

1 AN ACT relating to prepayment review of Medicaid claims.

2 *Be it enacted by the General Assembly of the Commonwealth of Kentucky:*

3 ➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
4 READ AS FOLLOWS:

5 (1) As used in this section:

6 (a) "Department" means the Department for Medicaid Services; and

7 (b) "Managed care organization" has the same meaning as in KRS 205.532.

8 (2) In order to ensure that claims presented by a Medicaid-enrolled provider for
9 payment by the department or a managed care organization meet the
10 requirements of state and federal laws and administrative regulations, including
11 but not limited to medical necessity criteria, a Medicaid-enrolled provider may be
12 subject to prepayment claims review by the department or a managed care
13 organization.

14 (3) A Medicaid-enrolled provider shall only be subjected to prepayment claims review
15 following:

16 (a) Receipt of a credible allegation of waste, fraud, or abuse by the department;

17 (b) Identification of a pattern of uncorrected aberrant billing practices as a
18 result of an investigation conducted by the department or a managed care
19 organization;

20 (c) Failure by the provider to timely, as defined by the department, respond to a
21 request for reasonable documentation made by the department or a
22 managed care organization; or

23 (d) Any other reason established by the department.

24 (4) (a) A managed care organization may only subject a Medicaid-enrolled
25 provider to prepayment claims review after:

26 1. Requesting, in writing, approval from the department to subject a
27 Medicaid-enrolled provider to prepayment claims review. The written

- 1 request for approval required by this subparagraph shall include a
2 justification for the request which shall identify the specific provision
3 of subsection (3) of this section under which the request is being made
4 and specific facts as may support that justification; and
- 5 2. Receiving written approval from the department to subject a provider
6 to prepayment claims review. The written approval required by this
7 subparagraph shall include justification for the approval which shall
8 identify the specific provision of subsection (3) of this section under
9 which the request was approved, the approved timeframe for which the
10 Medicaid-enrolled provider may be subject to prepayment claims
11 review, and the approved scope of the prepayment claims review to
12 which the provider may be subjected.
- 13 (b) Prior to approving any request submitted by a managed care organization
14 under this subsection, the department shall solicit a response from the
15 provider against whom the managed care organization is seeking to initiate
16 prepayment claims review. In soliciting a response from the provider, the
17 department shall provide the provider with an unredacted and complete
18 copy of the written request submitted by the managed care organization,
19 and the provider shall have fifteen (15) calendar days from the date on
20 which the department solicited a response to respond in writing.
- 21 (c) The department shall approve, deny, or return for further information each
22 request from a managed care organization for prepayment claims review
23 within fifteen (15) days after it receives a response from the provider or
24 after the expiration of the fifteen (15) day period in which a provider may
25 submit a response.
- 26 (d) Notwithstanding paragraph (b) of this subsection, the department may deny
27 a managed care organization's request to initiate prepayment claims review

1 without soliciting a response from the provider.

2 (e) The department may require managed care organizations to submit requests
3 under this subsection in a form and manner prescribed by the department.

4 (5) Written notice of being subject to prepayment claims review shall be sent by
5 certified mail, return receipt requested, to the Medicaid-enrolled provider's point
6 of contact, as set forth in the provider's enrollment agreement, and to the
7 provider's principal place of business, as it appears on the Secretary of State's
8 website, if the provider is an entity required to register as a business entity.
9 Prepayment claims review shall be initiated no less than twenty (20) calendar
10 days from the date of receipt by the Medicaid-enrolled provider of the written
11 notice as evidenced by the certified mail return receipt. The notice shall contain
12 the following:

13 (a) A copy of the written approval received by the managed care organization
14 as required under subsection (4) of this section, any additional information
15 that may be necessary to explain with specific supporting facts the provision
16 of subsection (3) of section upon which approval was granted, the approved
17 timeframe for which the Medicaid-enrolled provider may be subject to
18 prepayment claims review, and the approved scope of the prepayment claims
19 review to which the provider may be subjected;

20 (b) A description of the review process and claims processing times;

21 (c) A description of the specific claims, including specific current procedural
22 terminology or CPT codes subject to prepayment review;

23 (d) A detailed list of all supporting documents that the provider will be required
24 to submit for claims that are subject to prepayment review;

25 (e) Information on accessing the secure online portal for uploading supporting
26 documents required under subsection (6) of this section;

27 (f) The process for submitting claims and supporting documents;

- 1 (g) The standard of evaluation used to determine when a provider's claims will
2 cease to be subject to prepayment claims review;
- 3 (h) Information on requesting a provider education session on the prepayment
4 claims review process which, if requested by the provider, shall be provided
5 by the department or the managed care organization that will conduct the
6 reviews prior to the start of the prepayment claims review; and
- 7 (i) Information on the appeals process for both the prepayment review and any
8 denied claims.
- 9 (6) A managed care organization shall allow supporting documents that may be
10 required for claims that are subject to prepayment claims review to be
11 electronically uploaded via a secure online portal and shall provide each
12 Medicaid-enrolled provider who is subject to prepayment claims review access to
13 that portal. A managed care organization shall not require supporting documents
14 that may be required for claims that are subject to prepayment claims review to be
15 submitted by mail, fax, or any other method of transmittal other than a secure
16 online portal.
- 17 (7) The department and managed care organizations shall process all clean claims
18 submitted for prepayment review within twenty (20) calendar days of receipt of all
19 required supporting documents for each claim that is subject to prepayment
20 review. If a provider fails to provide all required supporting documents necessary
21 to process a claim, the department or managed care organization shall send the
22 written notice of the missing or deficient documents to the Medicaid-enrolled
23 provider within fifteen (15) calendar days of the due date of the required
24 supporting documents, and the department or managed care organization shall
25 have an additional twenty (20) calendar days to process claims upon receipt of the
26 previously missing or deficient supporting documents.
- 27 (8) The department and managed care organization shall process and pay claims

1 submitted for services not subject to prepayment claims review in a timely
2 manner. This shall include timely payments for all services included on the same
3 claim as a service that may be subject to prepayment claims review.

4 (9) For any claim for which the department or a managed care organization has
5 provided prior authorization, prepayment claims review shall not include review
6 of the medical necessity for the approved service.

7 (10) The department shall not require managed care organizations to subject any
8 predetermined percentage of claims or Medicaid-enrolled providers to
9 prepayment claims review. A Medicaid-enrolled provider shall only be made
10 subject to prepayment claims review in accordance with this section.

11 (11) Any prepayment claims review process to which a Medicaid-enrolled provider
12 may be subject shall comply with Chapter 3 of the Medicare Provider Integrity
13 Manual and other applicable guidance from the federal Centers for Medicare
14 and Medicaid Services on conducting prepayment claims review.

15 (12) The department may promulgate administrative regulations in accordance with
16 KRS Chapter 13A necessary to carry out this section.

17 ➔Section 2. If the Department for Medicaid Services or the Cabinet for Health
18 and Family Services determines that a state plan amendment, waiver, or any other form
19 of authorization or approval from any federal agency is necessary prior to implementation
20 of Section 1 of this Act for any reason, including the loss of federal funds, the department
21 or cabinet shall, within 90 days after the effective date of this Act, request any necessary
22 state plan amendment, waiver, authorization, or approval, and may only delay full
23 implementation of those provisions for which a state plan amendment, waiver,
24 authorization, or approval was deemed necessary until the state plan amendment, waiver,
25 authorization, or approval is granted or approved.

26 ➔Section 3. The Department for Medicaid Services or the Cabinet for Health and
27 Family Services shall, in accordance with KRS 205.525, provide a copy of any state plan

1 amendment, waiver application, or other request for authorization or approval submitted
2 pursuant to Section 2 of this Act to the Legislative Research Commission for referral to
3 the Interim Joint Committee on Health Services and the Interim Joint Committee on
4 Appropriations and Revenue and shall provide an update on the status of any application
5 or request submitted pursuant to Section 2 of this Act at the request of the Legislative
6 Research Commission or any committee thereof.