

**205.534 Toll-free telephone line -- Duties relating to adverse determinations -- In-person meeting -- Reprocessing claims -- Internal appeals -- Provider audits -- Timely decisions on authorization and preauthorization requests -- Monthly and annual reports -- Penalties -- Administrative regulations.**

(1) A Medicaid managed care organization with whom the department contracts for the delivery of Medicaid services shall:

(a) Provide:

1. A toll-free telephone line for providers to contact the insurer for claims resolution for forty (40) hours a week during normal business hours in this state;
2. A toll-free telephone line for providers to submit requests for authorizations of covered services during normal business hours and extended hours in this state on Monday and Friday through 6 p.m., including federal holidays;
3. With regard to any adverse payment or coverage determination, copies of all documents, records, and other information relevant to a determination, including medical necessity criteria and any processes, strategies, or evidentiary standards relied upon, if requested by the provider. Documents, records, and other information required to be provided under this paragraph shall be provided at no cost to the provider; and
4. For any adverse payment or coverage determination, a written reply in sufficient detail to inform the provider of all reasons for the determination. The written reply shall include information about the provider's right to request and receive at no cost to the provider documents, records, and other information under subparagraph 3. of this paragraph;

(b) Afford each participating provider the opportunity for an in-person meeting with a representative of the managed care organization on:

1. Any clean claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and
2. Any claim that remains unpaid for forty-five (45) days or more after the date the claim is received by the managed care organization and that individually or in the aggregate exceeds two thousand five hundred dollars (\$2,500);

(c) Reprocess claims that are incorrectly paid or denied in error, in compliance with KRS 304.17A-708. The reprocessing shall not require a provider to rebill or resubmit claims to obtain correct payment. A claim shall not be denied for timely filing if the initial claim was timely submitted;

(d) Establish processes for internal appeals, including provisions for:

1. Allowing a provider to file any grievance or appeal related to the reduction or denial of the claim within one hundred twenty (120) days of confirmed receipt of a notification from the managed care organization that payment for a submitted claim has been reduced or denied;

2. a. Ensuring the timely consideration and disposition of any grievance or any appeal within thirty (30) days from the date the grievance or appeal is filed with the managed care organization by a provider under this paragraph.
    - b. Failure of the managed care organization to comply with subdivision a. of this subparagraph shall result in a fine or penalty as provided in subsection (6) of this section; and
  3. Ensuring that, following the resolution of an appeal that results in a determination that a monetary amount is owed to a provider, payment is made in full to the provider within thirty (30) days from the date on which the appeal was resolved; and
- (e) With regard to provider audits:
  1. Allow at least thirty (30) calendar days for a provider to provide or grant access to the requested records;
  2. Complete an audit within one hundred eighty (180) calendar days from the date on which the audit was initiated by the managed care organization unless the provider subject to the audit fails to provide or grant access to requested records in a timely manner;
  3. Only recoup denied payments or issue a demand for payment from a provider upon the final disposition of the audit, including the appeals process established in KRS 205.646; and
  4. Base recoupment of claims on the actual overpayment or underpayment of claims unless the provider agrees to a settlement to the contrary.
- (2) (a) As used in this subsection:
  1. "Timely" means that an authorization or preauthorization request shall be approved:
    - a. For an expedited authorization request, within twenty-four (24) hours after receipt of the request. The timeframe for an expedited authorization request may be extended by up to fourteen (14) days if:
      - i. The enrollee requests an extension; or
      - ii. The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and
    - b. For a standard authorization request, within five (5) calendar days. The timeframe for a standard authorization request may be extended by up to fourteen (14) additional days if:
      - i. The provider or enrollee requests an extension; or
      - ii. The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and
  2. a. "Expedited authorization request" means a request for authorization or preauthorization where the provider determines



- (5) By December 15 of each year, the department shall submit to the Legislative Research Commission for referral to the Interim Joint Committee on Health Services, the Legislative Oversight and Investigations Committee, and the Medicaid Oversight and Advisory Board a report containing the following information for the previous state fiscal year and reported separately for each managed care organization with whom the department has contracted for the delivery of Medicaid services:
- (a) The number and dollar value of all claims that were received by the managed care organization and the number and dollar value of those claims that were approved for payment, denied, or suspended;
  - (b) The number of requests for authorization of services received and the number of those requests that were approved or denied;
  - (c) The number of internal appeals and grievances filed by Medicaid enrollees and by providers, the types of services to which the internal appeals and grievances relate, the total dollar amount of denials that were appealed, the average length of time to resolution, the number of internal appeals and grievances where the initial denial was overturned, and the types of services and dollar amount of overturned denials; and
  - (d) The number of internal appeals and grievances not resolved within sixty (60) calendar days, the ten (10) most common reasons given for delays, the total dollar amount when a denial is being appealed, and the number of final determinations made in favor of a provider.
- (6) Any Medicaid managed care organization that fails to comply with subsection (1)(d)2. of this section or KRS 205.522, 205.532 to 205.536, or 304.17A-515 may be subject to fines, penalties, and sanctions, up to and including termination, as established under its Medicaid managed care contract with the department.
- (7) The department may promulgate administrative regulations in accordance with KRS Chapter 13A to implement and enforce this section.

**Effective:** April 14, 2026

**History:** Amended 2026 Ky. Acts ch. 179, sec. 13, effective April 14, 2026. -- Created 2018 Ky. Acts ch. 106, sec. 3, effective January 1, 2019.