205.8455 Recipient Utilization Review Committee -- Authority.

(1) To implement provisions of this section, the commissioner of the Department for Medicaid Services shall create, no later than July 30, 1994, a Recipient Utilization Review Committee with the authority to:

(a) Review individual recipient utilization or program benefits, recipient medical records, and other additional information or data necessary to make a decision;

(b) Determine if a recipient has utilized the program or services in a fraudulent or abusive manner;

(c) Refer cases of suspected recipient fraud to the Office of the Inspector General in the Cabinet for Health and Family Services;

(d) Institute administrative actions to restrict or revoke the recipient's participation in the Medical Assistance Program; and

(e) Initiate actions to recover the value of benefits received by the recipient which were determined to be related to fraudulent or abusive activities.

(2) The Recipient Utilization Review Committee shall be composed of five (5) members as follows: one (1) licensed physician, one (1) representative from the same program benefit area that is the subject of the review, one (1) recipient or representative of medical assistance benefits, one (1) representative of the Surveillance and Utilization Review Subsystems Unit, as required under Title XIX of the Social Security Act, and the commissioner of the Department for Public Health, who shall serve by virtue of his or her office.

(3) A medical assistance recipient whose eligibility has been revoked due to defrauding the Medical Assistance Program shall not be eligible for future medical assistance services for a period of not more than one (1) year or until full restitution has been made to the Department for Medicaid Services, whichever comes first.

(4) When a medical assistance recipient whose eligibility has been revoked due to defrauding of the Medical Assistance Program reapplies for coverage, during the period of revocation, due to pregnancy, a communicable disease, or other condition that creates a risk to public health, or a condition which if not treated could result in immediate grave bodily harm, the recipient utilization review committee for the Department for Medicaid Services may change the revoked status of the previously eligible recipient to restricted status if it has been determined that it would be in the best interest of the previously eligible medical assistance recipient to receive coverage for medical assistance services and the person is otherwise eligible. If this change in status is granted, the case shall be reconsidered by the Recipient Utilization Review Committee within sixty (60) days after the restricted status takes effect.

(5) Upon determination by the Recipient Utilization Review Committee of the Department for Medicaid Services that a medical assistance recipient has abused the benefits of the Medical Assistance Program, the recipient shall immediately be assigned and restricted to a managed care primary physician designated by the Department for Medicaid Services. Except in the case of an emergency as defined by the recipient utilization review committee and set forth by the Cabinet for Health and Family Services in an administrative

regulation promulgated pursuant to KRS Chapter 13A, the restricted recipient shall be eligible to receive covered services only upon presenting to a participating provider, prior to the receipt of services, a dated written referral by the assigned managed care primary physician. Any participating provider who provides services to a medical assistance recipient in violation of the provisions of this subsection shall not be eligible for reimbursement for any services rendered.

(6) The Cabinet for Health and Family Services shall request any waivers of federal law that are necessary to implement the provisions of this section.

(7) The provisions of paragraphs (d) and (e) of subsection (1) of this section and of subsections (3), (4), and (5) of this section shall have no force or effect until and unless the requested waivers are granted.

(8) Nothing in this section shall authorize the Cabinet for Health and Family Services to waive the recipient's or provider's rights to prior notice and hearing as guaranteed by federal law.

(9) All complaints received by the Department for Medicaid Services, the Office of the Inspector General, the Office of the Attorney General, or by personnel of the Cabinet for Health and Family Services concerning possible fraud or abuse by a medical assistance recipient shall be forwarded immediately to the Recipient Utilization Review Committee for its consideration. Any cases of possible recipient fraud or abuse uncovered by personnel of the Cabinet for Health and Family Services or by providers shall also be referred immediately to the Recipient Utilization Review Committee for its review. Records shall be kept of all cases, including records of disposition, considered by the Recipient Utilization Review Committee.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 277, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 224, effective July 15, 1998. -- Created 1994 Ky. Acts ch. 96, sec. 3, effective July 15, 1994; and ch. 316, sec. 3, effective July 15, 1994.