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 this section upon which approval was granted, the*
17 *approved timeframe for which the Medicaid-enrolled provider may be*
18 *subject to prepayment claims review, and the approved scope of the*
19 *prepayment claims 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;*

(g) The standard of evaluation used to determine when a provider's claims will cease to be subject to prepayment claims review;

(h) Information on requesting a provider education session on the prepayment claims review process which, if requested by the provider, shall be provided by the department or the managed care organization that will conduct the reviews prior to the start of the prepayment claims review; and

(i) Information on the appeals process for both the prepayment review and any denied claims.

(6) A managed care organization shall allow supporting documents that may be required for claims that are subject to prepayment claims review to be electronically uploaded via a secure online portal and shall provide each Medicaid-enrolled provider who is subject to prepayment claims review access to that portal. A managed care organization shall not require supporting documents that may be required for claims that are subject to prepayment claims review to be submitted by mail, fax, or any other method of transmittal other than a secure online portal.

(7) The department and managed care organizations shall process all clean claims submitted for prepayment review within twenty (20) calendar days of receipt of all required supporting documents for each claim that is subject to prepayment review. If a provider fails to provide all required supporting documents necessary to process a claim, the department or managed care organization shall send the written notice of the missing or deficient documents to the Medicaid-enrolled provider within fifteen (15) calendar days of the due date of the required supporting documents, and the department or managed care organization shall have an additional twenty (20) calendar days to process claims upon receipt of the previously missing or deficient supporting documents.

(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 ***(13) The provisions of this section shall only be enforceable to the extent permitted***
18 ***under federal law and shall not apply to any investigation against a Medicaid-***
19 ***enrolled provider who has been placed on a stand-down list by the federal***
20 ***Medicaid Fraud Control Unit or the Attorney General.***
21 ➔Section 2. If the Department for Medicaid Services or the Cabinet for Health
22 and Family Services determines that a state plan amendment, waiver, or any other form
23 of authorization or approval from any federal agency is necessary prior to implementation
24 of Section 1 of this Act for any reason, including the loss of federal funds, the department
25 or cabinet shall, within 90 days after the effective date of this Act, request any necessary
26 state plan amendment, waiver, authorization, or approval, and may only delay full
27 implementation of those provisions for which a state plan amendment, waiver,

1 authorization, or approval was deemed necessary until the state plan amendment, waiver,
2 authorization, or approval is granted or approved.
3 ➔Section 3. The Department for Medicaid Services or the Cabinet for Health and
4 Family Services shall, in accordance with KRS 205.525, provide a copy of any state plan
5 amendment, waiver application, or other request for authorization or approval submitted
6 pursuant to Section 2 of this Act to the Legislative Research Commission for referral to
7 the Interim Joint Committee on Health Services and the Interim Joint Committee on
8 Appropriations and Revenue and shall provide an update on the status of any application
9 or request submitted pursuant to Section 2 of this Act at the request of the Legislative
10 Research Commission or any committee thereof.