44-510j. Medical benefits; fee disputes; utilization and peer review. When an employer's insurance carrier or a self-insured employer disputes all or a portion of a bill for services rendered for the care and treatment of an employee under this act, the following procedures apply:

(a) (1) The employer or carrier shall notify the service provider within 30 days of receipt of the bill of the specific reason for refusing payment or adjusting the bill. Such notice shall inform the service provider that additional information may be submitted with the bill and reconsideration of the bill may be requested. The provider shall send any request for reconsideration within 30 days of receiving written notice of the bill dispute. If the employer or carrier continues to dispute all or a portion of the bill after receiving additional information from the provider, the employer, carrier or provider may apply for an informal hearing before the director.

(2) If a provider sends a bill to such employer or carrier and receives no response within 30 days as allowed in subsection (a) and if a provider sends a second bill and receives no response within 60 days of the date the provider sent the first bill, the provider may apply for an informal hearing before the director.

(3) Payments shall not be delayed beyond 60 days for any amounts not in dispute. Acceptance by any provider of a payment amount which is less than the full amount charged for the services shall not affect the right to have a review of the claim for the outstanding or remaining amounts.

(b) The application for informal hearing shall include copies of the disputed bills, all correspondence concerning the bills and any additional written information the party deems appropriate. When anyone applies for an informal hearing before the director, copies of the application shall be sent to all parties to the dispute and the employee. Within 20 days of receiving the application for informal hearing, the other parties to the dispute shall send any additional written information deemed relevant to the dispute to the director.

(c) The director or the director's designee shall hold the informal hearing to hear and determine all disputes as to such bills and interest due thereon. Evidence in the informal hearing shall be limited to the written submissions of the parties. The informal hearing may be held by electronic means. Any employer, carrier or provider may personally appear in or be represented at the hearing. If the parties are unable to reach a settlement regarding the dispute, the officer hearing the dispute shall enter an order so stating.

(d) After the entry of the order indicating that the parties have not settled the dispute after the informal hearing, the director shall schedule a formal hearing.

(1) Prior to the date of the formal hearing, the director may conduct a utilization review concerning the disputed bill. The director shall develop and implement, or contract with a qualified entity to develop and implement, utilization review procedures relating to the services rendered by providers and facilities, which services are paid for in whole or in part pursuant to the workers compensation act. The director may contract with one or more private foundations or organizations to provide utilization review of service providers pursuant to the workers compensation act. Such utilization review shall result in a report to the director indicating whether a provider improperly utilized or otherwise rendered or ordered unjustified treatment or services or that the fees for such treatment or services were excessive and a statement of the basis for the report's conclusions. After receiving the utilization review report, the director also may order a peer review. A copy of such reports shall be provided to all parties to the dispute at least 20 days prior to the formal hearing. No person shall be subject to civil liability for libel, slander or any other relevant tort cause of action by virtue of performing a peer or utilization review under contract with the director.

(2) The formal hearing shall be conducted by hearing officers, the medical administrator or both as appointed by the director. During the formal hearing parties to the dispute shall have the right to appear or be represented and may produce witnesses, including expert witnesses, and such other relevant evidence as may be otherwise allowed under the workers compensation act. If the director finds that a provider or facility has made excessive charges or provided or ordered unjustified treatment, services, hospitalization or visits, the provider or facility may, subject to the director's order, receive payment pursuant to this section from the carrier, employer or employee for the excessive fees or unjustified treatment, services, hospitalization or visits and such provider may be ordered to repay any fees or charges collected therefor. If it is determined after the formal hearing that a provider improperly utilized or otherwise rendered or ordered unjustified treatment or services or that the fees for such treatment or services were excessive, the director may provide a report to the licensing board of the service provider with full documentation of any such determination, except that no such report shall be provided until after judicial review if the order is appealed. Any decision rendered under this section may be reviewed by the workers compensation appeals board. A party must file a notice of appeal within 10 days of the issuance of any decision under this section. The record on appeal shall be limited only to the evidence presented to the hearing officer. The decision of the director shall be affirmed unless the board determines that the decision was not supported by substantial competent evidence.

(e) By accepting payment pursuant to this section for treatment or services rendered to an injured employee, the provider shall be deemed to consent to submitting all necessary records to substantiate the nature and necessity of the service or charge and other information concerning such treatment to utilization review under this section. Such health care provider shall comply with any decision of the director pursuant to this section.

(f) Except as provided in K.S.A. 60-437, and amendments thereto, and this section, findings and records which relate to utilization and peer review conducted pursuant to this section shall be privileged and shall not be subject to discovery, subpoena or other means of legal compulsion for release to any person or entity and shall not be admissible in evidence in any judicial or administrative proceeding, except those proceedings authorized pursuant to this section. In any proceedings where there is an application by an employee, employer, insurance carrier or the workers compensation fund for a hearing pursuant to K.S.A. 44-534a, and amendments thereto, for a change of medical benefits which has been filed after a health care provider, employer, insurance carrier or the workers compensation fund has made application to the medical services section of the division for the resolution of a dispute or matter pursuant to the provisions of this section, all reports, information, statements, memoranda, proceedings, findings and records which relate to utilization and peer review including the records of contract reviewers and findings and records of the medical services section of the division shall be admissible at the hearing before the administrative law judge on the issue of the medical benefits to which an employee is entitled.

(g) A provider may not improperly overcharge or charge for services which were not provided for the purpose of obtaining additional payment. Any dispute regarding such actions shall be resolved in the same manner as other bill disputes as provided by this section. Any violation of the provisions of this section or K.S.A. 44-510i, and amendments thereto, which is willful or which demonstrates a pattern of improperly charging or overcharging for services rendered pursuant to this act constitutes grounds for the director to impose a civil fine not to exceed $5,000. Any civil fine imposed under this section shall be subject to review by the board. All moneys received for civil fines imposed under this section shall be deposited in the state treasury to the credit of the workers compensation fund.

(h) Any health care provider, nurse, physical therapist, any entity providing medical, physical or vocational rehabilitation services or providing reeducation or training pursuant to K.S.A. 44-510g, and amendments thereto, medical supply establishment, surgical supply establishment, ambulance service or hospital which accept the terms of the workers compensation act by providing services or material thereunder shall be bound by the fees approved by the director and no injured employee or dependent of a deceased employee shall be liable for any charges above the amounts approved by the director. If the employer has knowledge of the injury and refuses or neglects to reasonably provide the services of a health care provider required by this act, the employee may provide the same for such employee, and the employer shall be liable for such expenses subject to the regulations adopted by the director. No action shall be filed in any court by a health care provider or other provider of services under this act for the payment of an amount for medical services or materials provided under the workers compensation act and no other action to obtain or attempt to obtain or collect such payment shall be taken by a health care provider or other provider of services under this act, including employing any collection service, until after final adjudication of any claim for compensation for which an application for hearing is filed with the director under K.S.A. 44-534, and amendments thereto. In the case of any such action filed in a court prior to the date an application is filed under K.S.A. 44-534, and amendments thereto, no judgment may be entered in any such cause and the action shall be stayed until after the final adjudication of the claim. In the case of an action stayed hereunder, any award of compensation shall require any amounts payable for medical services or materials to be paid directly to the provider thereof plus an amount of interest at the rate provided by statute for judgments. No period of time under any statute of limitation, which applies to a cause of action barred under this subsection, shall commence or continue to run until final adjudication of the claim under the workers compensation act.

(i) As used in this section, unless the context or the specific provisions clearly require otherwise, "carrier" means a self-insured employer, an insurance company or a qualified group-funded workers compensation pool and "provider" means any health care provider, vocational rehabilitation service provider or any facility providing health care services or vocational rehabilitation services, or both, including any hospital.

History: L. 2000, ch. 160, § 3; L. 2013, ch. 104, § 5; Apr. 25.