

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Healthcare Facilities Management

4 (Amendment)

5 907 KAR 1:012. Inpatient hospital service coverage~~[services]~~.

6 RELATES TO: KRS 205.520, 42 USC 1395ww

7 STATUTORY AUTHORITY: KRS 194A.010(1) and (2), 194A.030(2), 194A.050,  
8 205.520(3), 42 C.F.R. 440.10, 440.210, 440.220, 42 U.S.C. 1396, a, b, d, r-4, Pub. L.  
9 111-148

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
11 Services, Department for Medicaid Services has responsibility to administer the Medica-  
12 id program. KRS 205.520 authorizes the cabinet, by administrative regulation, to comply  
13 with any requirement that may be imposed or opportunity presented by federal law for  
14 the provision of medical assistance to Kentucky's indigent citizenry. This administrative  
15 regulation establishes the provisions relating to inpatient hospital services for which  
16 payment shall be made by the Medicaid Program for a hospital inpatient service.

17 Section 1. Definitions. (1) "Acute care hospital" is defined by KRS 205.639(1).

18 (2) "Critical access hospital" means a hospital meeting the licensure requirements es-  
19 tablished in 906 KAR 1:110 and designated as a critical access hospital by the depart-  
20 ment.

21 (3) "Department" means the Department for Medicaid Services or its designee.

1 (4)[(2)] "Emergency" means a condition or situation which requires an emergency-  
2 service pursuant to 42 C.F.R. 447.53.

3 (5) "Federal financial participation" is defined by 42 CFR 400.203.

4 (6) "Hospital-acquired condition" means a condition:

5 (a)1. Associated with a diagnosis code selected by the Secretary of the U.S. Depart-  
6 ment of Health and Human Services pursuant to 42 USC 1395ww(d)(4)(D); and

7 2. Not present upon the recipient's admission to the hospital; or

8 (b)1. Which is recognized by the Centers for Medicare and Medicaid Services as a  
9 hospital-acquired condition.

10 (7) "Long-term acute care hospital" means a hospital that meets the requirements es-  
11 tablished in 42 CFR 412.23(e).

12 (8)[(3)] "Medical necessity" or "medically necessary" means that a covered benefit is  
13 determined to be needed in accordance with 907 KAR 3:130.

14 (9) "Never event" means:

15 (a) A procedure, service, or hospitalization not reimbursable by Medicare pursuant to  
16 CMS Manual System Pub 100-03 Medicare National Coverage Determinations Trans-  
17 mittal 101; or

18 (b) A hospital-acquired condition.

19 (10)[(4)] "Nonemergency" means a condition or situation which does not require an  
20 emergency service pursuant to 42 C.F.R. 447.53.

21 (11) "Psychiatric hospital" means a hospital meeting the licensure requirements es-  
22 tablished in 902 KAR 20:180.

23 (12) "Rehabilitation hospital" means a hospital meeting the licensure requirements

1 established in 902 KAR 20:240.

2 Section 2. Prior Authorization. To be covered by the department: (1) Prior to a non-  
3 emergency admission, including an elective admission or a weekend admission the de-  
4 partment shall have made a determination that the nonemergency admission was:

5 (a) Medically necessary; and

6 (b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and[-]

7 (2) Within seventy-two (72) hours after an emergency admission, the department  
8 shall have made a determination that the emergency admission was:

9 (a) Medically necessary; and

10 (b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

11 Section 3. Covered Admissions. (1) The department shall reimburse for an admission  
12 primarily indicated in the management of acute or chronic illness, injury or impairment,  
13 or for maternity care that could not be rendered on an outpatient basis.

14 ~~(2) [shall be covered.~~

15 ~~(2) An admission relating to only observation or diagnostic purposes shall not be~~  
16 ~~covered.~~

17 ~~(3)]~~ Cosmetic surgery shall not be covered except as required for prompt repair of  
18 accidental injury or for the improvement of the functioning of a malformed or diseased  
19 body member.

20 Section 4. Noncovered Services. (1) The department shall not reimburse an acute  
21 care hospital reimbursed via a diagnosis-related group (DRG) methodology, a critical  
22 access hospital, a long-term acute care hospital, a psychiatric hospital, a rehabilitation  
23 hospital, or a Medicare-designated psychiatric or rehabilitation distinct part unit for the

1 following~~[Inpatient hospital services not covered shall include]~~:

2 (a)~~[(1)]~~ A service which is not medically necessary including television, telephone, or  
3 guest meals;

4 (b)~~[(2)]~~ Private duty nursing;

5 (c)~~[(3)]~~ Supplies, drugs, appliances, or equipment which are furnished to the patient  
6 for use outside the hospital unless it would be considered unreasonable or impossible  
7 from a medical standpoint to limit the patient's use of the item to the periods during  
8 which he is an inpatient;

9 (d)~~[(4)]~~ A laboratory test not specifically ordered by a physician and not done on a  
10 preadmission basis unless an emergency exists;

11 (e)~~[(5)]~~ Private accommodations unless medically necessary and so ordered by the  
12 attending physician; or

13 (f)~~[(6)]~~ The following listed surgical procedures, except if a life-threatening situation  
14 exists, there is another primary purpose for the admission, or the admitting physician  
15 certifies a medical necessity requiring admission to a hospital:

16 1.~~[(a)]~~ Biopsy: breast, cervical node, cervix, lesions (skin, subcutaneous, submuc-  
17 ous), lymph node (except high axillary excision), or muscle;

18 2.~~[(b)]~~ Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles,  
19 polyps, warts or condylomas, anterior nose bleeds, or cervix;

20 3.~~[(c)]~~ Circumcision;

21 4.~~[(d)]~~ Dilation: dilation and curettage (diagnostic or therapeutic nonobstetrical); dila-  
22 tion or probing of lacrimal duct;

23 5.~~[(e)]~~ Drainage by incision or aspiration: cutaneous, subcutaneous, or joint;

- 1        6.[(f)] Pelvic exam under anesthesia;
- 2        7.[(g)] Excision: bartholin cyst, condylomas, foreign body, lesions lipoma, nevi  
3 (moles), sebaceous cyst, polyps, or subcutaneous fistulas;
- 4        8.[(h)] Extraction: foreign body or teeth;
- 5        9.[(+)] Graft, skin (pinch, splint or full thickness up to defect size three-fourths (3/4)  
6 inch diameter);
- 7        10.[(j)] Hymenotomy;
- 8        11.[(k)] Manipulation and reduction with or without x-ray; cast change: dislocations  
9 depending upon the joint and indication for procedure or fractures;
- 10       12.[(+)] Meatotomy or urethral dilation, removal calculus and drainage of bladder with-  
11 out incision;
- 12       13.[(m)] Myringotomy with or without tubes, otoplasty;
- 13       14.[(+)] Oscopy with or without biopsy (with or without salpingogram): arthroscopy,  
14 bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, ga-  
15 stroscopy, hysteroscopy, laryngoscopy, laparoscopy, peritoneoscopy, otoscopy, and  
16 sigmoidoscopy or procto sidmoidoscopy;
- 17       15.[(e)] Removal; IUD, fingernail or toenails;
- 18       16.[(p)] Tenotomy hand or foot;
- 19       17.[(e)] Vasectomy; or
- 20       18.[(+)] Z-plasty for relaxation of scar or contracture;
- 21       (g) A service for which Medicare has denied payment;
- 22       (h) An admission relating only to observation or diagnostic purposes; or
- 23       (i) Cosmetic surgery, except as required for prompt repair of accidental injury or for

1 the improvement of the functioning of a malformed or diseased body member.

2 (2) The department shall not reimburse an acute care hospital reimbursed via a  
3 DRG-methodology pursuant to 907 KAR 1:825 for the following:

4 (a) Treatment for or related to a hospital-acquired condition;  
5 (b) A never event; or  
6 (c) Treatment related to a never event.

7 (3) A hospital shall not bill:

8 (a) A recipient for:  
9 1. Treatment for or related to a hospital-acquired condition;  
10 2. A never event; or  
11 3. Treatment related to a never event;

12 (b) The Cabinet for Health and Family Services for:  
13 1. Treatment for or related to a hospital-acquired condition associated with a child in  
14 the custody of the Cabinet for Health and Family Services;  
15 2. A never event associated with a child in the custody of the Cabinet for Health and  
16 Family Services; or  
17 3. Treatment related to a never event associated with a child in the custody of the  
18 Cabinet for Health and Family Services;

19 (c) The Department for Juvenile Justice for:  
20 1. Treatment for or related to a hospital-acquired condition associated with a child in  
21 the custody of the Department for Juvenile Justice;  
22 2. A never event associated with a child in the custody of the Department for Juvenile  
23 Justice; or

1 3. Treatment related to a never event associated with a child in the custody of the  
2 Department for Juvenile Justice.

3 (4) A recipient, the Cabinet for Health and Family Services, or the Department  
4 Juvenile Justice shall not be liable for:

5 (a) Treatment for or related to a hospital-acquired condition;

6 (b) A never event; or

7 (c) Treatment related to a never event.

8 Section 5. Federal Financial Participation. A provision established in this administra-  
9 tive regulation shall be null and void if the Centers for Medicare and Medicaid Services:

10 (1) Denies federal financial participation for the provision; or

11 (2) Disapproves the provision.

12 Section 6. Incorporation by Reference. (1) The “CMS Manual System Pub 100-03  
13 Medicare National Coverage Determinations Transmittal 101,” June 12, 2009 edition is  
14 incorporated by reference.

15 (2) The material referenced in subsection (1) of this section may be inspected, co-  
16 pied, or obtained, subject to applicable copyright law, at the Department for Medicaid  
17 Services, 275 East Main Street, Frankfort, KY 40621, Monday through Friday, 8:00 a.m.  
18 to 4:30 p.m.

907 KAR 1:012

REVIEWED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Elizabeth A. Johnson, Commissioner  
Department for Medicaid Services

APPROVED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Janie Miller, Secretary  
Cabinet for Health and Family Services

907 KAR 1:012

A public hearing on this administrative regulation shall, if requested, be held on August 23, 2010, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by August 16, 2010, five (5) work-days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business August 31, 2010. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

**CONTACT PERSON:** Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS  
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:012  
Cabinet for Health and Family Services  
Department for Medicaid Services  
Agency Contact: Jill Hunter (502) 564-5707 or Darlene Burgess (502) 564-5707

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation establishes the Kentucky Medicaid inpatient hospital coverage provisions.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Kentucky Medicaid inpatient hospital service provisions.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing Kentucky Medicaid inpatient hospital service provisions.
  - (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 KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing Kentucky Medicaid inpatient hospital service provisions.
  
- (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: The amendment eliminates Medicaid coverage of care related to conditions acquired by patients in a hospital unrelated to the condition for which the patient was admitted to the hospital and care associated with events which never should have happened. The policy only applies to acute care hospitals as the Centers for Medicare and Medicaid Services (CMS) exempts miscellaneous other hospital types from the policy. The amendment also entails language and formatting revisions to comply with KRS Chapter 13A requirements.
  - (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to comply with guidance from the Centers for Medicare and Medicaid Services (CMS). The amendment is also necessary to provide a substantial incentive to hospitals to ensure that they avoid putting patients at risk of acquiring a medical problem – while in the hospital – unrelated to the patient’s admitting problem. Lastly, the policy is not currently mandated by CMS but will be mandated for state Medicaid programs effective July 1, 2011.
  - (c) How the amendment conforms to the content of the authorizing statutes: The amendment – which addresses Medicaid inpatient hospital coverage - conforms with KRS 194A030(2) which establishes the Department for Medicaid Services as the single state agency authorized to administer Title XIX of the Social Security Act. The amendment also conforms with KRS 194A.050(1) which charges the Cabinet for Health and Family Services secretary to “. . . . adopt . . . . administra-

tive regulations necessary under applicable laws to protect, develop, and maintain the health . . . of the individual citizens of the Commonwealth . . . .”

- (d) How the amendment will assist in the effective administration of the statutes: The amendment is expected to assist in the effective administration of KRS 194A.050(1) by providing a substantial incentive to hospitals to ensure that they avoid putting patients at risk of acquiring a medical problem – while in the hospital – unrelated to the patient’s admitting problem.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The amendment applies to acute care hospitals as the Centers for Medicare and Medicaid Services (CMS) exempts miscellaneous other hospital types from the policy. Currently these number approximately sixty-five (65) in Kentucky.
- (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. No compliance action is mandated; however, acute care hospitals will not be reimbursed for treatment of a condition a patient acquires – unrelated to their admitting condition – while in the hospital or for care associated with a never event.
- (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment imposes no cost on the regulated entities.
- (c) As a result of compliance, what benefits will accrue to the entities identified in question (3)? The Department for Medicaid Services (DMS) hopes that the incidence rate of hospital-acquired conditions and never events will drop as a result of the amendment; thus, benefiting inpatient hospital patients.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: As a result of the amendment, DMS will experience minimal administrative cost in the form of Medicaid Management Information System (MMIS) programming changes. Conversely, the Department for Medicaid Services (DMS) projects that the amendment will reduce expenditures by approximately \$300,000 (state and federal shares combined) annually.
- (b) On a continuing basis: DMS projects that the amendment will reduce expenditures by approximately \$300,000 (state and federal shares combined) annually.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations. The amendment is expected to reduce expenditures.

- (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. Neither an increase in fees nor funding will be necessary to implement the amendment to this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is applied in that long-term acute care hospitals, rehabilitation hospitals, psychiatric hospitals, critical access hospitals and Medicare designated psychiatric or rehabilitation distinct part units are exempt from the hospital-acquired condition and never event policy as the Centers for Medicare and Medicaid Services (CMS) exempts them from the policy.

## FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:012

Agency Contact: Jill Hunter (502) 564-5707 or Darlene Burgess (502) 564-5707

1. Federal statute or regulation constituting the federal mandate. 42 USC 1396a(a)(10), 42 USC 1396d(a)(1), Public Law 111-148 (Section 2702), 42 USC 1395ww(d)(4)(D), 42 CFR 440.210 and 42 CFR 440.220.
2. State compliance standards. KRS 205.520(3) states, "to qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."
3. Minimum or uniform standards contained in the federal mandate. State Medicaid programs must provide inpatient hospital services other than in institutions for mental diseases to every covered group of Medicaid beneficiaries.

Public Law 111-148, Section 2702 states, "(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall identify current State practices that prohibit payment for health care acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries."

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The mandate requires coverage of inpatient hospital services. The amendment regarding hospital-acquired conditions has been mandated to become effective July 1, 2011 and is currently "encouraged" by the Centers for Medicare and Medicaid Services (CMS) via a letter to state Medicaid directors numbered "SMDL 08-004."
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The policy is not stricter than the federal standard.

## FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:012

Agency Contact: Jill Hunter (502) 564-5707 or Darlene Burgess (502) 564-5707

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  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? The Department for Medicaid Services (DMS) will be impacted by the amendment.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 USC 1396a(a)(10), 42 USC 1396d(a)(1), 42 CFR 440.210 and 42 CFR 440.220.

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? DMS anticipates no revenue being generated for the first year for state or local government due to the amendment to this administrative regulation.

(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? DMS anticipates no revenue being generated in subsequent years for state or local government due to the amendment to this administrative regulation.

(c) How much will it cost to administer this program for the first year? As a result of the amendment, DMS will experience minimal administrative cost in the form of Medicaid Management Information System (MMIS) programming changes. Conversely, the Department for Medicaid Services (DMS) projects that the amendment will reduce expenditures by approximately \$300,000 (state and federal shares combined) annually.

(d) How much will it cost to administer this program for subsequent years? No cost is anticipated for subsequent years. DMS projects that the amendment will reduce expenditures by approximately \$300,000 (state and federal shares combined) annually.

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

907 KAR 1:012, Inpatient Hospital Services

Summary of Material Incorporated by Reference

The “CMS Manual System Pub 100-03 Medicare National Coverage Determinations Transmittal 101”; June 12, 2009 edition is an eleven (11)-page document establishing procedures, services, or hospitalizations known as never events which are not reimbursable by the Centers for Medicare and Medicaid Services (CMS). The Department for Medicaid Services (DMS) is mirroring the CMS policy regarding these procedures, services, or hospitalizations. This is new material incorporated by reference.

A total of eleven (11) pages are incorporated by reference into this administrative regulation.