**304.17A-615 Prohibition against denying or reducing payments under certain circumstances.**

(1) No insurer or any other person providing or administering a health benefit plan shall deny or reduce payment for a service, procedure, treatment, drug or device covered under the covered person's health benefit plan if:

(a) The covered person's provider, during normal business hours, contacts the insurer, the designee, or agent on the day the covered person is expected to be discharged, in order to request review of the covered person's continued hospitalization, and the insurer, designee, or agent fails to provide a timely utilization review decision as required by KRS 304.17A-607; or

(b) The covered person's provider makes at least three (3) documented attempts during a four (4) consecutive hour period to contact the insurer, designee, or agent, during normal business hours in order to request review of a continued hospital stay, preauthorization of treatment for a covered person who is already hospitalized, or retrospective review of an emergency hospital admission where the covered person remains hospitalized at the time the review requested is made, and the insurer, designee, or private review agent fails to be accessible as required by KRS 304.17A-607.

(2) The insurer's liability to pay for the covered person's hospitalization under the circumstances set forth in subsection (1) of this section shall extend until the insurer, designee, or private review agent issues a utilization review decision applicable to requests for review relating to matters as set forth in subsection 1(b) of this section.

(3) The insurer's liability to pay under this section shall be conditioned on:

(a) The provider establishing verifiable documentation of the contact with, and subsequent failure of the insurer, designee, or agent to make the utilization review decision as set forth in subsection (1)(a) of this section; or

(b) The provider establishing verifiable documentation of the attempt to make contact with the insurer, designee, or agent as addressed in subsection (1)(b) of this section.

(4) In either instance, the contact, or attempts to contact, as set forth in this section, shall be made by the means required by the insurer, designee, or agent for requesting utilization review.

(5) This section applies only when the request for review concerns covered health benefits and it shall not supersede any limitations or exclusions in the covered person's health benefit plan. This section shall not apply if, in requesting a review, the provider does not furnish the information requested by the insurer or agent to make a utilization review decision, or if actions by the provider impede an insurer's or private review agent's ability to issue a utilization review decision.

**Effective:** July 14, 2000

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