

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Hospital and Provider Operations

4 (Amendment)

5 907 KAR 1:015. Payments for outpatient hospital [~~outpatient~~] services.

6 RELATES TO: KRS 205.520, 42 C.F.R. 440.2, 440.20(a)

7 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560,  
8 205.637, 42 U.S.C. 1396a, 1396b, 1396d[, ~~EO 2004-726~~]

9 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9,~~  
10 ~~2004, reorganized the Cabinet for Health Services and placed the Department for Medi-~~  
11 ~~caid Services and the Medicaid Program under the Cabinet for Health and Family Ser-~~  
12 ~~vices.~~] The Cabinet for Health and Family Services, Department for Medicaid Services,  
13 has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes  
14 the cabinet, by administrative regulation, to comply with any requirement that may be  
15 imposed, or opportunity presented, by federal law for the provision of medical assis-  
16 tance to Kentucky's indigent citizenry. This administrative regulation establishes the  
17 method for determining amounts payable by the Medicaid Program for [~~hospital~~] outpa-  
18 tient hospital services.

19 Section 1. Definitions. (1) "Critical access hospital" or "CAH" means a hospital meet-  
20 ing the licensure requirements established in 906 KAR 1:110.

21 (2) "Current procedural terminology code" or "CPT code" means a code used for the

1 reporting of medical services or procedures using the current procedural terminology  
2 developed by the American Medical Association.

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

4 (4) "Healthcare common procedure coding system" or "HCPCS" means a collection  
5 of codes acknowledged by the Centers for Medicare and Medicaid Services that repre-  
6 sent procedures.

7 (5) "Level 1 service" means a service [~~services~~] billed using CPT code 99281.

8 (6) "Level 2 service" means a service [~~services~~] billed using CPT code [~~codes~~] 99282  
9 or 99283.

10 (7) "Level 3 service" means a service [~~services~~] billed using CPT code [~~codes~~] 99284,  
11 99285, 99291, or 99292.

12 (8) "Outpatient cost-to-charge ratio" means the ratio determined by dividing the costs  
13 reported on Supplemental Worksheet E-3, Part III, Page 12 column 3, line 27 of the cost  
14 report by the charges reported on column 3, line 20 of the same schedule.

15 (9) "Revenue code" means a provider-assigned revenue code for each cost center  
16 for which a separate charge is billed.

17 (10) "Triage" means a medical screening and assessment billed using revenue code  
18 451.

19 Section 2. Outpatient Hospital Service Reimbursement [~~Services~~].

20 (1) Except for a critical access hospital, [~~for services provided on or after August 4,~~  
21 ~~2003,~~] the Department for Medicaid Services shall reimburse a participating in-state  
22 hospital for an outpatient service [~~outpatient services~~] in accordance with this subsec-  
23 tion.

1 (a) For the following procedures, the rates shall be as follows:

2 1. Cardiac catheterization lab:

3 a. Unilateral - \$1,478; or

4 b. Bilateral - \$1,770;

5 2. Computed tomography scan - \$479;

6 3. Lithotripsy - \$3,737;

7 4. Magnetic resonance imaging - \$593;

8 5. Observation room - \$458; and

9 6. Ultrasound - \$177.

10 (b) If multiple services listed in paragraph (a) of this subsection are provided, each  
11 service shall receive the corresponding rate established in paragraph (a) of this subsec-  
12 tion.

13 (c) The department shall utilize the [1996] Medicare ambulatory surgical center  
14 groups as published in the Federal Register on October 1<sup>st</sup> of each year to reimburse for  
15 an outpatient surgery. The following chart establishes the reimbursement rate for each  
16 corresponding surgical group:

Ambulatory Surgical Center Group	Reimbursement Rate
Group 1	\$397
Group 2	\$534
Group 3	\$610
Group 4	\$753
Group 5	\$858
Group 6	\$1,016

Group 7	\$1,191
Group 8	\$1,191

1 (d) Reimbursement for an outpatient surgery which does not have a surgical group  
2 rate shall be at a facility-specific outpatient cost-to-charge ratio.

3 (e) For multiple surgeries provided to the same recipient on the same day, only the  
4 surgery with the highest reimbursement rate established in paragraph (c) of this subsec-  
5 tion, shall be paid.

6 (f) Except for the services listed in paragraph (g) of this subsection, all other services  
7 provided to the same recipient on the same day shall be reimbursed in accordance with  
8 paragraphs (a), (b), (c), (d), and (e) of this subsection.

9 (g) The following shall be reimbursed on an interim basis at a facility-specific outpa-  
10 tient cost-to-charge ratio for the following revenue codes:

Service	Revenue Code
Pharmacy	250, 251, 252, 254, 255, 258, 260, 261, 634, 635, 636
X-ray	320, 321, 322, 323, 324, 342, 400, 403, 920
Supplies	270, 271, 272, 274, 275, 621, 622, 623
EKG/ECG and Therapeutic Services	410, 412, 413, 420, 421, 422, 423, 424, 440, 441, 442, 443, 460, 470, 471, 472, 480, 482, 510, 512, 516, 517, 730, 731, 732, 740, 901, 922, 940, 942, 943
Room and Miscellaneous	280, 290, 370, 371, 372, 374, 700, 710, 750, 761, 890, 891, 892, 893, 921

Dialysis	821, 831, 841
Chemotherapy	330, 331, 332, 333, 334, 335

1 (h) Except as established in paragraph (i) of this subsection, a service [Services] re-  
2 imbursed in accordance with paragraph (g) of this subsection shall be settled to cost at  
3 year end.

4 (i) If a service or supply listed in paragraph (g) of this subsection appears on a claim  
5 with a line item reimbursed via a flat rate, reimbursement for the supply or services:

6 1. Shall not be cost settled; and

7 2. Shall be included in the flat rate.

8 (2) Except for pharmacy services billed using revenue codes 250, 251, 252, 254,  
9 255, 258, 260, 261, 634, 634, or 636, medical or surgical supplies billed using revenue  
10 codes 270-275, and triage billed using revenue code 451, a hospital shall include all ap-  
11 plicable CPT and HCPCS codes on a claim.

12 (3) Except for services listed in subsection (1)(g) of this section, [~~beginning August 4,~~  
13 ~~2003,~~] an out-of-state hospital providing outpatient services shall be reimbursed in ac-  
14 cordance with subsection (1) of this section.

15 (4) Reimbursement for an outpatient hospital service provided by an out-of-state  
16 hospital shall be as follows:

17 (a) Reimbursement for a service or supply listed in subsection (1)(g) of this Section  
18 appearing on a claim with a line item reimbursed via a flat rate shall be included in the  
19 flat rate;

20 (b) Except for a service or supply appearing on a claim with a line item reimbursed  
21 via a flat rate, a service [Services] listed in subsection (1)(g) of this section shall be re-

1    imbursed by multiplying the average outpatient cost-to-charge ratio of in-state hospitals,  
2    excluding critical access hospitals, by billed charges; and

3    (c) There shall be no cost settling.

4    (5)(a) An outpatient hospital laboratory service shall be reimbursed at the Medicare-  
5    established technical component rate in accordance with 907 KAR 1:029.

6    (b) An outpatient hospital laboratory service with no established Medicare rate shall  
7    be reimbursed by multiplying a facility-specific outpatient cost-to-charge ratio by billed  
8    charges.

9    (6) A critical access hospital shall be reimbursed on an interim basis:

10   (a) By multiplying charges by the lesser of:

11    1. The Medicare cost-to-charge ratio issued by the Medicare fiscal intermediary in  
12    effect at the time; or

13    2. The Medicaid outpatient cost-to-charge ratio;

14   (b) For a laboratory service in accordance with the Medicare fee schedule; and

15   (c) With a settlement to cost at the end of the year.

16   (7) A hospital providing outpatient services shall be required to submit a cost report  
17   within five (5) months after a hospital's fiscal year end.

18   (8) Failure to provide a cost report within the timeframe established in subsection (7)  
19   of this section shall result in a suspension of future payment until the cost report is re-  
20   ceived by the department.

21   (9) If a cost report indicates payment is due, a provider shall remit payment in full or a  
22   request for a payment plan with the cost report.

23   (10) If a cost report indicates a payment is due and a hospital fails to remit a payment

1 or request for a payment plan, the department shall suspend future payment to the hos-  
2 pital.

3 (11) An estimated payment shall not be considered payment-in-full until a final de-  
4 termination of cost has been made by the department.

5 (12) If it is determined that an additional payment is due after a final determination of  
6 cost has been made by the department, the additional payment shall be due sixty (60)  
7 days after notification.

8 (13) If a hospital fails to submit an additional payment in accordance with subsection  
9 (12) of this section, the department shall suspend future payment to the hospital.

10 Section 3. Supplemental Payments. (1) In addition to a payment received in accor-  
11 dance with Section 2 of this administrative regulation, a nonstate government hospital,  
12 as defined in 42 C.F.R. 447.321(2), whose county has entered into an intergovernmen-  
13 tal agreement with the Commonwealth shall receive a quarterly supplemental payment  
14 in an amount equal to the difference between the payments made in accordance with  
15 Sections 2 and 4 of this administrative regulation and the maximum amount allowable  
16 under 42 C.F.R. 447.321.

17 (2) A payment made under this section shall:

18 (a) Not be subject to the cost-settlement provisions established in Section 2 of this  
19 administrative regulation; and

20 (b) Apply to a service provided on or after April 2, 2001.

21 Section 4. In-state and Out-of-state Emergency Room Service Reimbursement [~~Ser-~~  
22 ~~vices~~]. (1) Services provided in an emergency room shall be reimbursed as follows:

23 (a) The triage service reimbursement rate shall be twenty (20) dollars;

1 (b) The level 1 service reimbursement rate shall be eighty-two (82) dollars;

2 (c) The level 2 service reimbursement rate shall be \$164; and

3 (d) The level 3 service reimbursement rate shall be \$264.

4 (2) In addition to the rate paid for services listed in subsection (1) of this section, the  
5 following shall be paid at the following rates:

6 (a) Cardiac catheterization lab:

7 1. Unilateral - \$1,478; or

8 2. Bilateral - \$1,770;

9 (b) Computed tomography scan - \$479;

10 (c) Lithotripsy - \$3,737;

11 (d) Magnetic resonance imaging - \$593;

12 (e) Observation room - \$458; and

13 (f) Ultrasound - \$177.

14 (3) If multiple services listed in subsection (2) of this section are provided, each ser-  
15 vice shall receive the corresponding rate established in subsection (2) of this section.

16 (4) Except as listed in subsection (5) of this section, a separate payment shall not be  
17 made for the services or supplies listed in Section 2(1)(g) of this administrative regula-  
18 tion.

19 (5) A thrombolytic agent shall be reimbursed at the hospital's acquisition cost.

20 (6) A service provided in an emergency room of a critical access hospital shall be re-  
21 imbursed in accordance with Section 2(6) of this administrative regulation.

22 Section 5. Appeals. A hospital may appeal a decision as permitted by 907 KAR  
23 1:671.

1        Section 6. Cost Report Requirements.

2        (1) An in-state hospital participating in the Medicaid program shall submit to the de-  
3 partment a copy of the Medicare cost report it submits to CMS, the Supplemental Medi-  
4 caid Schedule KMAP-1, and the Supplemental Medicaid Schedule KMAP-4 as follows:

5        (a) A cost report shall be submitted:

6        1. For the fiscal year used by the hospital; and

7        2. Within five (5) months after the close of the hospital's fiscal year; and

8        (b) Except as follows, the department shall not grant a cost report submittal exten-  
9 sion:

10       1. If an extension has been granted by Medicare, the cost report shall be submitted  
11 simultaneously with the submittal of the Medicare cost report; or

12       2. If a catastrophic circumstance exists, for example flood, fire, or other equivalent  
13 occurrence, the department shall grant a thirty (30) day extension.

14       (2) If a cost report submittal date lapses and no extension has been granted, the de-  
15 partment shall immediately suspend all payment to the hospital until a complete cost  
16 report is received.

17       (3) The cost report submitted by a hospital shall be subject to audit and review.

18       (4) An in-state hospital shall submit a final Medicare-audited cost report upon com-  
19 pletion by the Medicare intermediary to the department.

20       Section 7. Incorporation by Reference.

21       (1) The following material is incorporated by reference:

22       (a) "Supplemental Worksheet E-3, Part III, Page 12", November 1992 edition;

23       (b) "Supplemental Medicaid Schedule KMAP-1", January 2007 edition; and

1       (c) "Supplemental Medicaid Schedule KMAP-4", January 2007 edition. [~~is incorpo-~~  
2 ~~rated by reference.~~]

3       (2) The [This] material incorporated by reference may be inspected, copied, or ob-  
4 tained, subject to applicable copyright law, at the Department for Medicaid Services,  
5 275 East Main Street, Frankfort, Kentucky 40601, Monday through Friday 8 am to 4:30  
6 pm.

907 KAR 1:015

REVIEWED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Glenn Jennings, Commissioner  
Department for Medicaid Services

APPROVED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mark D. Birdwhistell, Secretary  
Cabinet for Health and Family Services

907 KAR 1:015

A public hearing on this administrative regulation shall, if requested, be held on August 21, 2007, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by August 14, 2007, five (5) workdays 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, 2007. 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 #: 907 KAR 1:015

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (502-564-6204)

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation establishes the reimbursement methodology for outpatient hospital services.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary in order to reimburse hospitals for the provision of outpatient services.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: The authorizing statutes of this administrative regulation grant the Department for Medicaid Services (DMS) the authority to reimburse hospitals for the provision of outpatient services.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation establishes the reimbursement methodology for outpatient hospital services.
  
- (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: This amendment clarifies that reimbursement for the services and supplies identified in Section 2(1)(g) of this administrative regulation shall be included in a flat rate (not cost settled) if the service or supply appears on a claim with a line item that is reimbursed via a flat rate. This amendment further establishes cost reporting requirements for in-state hospitals.
  - (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to streamline the reimbursement process for services and supplies identified in Section 2(1)(g) of this administrative regulation, thereby helping to maintain the viability of the Medicaid program.
  - (c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by establishing outpatient procedures reimbursed via a flat rate rather than via a cost basis.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This amendment assists in the effective administration of the authorizing statutes by establishing outpatient procedures reimbursed via a flat rate rather than via a cost basis.
  
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All hospitals providing outpatient services are affected by this amendment.

- (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. Regulated entities will not have to take any action to comply with the amendment as the amendment alters outpatient hospital reimbursement.
  - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment does not impose a cost on regulated entities.
  - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Regulated entities will not have to take any action to comply with the amendment as the amendment alters outpatient hospital reimbursement.
  
- (4) Provide an estimate of how much it will cost to implement this administrative regulation:
  - (a) Initially: While implementation of the amendment to this administrative regulation could improve cash flow, the fiscal impact is indeterminable.
  - (b) On a continuing basis: While implementation of the amendment to this administrative regulation could improve cash flow, the fiscal impact is indeterminable.
  
- (5) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.
  
- (6) 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 funds or funding will be necessary to implement this amendment.
  
- (7) 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, nor does it directly or indirectly increase any fees.
  
- (8) 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 Con-

stitution.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:015

Contact Person: Stuart Owen or Stephanie Brammer-Barnes (502) 564-6204

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? All hospitals providing outpatient services are affected by this amendment.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 CFR 440.20, 42 CFR 447.321
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 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 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? While implementation of the amendment to this administrative regulation could improve cash flow, the fiscal impact is indeterminable.
  - (d) How much will it cost to administer this program for subsequent years? While implementation of the amendment to this administrative regulation could improve cash flow, the fiscal impact is indeterminable.

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 1:015, Payments for outpatient hospital services

Summary of Material Incorporated by Reference

1. "Supplemental Worksheet E-3, Part III, Page 12", November 1992 edition. This form is used by in-state hospitals to report data that determines the outpatient cost-to-charge ratio upon which reimbursement is based for designated services. This form contains one (1) page.
2. "Supplemental Medicaid Schedule KMAP-1", January 2007 edition. This form is used by in-state hospitals to document the following information necessary to comply with Medicaid's cost reporting requirements: legal fees, political contributions, and out-of-state travel expenses. This form contains one (1) page.
3. "Supplemental Medicaid Schedule KMAP-4", January 2007 edition. This form is used by in-state disproportionate share hospitals to report information necessary to comply with Medicaid's cost reporting requirements. This form contains one (1) page.

A total of three (3) pages is incorporated into this administrative regulation by reference.