. 40-4-41e is the regulation that outlines staff requirements. The revisions outline what nonclinical staff can do, supervision that is required, and what qualifications peer reviewers shall have.

K.A.R. 40-4-41f sets out review requirements. The revisions require utilization review organizations to have a quality management program and the basic requirements of such a program.

K.A.R. 40-4-41g has such minor revisions that I would estimate that these changes have no economic impact.

K.A.R. 40-4-41h is a new regulation and sets out the criteria if utilization review organization subcontract out their functions.

K.A.R. 40-4-41i is a new regulation and sets out the criteria for scripted clinical screening and explicit clinical review criteria.

K.A.R. 40-4-41j is a new regulation and requires utilization review organizations to have policies and procedures to maintain the confidentiality of patient specific information.

Again if your organization already meets the standards set out in these regulations then the only statement I would need is no economic impact. It would be helpful to know why you are already meeting these standards like you are URAC accredited or these have always been our procedure or procedures.

Again thank you again for your assistance in this project and I look forward to hearing from you.

# NCQA

*Measuring the Quality of America's Health Care*

December 13, 2000

Ms. Julie Gonzales
Policy Examiner
Kansas Department of Insurance
420 SW 9th Street
Topeka, KS 66612

FACSIMILE TRANSMISSION – (785) 291-3673

RE: K.S.A. Section 40-22a-06(b)(2) and recognition of accreditation by the National Committee for Quality Assurance (NCQA) for utilization review

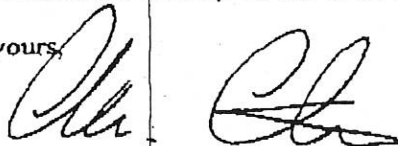
Dear Ms. Gonzales:

Thank you for the opportunity to provide to you in writing NCQA's intention to request recognition from the Kansas Department of Insurance for the purposes of Kansas Statutes Annotated Section 40-22a-06(b)(2). NCQA recognizes that, for the purposes of that code section, the Advisory Committee must recommend what types of utilization review organizations will qualify. While the statute currently recognizes URAC accreditation explicitly, NCQA believes that this statutory provision gives the Commissioner and the Advisory Committee the authority to also recognize NCQA accreditation along similar lines. As you are aware, NCQA has several accreditation programs that incorporate stringent utilization review standards. These standards are an integral part of our Managed Care Organization (MCO), Preferred Provider Organization (PPO), and other health plan accreditation programs.

Our goal is to provide the Advisory Committee with a formal request for consideration in the coming weeks. In the meantime, please do not hesitate to advise us on the types of documentation or information the Commissioner and the Advisory Committee will require from us in order to make an informed determination.

Feel free to contact me directly on this issue at (202) 955-3581. I am,

Very truly yours,



Alexander S. Choinski
Senior Analyst, Public Policy

Article 4 – Accident and Health Insurance – Utilization Review and Utilization Review Organizations

KAR 40-4-41 – 40-4-41j

History: Effective June 12, 1995 (40-4-41 through 40-4-41g).
Effective May 16, 1997: Amended 40-4-41c
Effective June 22, 2001: Amended all but 40-4-41a and added 40-4-41h, 40-4-41i, 40-4-41j

| | |
|---|---|
| KAR 40-4-41. | Application and definitions |
| KAR 40-4-41a. | URO responsibility for requesting certification. |
| KAR 40-4-41b. | Requirements for collecting information. |
| KAR 40-4-41c. | Written procedures |
| KAR 40-4-41d. | Appeal procedures |
| KAR 40-4-41e. | Staff requirements |
| KAR 40-4-41f. | Review requirements |
| KAR 40-4-41g. | Access to review staff |
| KAR 40-4-41h. | Subcontracting and delegation |
| KAR 40-4-41i. | Program qualifications |
| KAR 40-4-41j. | Written procedures to maintain confidentiality |

(9) metal crates with compartments that are at least 36 inches wide, 42 inches deep, and 36 inches high and equipped with drop latches and casters;

(10) not more than 72 greyhounds housed in each kennel building with not more than one greyhound in each crate, unless the racing judges have approved a specific request otherwise;

(11) a kitchen area equipped with a hot water heater with a minimum capacity of 20 gallons, a deep sink of durable construction with a drain board, adequate shelving and cabinet space, and a shower and commode in an enclosed area;

(12) one floor drain in each crate area and one floor drain in each kitchen area;

(13) a climate control system that is capable of maintaining a temperature between 68 and 75 degrees fahrenheit;

(14) smoke and temperature alarms in each kennel area connected to the compound security office and capable of alerting security of emergency conditions;

(15) emergency backup power adequate to provide continuous ventilation that will protect the greyhounds if a power failure occurs at any time during a racing season scheduled in the months of May through September;

(16) a fresh air ventilation system or at least four windows of approximately four square feet each that are equipped with screens and may be opened;

(17) lighting to adequately illuminate all areas inside the kennel;

(18) adequate space within the kennel building for each contract kennel to place a dog walking machine and adequate floor space within the crate area for a hydrotherapy vat; and

(19) on-line hookup for a telephone and a video monitoring system that permits the trainers to watch the races.

(h) Unless otherwise approved by the commission, each organization licensee shall provide sprint paths as follows:

(1) One sprint path measuring at least 16 feet by 350 feet, equipped with a common center fence, and heated by a closed-fluid winterization system extending the length and width of the sprint path;

(2) two open sprint paths measuring at least 20 feet by 500 feet;

(3) one all-weather surface road sufficient to operate a vehicle adjacent to each sprint path; and

(4) a sprint path surface to which chemicals shall not be applied.

(i) Each sprint path shall be located so that sprint activity does not disturb greyhounds in the kennel compound area. Each sprint path shall be available for use at all times, except during racing hours, and shall be equipped with side gates through which greyhounds may enter the path and a gate through which a kennel vehicle may be driven. (Authorized by K.S.A. 2000 Supp. 74-8804; implementing K.S.A. 2000 Supp. 74-8804, K.S.A. 2000 Supp. 74-8813; effective July 23, 1989; amended March 19, 1990; amended Aug. 9, 1996; amended June 22, 2001.)

Tracy T. Diel
Acting Executive Director

Doc. No. 026686

State of Kansas

## Kansas Insurance Department

### Permanent Administrative Regulations

#### Article 1.—GENERAL

**40-1-8.** (Authorized by K.S.A. 40-103, 40-928(f); implementing K.S.A. 40-216, 40-246a, 40-1113; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; revoked June 22, 2001.)

**40-1-13.** (Authorized by K.S.A. 40-103; implementing 40-246a, 40-252; effective Jan. 1, 1966; amended Jan. 1, 1973; amended May 1, 1986; revoked June 22, 2001.)

#### Article 3.—FIRE AND CASUALTY INSURANCE

**40-3-29.** (Authorized by K.S.A. 40-103; implementing K.S.A. 40-281; effective Jan. 1, 1968; amended May 1, 1986; revoked June 22, 2001.)

#### Article 4.—ACCIDENT AND HEALTH INSURANCE

**40-4-41. Utilization review organizations; application; definitions.** (a) Except as provided in K.S.A. 40-22a06(b), and amendments thereto, each organization offering utilization review services that is required to apply for a certificate pursuant to K.S.A 40-22a01, et seq., and amendments thereto, shall comply with these regulations. Utilization review services subject to these regulations shall include the following:

(1) Prospective, concurrent, and retrospective utilization review for inpatient and outpatient care rendered by a health care provider; and

(2) utilization review activity conducted in connection with health benefit plans.

(b) Notwithstanding adherence to the standards prescribed by these regulations, the decision as to what treatment to prescribe for an individual patient shall remain that of the health care provider, and either the patient or the patient's representative. The final decision as to whether the prescribed treatment constitutes a covered benefit shall be the responsibility of the claims administrator or health benefit plan.

(c) As used in these regulations, these terms shall have the following meanings:

(1) "Advisory board of osteopathic specialists (ABOS)" means the American osteopathic association (AOA) certification agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and the pattern of training.

(2) "American board of medical specialties (ABMS)" means the entity that was organized originally in 1933 as the advisory board of medical specialties, collaborated in 1970 with the American medical association (AMA), and is the recognized certifying agent for establishing and maintaining standards of medical specialization and the pattern of training.

(3) "Appeal" means a formal request to reconsider a determination not to certify an admission, extension of stay, or other health care service.

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(4) "Appeals consideration" means clinical review conducted by appropriate clinical peers who were not involved in peer clinical review, when a decision not to certify a requested admission, procedure, or service has been appealed. This term is sometimes referred to as "third-level review."

(5) "Attending health care provider" means the health care provider who is selected by, or assigned to the patient and who has primary responsibility for the treatment and care of the patient as provided by the applicable licensing, registration, or certification requirements of Kansas.

(6) "Board-certified" means a label indicating that a physician has passed an examination given by a medical specialty board and has other eligibility requirements that certify the physician as a specialist in that area.

(7) "Case management" means a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

(8) "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(9) "Claims administrator" means any entity that recommends or determines whether to pay claims to enrollees, health care providers, physicians, hospitals, or others on behalf of the health benefit plan. These payment determinations shall be made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third party administrators, or other private contractors.

(10) "Clinical director" means a health professional who meets the following criteria:

(A) Is duly licensed or certified;

(B) is an employee of, or party to a contract with, a utilization review organization; and

(C) is responsible for clinical oversight of the utilization review program, including the credentialing of professional staff and quality assessment and improvement functions.

(11) "Clinical peer" means a physician or other health professional who holds an unrestricted license and is in the same or similar specialty as that which typically manages the medical condition, procedures, or treatment under review. As a peer in a similar specialty, the individual shall be in the same profession, which shall mean the same licensure category, as that of the ordering provider.

(12) "Clinical rationale" means a statement providing additional clarification of the clinical basis for a noncertification determination. The clinical rationale shall relate the noncertification to the patient's condition or treatment plan and shall supply a sufficient basis for a decision to pursue an appeal.

(13) "Clinical review criteria" means the written policies, screens, decision rules, medical protocols, or guidelines used by the utilization review organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

(14) "Concurrent review" means a utilization review conducted during a patient's inpatient stay or course of treatment and is sometimes called a "continued stay review."

(15) "Discharge planning" means the process that assesses a patient's needs in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

(16) "Enrollee" means an individual who participates in, and is covered by a health plan.

(17) "Expedited appeal" means a request by telephone for an additional review of a determination not to certify imminent or ongoing services that requires a review conducted by a clinical peer who was not involved in the original determination not to certify.

(18) "Facility rendering service" means the institution or organization in which the requested admission, procedure, or service is provided. These facilities may include the following:

(A) Hospitals and outpatient surgical facilities;

(B) individual practitioner offices;

(C) rehabilitation centers;

(D) residential treatment centers;

(E) skilled nursing facilities;

(F) laboratories; and

(G) imaging centers.

(19) "Health benefit plan" means any public or private organization's written plan that insures or pays for specific health care expenses on behalf of enrollees or covered persons.

(A) "Health benefit plan" shall include the following:

(i) Any individual, group, or blanket policy of accident and sickness, medical, or surgical expense coverage; and

(ii) any provision of a policy, contract, plan, or agreement for medical service, including any contract of a health maintenance organization, non-profit medical and hospital service corporation, or municipal group-funded sickness and accident pool.

(B) "Health benefit plan" shall not include any of the following:

(i) A policy or certificate covering only credit;

(ii) a policy or certificate covering only disability income;

(iii) coverage issued as a supplement to liability insurance;

(iv) insurance arising out of a workers compensation or similar law;

(v) automobile medical payment insurance;

(vi) insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy;

(vii) medicare; or

(viii) medicaid.

(20) "Health care provider" shall have the meaning ascribed by K.S.A. 40-22a03(d) and amendments thereto.

(21) "Health professional" means an individual who meets the following criteria:

(continued)

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(A) Has undergone formal training in a health care field; and

(B) holds a state license or state certificate in a health care field.

(22) "Initial clinical review" means the clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but shall refer requests that do not meet clinical review criteria to peer clinical review for certification or noncertification. The term is sometimes referred to as "first-level review."

(23) "Inpatient care" means admissions to and services provided in all licensed medical care facilities and other licensed inpatient facilities, including skilled nursing facilities, residential treatment centers, and freestanding rehabilitation facilities.

(24) "License" means a license or permit to practice medicine or a health profession issued by any state or jurisdiction of the United States.

(25) "Medical director" means a doctor of medicine or doctor of osteopathic medicine who meets the following criteria:

(A) Is duly licensed to practice medicine;

(B) is an employee of, or a party to a contract with, a utilization review organization; and

(C) has responsibility for clinical oversight of the utilization review organization's utilization review, credentialing, quality management, and other clinical functions.

(26) "Nonclinical administrative staff" means staff who do not meet the definition of "health professional."

(27) "Ordering provider" means the specific physician or other provider who prescribed the health care service being reviewed.

(28) "Outpatient care" means health care provider diagnostic and therapeutic services provided at any medical care facility, and other outpatient locations, including laboratories, radiology facilities, provider offices, and patient homes.

(29) "Patient" means the enrollee or covered person who files a claim for benefits or for whom a claim for benefits has been filed.

(30) "Peer clinical review" means clinical review conducted by appropriate health professionals when a request for an admission, procedure, or service was not approved during the initial clinical review. This term is sometimes referred to as "second-level review."

(31) "Peer clinical reviewer" means a health care provider who holds a nonrestricted license in a state of the United States and who is in the same or similar profession as that which typically manages the health condition, procedure, or treatment under review.

(32) "Principal reason" or "principal reasons" means a clinical or nonclinical statement describing the reason or reasons for the noncertification determination. "Lack of medical necessity" shall not be deemed sufficient to meet this definition.

(33) "Prospective review" means any utilization review conducted before a patient's admission, stay, or other service or course of treatment and is sometimes called "precertification review."

(34) "Provider" means a licensed health care facility, program, agency, or health professional that delivers health care services.

(35) "Quality management program" means a structured program that, at a minimum, monitors and evaluates the quality and effectiveness of a utilization management organization's policies, progress, and practices and provides management intervention, as needed, to support compliance with these standards.

(36) "Reconsideration" means a request by telephone or written notification for additional review of a utilization review determination not to certify, which shall be performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

(37) "Retrospective review" means a review of services provided after the discharge of the patient.

(38) "Scripted clinical screening" is a process using scripted criteria by which trained personnel can perform a preliminary or continued standardized review or evaluation of medical care being provided or to be provided. If the scripted criteria are met, the medical services are authorized. If the scripted criteria are not met, the case is referred to a health professional for further review.

(39) "Review of service request" means the review of information submitted to the utilization review organization for health care services that neither require medical necessity certification nor result in a noncertification decision.

(40) "Second opinion" means the requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.

(41) "Standard appeal" means a request to review a determination not to certify an admission, extension of stay, or other health care service, which shall be conducted by a peer clinical reviewer who was not involved in any previous noncertification pertaining to the same episode of care.

(42) "Structured clinical data" means clinical information that is precise and permits exact matching against explicit medical terms, diagnoses, or procedure codes, or other explicit medical terms, diagnoses, or procedure codes, or other explicit choices, without the need for interpretation.

(43) "Utilization management (UM)" shall have the same meaning as that ascribed to "utilization review (UR)," which is defined in K.S.A. 40-22a03(b) and amendments thereto.

(44) "Utilization review (UR)" shall have the meaning ascribed by K.S.A. 40-22a03(b) and amendments thereto.

(45) "Utilization review organization" shall have the meaning ascribed by K.S.A. 40-22a03(c) and amendments thereto.

(46) "Variance" means a deviation from a specific standard that can be supported by a federal or state law or regulation or by a contractual agreement and that the commissioner of insurance determines as sufficient to reflect the intent of K.S.A. 40-2201 et seq., and amendments thereto, these regulations, and the rights of the parties involved.

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(47) "Written notification" means correspondence transmitted by mail, facsimile, or electronic medium. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.)

**40-4-41b. Utilization review organizations; requirements for collecting information.** When conducting routine prospective, concurrent, and retrospective utilization reviews, each utilization review organization shall comply with the following requirements:

(a) Each utilization review organization shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, and frequency or duration of services. Utilization review organizations shall not perform any of the following:

(1) Routinely require health care providers to supply numerically codified diagnoses or procedures to be considered for certification. Utilization review organizations may ask for this coding since, if it is known, its inclusion in the data collected increases the effectiveness of the communication;

(2) routinely request copies of clinical records on all patients reviewed. During prospective and concurrent review, copies of clinical records shall be required only when a difficulty develops in certifying the necessity or appropriateness of the admission or extension of stay, or the frequency or duration of service. In those cases, only the necessary or pertinent sections of the record shall be required; or

(3) request a review of all records on all patients. This shall not preclude a request for copies of relevant clinical records retrospectively for clinical review for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or utilization review provisions. With the exception of reviewing records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers shall be entitled to reimbursement for the reasonable direct costs of duplicating requested records.

(b) Each utilization review organization shall accept required or requested information when submitted on claim forms as authorized by K.S.A. 40-2253, and amendments thereto, and K.A.R. 40-4-40.

(c) Each utilization review organization shall limit its data requirements to the following elements unless otherwise prescribed in these regulations:

(1) Patient information, which shall include the patient's name, address, telephone number, date of birth, gender, social security number or patient identification number, the name of the carrier or plan, including the plan type, and plan identification number;

(2) enrollee information, which shall include the enrollee's name, address, telephone number, social security number or employee identification number, relation to patient, employer, health benefit plan, group number or plan identification number, and other types of coverage available, including workers compensation, auto, tricare (formerly known as champus), medicare, or other coverage;

(3) health care provider information, which shall include the provider's name, address, telephone number, degree, specialty or certification status, and tax identification or other identification number;

(4) diagnosis or treatment information, which shall include the primary diagnosis, secondary diagnosis, tertiary diagnosis, multiaxial diagnosis, proposed or provided procedures or treatments, surgical assistant requirement, anesthesia requirement, admission or service dates, the procedure date, and the proposed length of stay;

(5) clinical information sufficient to support the appropriateness and level of service proposed or provided, and the name of a contact person for detailed clinical information;

(6) facility information, which shall include the following:

(A) The type of facility, including an inpatient or outpatient facility, special unit, skilled nursing facility, rehabilitation facility, office, or clinic;

(B) the licensing or certification status of the facility, including any applicable diagnostic-related group exempt status; and

(C) the facility's name, address, telephone number, and tax identification number or other identification number;

(7) concurrent or continued stay review information, which shall include the following:

(A) The number of additional days, services, or procedures proposed;

(B) a description of the reasons for the extension, including clinical information sufficient to support the appropriateness and level of service proposed;

(C) information regarding the continued or changed diagnoses; and

(D) discharge planning;

(8) information on admissions to facilities other than medical care facilities, which shall include a history of the present illness, the patient treatment plan and goals, the prognosis, staff qualifications, and 24-hour availability of appropriate staff;

(9) additional information for specific review functions, which may include discharge planning or catastrophic case management or, when applicable, second opinion information sufficient to support benefit plan requirements; and

(10) other additional information when there is a significant lack of agreement between the utilization review organization and health care provider regarding the appropriateness of certification. Significant lack of agreement shall mean that the utilization review organization meets the following conditions:

(A) Has tentatively determined, through its professional staff, that a service cannot be certified;

(B) has referred the case to a peer clinical reviewer for review; and

(C) for prospective and concurrent review, has talked to or attempted to talk to the health care provider for further information.

(d) Each utilization review organization shall share all clinical and demographic information on individual pa-

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tients among its various divisions to avoid duplicate requests for information from enrollees or providers.

(e) For prospective review and concurrent review, each utilization review organization shall base its review determinations solely on the medical information obtained by the utilization review organization at the time of the review determination.

(f) For retrospective review, each utilization review organization shall base its review determinations solely on the medical information available to the attending health care provider or ordering provider at the time the medical care was provided.

(g) Each utilization review organization shall reverse its certification determination only if information provided to the utilization review organization is materially different from that which was reasonably available at the time of the original determination. (Authorized by K.S.A. 40-103 and K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.)

**40-4-41c. Utilization review organizations; written procedures.** Each utilization review organization shall maintain the following written procedures:

(a) Written procedures to assure that reviews and second opinions are conducted in a timely manner shall be maintained as follows:

(1) Each utilization review organization shall make prospective or concurrent certification determinations within two working days of receipt of the necessary information on a proposed admission or service requiring a review determination. Collection of the necessary information may necessitate a discussion with the health care provider or, based on the requirements of the health benefit plan, may involve a completed second opinion review.

(2) The utilization review organization may review ongoing inpatient stays, but shall not routinely conduct a daily review of all these stays. The frequency of the review for extension of the initial determination may vary, based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(3) Each utilization review organization shall make retrospective determinations, in the absence of any contractual agreement, within 30 days of the receipt of the necessary information.

(b) Each utilization review organization shall maintain written procedures for providing notification of determinations regarding all forms of certification in accordance with the following:

(1) When an initial determination is made to certify, the utilization review organization shall notify the attending health care provider or other ordering provider, facility rendering service, and enrollee or patient promptly in writing, by telephone, or by electronic transmission.

(2) The utilization review organization shall transmit each determination to certify an extended stay or additional services resulting from a concurrent review to the attending health care provider or other ordering provider and the facility rendering services by telephone, by electronic transmission, or in writing. The determination shall be transmitted within one working day of receipt of all information necessary to complete the review process, but not later than the end of a current certified period.

(3) If a utilization review organization transmits written confirmation of certification for continued hospitalization or services, that notification shall include, when possible, the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or onset of services.

(4) When a prospective or concurrent review determination is made not to certify an admission or extension of an inpatient stay, course of treatment, or other service requiring a review determination, the decision shall be made by a peer clinical reviewer only after not less than two bona fide attempts have been made to contact and consult with the attending health care provider.

(A) If the attending health care provider cannot be contacted in a timely manner, the utilization review organization shall send written notification to the attending health care provider or ordering provider and the enrollee or patient within one working day following the determination. Each notification shall be accompanied by the most appropriate telephone number necessary to facilitate an expedited appeal.

(i) The utilization review organization shall provide within one business day of receipt of the request the opportunity for the attending health care provider or other ordering provider to discuss the noncertification decision with a clinical peer reviewer, if the original peer reviewer cannot be available within one business day.

(ii) If a reconsideration or peer-to-peer conversation does not resolve a difference of opinion, the utilization review organization shall, at the time of the conversation, inform the attending health care provider or other ordering provider of the right to initiate an expedited appeal or standard appeal and the procedure to do so.

(B) The written notification shall include the principal reasons for the determination and procedures to initiate an appeal of the determination. A determination not to certify may be based on a lack of adequate information to certify after a reasonable attempt has been made to contact the health care provider.

(C) Each of the letters to the provider, patient, and facility shall include a statement that the clinical rationale used in making the noncertification decision shall be provided in writing upon request.

(D) Upon request, the utilization review organization shall provide the clinical rationale in writing to the provider, patient, or facility rendering service.

(5) When a retrospective determination is made not to certify an admission, stay, or other service, the decision shall be made only by a peer clinical reviewer. The utilization review organization shall provide written notification of the determination to attending health care provider or other ordering provider, patient, and hospital or facility rendering services. The written notification shall include the principal reasons for the determination and procedures to initiate a standard appeal of the determination. The notification shall include a statement that the clinical rationale used in making the determination will

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be provided in writing upon request. A determination not to certify may be based on a lack of adequate information to certify after a reasonable attempt has been made to contact the health care provider.

(c) Each utilization review organization shall maintain written procedures to address the failure or inability of a health care provider, patient, or other representative to provide the necessary information for review. If the patient or provider will not release the necessary, clinically relevant information to the utilization review organization, the utilization review organization may administratively deny certification in accordance with its own policy or that of the health benefit plan. (Authorized by K.S.A. 40-103 and K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended May 16, 1997; amended June 22, 2001.)

**40-4-41d. Utilization review organizations; appeal procedures.** Each utilization review organization shall have in place procedures for appeals of a determination not to certify an admission, procedure, service, or extension of stay. The right to appeal shall be available to the patient or enrollee, the representative of the patient or enrollee, and the attending health care provider, other ordering provider, or facility rendering service on behalf of the patient. Hospitals or other health care providers may assist in an appeal. The procedures for appeals shall include, at a minimum, the following:

(a) Expedited appeal.

(1) When an initial determination not to certify a health care service is made before or during an ongoing service requiring review, and the attending health care provider or other ordering provider believes that the determination warrants immediate appeal, the attending health care provider or other ordering provider shall have an opportunity to appeal that determination over the telephone or via facsimile on an expedited basis.

(2) Each utilization review organization shall provide reasonable access to a peer clinical reviewer, not to exceed one working day, by telephone or in person to discuss the determination with the attending health care provider or other ordering providers. The peer clinical reviewer shall be available for these appeals during normal business hours.

(3) The peer clinical reviewer shall have immediate access to the material that formed the basis for the original determination when discussing an appeal.

(4) The utilization review organization shall not be required to provide a peer clinical reviewer other than the peer clinical reviewer who made the original decision if the attending health care provider or other ordering provider only needs to supply additional or new information that will justify the need for the health care service or treatment.

(5) Health care providers and utilization review organizations shall attempt to share the maximum amount of information by telephone, facsimile, or other means to resolve the expedited appeal satisfactorily.

(6) The utilization review organization shall notify the attending health care provider or the ordering provider of its decision regarding the expedited appeal by telephone at the time the decision is made and shall notify either the attending health care provider or other ordering provider and the enrollee in writing within one working day.

(7) Expedited appeals that do not resolve a difference of opinion may be resubmitted through the standard appeal process.

(8) Noncertifications made on a retrospective basis may be appealed only through the standard appeal process.

(b) Standard appeal. The utilization review organization shall establish procedures for appeals to be made either in writing or by telephone.

(1) Each utilization review organization shall notify in writing the enrollee or patient, attending health care provider or other ordering provider, and claims administrator of its determination on the appeal as soon as practical, but never later than 30 days, in the absence of any contractual agreement, after receiving the required documentation for the appeal.

(2) The documentation required by the utilization review organization may include copies of part or all of the clinical record or a written statement from the attending health care provider or other ordering provider.

(3) Before upholding the original decision not to certify for clinical reasons, a peer clinical reviewer who did not make the original noncertification determination shall review the documentation.

(4) The process established by a utilization review organization may include a period within which an appeal shall be filed to be considered.

(5) Each attending health care provider or other ordering provider who unsuccessfully appeals a determination not to certify shall be provided the clinical basis for that determination in writing, upon request.

(6) In cases involving physician-directed services in which an appeal to reverse a determination not to certify for medical reasons is unsuccessful, the utilization review organization shall assure that a peer clinical reviewer, in the same or a similar medical specialty as that of the attending health care provider or other ordering provider, is reasonably available to review the case as mutually deemed appropriate.

(7) In cases involving other than physician-directed services in which an appeal to reverse a determination not to certify for clinical reasons is unsuccessful, the utilization review organization shall assure that a peer clinical reviewer in the same or similar profession as that of the attending health care provider or other ordering provider, is reasonably available to review the case as mutually deemed appropriate.

(8) Each utilization review organization shall forward, by written notification, a certification or a determination not to certify to the enrollee or patient, attending health care provider or other ordering provider, and claims administrator for the health benefit plan.

(9) The utilization review organization shall conduct appeals considerations by requiring health professionals who serve as clinical peers and who consider appeals to meet the following conditions:

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(A) Hold a current active, unrestricted license to practice medicine or a health profession;

(B) for services provided by a physician, medical doctor, or doctor of osteopathic medicine, be board-certified by either of the following:

(i) A specialty board approved by the American board of medical specialties, for doctors of medicine; or

(ii) the advisory board of osteopathic specialists from the major areas of clinical services, for doctors of osteopathic medicine;

(C) for services provided by a nonmedical doctor or doctor of osteopathic medicine, be in the same profession and in a similar specialty as that which typically manages the medical condition, procedure, or treatment mutually deemed appropriate; and

(D) be oriented to the principles and procedures of utilization review and peer review. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.)

**40-4-41e. Utilization review organizations; staff requirements.** Each utilization review organization shall have utilization review staff who are properly trained, qualified, supervised, and supported by written, clinically substantiated criteria and review procedures.

(a)(1) For data collection, intake screening, and scripted clinical screening, the use of nonclinical administrative staff shall be limited to the following:

(A) The performance of "review of service requirements";

(B) the collection and transfer of nonclinical data;

(C) the acquisition of structured clinical data; and

(D) any scripted clinical screening that does not require evaluation or interpretation of clinical information.

(2) Nonclinical administrative staff performing the functions listed in paragraph (a)(1)(A) through (D) shall meet the following conditions:

(A) Be qualified and trained to perform "review of service requests";

(B) be supported by explicit instructions and scripts;

(C) be trained in the principles and procedures of the collection and transfer of nonclinical data, the acquisition of structured clinical data, scripted clinical screening, and the maintenance of confidentiality of patient-specific information;

(D) through an established process, promptly transfer a telephone call for review of services to an initial clinical reviewer if the review cannot be completed based on a formal script; and

(E) be monitored by a licensed health professional while performing administrative review.

(b) The utilization review organization, when conducting initial clinical review, shall perform the following:

(1) Refer review of services that do not meet initial review criteria to peer clinical review;

(2) restrict the performance of the initial clinical review to individuals who meet both of the following requirements:

(A) Are health professionals; and

(B) possess a current and valid professional license or certificate in the state or states in which they work. If the state in which they work does not require professional licensure, each of the individuals shall possess a current and valid professional license or certificate in another state or shall be certified by the national accrediting body appropriate to each individual's profession;

(3) require initial clinical reviewers to be trained in the principles and procedures of utilization review; and

(4) require initial clinical reviewers to be supported by a doctor of osteopathic medicine or a clinical director who has an unrestricted license to practice medicine.

(c)(1) The utilization review organization shall conduct peer clinical reviews for all cases in which a clinical determination to certify cannot be made by initial clinical review. Peer clinical reviews shall be conducted by health professionals who meet the following criteria:

(A) Directly support the utilization review activity;

(B) are oriented in the principles and procedures of utilization management and peer review;

(C) are qualified to render a clinical opinion about the medical condition, procedures, and treatment under review; and

(D) meet one of the following criteria:

(i) Hold a current, unrestricted license in the same licensure category as that of the attending health care provider or other ordering provider; or

(ii) for standard appeals, are in active practice.

(2) The utilization review organization shall have a medical director or clinical director with professional postresidency experience in direct patient care who meets one of the following criteria:

(A) Holds an unrestricted license to practice medicine; or

(B) has a clinical specialty appropriate to the type of single service utilization management conducted. (Authorized by K.S.A. 40-103 and K.S.A. 1999 Supp. 44-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.)

**40-4-41f. Utilization review organizations; review requirements.** (a) Each utilization review organization shall use written, clinically substantiated criteria, as needed, for the purpose of determining or screening the appropriateness of the certification.

(1) This criteria shall be periodically evaluated and updated, and shall be made available to the attending health care provider or other ordering provider upon request.

(2) Professionally accepted review criteria shall be used for concurrent reviews and shall be periodically evaluated and updated.

(3) When copyright laws prohibit the copying of criteria for health care providers, the utilization review organization shall identify the type of criteria being utilized so that the health care provider may purchase the criteria directly from the source.

(4) Clinical protocols, as well as other relevant review processes used in a health benefit plan's concurrent review program, shall be established with appropriate involvement from health care provider panels made up of health care providers contracting with the utilization review organization.

(b) Each utilization review organization shall use one or more health care provider consultants, including, as

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needed and available, one or more specialists who are board-certified and working toward certification in a specialty board approved by the American board of medical specialists or the American board of osteopathy from the major areas of clinical services.

(c) Each utilization review organization shall use one or more peer clinical reviewers who meet the following criteria:

(1) Have a firm understanding of clinical practice;

(2) are familiar with current treatment guidelines;

(3) are able to access expert clinical opinions when necessary; and

(4) take into consideration any local specific issues as described by the attending health care provider.

(d) Each utilization review organization shall provide a formal program for orientation and training of utilization review staff and professional consultants.

(e) Each utilization review organization shall maintain written documentation of an active quality management program that promotes objective and systematic monitoring and evaluation of utilization review processes and services.

(f) The utilization review organization shall, as part of its quality management program, include a written plan addressing the following:

(1) Scope and objectives;

(2) program organization;

(3) monitoring and oversight mechanisms; and

(4) evaluation and organizational improvement of clinical review activities.

(g) The utilization review organization shall, as part of its UR quality review program, provide written documentation that verifies the ongoing monitoring for compliance with this regulation, including the following:

(1) Objectives and approaches utilized in the monitoring and evaluation of clinical review activities, including the systematic evaluation of complaints for patterns or trends;

(2) the implementation of action plans to improve or correct identified problems; and

(3) the mechanisms to communicate the results of the action plans to utilization review staff. (Authorized by K.S.A. 40-103, 44-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.)

**40-4-41g. Utilization review organizations; access to review staff.** (a) Each utilization review organization shall provide access to its review staff by a toll-free or collect call telephone line, at a minimum, from 9:00 a.m. to 4:00 p.m. of each normal working day in the central time zone. Each utilization review organization shall also have a mechanism to receive timely callbacks from health care providers and shall establish written procedures for receiving or redirecting after-hour calls, either in person or by recording.

(b) Each utilization review organization and its staff shall conduct its telephone reviews, on-site information gathering reviews, and health care provider communications during reasonable and normal business hours for health care providers, unless otherwise mutually agreed.

(c) Utilization review organization staff members shall identify themselves by name and by the name of their organization, and for on-site reviews, shall carry photograph identification and their organization's company identification card. On-site concurrent reviews shall, whenever possible, be scheduled at least one business day in advance of the appropriate health care provider contact. If requested by a health care provider or inpatient facility, the utilization review organization shall assure that its on-site review staff register with the appropriate contact person, if available, before requesting any clinical information or assistance from health care provider staff, and the on-site review staff shall wear appropriate hospital-supplied identification while on the premises.

(d) Each utilization review organization and its staff shall agree, if so requested, that the clinical records remain available in designated areas during the on-site review and that reasonable health care provider administrative procedures be followed by on-site review staff so as to not disrupt health care provider operations or patient care. These procedures, however, shall not limit the ability of a utilization review organization to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

(e) Upon request, each utilization review organization shall perform the following:

(1) Verbally inform patients, designated health care provider facility personnel, and any other ordering provider of the utilization review requirements and the general type of criteria used by the review agent; and

(2) verbally inform patients, hospitals, physicians, and other health professionals of its operational review procedures. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001.)

**40-4-41h. Utilization review organizations; subcontracting and delegation.** (a) If a utilization review organization delegates or subcontracts any of its utilization review functions, the utilization review organization shall exercise oversight of the delegated or subcontracted functions to ensure that these functions are performed in accordance with this regulation. The utilization review organization shall meet the following criteria:

(1) Have a written contract with the subcontractor that requires the subcontractor to be in compliance with this regulation;

(2) periodically review the subcontractor's policies and procedures and quality improvement plan relevant to the subcontracted functions;

(3) monitor the subcontractor's performance and compliance with the subcontractor's stated policy and procedure and with applicable regulations;

(4) periodically review the subcontractor's adherence to its quality improvement plan; and

(5) monitor the effectiveness of communication and coordination of processes between the utilization review organization and the subcontractor.

(b) Any subcontracted entity shall be certified as a utilization review organization. (Authorized by K.S.A. 40-

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103 and K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04 and 40-22a11; effective June 22, 2001.)

**40-4-41i. Utilization review organizations; program qualifications.** (a) The utilization review organization shall utilize explicit clinical review criteria or scripts for scripted clinical screening that meet the following criteria:

(1) Are developed with involvement from appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts under review;

(2) are based on sound clinical principles and processes;

(3) are evaluated at least annually and are updated, if necessary; and

(4) if used in a review that leads to a noncertification decision for a specific case under review, are disclosed to the physician, provider, and patient upon request.

(b) The utilization review organization shall implement and document a structured professional staff review program that demonstrates a formal program of orientation and training for all clinical reviewers.

(c) The utilization review organization shall establish written clinical qualifications and a process for periodic performance evaluation for all clinical reviewers, both staff and consultant.

(d) The utilization review organization shall conduct a periodic formal program for training, as well as ongoing monitoring and evaluation of the performance of nonclinical administrative staff involved in all levels of the review process. (Authorized by K.S.A. 40-103, K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04, 40-22a06, 40-22a07, and 40-22a11; effective June 22, 2001.)

**40-4-41j. Utilization review organizations; written procedures to maintain confidentiality.** (a) The utilization review organization shall have written policies and procedures for assuring that patient-specific information obtained during the utilization management process meets the following criteria:

(1) Be limited to only that information necessary for utilization management of the services under review; and

(2) be shared with only those entities who have authority to receive this information.

(b) If provider-specific data is to be released to the public, the utilization management organization shall have policies and procedures for exercising due care in compiling and releasing this data. These policies and procedures shall address the following:

(1) How data are obtained using valid methodology and verified for accuracy;

(2) how the subjects of these disclosures are informed of the disclosures;

(3) how potential users of the information are informed about the uses and limitations of the data; and

(4) how the release of the data complies with applicable confidentiality laws and regulations. (Authorized by K.S.A. 40-103, K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04, 40-22a06, 40-22a07, 40-22a09, and 40-22a11; effective June 22, 2001.)

Article 9.—ADVERTISING

**40-9-100. Accident and sickness insurance; advertising.** The national association of insurance commissioners' "advertisements of accident and sickness insurance model regulation," April 1999 edition, is hereby adopted by reference, subject to the following exceptions:

(a) Section 1 is not adopted.

(b) Section 13 C is not adopted by reference and is replaced with the following language: "An advertisement which is seen or heard in this state shall not directly or indirectly create the impression that the policy being advertised is approved for issuance in the state, unless that is the fact. If the policy is not approved for issuance in this state, that fact shall be disclosed in the advertisement by a statement reading, 'This policy is not available in Kansas.' "

(c) Section 16 A(2) is completed by the insertion of "6" in the space requiring specification of a number of months.

(d) Section 18 B is not adopted. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 1999 Supp. 40-2404(1); effective May 1, 1982; amended May 1, 1987; amended June 22, 2001.)

Kathleen Sebelius
Kansas Insurance Commissioner

Doc. No. 026682

**State of Kansas**

## Secretary of State

### Certification of New State Laws

I, Ron Thornburgh, Secretary of State of the State of Kansas, do hereby certify that the following bill is a correct copy of the original enrolled bill now on file in my office.

Ron Thornburgh
Secretary of State

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**(Editor's Note: Sections of the following bill were vetoed by the Governor and sustained by the Legislature. The Governor's line-item veto message is printed immediately following the bill. A certificate from the Kansas Senate concerning an attempted override by the Legislature of several line-item vetoes is printed following the Governor's message.)**

(Published in the Kansas Register June 7, 2001.)

### HOUSE BILL No. 2283

AN ACT making and concerning appropriations for the fiscal years ending June 30, 2001, June 30, 2002, and June 30, 2003; authorizing certain transfers and fees, imposing certain restrictions and limitations and directing or authorizing certain receipts, disbursements, capital improvements and acts incidental to the foregoing; amending K.S.A. 2000 Supp. 2-223, 79- 2959, as amended by section 167 of 2001 Senate Bill No. 57, 79-2964, as amended by section 168 of 2001 Senate Bill No. 57, 79-3425i, as amended by section 169 of 2001 Senate Bill No. 57, 79-34,147, as amended by section 170 of 2001 Senate Bill No. 57, 82a-953a and section 171 of 2001 Senate Bill No. 57 and repealing the existing sections.

*Be it enacted by the Legislature of the State of Kansas:*

Section 1. (a) For the fiscal years ending June 30, 2001, June 30, 2002, and June 30, 2003, appropriations are hereby made, restrictions and limitations are hereby imposed, and transfers, fees, receipts, disbursements, and acts incidental to the foregoing are hereby directed or authorized as provided in this act.

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## Kansas Administrative Regulation No. 40-4-41a

**40-4-41a Utilization review organizations; responsibility for requesting certification.** If specified in the health benefit plan which imposes the utilization review requirements:

(a) The insured individual seeking the health care services shall be responsible for notifying the utilization review organization in a timely manner and initiating the request for certification of health care services; and

(b) any health care provider or responsible patient representative, including a family member, may assist in fulfilling the responsibility of initiating the request for certification. (Authorized by K.S.A. 40-103 and K.S.A. 1994 Supp. 40-22a01, et seq.; implementing K.S.A. 1994 Supp. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995.)

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208 total

| URO Name | STD/URA | Date expires |
|---|---|---|
| Accountable Health Plans of America, Inc. | U | 8/1/2003 |
| Aetna Life Ins. Co. and Affiliates (d/b/a Aetna U.S. HealthCare) Alpharetta, GA | U | 5/1/2002 |
| Aetna Life Ins. Co. and Affiliates (d/b/a Aetna U.S. HealthCare) Blue Bell, PA | U | 5/1/2002 |
| Aetna Life Ins. Co. and Affiliates (d/b/a Aetna U.S. HealthCare) Chicago, IL | U | 5/1/2002 |
| Aetna Life Ins. Co. and Affiliates (d/b/a Aetna U.S. HealthCare) Dallas TX | U | 5/1/2002 |
| Aetna Life Ins. Co. and Affiliates (d/b/a Aetna U.S. HealthCare) Middletown, CT | U | 5/1/2002 |
| Aetna Life Ins. Co. and Affiliates (d/b/a Aetna U.S. HealthCare) Richfield, OH | U | 5/1/2002 |
| Aetna Life Ins. Co. and Affiliates (d/b/a Aetna U.S. HealthCare) San Ramon, CA | U | 5/1/2002 |
| Alicare Medical Management, Inc. | U | 12/1/2002 |
| American Benefit Plan Administrators, Inc. | U | 5/1/2003 |
| American Chiropractic Network, Inc. | U | 9/1/2002 |
| American Health Holding, Inc. | U | 6/1/2002 |
| American Specialty Health Networks, Acupuncture and Chiropractic | U | 11/1/2002 |
| Anthem Health Plans of Kentucky, Inc. d/b/a Anthem BC & BS, Louisville KY | U | 3/1/2003 |
| Anthem Ins. Companies, Inc., dba Anthem Blue Cross & Blue Shield (in Indiana), | U | 3/1/2003 |
| Anthem Ins. Companies, Inc., dba Anthem Blue Cross & Blue Shield, Mason, OH | U | 3/1/2003 |
| APS Healthcare Bethesda, Inc.. | U | 7/1/2003 |
| Araz Group, Inc., (The) | U | 3/1/2002 |
| Beech Street Corporation, Irvine, CA | U | 6/1/2002 |
| Blue Cross and Blue Shield of Kansas, Inc. | U | 11/1/2002 |
| Blue Cross and Blue Shield of Michigan | U | 1/1/2003 |
| Blue Cross and Blue Shield of Nebraska | U | 6/1/2002 |
| Blue Cross and Blue Shield of New Hampshire/Matthew Thornton Health Plan | U | 7/1/2001 |
| Blue Cross Blue Shield of Kansas City (HMO & PPO) | U | 3/1/2001 |
| Blue Cross Blue Shield of Texas, Inc. | U | 2/1/2002 |
| Bowers and Associates Inc | U | 8/1/2002 |
| Care Continuum | U | 11/1/2001 |
| CARE Programs, a Division of Spectera, Inc. | U | 5/1/2003 |
| CareAdvantage, Inc | U | 3/1/2002 |
| CCN Managed Care, Inc. (dba: CCN), Phoenix, AZ | U | 7/1/2003 |
| CCN Managed Care, Inc. (dba: CCN), San Diego, CA | U | 7/1/2003 |
| Ceres Health Care, Inc. | U | 10/1/2002 |
| Cigna Behavioral Health, Inc., National Care Center | U | 11/1/2001 |
| Cigna Behavioral Health, Inc., Regional Care Office | U | 11/1/2001 |
| CIMRO Medical Management, Inc. | U | 11/1/2003 |
| Clinix Healthcare | U | 12/1/2003 |
| Concentra Managed Care Services, Inc., Carrolton TX | U | 11/1/2002 |
| Concentra Managed Care Services, Inc., Morristown, NJ | U | 11/1/2002 |
| Concentra Managed Care Services, Inc., Tampa, FL | U | 11/1/2002 |
| Concentra Managed Care Services, Inc., Waltham MA | U | 11/1/2002 |
| Core, Inc., Burlington MA | U | 3/1/2002 |
| Core, Inc., Los Angeles, CA | U | 3/1/2002 |
| CoreSource, Inc., Lancaster, PA | U | 3/1/2003 |
| CoreSource, Inc., Westerville, OH | U | 3/1/2003 |
| Corphealth, Inc. | U | 10/1/2002 |
| CorVel Corporation | U | 2/1/2002 |



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| URO Name | STD/URA | Date expires |
|---|---|---|
| Cost Care, Inc. (dba UNICARE/Cost care) | U | 9/1/2002 |
| Coventry Health Care of Kansas, Inc. | U | 2/1/2003 |
| Employers Health Insurance Company | U | 5/1/2002 |
| ENCOMPASS Corporation | U | 7/1/2003 |
| First Health Group Corp., Downers Grove, IL | U | 2/1/2002 |
| First Health Group Corp., Scottsdale, AZ | U | 2/1/2002 |
| Fortis Health(Fortis Insurance Company, Fortis Benefits Insurance Company) | U | 7/1/2003 |
| FortisHealth/John Alden Life Insurance Company | U | 7/1/2003 |
| Gateway Health Management Services | U | 4/1/2002 |
| GENEX Services, Inc., Dallas TX | U | 12/1/2002 |
| GENEX Services, Inc., San Mateo CA | U | 12/1/2002 |
| GENEX Services, Inc., Orange, CA | U | 12/1/2002 |
| GENEX Services, Inc., Wayne PA | U | 12/1/2002 |
| GENEX Services, Inc., Winter Park, FL | U | 12/1/2002 |
| Health Care Evaluation, Inc. | U | 5/1/2002 |
| Health Cost Consultants, Inc. | U | 9/1/2002 |
| Health International, Inc.-Scottsdale, AZ | U | 4/1/2002 |
| Health Management Strategies, Falls Church, VA | U | 3/1/2001 |
| Health Net, Incorporated | U | 7/1/2002 |
| Health Services Advisory Group, Inc. | U | 12/1/2001 |
| HealthLink, Inc. | U | 4/1/2003 |
| HealthSmart Preferred Care, Inc. | U | 4/1/2003 |
| Hines and Associates, Inc. | U | 2/1/2002 |
| Humana Kansas City, Inc. | U | 5/1/2002 |
| Individualized Care Management, Inc. | U | 12/1/2002 |
| Innovative Resource Group, LLC dba Allegro Southwest | U | 2/1/2003 |
| Innovative Resource Group, LLC, Houston TX | U | 2/1/2003 |
| Innovative Resource Group, LLC, West Allis, WI | U | 2/1/2003 |
| Intracorp, Chattanooga, TN | U | 1/1/2001 |
| Intracorp, Dallas, TX | U | 1/1/2001 |
| Intracorp, Itasca, IL | U | 1/1/2001 |
| Intracorp, Norcross,GA | U | 1/1/2001 |
| Intracorp, Philadelphia, PA | U | 1/1/2001 |
| Intracorp, Pittsburg, PA | U | 1/1/2001 |
| Intracorp, Plymouth Woods, PA | U | 1/1/2001 |
| Kanawha Healthcare Solutions, Inc. | U | 12/1/2003 |
| Keystone Health Plan West, Inc., Erie, PA | U | 3/1/2001 |
| Keystone Health Plan West, Inc., Johnstown, PA | U | 3/1/2001 |
| Keystone Health Plan West, Inc., Pittsburgh, PA | U | 3/1/2001 |
| Magellan Behavioral Health/CMG Health, Inc. | U | 6/1/2002 |
| Magellan Behavioral Health/Gr Sprg/Merit Behavioral/Human Affairs International | U | 6/1/2002 |
| Magellan Behavioral Health/Green Sprg/Merit Behavioral/Human Affairs Internati | U | 6/1/2002 |
| Magellan Behavioral Health/Green Spring Health Services,Inc. | U | 6/1/2002 |
| Magellan Behavioral Health/Green Spring Health Services,Inc./Merit Behavior Ca | U | 6/1/2002 |
| Magellan Behavioral Health/Human Affairs International, Inc. | U | 6/1/2002 |
| Magellan Behavioral Health/Human Affairs International, Inc., | U | 6/1/2002 |



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| URO Name | STD/URA | Date expires |
|---|---|---|
| Magellan Behavioral Health/Magellan Health Services/Human Affairs of Alaska, I | U | 6/1/2002 |
| Magellan Behavioral Health/Merit Behavioral/ Human Affairs International, Inc., D | U | 6/1/2002 |
| Magellan Behavioral Health/Merit Behavioral/Human Affairs International, Inc., Ki | U | 6/1/2002 |
| MedCost, LLC | U | 5/1/2002 |
| Medical Mutual of Ohio | U | 4/1/2003 |
| Medical Society Medical Review Foundation | U | 7/1/2002 |
| MedSolutions, Inc. | U | 11/1/2003 |
| Med-Valu, Inc. | U | 2/1/2003 |
| Mennonite Mutual Aid Association(MMAA) and its sudsidiary company, MMA Insu | U | 2/1/2002 |
| Mental Health Case Management, Inc. | U | 1/1/2003 |
| Midlands Health Partners, Omaha NE | U | 10/1/2002 |
| Midlands Health Partners, Sioux City, IA | U | 10/1/2002 |
| Moody Review Inc. | U | 10/1/2001 |
| National Health Services, Inc. | U | 4/1/2003 |
| National Healthcare Resources, Inc., Daphne, AL | U | 12/1/2001 |
| National Healthcare Resources, Inc., Golden Valley, MN | U | 12/1/2001 |
| National Healthcare Resources, Inc., Pittsburgh, PA | U | 12/1/2001 |
| National Imaging Associates, Inc., Rancho Cordova, CA | U | 12/1/2002 |
| National Imaging Associates, Inc., San Bruno, CA | U | 12/1/2002 |
| National Utilization Management Corp. | U | 1/1/2002 |
| Nationwide Management Systems, Inc. | U | 4/1/2003 |
| NATLSCO, Inc. | U | 11/1/2001 |
| New Directions Behavioral Health L.L.C. | U | 9/1/2003 |
| OHARA, L.L.C. | U | 11/1/2002 |
| Ohio Health Choice | U | 3/1/2002 |
| One Health Plan of Colorado, Inc. | U | 7/1/2003 |
| POMCO | U | 12/1/2002 |
| Preferred Health Professionals | U | 7/1/2002 |
| Principal Life Ins. Co., Cedar Rapids, IA. | U | 5/1/2002 |
| Principal Life Ins. Co., Des Moines, IA | U | 5/1/2002 |
| Private Healthcare Systems, Inc. - Irvine, CA | U | 7/1/2003 |
| Private Healthcare Systems, Inc. - Waltham, MA | U | 7/1/2003 |
| Professional Reviews, Inc. | U | 7/1/2002 |
| PRO-West, a Professional Review Organization, Seattle, WA | U | 10/1/2002 |
| RightCHOICE Managed Care, Inc. | U | 1/1/2003 |
| Select HealthCare Management Services | U | 10/1/2002 |
| SHPS Care Management | U | 5/1/2001 |
| TRIAD Healthcare, Inc. | U | 1/1/2002 |
| ULLICARE/Union Labor Life | U | 6/1/2003 |
| Uniprise, Inc., Dayton, OH | U | 4/1/2003 |
| Uniprise, Inc., Golden Valley, MN | U | 4/1/2003 |
| Uniprise, Inc., Long Beach, CA | U | 4/1/2003 |
| Uniprise, Inc., Tampa, FL | U | 4/1/2003 |
| Uniprise, Inc., Westborough, MA | U | 4/1/2003 |
| Uniprise, Inc., Westmont, IL | U | 4/1/2003 |
| United Behavioral Health, Atlanta, GA | U | 2/1/2003 |

| URO Name | STD/URA | Date expires |
|---|---|---|
| United Behavioral Health, Hilliard, OH | U | 2/1/2003 |
| United Behavioral Health, Brea, CA | U | 5/1/2001 |
| United Behavioral Health, Corral Gables, FL | U | 2/1/2003 |
| United Behavioral Health, Dayton, OH | U | 5/1/2001 |
| United Behavioral Health, Glastonbury, CT | U | 5/1/2001 |
| United Behavioral Health, Itasca, IL | U | 2/1/2003 |
| United Behavioral Health, Minnetonka, MN | U | 2/1/2003 |
| United Behavioral Health, Philadelphia, PA | U | 5/1/2001 |
| United Behavioral Health, San Diego, CA | U | 2/1/2003 |
| United Behavioral Health, San Francisco, CA | U | 5/1/2001 |
| United Behavioral Health, St. Louis, MO | U | 2/1/2003 |
| United Behavioral Health, Westmont, IL | U | 5/1/2001 |
| United Healthcare Insurance Company, Dayton, OH | U | 4/1/2003 |
| United HealthCare Insurance Company, Golden Valley, MN | U | 4/1/2003 |
| United Healthcare Insurance Company, Long Beach, CA | U | 4/1/2003 |
| United Healthcare Insurance Company, Tampa, FL | U | 4/1/2003 |
| United HealthCare Insurance Company, Westborough, MA | U | 4/2/2003 |
| United Healthcare Insurance Company, Westmont, IL | U | 4/1/2003 |
| United HealthCare Services, Inc., Golden Valley, MN | U | 4/1/2003 |
| United HealthCare Services, Inc., Westborough, MA | U | 4/1/2003 |
| United of Omaha Life Ins. Co/Mutual of Omaha Ins. Co. | U | 5/1/2003 |
| USI Care Management, Inc., Dallas, TX | U | 7/1/2002 |
| USI Care Management, Inc., Melville, NY | U | 7/1/2002 |
| ValueCheck, Inc. | U | 10/1/2003 |
| ValueOptions, Inc. | U | 3/1/2001 |
| ValueOptions/HMS, Topeka, KS | U | 3/1/2001 |
| Vision Service Plan | U | 3/1/2002 |
| Wellmark, Inc. | U | 3/1/2002 |
| Wisconsin Physicians Service Insurance Corporation | U | 8/1/2003 |

| URO Name | STD/URA | Date expires |
|---|---|---|
| Admar Corporation | S | 5/16/2002 |
| Allied National, Inc. | S | 5/4/2002 |
| American Dental Examiners, Inc. | S | 7/14/2002 |
| American Family Mutual Insurance Company | S | 2/2/2002 |
| American Medical Security, Inc. | S | 7/12/2001 |
| American Physicians Network, Inc., Dallas, TX | S | 5/10/2002 |
| American Physicians Network, Inc., Encinitas, CA | S | 5/10/2001 |
| Associates in Women's Health, P.A. | S | 2/24/2002 |
| Cemara, Inc. | S | 1/30/2002 |
| Century Health Solutions, Inc. | S | 10/30/2002 |
| Cigna HealthCare of OH d/b/a Cigna HealthCare of KS/MO | S | 5/13/2002 |
| Corporate Benefit Services of AM.,Inc. d/b/a CBSA Health Perspective | S | 5/16/2002 |
| Delta Dental Plan of Kansas, Inc. | S | 6/30/2002 |
| DENTISTAT, Inc. | S | 6/5/2002 |
| Doral Dental Services of Kansas, Inc. | S | 4/5/2002 |
| eoshealth, inc. | S | 7/24/2002 |
| FirstGuard Health Plan, Inc. | S | 11/16/2002 |
| Health Choice of Northwest Missouri | S | 6/26/2002 |
| Health Partners of Kansas | S | 4/28/2002 |
| International Healthcare Consultants, Inc. | S | 6/7/2002 |
| JLT Services Corporation | S | 1/17/2002 |
| Kansas Chiropractic Association Peer Review Committee | S | 5/19/2002 |
| Kansas Foundation for Medical Care, Inc. | S | 5/8/2002 |
| Medical Cost Management | S | 2/25/2002 |
| Medical Review Institute, Inc., "LIMITED" | S | 6/1/2002 |
| Mental Health Network, Inc. | S | 8/13/2002 |
| Mid-America Health Partners, Inc., d/b/a HealthNet | S | 4/13/2002 |
| New Century Health Quality Alliance, Inc. | S | 4/5/2002 |
| P&R Dental Strategies, Inc. | S | 10/24/2001 |
| Physician Vision Providers, Inc. | S | 10/19/2001 |
| Physician WebLink of Kansas City, Inc. | S | 3/1/2002 |
| Physicians' Review Network, Inc., "LIMITED" | S | 6/28/2002 |
| Preferred Health Care, Inc. | S | 5/8/2002 |
| Preferred Mental Health Management, Inc. | S | 4/28/2002 |
| Preferred Mental Health, Inc. | S | 4/24/2002 |
| Preferred Plus of Kansas, Inc. | S | 4/28/2002 |
| Shorman & Associates, Inc. | S | 10/22/2002 |
| Trustmark Insurance Company | S | 11/29/2001 |
| United HealthCare of the Midwest, Inc. | S | 4/1/2002 |
| Via Christi Medical Management | S | 10/31/2002 |
| WellCor America, Inc. | S | 6/5/2002 |