**205.534 Toll-free telephone line -- Duties relating to adverse determinations -- In-person meeting -- Reprocessing claims -- Internal appeals -- Timely decisions on authorization and preauthorization requests -- Monthly reports -- Penalties.**

(1) A Medicaid managed care organization shall:

(a) Provide:

1. A toll-free telephone line for providers to contact the insurer for claims resolution for forty (40) hours a week during normal business hours in this state;

2. A toll-free telephone line for providers to submit requests for authorizations of covered services during normal business hours and extended hours in this state on Monday and Friday through 6 p.m., including federal holidays;

3. With regard to any adverse payment or coverage determination, copies of all documents, records, and other information relevant to a determination, including medical necessity criteria and any processes, strategies, or evidentiary standards relied upon, if requested by the provider. Documents, records, and other information required to be provided under this paragraph shall be provided at no cost to the provider; and

4. For any adverse payment or coverage determination, a written reply in sufficient detail to inform the provider of all reasons for the determination. The written reply shall include information about the provider's right to request and receive at no cost to the provider documents, records, and other information under subparagraph 3. of this paragraph;

(b) Afford each participating provider the opportunity for an in-person meeting with a representative of the managed care organization on:

1. Any clean claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and

2. Any claim that remains unpaid for forty-five (45) days or more after the date the claim is received by the managed care organization and that individually or in the aggregate exceeds two thousand five hundred dollars ($2,500);

(c) Reprocess claims that are incorrectly paid or denied in error, in compliance with KRS 304.17A-708. The reprocessing shall not require a provider to rebill or resubmit claims to obtain correct payment. No claim shall be denied for timely filing if the initial claim was timely submitted; and

(d) Establish processes for internal appeals, including provisions for:

1. Allowing a provider to file any grievance or appeal related to the reduction or denial of the claim within sixty (60) days of receipt of a notification from the managed care organization that payment for a submitted claim has been reduced or denied; and

2. Ensuring the timely consideration and disposition of any grievance or any appeal within thirty (30) days from the date the grievance or appeal is filed with the managed care organization by a provider under this paragraph.

(2) (a) For the purposes of this subsection:

1. "Timely" means that an authorization or preauthorization request shall be approved:

a. For an expedited authorization request, within seventy-two (72) hours after receipt of the request. The timeframe for an expedited authorization request may be extended by up to fourteen (14) days if:

i. The enrollee requests an extension; or

ii. The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and

b. For a standard authorization request, within two (2) business days. The timeframe for a standard authorization request may be extended by up to fourteen (14) additional days if:

i. The provider or enrollee requests an extension; or

ii. The Medicaid managed care organization justifies to the department a need for additional information and how the extension is in the enrollee's interest; and

2. a. "Expedited authorization request" means a request for authorization or preauthorization where the provider determines that following the standard a timeframe could seriously jeopardize an enrollee's life or health, or ability to attain, maintain, or regain maximum function; and

b. A request for authorization or preauthorization for treatment of an enrollee with a diagnosis of substance use disorder shall be considered an expedited authorization request by the provider and the managed care organization.

(b) A decision by a managed care organization on an authorization or preauthorization request for physical, behavioral, or other medically necessary services shall be made in a timely and consistent manner so that Medicaid members with comparable medical needs receive a comparable, consistent level, amount, and duration of services as supported by the member's medical condition, records, and previous affirmative coverage decisions.

(3) (a) Each managed care organization shall report on a monthly basis to the department:

1. The number and dollar value of claims received that were denied, suspended, or approved for payment;

2. The number of requests for authorization of services and the number of

such requests that were approved and denied;

3. The number of internal appeals and grievances filed by members and by providers and the type of service related to the grievance or appeal, the time of resolution, the number of internal appeals and grievances where the initial denial was overturned and the type of service and dollar amount associated with the overturned denials; and

4. Any other information required by the department.

(b) The data required in paragraph (a) of this subsection shall be separately reported by provider category, as prescribed by the department, and shall at a minimum include inpatient acute care hospital services, inpatient psychiatric hospital services, outpatient hospital services, residential behavioral health services, and outpatient behavioral health services.

(4) On a monthly basis, the department shall transmit to the Department of Insurance a report of each corrective action plan, fine, or sanction assessed against a Medicaid managed care organization for violation of a Medicaid managed care organization's contract relating to prompt payment of claims. The Department of Insurance shall then make a determination of whether the contract violation was also a violation of KRS 304.17A-700 to 304.17A-730.

(5) Any Medicaid managed care organization that fails to comply with KRS 205.522, 205.532 to 205.536, and 304.17A-515 may be subject to fines, penalties, and sanctions, up to and including termination, as established under its Medicaid managed care contract with the department.

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