

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Hospital and Provider Operations

4 (Amended after Comments)

5 907 KAR 1:672. Provider enrollment, disclosure, and documentation for Medicaid
6 participation.

7 RELATES TO: KRS 205.520, 205.8451(2),(7),(8),(9), 205.8477, 304.17A-545(5),
8 311.621 – 311.643, 42 USC 1396a(w), 42 CFR 455.100 - 455.106, Ky. Acts Chapter 34

9 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3),
10 205.560(12), 42 U.S.C. 1396a, b, c[, ~~EO 2004-726~~]

11 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9,~~
12 ~~2004, reorganized the Cabinet for Health Services and placed the Department for~~
13 ~~Medicaid Services and the Medicaid Program under the Cabinet for Health and Family~~
14 ~~Services.~~] The Cabinet for Health and Family Services, Department for Medicaid
15 Services, has responsibility to administer the Medicaid Program. KRS 205.520(3)
16 authorizes [empowers] the cabinet, by administrative regulation, to comply with any
17 requirement that may be imposed or opportunity presented by federal law for the
18 provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560(12)
19 requires the Medical Assistance Program to use the form and guidelines established
20 pursuant to KRS 304.17A-545(5) for assessing the credentials of those applying for

1 participation in the Medical Assistance Program. Ky. Acts Chapter 34 (SB 98 from the
2 2007 Session of the General Assembly) requires the department to develop a specific
3 form and establish guidelines for assessing the credentials of dentists applying for
4 participation in the Medical Assistance Program. The administrative regulation
5 establishes provisions related [~~sets forth the provisions relating~~] to Medicaid provider
6 enrollment, disclosure, [~~and~~] documentation requirements, and guidelines for assessing
7 the credentials of those applying for participation in the Medicaid Program.

8 Section 1. Definitions. (1) "Applicant" means a person or entity who applies for
9 enrollment as a participating [~~submits an application to become a~~] Medicaid provider.

10 (2) [~~"Application" means the completion and submission of a Medicaid provider~~
11 ~~agreement, and any required addendum specific to a provider type, which is the~~
12 ~~contract between the provider and the department for the provision of Medicaid~~
13 ~~services.~~

14 (3) [~~3~~] "Cabinet" means the Cabinet for Health and Family Services.

15 (3) [(4)] "Claim" means a [~~any~~] request for payment under the Medicaid Program that:

16 (a) Relates to each individual billing submitted by a provider to the department;

17 (b) [~~which~~] Details services rendered to a recipient on a specific date; and

18 (c) [~~date(s). The claim~~] May be [~~either~~] a line item of service or all services for one (1)
19 recipient on a bill.

20 (4) "Credentialed provider" means a provider that is required to complete the
21 credentialing process in accordance with KRS 205.560(12) and Ky. Acts Chapter 34
22 and includes the following individuals who apply for enrollment in the Medicaid Program:

23 (a) A dentist;

1 (b) A physician;

2 (c) An audiologist;

3 (d) A certified registered nurse anesthetist;

4 (e) An optometrist;

5 (f) An advance registered nurse practitioner;

6 (g) A podiatrist;

7 (h) A chiropractor; or

8 (i) A physician assistant.

9 (5) "Department" means the Department for Medicaid Services or its designated
10 agent [and its designated agents].

11 (6) [~~"Disclosing entity" means a Medicaid provider or the fiscal agent for the~~
12 ~~department.~~

13 ~~(7)] "Disclosure" means the provision of information required by 42 CFR 455.100
14 through 455.106 [in accordance with the requirements shown in 42 CFR 455, Subpart
15 B].~~

16 (7) [~~(8)] "Exclusion" means **as defined in 42 CFR 1003.101.**~~[the termination of a~~
17 ~~**provider's participation in the Medicaid Program or the denial of a provider's**~~
18 ~~**enrollment in the Medicaid Program.**~~~~

19 (8) "Evaluation" or "credentialing" means:

20 (a) A process for collecting and verifying professional qualifications of a health care
21 provider;

22 (b) An assessment of whether a health care provider meets specified criteria relating
23 to professional competence and conduct; and

1 (c) A process to be completed before a health care provider may participate in the
2 Medicaid program on an initial or ongoing basis.

3 (9) "Furnish" means to provide medical care, services, or supplies that are:

4 (a) Provided directly by a provider;

5 (b) Provided under the supervision of a provider; or

6 (c) Prescribed by a provider.

7 (10) "Managing employee" means a general manager, business manager,
8 administrator, director, or other individual who exercises operational or managerial control
9 over or conducts the day-to-day operation of an institution, entity, organization, or agency.

10 (11) "Medically necessary" or "medical necessity" means a covered benefit is:

11 (a) Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or
12 prevent a disease, illness, injury, disability, or other medical condition, including
13 pregnancy;

14 (b) Appropriate in terms of the service, amount, scope, and duration based on
15 generally accepted standards of good medical practice;

16 (c) Provided for medical reasons rather than primarily for the convenience of the
17 individual, the individual's caregiver, or the health care provider, or for cosmetic
18 reasons;

19 (d) Provided in the most appropriate location, with regard to generally accepted
20 standards of good medical practice, where the service may, for practical purposes, be
21 be safely and effectively provided;

22 (e) Needed, if used in reference to an emergency medical service, to evaluate or
23 stabilize an emergency medical condition that is found to exist using the prudent

1 layperson standard;

2 (f) Provided in accordance with Early and Periodic Screening, Diagnosis, and
3 Treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR Part 441
4 Subpart B for individuals under twenty-one (21) years of age; and

5 (g) Provided in accordance with 42 CFR 440.230.

6 (12) "Non-credentialed provider" means a provider that is not required to complete
7 the credentialing process in accordance with KRS 205.560(12) and includes any
8 individual or entity not identified in subsection (4) of this section.

9 (13) "Provider" is defined by KRS 205.8451(7).

10 (14) "Recipient" is defined by KRS 205.8451(9).

11 (15) "Reevaluation" or "recredentialing" means a process for identifying a change
12 that may have occurred in a health care provider since the last evaluation or
13 credentialing that may affect the health care provider's ability to perform services.

14 ~~(16) [as defined in 907 KAR 1:671. (9) "Fiscal agent" means a contractor that~~
15 ~~processes or pays provider claims on behalf of the department.~~

16 ~~(10) "Furnish" means as defined in 907 KAR 1:671.~~

17 ~~(11) "Managing employee" means as defined in 907 KAR 1:671.~~

18 ~~(12) "Provider" means as defined by KRS 205.8451.~~

19 ~~(13) "Recipient" means as defined by KRS 205.8451.~~

20 ~~(14)] "Services" means medical care, services, or supplies provided to a Medicaid~~
21 ~~recipient [recipients].~~

22 (17) "Subcontractor" means an individual, agency, entity, or organization to which a
23 Medicaid provider or the department's fiscal agent has:

1 (a) Contracted or delegated some of its management functions or responsibilities of
2 providing medical care or services to its patients; or

3 (b) Entered into a contract, agreement, purchase order, or lease, including lease of
4 real property, to obtain space, supplies, equipment, or nonmedical services associated
5 with providing services and supplies that are covered under the Medicaid Program.

6 (18) "Terminated" means a provider's participation in the Medicaid Program has
7 ended and a contractual relationship no longer exists between the provider and the
8 department for the provision of Medicaid covered services to eligible recipients by the
9 provider or its subcontractor.

10 (19) "Unacceptable practice" means conduct by a provider which constitutes "fraud" or
11 "provider abuse", as defined in KRS 205.8451(2) or (8), or willful misrepresentation, and
12 includes the following practices:

13 (a) Knowingly submitting, or causing the submission of false claims, or inducing, or
14 seeking to induce, a person to submit false claims;

15 (b) Knowingly making, or causing to be made, or inducing, or seeking to induce, a
16 false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a
17 Medicaid payment, or for use in determining the right to payment;

18 (c) Having knowledge of an event that affects the right of a provider to receive
19 payment and concealing or failing to disclose the event or other material omission with
20 the intention that a payment be made or the payment is made in a greater amount than
21 otherwise owed;

22 (d) Conversion;

23 (e) Soliciting or accepting bribes or kickbacks;

1 (f) Failing to maintain or to make available, for purposes of audit or investigation,
2 administrative and medical records necessary to fully disclose the medical necessity for
3 the nature and extent of the medical care, services and supplies furnished, or to comply
4 with other requirements established in 907 KAR 1:673, Section 2;

5 (g) Knowingly submitting a claim or accepting payment for medical care, services, or
6 supplies furnished by a provider who has been terminated or excluded from the program;

7 (h) Seeking or accepting additional payments, for example, gifts, money, donations, or
8 other consideration, in addition to the amount paid or payable under the Medicaid
9 Program for covered medical care, services, or supplies for which a claim is made;

10 (i) Charging or agreeing to charge or collect a fee from a recipient for covered services
11 which is in addition to amounts paid by the Medicaid Program, except for required
12 copayments or recipient liability, if any, required by the Medicaid Program;

13 (j) Engaging in conspiracy, complicity, or criminal syndication;

14 (k) Furnishing medical care, services, or supplies that fail to meet professionally
15 recognized standards, or which are found to be noncompliant with licensure standards
16 promulgated under KRS Chapter 216B and failing to correct the deficiencies or violation
17 as reported to the department by the Office of Inspector General, for health care or which
18 are beyond the scope of the provider's professional qualifications or licensure;

19 (l) Discriminating in the furnishing of medical care, services, or supplies as prohibited
20 by 42 U.S.C. 2000d;

21 (m) Having payments made to or through a factor, either directly or by power of
22 attorney, as prohibited by 42 CFR 447.10;

23 (n) Offering or providing a premium or inducement to a recipient in return for the

1 recipient's patronage of the provider or other provider to receive medical care, services or
2 supplies under the Medicaid Program;

3 (o) Knowingly failing to meet disclosure requirements;

4 (p) Unbundling; or

5 (q) An act committed by a nonprovider on behalf of a provider which, if committed by a
6 provider, would result in the termination of the provider's enrollment in the program.

7 ~~[(15) "Subcontractor" means as defined in 907 KAR 1:671.~~

8 ~~(16) "Terminated" means as defined in 907 KAR 1:671.~~

9 ~~(17) "Unacceptable practice(s)" means as defined in 907 KAR 1:671.]~~

10 Section 2. Enrollment Process for Provider Participation in Medicaid. (1) Scope.

11 (a) The department shall contract only with an individual or entity **who meets**
12 **[capable of demonstrating its ability to meet]** the conditions of Medicaid provider
13 participation ~~[only those providers or entities who can demonstrate that they are~~
14 ~~qualified] in accordance with 907 KAR 1:671 [as determined by the department to~~
15 ~~participate as a provider].~~

16 (b) The department reserves the right to contract or not contract with any potential
17 provider.

18 (c) An individual or entity that wishes to participate:

19 1. ~~[(b) All providers or entities who wish to participate]~~ In the Medicaid Program shall
20 be enrolled as a participating provider ~~[participating providers]~~ prior to being eligible to
21 receive reimbursement in accordance with federal and state laws; and

22 2. As a KenPAC primary care provider shall meet the provider participation criteria
23 set forth in 907 KAR 1:320, Kentucky Patient Access and Care System (KenPAC).

1 (2) To apply for enrollment in the Medicaid Program as a non-credentialed provider,
2 an individual or entity shall submit:

3 (a) A completed MAP-811, Non-Credentialed Provider Application; and

4 (b) Proof of a valid professional license, registration, or certificate that allows the:

5 1. Individual to provide services within the individual's scope of practice; or

6 2. Entity to operate or provide services within the entity's scope of practice.

7 (3) To apply for enrollment in the Medicaid Program as a credentialed provider, an
8 individual shall submit:

9 (a) A completed MAP-811, Individual Provider Application;

10 (b) Proof of a valid professional license, registration, or certificate that allows the
11 individual to provide services within the individual's scope of practice; and

12 (c) 1. Except for a dentist, a completed KAPER-1, Kentucky Application for Provider
13 Evaluation and Re-evaluation; and

14 2. If licensed to practice as a dentist, a completed Dental Credentialing Form; or

15 3. Pursuant to 806 KAR 17:480, Section 2(4) and in lieu of the KAPER-1, the
16 provider application form of the Council for Affordable Quality Healthcare.

17 **(4)(a) Within forty-five (45) days of receipt of a required credentialing form, the**
18 **department shall notify the health care provider or entity applying for enrollment**
19 **in the Medicaid program of any omitted information or questionable information**
20 **included on the form.**

21 **(b) If the applicant does not respond within the time period specified in the**
22 **department's notice of omitted or questionable information, the department shall**
23 **deny enrollment unless an extension of time is requested by the provider and**

1 **granted by the department.** [~~New enrollments. Any provider or entity interested in~~
2 ~~participating as a Medicaid provider shall be required to submit an application for~~
3 ~~enrollment in accordance with this section.~~

4 ~~(3) Enrolled providers. Upon receiving notice from the department, all existing~~
5 ~~providers or entities enrolled as participating providers in the Medicaid Program shall be~~
6 ~~required to submit a new or revised application for enrollment to continue their Medicaid~~
7 ~~participation.~~

8 ~~(a) Providers shall have thirty-five (35) days from the date of the notice to submit a~~
9 ~~completed and signed application to the department.~~

10 ~~(b) The notice shall inform the provider that failure to return the completed and signed~~
11 ~~application within thirty-five (35) days from the date of the notice shall result in~~
12 ~~termination of participation.~~

13 ~~(c) Submission of the application within thirty-five (35) days from the date of the~~
14 ~~notice shall permit the continuation of the existing provider participation until the~~
15 ~~application for enrollment the Medicaid Program has been approved or denied and~~
16 ~~notice has been sent to the provider.~~

17 ~~(d) The department may revise enrollment requirements by regulatory revision made~~
18 ~~in accordance with the requirements of KRS Chapter 13A and reenroll providers, if~~
19 ~~necessary, for effective management of the Medicaid Program.]~~

20 ~~(4) Application for enrollment as a participating provider shall be processed in the~~
21 ~~following manner:~~

22 ~~(a) All applicants for participation shall complete and sign a provider agreement,~~
23 ~~disclosure of ownership and control interest statement, certification with regard to~~

1 lobbying activity, pursuant to 31 USC 1352, provide proof of a valid professional license,
2 registration, or certificate which allows the applicant to provide the services for which
3 the applicant contracts, and provide any additional clarifying information requested for
4 processing of the application.

5 ~~(b)] [The department may require] [any] [additional clarifying information from~~
6 ~~**an individual or entity that applies for enrollment in the Medicaid Program as a**~~
7 ~~**participating provider**] [the applicant with regard to qualifications for participation].~~

8 ~~[(b) If the applicant does not respond within the time period specified in the~~
9 ~~**department's request for additional clarifying information, the department may**~~
10 ~~**deny enrollment**] [application for participation may be denied] [**unless an extension**~~
11 ~~**of time is requested by the provider and granted by the department.**]~~

12 (c) The department may require that an on-site inspection be performed to ascertain
13 compliance with applicable licensure standards established in [as promulgated under]
14 KRS Chapter 216B, and certification standards, prior to an enrollment determination.

15 (d)1. The department shall [complete its application review and] make an enrollment
16 determination within ninety (90) days of [after] receipt of:

17 a. The completed application documents described in subsection (2) or (3) of this
18 section; and

19 b. Any additional information requested by the department.

20 2. The department may take additional time beyond ninety (90) days to render a
21 decision if [for the decision when] necessary for resolution of an issue or dispute [issues
22 or disputes].

23 3. If additional time is needed to render a decision, the department shall notify the

1 applicant that a decision will be issued after the ninety (90) day timeframe described in
2 subparagraph 1. [~~However, notice shall be sent to the applicant in those matters~~
3 ~~requiring additional time to process.~~]

4 (5) Approval of enrollment in the Medicaid Program as a participating provider. [~~an~~
5 ~~application.~~]

6 (a) Upon approval of enrollment, the department shall issue a provider number that
7 shall be used by the provider solely for billing and identification purposes. [~~of an~~
8 ~~application, the provider shall be issued an identifying number, known as a provider~~
9 ~~number, which shall be used exclusively by the provider for billing and identification~~
10 ~~purposes.~~]

11 (b) A provider's participation shall begin and end on the dates specified in the
12 notification of approval for [~~of~~] program participation, unless the provider's [~~provider~~]
13 participation is [~~otherwise~~] terminated in accordance with this administrative regulation,
14 907 KAR 1:671, or other applicable state or federal laws.

15 (6) By enrolling in the Medicaid Program, a [~~the~~] provider, the provider's [~~its~~] officers,
16 directors, agents, employees, and subcontractors agree to:

17 (a) Maintain the documentation for claims as required by Section 4 of this
18 administrative regulation;

19 (b) Provide [~~Furnish~~], upon request, all information regarding the nature and extent of
20 services and claims [~~for payment~~] submitted by, or on behalf of[,], the provider, to the:

21 1. [~~The~~] Cabinet [~~for Health and Family Services~~];

22 2. [~~The~~] Department;

23 3. [~~The~~] Attorney General;

1 4. ~~The~~ Auditor of Public Accounts;

2 5. ~~The~~ Secretary of the United States Department of Health and Human Services; or
3 ~~and~~

4 6. ~~The~~ Office of the United States Attorney;

5 (c) Comply with the disclosure requirements established in ~~of~~ Section 3 of this
6 administrative regulation;

7 (d) Comply with the applicable advance directive ~~directives~~ requirements
8 established in ~~of~~ 42 USC 1396a(w) regarding ~~with regard to~~ the right to accept or
9 reject life-saving medical procedures as described in KRS 311.621 – 311.643 ~~et seq~~;

10 (e) Accept payment from Medicaid as payment in full for all care, services, benefits,
11 or ~~and~~ supplies billed to the Medicaid Program, except with regard to recipient cost-
12 sharing charges ~~copayments~~ and beneficiary liability, if any;

13 (f) Submit claims for payment only for care, services, benefits, or ~~and~~ supplies;

14 1. Actually furnished to eligible recipients; ~~beneficiaries~~ and

15 2. Medically necessary or otherwise authorized by law;

16 (g) Provide true, accurate, and complete information in relation to any claim for
17 payment;

18 (h)1. Permit review or audit of all books or records or, at the discretion of the auditing
19 agency, a sample of books or records related ~~thereof, relating~~ to services furnished
20 and payments received from ~~under~~ Medicaid, including recipient histories, case files,
21 and recipient specific data ~~as listed below~~.

22 2. Failure to allow access to records may result in the provider's liability for costs
23 incurred by the cabinet associated with the review of records, including food, lodging

1 and mileage; [-]

2 (i) Not engage in any activity that [which] would constitute an unacceptable practice;

3 (j) Comply with all terms and provisions contained in the application documents
4 described in subsection (2) or (3) this section; [~~the provider agreement; and~~]

5 (k) Comply with all applicable federal laws, [~~and~~] state statutes, and state
6 administrative regulations related to the applicant's [~~relating to their~~] provider type and
7 provision of services under the Medicaid Program; and

8 (l) Bill third party payors in accordance with Medicaid statutes and administrative
9 regulations.

10 (7) Denial of enrollment or re-enrollment in the Medicaid Program. [~~an application for~~
11 ~~participation.~~]

12 (a) The department shall deny enrollment if an applicant meets one (1) of the
13 following conditions: [~~reasons for denial of application for participation shall include the~~
14 ~~following factors:~~]

15 1. Falsely represents, omits, or fails [~~Any false representation, omission, or failure~~] to
16 disclose [of] any material fact in making an application for enrollment in accordance with
17 subsection (2) or (3) of this section;

18 2. Is currently suspended, excluded, terminated, or involuntarily withdrawn from
19 participation [~~Any suspension, exclusion, termination, or involuntary withdrawal from~~
20 ~~participation currently in effect~~] in any governmental medical insurance program as a
21 result of fraud or abuse of that program;

22 3. Falsely represents, omits, or fails to disclose any material of fact in making [~~Any~~
23 ~~false representation or omission of~~] an application for a [~~any~~] license, permit, certificate,

1 or registration related to a health care profession or business;

2 4. Has failed [~~Any previous failure~~] to comply with applicable standards in the

3 operation of a health care business or enterprise after having received written notice of

4 noncompliance from:

5 a. The department; or

6 b. A state or federal licensing, certifying, or auditing agency;

7 5. Is under [A] current investigation, indictment or conviction for fraud and abuse or

8 an unacceptable practice in:

9 a. The Kentucky Medicaid Program;

10 b. Another state's Medicaid Program;

11 c. [~~in Kentucky or any other state,~~] The Medicare Program;[,] or

12 d. [~~Any~~] Other publicly funded health care program;

13 6. Fails [~~Failure~~] to comply with any Medicaid policy as specified in the Kentucky

14 statutes or department's administrative regulations; [~~of the department; or~~]

15 7. Fails [~~Failure~~] to pay any outstanding debt owed to the department; or

16 8. Has engaged in an activity that would constitute an unacceptable practice.

17 (b) If enrollment or re-enrollment [~~an application~~] is denied, the department shall

18 consider reapplication only:

19 1. If the applicant corrects each deficiency that led to the denial; and

20 2. After the expiration of a period of exclusion imposed in accordance with 907 KAR

21 1:671, if applicable. [~~the applicant may resubmit only upon correction of the factors~~

22 ~~leading to its denial, and after the expiration of any period of exclusion imposed in~~

23 ~~accordance with 907 KAR 1:671.]~~

1 (c) Notice of denial of enrollment or re-enrollment. The department shall send [A]
2 written notice of [the] denial to an [~~shall be mailed to the~~] applicant's last known address
3 and provide [~~contain the following: 1.~~] the reason for the denial. [~~;~~ and

4 ~~2. The Date in which the applicant may reapply for enrollment.~~]

5 (d) The denial shall be effective upon the date of the written notice.

6 (8)1. A provider may request limited enrollment for a period of time, not to exceed
7 thirty (30) days, in an exceptional situation for emergency services provided to an
8 eligible recipient [~~beneficiary~~].

9 2. The department shall make an enrollment determination regarding [~~of~~] the
10 exceptional circumstances and notify the provider in writing of its decision.

11 (9) Re-credentialing. A credentialed provider currently enrolled in the Medicaid
12 Program shall submit to the department's re-credentialing process three (3) years from
13 the date of the provider's initial evaluation or last re-evaluation.

14 Section 3. Required Provider Disclosure. (1) A provider [~~Providers and the fiscal~~
15 ~~agent~~] shall comply with the disclosure of information requirements contained in 42 CFR
16 455.100 through 455.106 [~~455 Subpart B~~] and KRS 205.8477.

17 (2) Time and manner of disclosure. Information disclosed in accordance with 42 CFR
18 455.100 through 455.106 [~~(a) The required provider information specified in 42 CFR~~
19 ~~455, Subpart B~~] shall be provided:

20 (a) [~~1.~~] Upon application for enrollment;

21 (b) [~~2.~~] Annually thereafter; and

22 (c) [~~3.~~] Within thirty-five (35) days of a written [~~the~~] request by the department or the
23 United States Department of Health and Human Services.

1 ~~[(b) The disclosure requirement may coincide with the certification or recertification,~~
2 ~~periods except when the provider is certified other than on an annual basis.]~~

3 (3) If a ~~[the]~~ provider ~~[or fiscal agent]~~ fails to disclose ~~[required]~~ information required
4 by 42 CFR 455.100 through 455.106 within thirty-five (35) days of the department's
5 written request ~~[the time period specified]~~, the department shall terminate the provider's
6 ~~[provider shall be terminated from]~~ participation in the Medicaid Program in accordance
7 with 907 KAR 1:671, Section 6 on the day following the last day for submittal of the
8 required information ~~[in accordance with 907 KAR 1:671]~~.

9 (4)(a) ~~A~~ ~~[The]~~ provider shall file an amended, signed ownership and disclosure form
10 with the department within thirty-five (35) days following a change in: ~~[from the change~~
11 ~~in the following:]~~

12 1. ~~[(a)]~~ Ownership or control;

13 2. ~~[(b)]~~ The managing employee or management company; or

14 3. ~~[(c)]~~ A provider's federal tax identification number.

15 (b) ~~[(5)]~~ Failure to comply with the requirements of paragraph (a) of this subsection
16 may result in termination from the Medicaid Program.

17 Section 4. Required Provider Documentation. (1) A ~~[Each]~~ provider shall maintain
18 documentation of:

19 (a) Care, services, benefits, or supplies provided to an eligible recipient ~~[beneficiary]~~;

20 (b) The recipient's medical record or other provider file, as appropriate, which shall
21 demonstrate that the care, services, benefits, or supplies ~~[billed]~~ for which the provider
22 submitted a claim~~[,]~~ were actually performed or delivered;

23 (c) The diagnostic condition necessitating the service performed or supplies provided;

1 and

2 (d) Medical necessity as substantiated by appropriate documentation including an
3 appropriate medical order.

4 (2) A provider who is reimbursed using a cost-based method shall maintain all:

5 (a) Fiscal and statistical records and reports [~~which are~~] used for the purpose of
6 establishing rates of payment made in accordance with Medicaid policy;[,] and

7 (b) [~~All~~] Underlying books, records, documentation and reports that [~~which~~] formed
8 the basis for the fiscal and statistical records and reports.

9 (3) All documentation required by this section shall be maintained by the provider for
10 a minimum of five (5) years from the latter of:

11 (a) The date of final payment for services;

12 (b) The date of final cost settlement for cost reports; or

13 (c) The date of final resolution of disputes, if any.

14 (4) If any litigation, claim, negotiation, audit, investigation, or other action involving
15 the records [~~has been~~] started before [~~the~~] expiration of the five (5) year retention
16 period, the records shall be retained until the latter of:

17 (a) The completion of the action and resolution of all issues which arise from it; or

18 (b) The end of the regular five (5) year period.

19 Section 5. Material Incorporated by Reference. The following material is incorporated
20 by reference:

21 (1) "Kentucky Application for Provider Evaluation and Re-evaluation, Form KAPER-
22 1", December 2005 edition.

23 (2) "MAP-811, Non-credentialed provider application", July 2007 edition.

- 1 (3) "MAP-811, Individual provider application", July 2007 edition.
- 2 (4) "Dental Credentialing Form", October [July] 2007 edition.
- 3 (5) The material incorporated by reference may be inspected, copied, or obtained,
4 subject to applicable copyright law, at the Department for Medicaid Services, 275 East
5 Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:672

REVIEWED:

Date

Shawn M. Crouch, Commissioner
Department for Medicaid Services

APPROVED:

Date

Mark Birdwhistell, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:672
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-6204 or Barry Ingram (502) 564-5969

(1) Provide a brief summary of:

- (a) What this administrative regulation does: This administrative regulation establishes provisions related to Medicaid provider enrollment, disclosure, documentation requirements, and guidelines for assessing the credentials of those applying for participation in the Medicaid Program.
- (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish provisions related to Medicaid provider enrollment, disclosure, documentation requirements, and guidelines for assessing the credentials of those applying for participation in the Medicaid Program.
- (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the provisions related to Medicaid provider enrollment, disclosure, documentation requirements, and guidelines for assessing the credentials of those applying for participation in the Medicaid Program.
- (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing provisions related to Medicaid provider enrollment, disclosure, documentation requirements, and guidelines for assessing the credentials of those applying for participation in the Medicaid Program.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

- (a) How the amendment will change this existing administrative regulation: Pursuant to KRS 205.560(12), this amendment implements use of the form and guidelines required by KRS 304.17A-545(5) and 806 KAR 17:480 for assessing the credentials of those applying for participation in the Medicaid program. Pursuant to Ky. Acts Chapter 34 (SB 98 from the 2007 Session of the General Assembly), this amendment establishes a specific form for assessing the credentials of dentists applying for participation in the Medicaid program. The amendment after comments replaces the prior definition of exclusion with the federal definition, clarifies that the Department for Medicaid Services will only contract with an individual or entity who meets Medicaid provider participation requirements pursuant to 907 KAR 1:671 rather than simply demonstrates a capability of meeting such requirements, and in response to public comment establishes a timeframe for DMS to notify an applicant of omitted or questionable information provided by the applicant. Additionally, the department is adding "CAQH #" to the information required on the Dental Credentialing Form. The department recognizes Council for Affordable Quality Health Care (CAQH) credentialing and is inserting a line on which dental providers

can designate their CAQH number. The department anticipates that this option would expedite credentialing and reduce providers' administrative burden associated with credentialing. The KAPER-1 already contains such an option for other provider types.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to comply with KRS 205.560(12), KRS 304.17A-545(5), and 806 KAR 17:480 in recognizing a uniform provider credentialing and application process. This amendment is also required by Ky. Acts Chapter 34 (SB 98 from the 2007 Session of the General Assembly) to establish a specific form for assessing the credentials of dentists applying for participation in the Medicaid program. The department does not want to punish a provider for offering charity care. The amendment after comments replaces the prior definition of exclusion with the federal definition which is a more appropriate definition. The amendment after comments also clarifies that the Department for Medicaid Services will only contract with an individual or entity who meets Medicaid provider participation requirements pursuant to 907 KAR 1:671 rather than simply demonstrates a capability of meeting such requirements. This amendment is necessary to ensure that only qualified providers are enrolled. The amendment after comments, in response to public comment, establishes a timeframe for DMS to notify an applicant of omitted or questionable information provided by the applicant. This action promotes the timely processing of an application as well as emphasizes that pending information is confined to information required that was omitted or was questionable. Additionally, the department is adding "CAQH #" to the information required on the Dental Credentialing Form. The department recognizes Council for Affordable Quality Health Care (CAQH) credentialing and is inserting a line on which dental providers can designate their CAQH number. The department anticipates that this option would expedite credentialing and reduce providers' administrative burden associated with credentialing. The KAPER-1 already contains such an option for other provider types.

(c) How the amendment conforms to the content of the authorizing statutes: The initial amendment and the amendment after comments conform to the content of the authorizing statutes by complying with KRS 205.560(12), KRS 304.17A-545(5), 806 KAR 17:480, and Ky. Acts Chapter 34 (SB 98 from the 2007 Session of the General Assembly) in recognizing a uniform provider credentialing and application process.

(d) How the amendment will assist in the effective administration of the statutes: The initial amendment and the amendment after comments assist in the effective administration of the statutes by complying with KRS 205.560(12), KRS 304.17A-545(5), 806 KAR 17:480, and Ky. Acts Chapter 34 (SB 98 from the 2007 Session of the General Assembly) in recognizing a uniform provider credentialing and application process.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Any entity desiring to be a Medicaid provider will be affected by this administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by

either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Entities applying for enrollment as a Medicaid provider shall be required to submit a KAPER-1 form in addition to a MAP-811. Dentists applying for participation as a Medicaid provider shall be required to submit a "Dental Credentialing" form in addition to a MAP-811. The amendment after comments allows providers to indicate a CAQH number, if applicable, to expedite credentialing and requires providers to meet Medicaid participation requirements pursuant to 907 KAR 1:671 in order to be enrolled.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): An entity that applies for enrollment as a Medicaid provider would experience no significant costs associated with completing the required KAPER-1 or Dental Credentialing form. The amendment after comments mandates that providers meet Medicaid participation requirements pursuant to 907 KAR 1:671 in order to be enrolled.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Entities that comply with this amendment will be eligible to receive Medicaid reimbursement if approved as participating providers. In addition, because this amendment complies with the provisions of SB 98 from the 2007 Session of the General Assembly, dentists benefit from the Cabinet's development of the new "Dental Credentialing Form", a form used in lieu of the KAPER-1 to streamline the process for assessing the credentials of dentists. The amendment after comments allows dental providers to indicate a CAQH number, if applicable, to expedite credentialing and establishes a timeframe for DMS to notify an applicant of omitted or questionable information provided by the applicant. The latter action promotes the timely processing of an application as well as emphasizes that pending information is confined to information required that was omitted or was questionable.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates no fiscal impact as a result of the initial amendment or amendment after comments to this administrative regulation.

(b) On a continuing basis: DMS anticipates no fiscal impact as a result of the initial amendment or amendment after comments to this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under Title XIX of the Social Security Act and state matching funds from general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary to implement the

amendment or amendment after comments to this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees and it does not directly or indirectly increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The "equal protection" and "due process" clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:672 Contact Person: Stuart Owen (502) 564-6204 or Barry Ingram (502) 564-5969

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes X No _____
If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment and amendment after comments will affect each applicant for participation as a credentialed provider in the Medicaid program.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is required by KRS 205.560(12), which provides that the Medicaid program use the form and guidelines established by KRS 304.17A-545(5) and 806 KAR 17:480 for assessing the credentials of those applying for participation in the Medicaid program. This amendment is further required by Ky. Acts Chapter 34 (SB 98 from the 2007 Session of the General Assembly) which requires that the Medicaid program develop a specific form and guidelines for assessing the credentials of dentists applying for participation in the Medicaid program.
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment and amendment after comments will not generate any additional revenue for state or local governments during the first year of implementation.
 - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment and amendment after comments will not generate any additional revenue for state or local governments during subsequent years of implementation.
 - (c) How much will it cost to administer this program for the first year? Implementation of this amendment and amendment after comments will not

result in any additional costs during the first year.

- (d) How much will it cost to administer this program for subsequent years?
Implementation of this amendment and amendment after comments will not result in any additional costs during subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): _____

Expenditures (+/-): _____

Other Explanation: No additional expenditures are necessary to implement this amendment.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:672 Provider enrollment, disclosure, and documentation for Medicaid participation

Summary of Material Incorporated by Reference

Amendment after Comments

The "Dental Credentialing Form" July 2007 edition is altered to an October 2007 edition by adding "CAQH #" to the information required on the form. The department recognizes Council for Affordable Quality Health Care (CAQH) credentialing and is inserting a line on which providers can designate their CAQH number. The department anticipates that this option would expedite credentialing and reduce providers' administrative burden associated with credentialing. Additionally, the department inserted "October 2007" into the footer of each page on the form. This form contains fourteen (14) pages.

There are a total of ninety-five (95) pages incorporated by reference in this administrative regulation.