907 KAR 1:672. Provider enrollment, disclosure, and documentation for Medicaid participation.

RELATES TO: KRS 205.520, 205.560, 205.8451(2),(7),(8),(9), 205.8477, 304.17A-545(5), 311.621-311.643, 42 U.S.C. 1396a(w), 42 C.F.R. 455.100-455.106, 42 C.F.R. 1003.101

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(12), 42 U.S.C. 1396a, b, c

CERTIFICATION STATEMENT:

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560(12) requires the Medical Assistance Program to use the form and guidelines established pursuant to KRS 304.17A-545(5) for assessing the credentials of those applying for participation in the Medical Assistance Program. KRS 205.560(13) requires the department to develop a specific form and establish guidelines for assessing the credentials of dentists applying for participation in the Medical Assistance Program. This administrative regulation establishes provisions related to Medicaid provider enrollment, disclosure, documentation requirements, and guidelines for assessing the credentials of those applying for participation in the Medicaid Program.

Section 1. Definitions.

(1) "Applicant" means a person or entity who applies for enrollment as a participating Medicaid provider.

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

(3) "Claim" means a request for payment under the Medicaid Program that:

(a) Relates to each individual billing submitted by a provider to the department;

(b) Details services rendered to a recipient on a specific date; and

(c) May be a line item of service or all services for one (1) recipient on a bill.

(4) "Credentialed provider" means a provider that is required to complete the credentialing process in accordance with KRS 205.560(12) and (13) and includes the following individuals who apply for enrollment in the Medicaid Program:

(a) A dentist;

(b) A physician;

(c) An audiologist;

(d) A certified registered nurse anesthetist;

(e) An optometrist;

(f) An advance registered nurse practitioner;

(g) A podiatrist;

(h) A chiropractor; or

(i) A physician assistant.

(5) "Department" means the Department for Medicaid Services or its designated agent.

(6) "Disclosure" means the provision of information required by 42 C.F.R. 455.100 through 455.106.

(7) "Evaluation" or "credentialing" means:

(a) A process for collecting and verifying professional qualifications of a health care provider;

(b) An assessment of whether a health care provider meets specified criteria relating to professional competence and conduct; and

(c) A process to be completed before a health care provider may participate in the Medicaid Program on an initial or ongoing basis.

(8) "Exclusion" is defined by 42 C.F.R. 1003.101.

(9) "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.

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

(11) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(12) "Noncredentialed provider" means a provider that is not required to complete the credentialing process in accordance with KRS 205.560(12) and includes any individual or entity not identified in subsection (4) of this section.

(13) "Provider" is defined by KRS 205.8451(7).

(14) "Recipient" is defined by KRS 205.8451(9).

(15) "Reevaluation" or "recredentialing" means a process for identifying a change that may have occurred in a health care provider since the last evaluation or credentialing that may affect the health care provider's ability to perform services.

(16) "Services" means medical care, services, or supplies provided to a Medicaid recipient.

(17) "Subcontractor" means an individual, agency, entity, or organization to which a Medicaid provider or the department's fiscal agent 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 lease of real property, to obtain space, supplies, equipment, or nonmedical services associated with providing services and supplies that are covered under the Medicaid Program.

(18) "Terminated" means a provider's participation in the Medicaid Program has ended and a contractual relationship no longer exists between the provider and the department for the provision of Medicaid-covered services to eligible recipients by the provider or its subcontractor.

(19) "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 practices specified in Section 5 of this administrative regulation.

Section 2. Enrollment Process for Provider Participation in Medicaid.

(1) Scope.

(a) The department shall contract only with an individual or entity who meets the conditions of Medicaid provider participation in accordance with 907 KAR 1:671.

(b) The department shall reserve the right to contract or not contract with any potential provider.

(c) An individual or entity that wishes to participate:

1. in the Medicaid Program shall be enrolled as a participating provider prior to being eligible to receive reimbursement in accordance with federal and state laws; and

2. As a KenPAC primary care provider shall meet the provider participation criteria established in 907 KAR 1:320, Kentucky Patient Access and Care System (KenPAC).

(2) To apply for enrollment in the Medicaid Program as a noncredentialed provider, an individual or entity shall:

(a) Complete, and submit to the department, the noncredentialed provider section of a MAP-811, Provider Application; and

(b) Submit of a valid professional license, registration, or certificate that allows the:

1. Individual to provide services within the individual's scope of practice; or
2. Entity to operate or provide services within the entity's scope of practice.

(3) To apply for enrollment in the Medicaid Program as a credentialed provider, an individual shall:

(a) Complete, and submit to the department, the individual provider application section of a MAP-811, Provider Application;

(b) Submit proof of a valid professional license, registration, or certificate that allows the individual to provide services within the individual's scope of practice; and

(c)

1. Except for a dentist, submit either:
   a. A completed KAPER-1, Kentucky Application for Provider Evaluation and Reevaluation; or
   b. Pursuant to 806 KAR 17:480, Section 2(4), the provider application form of the Council for Affordable Quality Healthcare; or
2. If licensed to practice as a dentist, submit a completed Dental Credentialing Form.

(4)

(a) Within forty-five (45) days of receipt of a required credentialing form, the department shall notify the health care provider or entity applying for enrollment in the Medicaid Program of any omitted information or questionable information included on the form.

(b) The department shall deny enrollment if the applicant does not:

1. Respond with the requested information within the time period specified in the department's notice of omitted or questionnaire information; or
2. Requests an extension of time that is:
   a. Requested during the time period specified in the department's notice; and
   b. Grant by the department.

(c) The department may require that an on-site inspection be performed to ascertain compliance with applicable licensure standards established in KRS Chapter 216B, and certification standards, prior to an enrollment determination.

(d)

1. The department shall make an enrollment determination within ninety (90) days of receipt of:
   a. The completed application documents required by subsection (2) or (3) of this section; and
   b. Any additional information requested by the department.
2. The department:
   a. May take additional time beyond ninety (90) days to render a decision if necessary for resolution of an issue or dispute; and
   b. Shall notify the applicant that a decision will be issued after the ninety (90) day timeframe established in subparagraph 1 of this paragraph if additional time is needed to render a decision.

(5) Approval of enrollment in the Medicaid Program as a participating provider.

(a) Upon approval of enrollment, the department shall issue a provider number that shall be used by the provider solely for billing and identification purposes.

(b) A provider's participation shall begin and end on the dates specified in the notification of approval for program participation, unless the provider's participation is terminated in accordance with this administrative regulation, 907 KAR 1:671, or other applicable state or federal laws.

(6) By enrolling in the Medicaid Program, a provider, the provider's officers, directors, agents, employees, and subcontractors agree to:

(a) Maintain the documentation for claims as required by Section 4 of this administrative regulation;

(b) Provide, upon request, all information regarding the nature and extent of services and claims submitted by, or on behalf of the provider, to the:

1. Cabinet;
2. Department;
3. Attorney General;
4. Auditor of Public Accounts;
5. Secretary of the United States Department of Health and Human Services; or
6. Office of the United States Attorney;

(c) Comply with the disclosure requirements established in Section 3 of this administrative regulation;

(d) Comply with the applicable advance directive requirements established in 42 U.S.C. 1396a(w) regarding the right to accept or reject life-saving medical procedures as described in KRS 311.621 through 311.643;

(e) Accept payment from Medicaid as payment in full for all care, services, benefits, or and supplies billed to the Medicaid Program, except with regard to recipient cost-sharing charges and beneficiary liability, if any;

(f) Submit claims for payment only for care, services, benefits, or supplies;

1. Actually furnished to eligible recipients; and
2. Medically necessary or otherwise authorized by law;

(g) Provide true, accurate, and complete information in relation to any claim for payment;

(h) Permit review or audit of all books or records or, at the discretion of the auditing agency, a sample of books or records related to services furnished and payments received from Medicaid, including recipient histories, case files, and recipient specific data. Failure to allow access to records may result in the provider's liability for costs incurred by the cabinet associated with the review of records, including food, lodging and mileage;

(i) Not engage in any activity that would constitute an unacceptable practice;

(j) Comply with all terms and provisions contained in the application documents required by subsection (2) or (3) of this section;

(k) Comply with all applicable federal laws, state statutes, and state administrative regulations related to the applicant's provider type and provision of services under the Medicaid Program; and

(l) Bill third party payers in accordance with Medicaid statutes and administrative regulations.

(7) Denial of enrollment or reenrollment in the Medicaid Program.

(a) The department shall deny enrollment if an applicant meets one (1) of the following conditions:

1. Falsely represents, omits, or fails to disclose of any material fact in making an application for enrollments in accordance with subsection (2) or (3) of this section;

2. Is currently suspended, excluded, terminated, or involuntarily withdrawn from participation in any governmental medical insurance program as a result of fraud or abuse of that program;

3. Falsely represents, omits, or fails to disclose any material fact in making an application for a license, permit, certificate, or registration related to a health care profession or business;

4. Has failed to comply with applicable standards in the operation of a health care business or enterprise after having received written notice of noncompliance from:

a. The department; or

b. A state or federal licensing, certifying, or auditing agency;

5. Is under current investigation, indictment or conviction for fraud and abuse or unacceptable practice in:

a. The Kentucky Medicaid Program;

b. Another state's Medicaid Program;

c. The Medicare Program; or

d. Other publicly funded health care program;

6. Fails to comply with any Medicaid policy as specified in the Kentucky statutes or department's administrative regulations;

7. Fails to pay any outstanding debt owed to the department; or

8. Has engaged in an activity that would constitute an unacceptable practice.

(b) If enrollment or reenrollment is denied, the department shall consider reapplication only:

1. If the applicant corrects each deficiency that led to the denial; and

2. After the expiration of a period of exclusion imposed in accordance with 907 KAR 1:671, if applicable.

(c) Notice of denial of enrollment or reenrollment. The department shall send written notice of denial to an applicant's last known address and provide the reason for the denial.

(d) The denial shall be effective upon the date of the written notice.

(8)

(a) A provider may request limited enrollment for a period of time, not to exceed thirty (30) days, in an exceptional situation for emergency services provided to an eligible recipient.

(b) The department shall make an enrollment determination regarding the exceptional circumstances and notify the provider in writing of its decision.

(9) Recredentialing. A credentialed provider currently enrolled in the Medicaid Program shall submit to the department's recredentialing process three (3) years from the date of the provider's initial evaluation or last reevaluation.

Section 3. Required Provider Disclosure.

(1) A provider shall comply with the disclosure of information requirements contained in 42 C.F.R. 455.100 through 455.106 and KRS 205.8477.

(2) Time and manner of disclosure. Information disclosed in accordance with 42 C.F.R. 455.100 through 455.106 shall be provided:

(a) Upon application for enrollment;

(b) Annually thereafter; and

(c) Within thirty-five (35) days of a written request by the department or the United States Department of Health and Human Services.

(3) If a provider fails to disclose information required by 42 C.F.R. 455,.100 through 455.106 within thirty-five (35) days of the department's written request, the department shall terminate the provider's participation in the Medicaid Program in accordance with 907 KAR 1:671, Section 6, on the day following the last day for submittal of the required information.

(4)

(a) A provider shall file an amended, signed ownership and disclosure form with the department within thirty-five (35) days following a change in:

1. Ownership or control;

2. The managing employee or management company; or

3. A provider's federal tax identification number.

(b) Failure to comply with the requirements of paragraph (a) of this subsection may result in termination from the Medicaid Program.

Section 4. Required Provider Documentation.

(1) A provider shall maintain documentation of:

(a) Care, services, benefits, or supplies provided to an eligible recipient;

(b) The recipient's medical record or other provider file, as appropriate, which shall demonstrate that the care, services, benefits, or supplies for which the provider submitted a claim were actually performed or delivered;

(c) The diagnostic condition necessitating the service performed or supplies provided; and

(d) Medical necessity as substantiated by appropriate documentation including an appropriate medical order.

(2) A provider who is reimbursed using a cost-based method shall maintain all:

(a) Fiscal and statistical records and reports used for the purpose of establishing rates of payment made in accordance with Medicaid requirements established in 907 KAR Chapters 1, 3, 4, and 23, as applicable; and

(b) Underlying books, records, documentation and reports that formed the basis for the fiscal and statistical records and reports.

(3) All documentation required by this section shall be maintained by the provider for a minimum of five (5) years from the latter of:

(a) The date of final payment for services;

(b) The date of final cost settlement for cost reports; or

(c) The date of final resolution of disputes, if any.

(4) If any litigation, claim, negotiation, audit, investigation, or other action involving the records started before expiration of the five (5) year retention period, the records shall be retained until the latter of:

(a) The completion of the action and resolution of all issues which arise from it; or

(b) The end of the regular five (5) year period.

Section 5. Unacceptable Practice. The activities listed in this section shall constitute unacceptable practice:

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

(2) 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;

(3) 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 owned;

(4) Conversion;

(5) Soliciting or accepting bribes or kickbacks;

(6) 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;

(7) 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;

(8) 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;

(9) 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 recipient liability, if any, required by the Medicaid Program;
(10) Engaging in conspiracy, complicity, or criminal syndications;
(11) Furnishing medical care, services, or supplies that fail to meet professionally recognized standards, or which are found to be non compliant with licensure standards promulgated under KRS Chapter 216B and failing to correct the deficiencies or violation as reported to the department by the Office provider's professional qualifications or licensure;
(12) Discriminating in the furnishing of medical care, services, or supplies as prohibited by 42 U.S.C. 2000d;
(13) Having payments made to or through a factor, either directly or by power of attorney, as prohibited by 42 C.F.R. 447.10;
(14) 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;
(15) Knowingly failing to meet disclosure requirements;
(16) Unbundling; or
(17) 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.

Section 6. Incorporation by Reference.
(1) The following material is incorporated by reference:
(a) "Kentucky Application for Provider Evaluation and Reevaluation", Form KAPER-1, March 2007 edition;
(b) "Map-811, Provider Application", July 2007 edition; and
(c) "Dental Credentialing form", July 2007 edition.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

(22 Ky.R. 2198; eff. 7-5-1996; 34 Ky.R. 446; 1040; 1470; eff. 1-4-2008; TAm eff. 3-15-2017; TAm eff. 10-6-2017; Crt eff. 12-6-2019; Crt eff. 9-24-2026.)