304.17A-706 Contested claims -- Delay of payment -- Conditions -- Procedure.

(1) An insurer may contest a clean claim only in the following instances:

(a) The insurer has reasonable documented grounds to believe that the clean claim involves a preexisting condition, coordination of benefits within the meaning of KRS 304.18-085, or that another insurer is primarily responsible for the claim;

(b) The insurer will conduct a retrospective review of the services identified on the claim;

(c) The insurer has information that the claim was submitted fraudulently; or

(d) The covered person's or group's premium has not been paid.

(2) (a) If an insurer requires a provider to submit health claim attachments to the claim before the claim will be paid, the insurer shall identify the specific required health claim attachments in its provider manual or other document that sets forth the procedure for filing claims with the insurer. The insurer shall provide sixty (60) days' advance written notice of modifications to the provider manual that materially change the type or content of the health claim attachments or other documents to be submitted.

(b) If a provider submits a clean claim with the required health claim attachments as specified in the provider manual or other document that sets forth the procedure for filing claims with the insurer, the insurer shall pay or deny the claim within the required claims payment time frame established in KRS 304.17A-702.

(c) If an insurer conducts a retrospective review of a claim and requires an attachment not specified in the provider manual or other document that sets forth the procedure for filing claims, the insurer shall:

1. Notify the provider, in writing or electronically within the claims payment time frame established in KRS 304.17A-702, of the service that will be retrospectively reviewed and the specific information needed from the provider regarding the insurer's review of a claim;

2. Complete the retrospective review within twenty (20) business days of the insurer's receipt of the medical information described in this subsection; and

3. Subject to paragraph (d) of this subsection, add interest to the amount of the claim, to be paid at a rate of twelve percent (12%) per annum, or at a rate in accordance with KRS 304.17A-730, accruing from the appropriate claim payment time frame established in KRS 304.17A-613 after the claim was received by the insurer through the date upon which the claim is paid.

(d) If the provider fails to submit the information requested under subparagraph (c) 1. of this subsection within fifteen (15) business days from the date of the receipt of the notice, the insurer shall not be required to pay interest.

(3) (a) If a claim or portion thereof is contested by an insurer on the basis that the insurer has not received information reasonably necessary to determine insurer liability for the claim or portion thereof, or if the insurer contests the claim on the reasonable and documented belief that the claim involves the coordination of benefits within the meaning of KRS 304.18-085, or questions of pre-existing conditions, the insurer shall, within the applicable claims payment time frame established in KRS 304.17A-702, provide written or electronic notice to the provider, covered person, group policyholder, or other insurer, as appropriate, with an itemization of all new, never-before-provided information that is needed.

(b) The insurer shall pay or deny the claim within thirty (30) calendar days of receiving the additional information described in paragraph (a) of this subsection. If the insurer does not receive the additional information described in paragraph (a) of this subsection within fifteen (15) business days from the date of receipt of the notice set forth in paragraph (a) of this subsection, the insurer may deny the claim. Any claim denied under this paragraph may be resubmitted by the provider and any resubmitted claim shall not be denied on the basis of timeliness if the resubmitted claim is made with the timeframe for submitting claims established by the insurer beginning on the date of denial.

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