

907 KAR 1:671. Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions.

RELATES TO: KRS Chapter 13B, 194.515, 205.510-205.990, 312.015, Chapter 360, 42 C.F.R. 431.107, 431.151-431.154, 447.10, 455, 1002, 1003, 42 U.S.C. 1128a-b(13), 1320a-3, a-3a, a-5, a-7, 1395cc, vv, 1396b, d, m, n, 2000d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.6318, 205.8467, 42 C.F.R. 1002.1-.230, 1003.105, 42 U.S.C. 1320a-7, 1396a, b(q), d(d), m, r(a), EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.8451 through 205.990, 205.624 and 194A.515 provide that the Cabinet for Health Services and the Department for Medicaid Services shall be responsible for the control of Medicaid provider fraud and abuse. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to Medicaid provider participation, withholding overpayments, appeal process and sanctions.

Section 1. Definitions. (1) "Abuse" means provider abuse or recipient abuse as defined by KRS 205.8451(8) and (10).

(2) "Active provider number" means the provider billing number issued by the department, or its fiscal agent, to a provider that has presented to the department, or its fiscal agent, a Medicaid claim for a supply or covered service for payment under that number during the period of the previous twelve (12) consecutive months.

(3) "Adequate access" means pursuant to 42 CFR 1396a(8) all individuals wishing to make application for medical assistance under the Medicaid Program shall have an opportunity to do so, and that assistance shall be furnished with reasonable promptness to all eligible individuals.

(4) "Administrative appeal process" means an initial written request for redress setting forth the issues in dispute, dispute resolution meeting, review of documentation, prehearing, administrative hearing, recommended order, final order and all deliberations or exchange of documents or information between a provider and the department in accordance with KRS Chapter 13B.

(5) "Affiliate" means an individual agency or organization controlled by a provider or associated with a provider under common ownership or control.

(6) "Applicant" means an individual, agency, entity, or organization that submits an application to become a Medicaid provider.

(7) "Application" means the completion and submission of a Medicaid provider agreement and all required addendum and documentation specific to a provider type, which is the contract between the provider and the department for the provision of Medicaid services.

(8) "Billing agent" means an individual, agency, entity or organization that is authorized by a provider to prepare and submit claims on behalf of a provider to the department, or its fiscal agent.

(9) "Bribes and kickbacks" means soliciting or receiving payment, or offering or making payment whether in cash or goods or services, in return for:

(a) Referring a recipient to a provider for medical care, services or supplies; or

(b) Purchasing, leasing, ordering or recommending medical care, services or supplies, for which payment is claimed under the Medicaid Program.

(10) "Cabinet" means the Cabinet for Health and Family Services.

(11) "Claim" means a manually-created paper, or a computer-based electronically-created and transmitted request for payment under the Medicaid Program that relates to each individual billing submitted by a provider, or their billing agent, to the department which details services rendered to a recipient on a specific date. A claim may be either a line item of service or multiple services for one (1) recipient on a bill.

(12) "Conversion" means converting a Medicaid payment, or a part of a payment, to a use or benefit other than for the use and benefit intended by the Medicaid Program.

(13) "Convicted" means as defined in KRS 205.8475.

(14) "Demand letter" means correspondence to an active or inactive provider stating a dollar amount is owed the program and shall be paid by a given date.

(15) "Department" means the Department for Medicaid Services and its designated agents.

(16) "Disclosing entity" means a Medicaid provider or the fiscal agent for the department.

(17) "Disclosure" means the provision of information in accordance with the requirements established in 42 CFR 455, Subpart B.

(18) "Exclusion" means the termination of the participation of a provider or the denial of the enrollment of a provider.

(19) "Factor" means as defined in 42 CFR 447.10.

(20) "False claim" means a claim for:

(a) Unfurnished medical care, services, or supplies; or

(b) Medical care, services, or supplies provided:

1. In excess of accepted standards of practice for the medical care or other type of service;

2. In excess of established limits which were communicated, in writing, to providers by the department; or

3. If there is documentation that the provider has knowledge of third-party coverage of the recipient, but the provider knowingly chooses not to bill the third-party payer.

(21) "Fiscal agent" means a contractor that processes or pays provider claims on behalf of the department.

(22) "Full investigation" means the activities of Kentucky's Medicaid Fraud and Abuse Control Unit of the Office of the Attorney General (MFACU) or other law enforcement or investigative agency having authority to resolve a complaint of Medicaid fraud or abuse.

(23) "Furnish" means to provide medical care, services, or supplies that are:

(a) Provided directly by a provider;

(b) Provided under the supervision of a provider; or

(c) Prescribed by a provider.

(24) "Inactive provider number" means the provider billing number issued by the department, or its fiscal agent, to a provider that failed to present a Medicaid claim for medical care, services, or supplies for payment under that number to the department, or its fiscal agent, during the period of the previous twelve (12) consecutive months;

(25) "Interest" means the prime interest rate that is:

(a) Charged as a simple interest by banks rounded to the nearest full percent, as quoted by commercial banks to large business, as determined by the board of governors of the Federal Reserve System; and

(b) In effect on the close of business, July 1, which is the first day of the state fiscal year.

(26) "Knowingly" means as defined in KRS 205.8451(5).

(27) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who conducts the day-to-day operation of, an institution, entity, organization, or agency.

(28) "Material omission" means a failure by a provider to report or advise the department of any fact, that if known to the department, would have caused the department to deny, reduce, or other-

wise withhold any portion of reimbursement for a billed covered service.

(29) "Medicaid Fraud and Abuse Control Unit" or "MFAUCU" means a unit in the Office of the Attorney General of Kentucky, certified under the provisions of 42 U.S.C. 1396b(q), that conducts a statewide program for the investigation and prosecution of violations of state laws regarding fraud and abuse in connection with the Medicaid Program.

(30) "Preliminary investigation" means the activities of the Office of Inspector General (OIG), MFAUCU, or the department to determine whether a complaint of Medicaid fraud or abuse has sufficient basis to warrant a full investigation.

(31) "Program" means the state Medicaid Program as defined by 42 U.S.C. 1396a.

(32) "Provider" means as defined by KRS 205.8451(7).

(33) "Recipient" means as defined by KRS 205.8451(9).

(34) "Reliable evidence" means:

(a) A preliminary determination based upon a preponderance of evidence as verified by the department by audit, of unacceptable practices or significant overpayments;

(b) Information of an ongoing investigation of a provider based on a preponderance of evidence, as verified by the department, involving fraud or criminal conduct pertaining to the Medicaid Program;

(c) Information based on a preponderance of evidence, as verified by the department, from a state professional medical licensing or certifying agency of an ongoing investigation of a Medicaid provider involving fraud, abuse, professional misconduct, unprofessional conduct, or utilization; or

(d) Information from the department or other sources based on a preponderance of evidence regarding unacceptable practices, relevant past criminal activities or program abuse.

(35) "Sanction" means an administrative action taken by the department which limits or bars an individual's, agency's, entity's, or organization's participation in the Medicaid Program or imposes a fiscal penalty against the provider, including the imposition of civil penalties, or interest imposed at the department's discretion, or the withholding of future payments.

(36) "Service" or "services" means a supply, covered care or covered service under the Medicaid Program.

(37) "Subcontractor" means an individual, agency, entity, or organization to which a disclosing entity has:

(a) Contracted or delegated some of its management functions or responsibilities of providing medical care or services to its patients; or

(b) Entered into a contract, agreement, purchase order or lease including real property, to obtain space, supplies, equipment or nonmedical services associated with providing services and supplies that are covered under the Medicaid Program.

(38) "Supplier" means an individual, agency, entity, or organization from which a provider purchases goods or services used in carrying out its responsibilities under the Medicaid Program.

(39) "Terminated" means a provider's participation in the Medicaid Program has been ended, and that a contractual relationship no longer exists between a provider and the department for the provision of Medicaid covered services to Medicaid eligible recipients by that individual, agency, entity, organization, fiscal agents or subcontractors of the provider.

(40) "Unacceptable practice" means conduct by a provider which constitutes "fraud" or "provider abuse", as defined in KRS 205.8451(2) or (8), or willful misrepresentation, and includes the following practices:

(a) Knowingly submitting, or causing the submission of false claims, or inducing, or seeking to induce, a person to submit false claims;

(b) Knowingly making, or causing to be made, or inducing, or seeking to induce, a false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment, or for use in determining the right to payment;

(c) Having knowledge of an event that affects the right of a provider to receive payment and concealing or failing to disclose the event or other material omission with the intention that a payment be made or the payment is made in a greater amount than otherwise owed;

(d) Conversion;

(e) Soliciting or accepting bribes or kickbacks;

(f) Failing to maintain or to make available, for purposes of audit or investigation, administrative and medical records necessary to fully disclose the medical necessity for the nature and extent of the medical care, services and supplies furnished, or to comply with other requirements established in 907 KAR 1:673, Section 2;

(g) Knowingly submitting a claim or accepting payment for medical care, services, or supplies furnished by a provider who has been terminated or excluded from the program;

(h) Seeking or accepting additional payments, for example, gifts, money, donations, or other consideration, in addition to the amount paid or payable under the Medicaid Program for covered medical care, services, or supplies for which a claim is made;

(i) Charging or agreeing to charge or collect a fee from a recipient for covered services which is in addition to amounts paid by the Medicaid Program, except for required copayments or recipient liability, if any, required by the Medicaid Program;

(j) Engaging in conspiracy, complicity, or criminal syndication;

(k) Furnishing medical care, services, or supplies that fail to meet professionally recognized standards, or which are found to be noncompliant with licensure standards promulgated under KRS Chapter 216B and failing to correct the deficiencies or violation as reported to the department by the Office of Inspector General, for health care or which are beyond the scope of the provider's professional qualifications or licensure;

(l) Discriminating in the furnishing of medical care, services, or supplies as prohibited by 42 U.S.C. 2000d;

(m) Having payments made to or through a factor, either directly or by power of attorney, as prohibited by 42 CFR 447.10;

(n) Offering or providing a premium or inducement to a recipient in return for the recipient's patronage of the provider or other provider to receive medical care, services or supplies under the Medicaid Program;

(o) Knowingly failing to meet disclosure requirements;

(p) Unbundling as defined under subsection (40) of this section; or

(q) An act committed by a nonprovider on behalf of a provider which, if committed by a provider, would result in the termination of the provider's enrollment in the program.

(41) "Unbundling" means submitting fragmented or multiple bills that results in a higher total reimbursement for tests and services that were performed within a specified time period that are required to be billed under a single bill code pursuant to 42 U.S.C. 1396b, that mandates a provider utilize the uniform identification coding system Current Procedural Terminology ("CPT") that establishes the specific range of services that are to be billed as one (1) CPT code.

(42) "Withholding" means not paying a provider for claims which have been processed, pending the results of an investigation of a report of fraud or willful misrepresentation based upon receipt of reliable evidence or as a result of provider bankruptcy, failure to submit timely cost reports, or closure or termination of a business.

Section 2. Methods for Recoupment of Overpayments. (1) If a determination is made by the department that a provider was overpaid, a demand letter shall be sent to the provider, at his last known mailing address. If a provider billed through an agent or entity, a copy of a demand letter may be mailed to a provider's designated payment last known mailing address. The demand letter shall contain:

- (a) The amount of the overpayment;
- (b) The period of time involved;
- (c) The basis for determining the overpayment exists;
- (d) Language granting a provider sixty (60) days advance notice that the repayment is due in full; and

(e) Appeal rights, if any.

(2) Departmental adjustments of the reimbursements rates, and differences between estimated and actual costs a provider incurred in determining reimbursements, may create situations where a provider was overpaid. The letter of notification of adjustments and the monies due under this subsection shall include:

(a) All required elements of subsection (1) of this section;

(b) Documentation to support the department's determination of adjustments; and

(c) Appeal rights, if any.

(3) The provider shall within:

(a) Sixty (60) calendar days from the date of the demand letter, pay the amount of overpayment in full; or

(b) Sixty (60) calendar days from the date of the demand letter, or during the administrative appeal process, submit a written request for a payment plan.

(4) If the amount of overpayment resulted from rate revisions and subsequent recalculations within the Medicaid Management Information System, the department shall apply a rate adjustment against the next payment cycle for the provider prior to notifying the provider in writing of the amount of the overpayment.

(5) A payment plan may be approved by the department, if a provider documents that payment in full would create an undue hardship. A written declaration of undue hardship shall include the following:

(a) Copies of financial statements which indicate payment in full within sixty (60) calendar days would create an undue hardship; and

(b) Copies of notarized letters from at least two (2) financial institutions indicating the provider's loan request was denied for the overpayment amount.

(6) Except as provided for in subsection (7) of this section, payment plans shall not extend beyond a six (6) month period.

(7) A payment plan approved, in writing, by the Commissioner of the Department for Medicaid Services, in accordance with subsection (5) of this section, may be approved in excess of six (6) months, if the monthly repayment exceeds twenty-five (25) percent of the provider's average monthly Medicaid payment based upon the payments made the previous twelve (12) months.

(8) A payment plan approved in excess of six (6) months shall include provisions for payments of both principal and interest as provided in KRS Chapter 360.

(9) If a provider fails to make a payment as specified in the payment plan or takes no action toward repayment, the department shall recoup the amount due from future payments. If a provider has insufficient funds available for recoupment through the payment system in the first payment cycle following the due date, or no longer participates in the Medicaid Program, payments shall continue to be recouped and the department may take all lawful actions to collect the debt.

(10) Disputes.

(a) If a provider disputes the amount of overpayment, a provider may initiate the administrative appeals process in accordance with Section 8 or 9 of this administrative regulation.

(b) A timely-filed request of administrative appeal process shall stay the recoupment activities by the department pertaining to the issues on appeal until the administrative appeal process is final.

(c) If the department, after reviewing all documentation submitted during the administrative ap-

peal process, determines that no adjustments are required, the initial determination shall stand.

(d) If the department determines that the amount of overpayment demand should be reduced, a refund due to the provider shall be refunded to him within thirty (30) calendar days from the date of the determination.

(e) If it is determined that the amount requested should be increased, a provider shall be notified by a new demand letter pursuant to subsection (1) of this section.

(11) Withholding Medicare payments to recover Medicaid overpayments.

(a) The department may request that the Centers for Medicare and Medicaid Services (CMS) withhold future Medicare payments to a provider in order to recover Medicaid overpayments to that provider, pursuant to 42 U.S.C. 1395vv.

(b) Amounts withheld and forwarded to the department by CMS which are ultimately determined by the department to be in excess of overpayments due to the Medicaid Program shall be returned to the provider.

(12) Statutory recovery. The department shall not issue payments otherwise due to a provider, if the department has been notified by a state or federal government agency or by a court that a court order exists requiring the department to withhold payments. The payments shall be withheld in accordance with the provisions of the order.

(13) Medicare overpayments. If ordered to recoup payment by CMS, the department shall recoup the federal share of Medicaid payments, which is the portion of the payment funded with federal funds, as a means to recover Medicare overpayments pursuant to 42 U.S.C. 1396m.

(14) A contract for the sale or change of ownership of a provider participating in the Medicaid Program shall specify whether the buyer or seller is responsible for amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of the sale. In the absence of specification in the contract for the sale or change of ownership, the recipient of the payment, who otherwise would be the provider of record at the time the department made the erroneous payment, shall have the responsibility for liabilities arising from that payment, regardless of when identified.

Section 3. Administrative Process for Identification and Referral of Unacceptable Practices. (1) A preliminary investigation of alleged unacceptable practice shall be conducted by the department or its agent, if:

(a) A complaint is received by or referred from:

1. The department;
2. The cabinet; or
3. The Office of Attorney General; or

(b) Questionable or unacceptable practices are identified by the department.

(2) If the findings of a preliminary investigation indicate that an incident of fraud or abuse involving substantial allegations or other indication of fraud may have occurred under the Medicaid Program, a referral for a full investigation shall be made to the MFACU or the Office of the United States Attorney, if appropriate.

(3) In order to facilitate a full investigation, the department shall, at the request of the MFACU or the Office of the United States Attorney, provide access to, and free copies of, records, data, or information kept by the department, its contractors, or providers, if authorized, as specified in 907 KAR 1:672, Section 4.

(4) A full investigation shall continue until:

- (a) Appropriate legal action is initiated;
- (b) The investigation is discontinued because of insufficient evidence to support the allegation of unacceptable practice; or
- (c) The case is returned to the department for administrative action.

(5) During a preliminary or full investigation, the department may make an administrative determination that a provider has committed an act of unacceptable practice based on receipt of reliable evidence. The department shall issue a written notice of a determination of unacceptable practice to a provider upon which an exclusion or sanction is intended to be imposed, as specified in Section 5 of this administrative regulation. The notice shall be mailed to a provider's last known mailing address. A copy may be mailed to the provider's designated payment last known mailing address. The notice shall clearly state:

- (a) The determination made;
- (b) The basis and specific reasons for the determination;
- (c) The effect of the action to be taken;
- (d) The amount of overpayment or penalty, if any;
- (e) The effective date of the action; and
- (f) The administrative appeal process rights of the provider, if any, as established in Sections 8 and 9 of this administrative regulation.

(6) During a preliminary or full investigation, the department may refer the case to the MFACU or the Office of the United States Attorney for appropriate action.

(7) The Medicaid Program or its fiscal agents or contractors may, as it deems necessary and reasonable, use random or other statistical sampling methodologies and extrapolate the Medicaid Program's findings based on the sample.

Section 4. Withholding of Payments During an Investigation of Fraud or Willful Misrepresentation.

(1) The department may withhold Medicaid payments pursuant to 42 CFR 455.23 upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid Program.

(2) The department may withhold payments without first notifying a provider of its intention to withhold payments.

(3) The department shall mail written notice to a provider at the provider's last known mailing address of its withholding of program payments within five (5) calendar days of the date upon which withholding began. The department may mail a copy of the written notice to an agent or entity that submitted the bills, which resulted in the amounts to be withheld pursuant to 42 CFR 455.23.

(a) The notice shall establish the general allegations of the nature of the withholding action, including the types of payments and payment code sections to which fraud or willful misrepresentation is alleged to have occurred. The notice shall not disclose specific information concerning its ongoing investigation.

(b) The notice shall advise a provider:

1. That payments are being withheld in accordance with this administrative regulation;
2. The statutory and regulatory basis for withholding and the facts upon which the action is taken;
3. The date upon which withholding began;
4. That withholding shall be for a temporary period;
5. The circumstances under which withholding shall be discontinued;
6. The type of Medicaid claim, as appropriate, to which withholding shall apply;
7. The provider's right to submit written evidence for consideration by the department; and
8. The provider's administrative appeal process rights, if any, in accordance with Sections 8 and 9 of this administrative regulation.

(4) A withholding of payment action under this section shall be temporary and shall not continue after:

(a) The investigation has been discontinued due to insufficient evidence of fraud or willful misrepresentation by the provider;

(b) Legal proceedings related to the provider's alleged unacceptable practice are final and not

subject to further appeal and court-ordered, deferred prosecution, or plea-bargained restitution has been paid; or

(c) The matter has been resolved between the department and the provider through an administrative determination of unacceptable practice, as specified in Section 3 of this administrative regulation.

(5) Upon completion of the process established in subsection (4)(a) and (b) of this section, all moneys withheld not otherwise used to offset a valid overpayment or court-ordered restitution, due on claims shall be promptly disbursed to a provider.

Section 5. Sanctions. (1) The department shall comply with the requirements of 42 CFR 1002 and 42 U.S.C. 1320a-7.

(2) The department shall impose sanctions as provided in KRS 205.8467 and Sections 3, 4, 5, and 6 of this administrative regulation.

(3) The department may hold, during its administrative determination of unacceptable practice, a provider responsible and liable for the conduct and actions of its affiliates, representatives, employees, or subcontractors. Conduct shall only be imputed to another if:

(a) The conduct was accomplished within the course of the duties of the provider to be sanctioned; and

(b) The provider had knowledge, if:

1. The provider knew or reasonably should have known of the conduct; or
2. The conduct was effected with the knowledge and consent of the provider.

(4) If the department sanctions a provider, it may also sanction an affiliate of the provider. A determination to sanction an affiliate shall be made during the process leading to the administrative determination of unacceptable practice, on a case-by-case basis, after full review and consideration of all relevant facts and circumstances leading to the sanction of the provider. An affiliate shall have the same notification, time limits to dispute, due process rights, and burden of proof as a provider.

(5) The sanction process may include a termination of a provider from the Medicaid Program. If a termination is made, the termination notice shall specify the period of exclusion. In determining the sanction, or the duration of exclusion, the department shall consider as appropriate:

(a) The number and nature of the unacceptable practice incidents;

(b) The nature and extent of the adverse impact the violations had on recipients;

(c) The amount of damages to the Medicaid Program;

(d) Past criminal records of activities involving a child, patient or adult in matters of abuse, neglect, sexual abuse, malpractice, or the personal involvement in fraud or another violation of 42 U.S.C. 1128a-b13, that may have been discovered as a result of the investigation of the unacceptable practice or other related material facts that may impact the health, safety and well-being of Medicaid recipients; and

(e) The previous record of violations by the provider under Medicare, Medicaid or other program administered by the department.

(6) The sanction process shall include liability for civil payments, restitution of overpayments and agency costs as specified in KRS 205.8467.

(7) The department shall use a lien, as specified in KRS 205.8471, to assure payment of restitution and monetary penalties imposed under the administrative determination of fraud.

(8) A provider excluded from the Medicare Program shall be excluded from the Medicaid Program for the same period of time.

(9) The provider shall be notified in writing by the department of the sanctions that are imposed pursuant to 42 CFR 1001.2002.

Section 6. Termination of Provider Participation. (1) Terminations and hearings.

(a) Before the participation of a nursing facility, as defined in 42 U.S.C. 1396r(a), or an intermediate care facility for the mentally retarded, as defined in 42 U.S.C. 1396d(d), is terminated, it shall have the right to receive an administrative hearing in accordance with Sections 8 and 9 of this administrative regulation and 42 CFR 431.151 through 431.154.

(b) Except as provided in paragraph (a) of this subsection, provider participation shall be terminated without prior hearing.

(2) A provider's participation may be terminated by either the provider or the department upon thirty (30) calendar days written notice to the other without cause or as otherwise specified in the provider agreement.

(3) A provider's participation may be terminated and a period of exclusion imposed, if an administrative determination is made, as established in Section 3 of this administrative regulation, that the provider engaged in an unacceptable practice.

(4) Except as provided for in 907 KAR 1:672, failure to maintain up-to-date information, or to submit the information within thirty-five (35) calendar days of a request by the department, shall result in termination of a provider's participation in the Medicaid Program.

(5) A provider's participation shall be terminated immediately, if it is determined that the information provided at the time of application or reinstatement was incorrect, inaccurate or incomplete and if provision of correct, accurate and complete information would have resulted in the denial of the application based upon one (1) or more of the factors established in 907 KAR 1:672 or this administrative regulation.

(6) A provider's participation may be terminated, if the provider fails or refuses to pay or enter into an agreement to pay the amount of a penalty imposed, including interest, in accordance with Section 5 of this administrative regulation and KRS 205.8467 within sixty (60) calendar days from the date of the department's notice or the date of a hearing decision, if they occur.

(7) A provider's participation in Medicaid shall be terminated, if the provider fails to submit a completed and signed application within thirty-five (35) calendar days from the date of the notice to provide the application.

(8) A provider's participation in Medicaid shall be terminated and a period of exclusion imposed upon a Medicare or Medicaid related conviction through the judicial process pursuant to 42 U.S.C. 1320a-7.

(9) A provider's participation in Medicaid shall be terminated in accordance with 42 CFR 1003.105 on the date of termination or suspension from Medicare.

(10) A provider's participation in Medicaid shall be terminated as of the date of a termination, revocation, or suspension of a registration, certification or license to practice a medical profession, or as required to provide medical care, services or supplies under Medicaid.

(11) A provider's participation in Medicaid shall be terminated and a new application required, if the ownership or controlling interest of the provider has substantially changed since the acceptance of the current enrollment application, which may include one (1) or more of the following actions:

(a) A sole proprietor transfers title and property to another party;

(b) The addition, removal, or substitution of one (1) or more partners of a provider organized as a partnership effects the termination of the partnership, and creates a successor partnership or other entity;

(c) An incorporated provider merges with an incorporated institution which is not participating in the program and the nonparticipating institution is the surviving corporation;

(d) Two (2) or more corporate providers consolidate and the consolidation results in the creation of a new corporate entity;

(e) Two (2) or more unincorporated providers consolidate;

(f) The sale, purchase, exchange of stock, merger or other consolidation of the business or assets directly related to the provision of health care, if the sale results in a change of ownership or

control of a provider;

(g) If the ownership or controlling interest of the provider has substantially changed since the acceptance of its enrollment application regardless of reason; or

(h) A provider, or a person, or organization having direct or indirect ownership, or control interest in the disclosing entity as defined by 42 CFR 455.101 and 102, is listed, or required to be listed, on the current Medicaid enrollment application and has been convicted in a court of appropriate jurisdiction of criminal violations involving either a Medicare- or Medicaid-related offense and that conviction is final and not under appeal.

(12) The department may take into consideration its requirement to provide recipients adequate access to medical care, prior to an actual provider's termination from the Medicaid Program.

(13) A provider shall submit a minimum of one (1) Medicaid claim for payment for each provider number issued to that provider within twelve (12) consecutive months to have that number remain as "active" and in good status.

(14) Termination of inactive provider numbers. A provider shall be determined to have abandoned his provider number if twenty-four (24) consecutive months shall have expired without a claim being submitted upon that provider number to the department, or its fiscal agent for payment.

(15) The department may terminate a provider number and the provider's corresponding right to participate in the program for inactivity of billing if:

(a) A provider fails to submit the first claim upon the number initially issued to the provider within a period of twenty (24) months from the date the number was issued by the department, or its fiscal agent; or

(b) A provider number, that has had at least one (1) Medicaid claim submitted to the department, or its fiscal agent for payment, has no bill submitted for that number for twenty-four (24) consecutive months defined as:

1. When a period of twelve (12) consecutive months shall pass without a Medicaid claim being submitted for payment, the number shall be inactive; and

2. When a period of an additional twelve (12) consecutive months has passed with the number remaining inactive.

(16) A notice advising a provider of the termination and of the requirements to make a new application for enrollment shall be sent to the provider thirty (30) calendar days prior to his termination from the program, unless:

(a) Twenty (20) days shall have elapsed from the date of the notice of Medicaid exclusion pursuant to 42 CFR 1001.2002;

(b) Immediately required due to federal exclusion pursuant to 42 U.S.C. 1320a-7;

(c) Immediately required due to revocation or suspension of professional license or other action of:

1. A court of competent jurisdiction; or

2. The professional board governing the profession; or

(d) Otherwise required pursuant to this administrative regulation.

(17) Notice of termination.

(a) A notice of termination shall:

1. Be in writing;

2. Be mailed to a provider's last known mailing address;

3. State the reason for the termination;

4. State the effective date of the termination;

5. State the date the provider may submit an application for reenrollment, if appropriate;

6. State a provider's hearing rights, if any, in accordance with Sections 8 and 9 of this administrative regulation; and

7. Contain the basis of the exclusion, the length of the exclusion, the factors considered in setting the length of the exclusion, and the effect of the exclusion pursuant to 42 CFR 1001.2002, if the termination is the result of a federal or state sanction exclusion.

(b) If notice has been provided in accordance with Section 3 (5) of this administrative regulation, no additional notice of termination shall be required.

(18) The department may extend participation or waive termination for a provider of covered care, service or supply under the Medicaid Program, if necessary to assure that adequate access to Medicaid services will be available in the area served by the provider pursuant to 42 CFR 1396a(8).

(19) The department may terminate a provider immediately, if necessary to protect the health, safety, or well-being of Medicaid recipients.

Section 7. Provider Reinstatement or Reenrollment Following Termination. (1) A provider whose participation has been terminated under the provisions of this administrative regulation may request reinstatement in accordance with:

(a) The requirements established in the department's written provider application;

(b) The enrollment requirements pursuant to 907 KAR 1:672;

(c) Other requirements pursuant to this administrative regulation; and

(d) A written declaration of the provider's request for reinstatement on the first page of the application form.

(2) The department may grant reinstatement from an exclusion based on a program violation, if the provider shall have:

(a) Demonstrated to the department that the violation which led to the sanction is corrected; or

(b) Otherwise established to the department's satisfaction that further violations will not be repeated.

(3) If the department approves a request for reinstatement after imposition of a sanction in accordance with Section 5 of this administrative regulation, the department shall provide written notice to the provider and to all others who were informed of the sanction, specifying the date on which program participation may resume. Participation by a provider, reinstated under this section, is conditional upon their compliance with their assurance of no further violations.

(4) A provider terminated from the Medicaid Program and excluded for a specified period of time shall be eligible for reenrollment upon the expiration of the period of exclusion. Providers excluded on the basis of a conviction for a Medicare- or Medicaid-related offense shall not be eligible for reenrollment until:

(a) The conviction shall be final and not under appeal;

(b) The specified period of exclusion shall have expired; and

(c) The provisions of subsections (1) and (2) of this section have been met.

(5) A provider that has an outstanding debt to the program shall not be reinstated or reapplied for Medicaid Program participation.

Section 8. Resolution of Provider Disputes Prior to Administrative Hearing. (1) If a provider disagrees with a Medicaid determination with regard to an appealable issue as provided for in Section 9 of this administrative regulation, the provider may request a dispute resolution meeting. The request shall be in writing and mailed to and received by the branch manager that initiated the department-written determination within thirty (30) calendar days of the date the notice was received by the provider. The department shall not accept or honor a request for administrative appeals process, or a part thereof, that is filed by a provider prior to receipt of the department-written determination that creates an administrative appeal right under this administrative regulation.

(2) A provider's request for a resolution meeting shall clearly:

(a) Identify each specific issue and dispute;

- (b) State the basis on which the department's decision on each issue is believed to be erroneous;
- (c) Provide documentation or a summary supporting the provider's position; and
- (d) State the name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf.

(3) Either the department or the provider may request the presence of a court reporter at the dispute resolution meeting. A court reporter shall be secured in advance of the meeting, and a dispute resolution meeting shall not be postponed solely due to the failure to timely secure a court reporter.

(4) Except if the court reporter was requested solely by the provider, the department shall bear the cost of a court reporter. Each party shall at all times bear the costs of requested transcribed copies.

(5) Dispute resolution meetings involving a court reporter shall be conducted face to face, and shall not be conducted via telephone.

(6) If an administrative hearing is requested, the transcript shall become part of the official record of the hearing pursuant to KRS 13B.130.

(7) The department shall, within ten (10) calendar days of receipt of the request for a dispute resolution meeting, send a written response to the provider identifying the time and place in which the meeting shall be held within thirty (30) days of receipt of the request and identifying the department's representative who is expected to attend the meeting. The meeting shall be held within forty (40) calendar days of receipt of the request, unless a postponement is requested. The dispute resolution meeting may be postponed for a maximum additional period of sixty (60) calendar days, at the request of any party.

(8) The dispute resolution meeting shall be conducted in an informal manner as directed by the department's representative. The provider may present evidence or testimony to support his case. Each party shall be given an opportunity to ask questions to clarify the disputed issue or issues.

(9) A provider may, within the same deadline specified in subsection (1) of this section, submit information that the provider wishes to be considered in relation to the department's determination without requesting a dispute resolution meeting. The submission of additional documentation shall not extend the thirty (30) day time period for requesting a resolution meeting.

(10) The department, after the dispute resolution meeting, or the date the information to be considered was presented to the department as established in subsection (9) of this section, shall within thirty (30) calendar days:

- (a) Uphold, rescind, or modify the original decision with regard to the disputed issue; and
- (b) Provide written notice to the provider of the department's decision and the facts upon which it is based with reference to applicable statutes and administrative regulations.

(11) Information submitted for the purpose of informally resolving a provider dispute shall not be considered a request for an administrative hearing.

(12) The department may waive the dispute resolution meeting, at its sole discretion, and issue a decision in lieu of the meeting, with the decision subject to administrative hearing under Section 9 of this administrative regulation.

(13) The department may postpone the issuance of its findings of the dispute resolution meeting, or its review of the materials submitted in lieu of a dispute resolution meeting, by mailing a written notice to the provider stating the reason for the delay and the anticipated date of completion of the review. A postponement shall not extend beyond 180 days.

Section 9. Administrative Hearing. (1) The administrative hearing shall be conducted in accordance with KRS Chapter 13B by a hearing officer who is knowledgeable of Medicaid policy, as established in federal and state laws.

(2) The secretary of the cabinet, pursuant to KRS 13B.030(1), shall delegate by administrative

order conferred powers to conduct administrative hearings under this administrative regulation.

(3) The department, in addition to Section 8(1) of this administrative regulation, shall not accept or honor a request for administrative appeals process, or a part thereof, by a provider that is:

(a) Filed at the state level for a federal-mandated exclusion subsequent to a federal notice of the exclusion containing the federal appeal rights; or

(b) Filed at the state level for program exclusion resulting from a criminal conviction by the court of competent jurisdiction, upon exhaustion or failure to timely pursue the judicial appeal process.

(4) The administrative hearing process shall be used in the following situations:

(a) If a provider is a nursing facility as defined in 42 U.S.C. 1396r(a), or is an intermediate care facility for the mentally retarded as defined in 42 U.S.C. 1396d(d), and participation is terminated regardless of reason;

(b) A provider alleges discrimination by the department as prohibited by 42 U.S.C. 2000d;

(c) The department imposes a sanction;

(d) The department requires repayment of a noncourt-established overpayment or noncourt-ordered restitution; or

(e) A provider's payments are being withheld in accordance with Section 4 of this administrative regulation.

(5) A written request for an administrative hearing shall be received by the department within thirty (30) calendar days of the date of receipt of the department's notice of a determination or a dispute resolution decision. This request shall be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002.

(6) The department shall forward to the hearing officer an administrative record which shall include the notice of action taken, the statutory or regulatory basis for the action taken, the department's decision following the resolution process, and all documentary evidence provided by the provider, his billing agent, subcontractor, fiscal agent or another provider-authorized individual to the department.

(7) The notice of the administrative hearing shall comply with KRS 13B.050.

(a) The administrative hearing shall be held in Frankfort, Kentucky no later than sixty (60) calendar days from the date the request for the administrative hearing is received by the department.

(b) The administrative hearing date may be extended beyond the sixty (60) calendar days by:

1. A mutual agreement by the provider and the department; or

2. A continuance granted by the hearing officer.

(8) If a prehearing conference is requested, it shall be held at least seven (7) calendar days in advance of the hearing date. Conduct of the prehearing conference shall comply with KRS 13B.070.

(9) If a provider does not appear at the hearing on the scheduled date and the hearing has not been previously rescheduled, the hearing officer may find a provider in default pursuant to KRS 13B.050(3)(h). A hearing request shall be withdrawn only under the following circumstances:

(a) The hearing officer receives a written statement from a provider stating that the request is withdrawn; or

(b) A provider makes a statement on the record at the hearing that he is withdrawing his request for the hearing.

(10) Documentary evidence to be used at the hearing shall be made available in accordance with KRS 13B.090.

(11) Information relating to the selection of the provider for audit, investigation notes or other materials which may disclose auditor investigative techniques, methodologies, material prepared for submission to a law enforcement or prosecutorial agency, information concerning law enforcement investigations, judicial proceedings, confidential sources or confidential information shall not be revealed, unless exculpatory in nature as required pursuant to KRS 13B.090(3).

(12) A hearing officer shall preside over the hearing and shall conduct the hearing in accordance with KRS 13B.080 and 13B.090.

(13) The issues considered at a hearing shall be limited to:

- (a) Issues directly raised in the initial request for a dispute resolution meeting;
- (b) Issues directly raised during the disputed resolution meeting; or
- (c) Materials submitted in lieu of a dispute resolution meeting.

(14) KRS 13B.090(7) shall govern the burdens of proof.

(a) The department shall have the initial burden of showing the existence of the administrative regulations or statutes upon which the determination was based.

(b) If the determination is based upon an alleged failure of a provider to comply with applicable generally accepted business, accounting, professional, chiropractic or medical practices or standards of health care, the department shall establish the existence of the practice or standard.

(c) The department shall be responsible for notifying the hearing officer of previous relevant violations by the provider under Medicare, Medicaid, or other program administered by the Cabinet for Health and Family Services, or relevant prior actions under Section 5(5) of this administrative regulation, which the department wishes the hearing officer to consider in his deliberations.

(15) The hearing officer shall issue a recommended order in accordance with KRS 13B.110.

(16) Except for the requirement that the request for the administrative appeal process, or a part thereof, be filed in a timely manner, the hearing officer may grant an extension of time specified in this section, if determined necessary for the efficient administration of the hearing process or to prevent an obvious miscarriage of justice with regard to the provider. An extension of time for completion of the recommended order shall comply with the requirements of KRS 13B.110(2) and (3).

(17) A final order shall be entered in accordance with KRS 13B.120.

(18) The cabinet shall maintain an official record of the hearing in compliance with KRS 13B.130.

(19) In the correspondence transmitting the final order, clear reference shall be made to the availability of judicial review pursuant to KRS 13B.140 and 13B.150

Section 10. Actions Taken at the Conclusion of the Administrative Appeal Process. (1) The stay on recoupment granted under Section 2(10)(b) of this administrative regulation shall not extend to judicial review, unless a stay is granted pursuant to KRS 13B.140(4).

(2) If during an administrative appeal process circumstances require a new or modified determination letter, new appeal rights shall be provided in accordance with this administrative regulation.

(3) Thirty (30) calendar days after the issuance of the final order pursuant to KRS 13B.120, the department:

(a) Shall initiate collection activities, and take all lawful actions to collect the debt; and

(b) May enact program terminations, sanctions pursuant to 42 U.S.C. 1320a-7, or other actions that were held in abeyance pending the decision of the administrative appeal process. (21 Ky.R. 2346; Am. 3043; 22 Ky.R. 73; eff. 6-21-95; 2178; eff. 7-5-96; 27 Ky.R. 137; eff. 7-17-2000; 28 Ky.R. 975; 1422; eff. 12-19-2001.)