

907 KAR 1:673. Claims processing.

RELATES TO: KRS 205.520, 205.8451

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 447.45, 42 U.S.C. 1396a, b, c, 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 205.520(3) empowers 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. This administrative regulation sets forth the provisions relating to Medicaid provider claims processing requirements.

Section 1. Definitions.

- (1) "Cabinet" means the Cabinet for Health and Family Services.
- (2) "Claim" means a request for payment that relates to each individual billing submitted by a provider to the department which details services rendered to a recipient on a specific date. The claim may be either a line item of service or all services for one (1) recipient on a bill.
- (3) "Department" means the Department for Medicaid Services or its designee.
- (4) "Home infusion therapy" means the parental administration of a premanufactured or sterile compounded product for intravenous, intramuscular, subcutaneous or intraspinal infusion to a patient in a nonacute alternative site setting.
- (5) "POS" means on-line real time point of sale claims electronically transmitted to the department.
- (6) "ProDUR" means prospective drug use review in accordance with 201 KAR 2:210.
- (7) "Provider" means as defined in 907 KAR 1:002, Section 1.
- (8) "Provider type fifty-four (54)" means an enrolled pharmacy provider who dispenses drugs to outpatient, long-term care residents, and personal care home residents who are Medicaid recipients. A number shall be assigned by the department to these providers and the first two (2) digits shall be fifty-four (54).
- (9) "Recipient" means as defined by KRS 205.8451(9).
- (10) "Services" means as defined in 907 KAR 1:671, Section 1.
- (11) "Unacceptable practice" means as defined in 907 KAR 1:671, Section 1.
- (12) "Withholding" means as defined in 907 KAR 1:671, Section 1.

Section 2. Claims Processing.

- (1) Claim submittal process for all Medicaid providers.
 - (a) Providers, except for type fifty-four (54), shall submit a claim by an electronic billing process or by paper form approved by the department.
 - (b) Claims shall be submitted for payment within twelve (12) months of the date the service was rendered to an eligible Medicaid recipient for covered services or supplies.
 - (c) A provider shall submit additional clarifying documentation for claims processing if required by the department.
 - (d) By submitting a claim a provider shall be:
 1. Liable for the accuracy of all claims submitted by the provider, its representatives employees or any individual or entity working on the provider's behalf; and
 2. Responsible for reviewing the statement of payment or remittance statement to assure that paid claims shown are true and correct, and for informing the department of any discrepancy.

- (e) If a provider submits a claim electronically, the provider's acceptance of payment shall be considered to be the provider's certification that a paid claim is true and correct; and
- (f) Any submittal of a false claim, statement, or document shall be considered an unacceptable practice and subject to all the remedies available to the department.
- (2) Provider type fifty-four (54) claims shall meet POS submittal requirements for services provided on or after December 1, 1996.
 - (a) A provider who files in excess of 100 claims in a twelve (12) month period shall transmit by POS and be subject to ProDUR.
 - (b) Providers that receive a POS exemption shall be subject to ProDUR as specified in 201 KAR 2:210. POS exemptions shall be as follows:
 - 1. Providers who are unable to submit POS claims for a period of two (2) or more hours, for drugs in an emergency situation which are essential to avoid life-threatening situations.
 - 2. If a claim requires paper documentation as requested by the department, this claim shall not be subject to POS.
 - 3. A provider type fifty-four (54) who files a maximum of 100 claims or less in a twelve (12) month period to the department may request an exemption from the department for the POS requirement.
 - 4. A provider type fifty-four (54) who dispenses drugs to be used in the provision of home infusion therapy shall request an exemption from the department for the POS requirement.
 - 5. Retroactive recipient eligibility or retroactive nursing facility resident status.

Section 3. Claim payment.

- (1) Payment shall be made by the department, if:
 - (a) The information required to pay the claim is complete;
 - (b) The claim is not under review for medical necessity;
 - (c) The provider has submitted all reports and information relevant to the claim required by the department; and
 - (d) The department is not withholding the provider's payments in accordance with 907 KAR 1:671.
- (2) The department may audit a claim paid to determine if any unacceptable practices have occurred that may result in a sanction.
(22 Ky.R. 2201; eff. 7-5-96; 23 Ky.R. 3453; 3786; eff. 4-16-97; Crt eff. 12-6-2019.)