

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Hospitals and Provider Operations

4 (Amendment)

5 907 KAR 1:038. Hearing and Vision Program services.

6 RELATES TO: KRS 205.520, 334.010(4) and (9), 334A.020(5), 334A.030, 42 C.F.R.

7 [440.140,] 441.30, 447.53, 457.310, 42 U.S.C. 1396a, b, d, 1396r-6

8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)~~[, EO-2004-~~

9 ~~726]~~

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
11 Services, Department for Medicaid Services has responsibility to administer the Medi-
12 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to
13 comply with any requirement that may be imposed or opportunity presented by federal
14 law for the provision of medical assistance to Kentucky's indigent citizenry. This admin-
15 istrative regulation establishes the hearing services and vision ~~[program]~~ services for
16 which payment shall be made by the Medicaid Program.

17 Section 1. Definitions. (1) "Audiologist" is defined by KRS 334A.020(5).

18 (2)"Comprehensive choices" means a benefit plan for an individual who:

19 (a) Meets the nursing facility patient status criteria established in 907 KAR 1:022,

20 Nursing facility services and intermediate care facility for individuals with mental retarda-
21 tion or a developmental disability services;

1 (b) Receives services through either:

2 1. A nursing facility in accordance with 907 KAR 1:022, Nursing facility services and
3 intermediate care facility for individuals with mental retardation or a developmental dis-
4 ability services;

5 2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090, Ac-
6 quired brain injury services;

7 3. The Home and Community Based Waiver Program in accordance with 907 KAR
8 1:160, Home and community based waiver services; or

9 4. The Model Waiver II Program in accordance with 907 KAR 1:595, Model Waiver II
10 services and payments; and

11 (c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.

12 ~~(3)~~ [(2)] "CPT code" means a code used for reporting procedures and services per-
13 formed by medical practitioners and published annually by the American Medical Asso-
14 ciation in Current Procedural Terminology.

15 ~~(4)~~ [(3)] "Department" means the Department for Medicaid Services or its designee.

16 ~~(5)~~ [(4)] "Emergency" means that a condition or situation requires an emergency ser-
17 vice pursuant to 42 C.F.R. 447.53.

18 ~~(6)~~ [(5)] "Family choices" means a benefit plan for an individual who:

19 (a) Is covered pursuant to:

20 1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u - 1;

21 2. 42 U.S.C. 1396a(a)(52) and 1396r - 6 (excluding children eligible under Part A or E
22 of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

23 3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

1 4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

2 5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

3 6. 42 C.F.R. 457.310; and

4 (b) Has a designated package code of 2, 3, 4, or 5.

5 ~~(7)~~ [(6)] "Global choices" means the department's default benefit plan, consisting of
6 individuals designated with a package code of A, B, C, D, or E and who are included in
7 one (1) of the following populations:

8 (a) Caretaker relatives who:

9 1. Receive K-TAP and are deprived due to death, incapacity, or absence;

10 2. Do not receive K-TAP and are deprived due to death, incapacity, or absence; or

11 3. Do not receive K-TAP and are deprived due to unemployment;

12 (b) Individuals aged sixty-five (65) and over who receive SSI and:

13 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
14 1:022, Nursing facility services and intermediate care facility for individuals with mental
15 retardation or a developmental disability services; or

16 2. Receive SSP and do not meet nursing facility patient status criteria in accordance
17 with 907 KAR 1:022, Nursing facility services and intermediate care facility for individu-
18 als with mental retardation or a developmental disability services;

19 (c) Blind individuals who receive SSI and:

20 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
21 1:022, Nursing facility services and intermediate care facility for individuals with mental
22 retardation or a developmental disability services; or

23 2. SSP, and do not meet nursing facility patient status criteria in accordance with 907

1 KAR 1:022, Nursing facility services and intermediate care facility for individuals with
2 mental retardation or a developmental disability services;

3 (d) Disabled individuals who receive SSI and:

4 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
5 1:022, Nursing facility services and intermediate care facility for individuals with mental
6 retardation or a developmental disability services, including children; or

7 2. SSP, and do not meet nursing facility patient status criteria in accordance with 907
8 KAR 1:022, Nursing facility services and intermediate care facility for individuals with
9 mental retardation or a developmental disability services;

10 (e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are
11 eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient
12 status criteria in accordance with 907 KAR 1:022, Nursing facility services and interme-
13 diated care facility for individuals with mental retardation or a developmental disability
14 services;

15 (f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through"
16 Medicaid benefits, and do not meet nursing facility patient status in accordance with 907
17 KAR 1:022, Nursing facility services and intermediate care facility for individuals with
18 mental retardation or a developmental disability services;

19 (g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass
20 through" Medicaid benefits, and do not meet nursing facility patient status in accordance
21 with 907 KAR 1:022, Nursing facility services and intermediate care facility for individu-
22 als with mental retardation or a developmental disability services; or

23 (h) Pregnant women.

1 (8) "Hearing instrument" is defined by KRS 334.010(4).

2 (9)[(7)] "Medically necessary" or "medical necessity" means that a covered benefit is
3 determined to be needed in accordance with 907 KAR 3:130, Medical necessity and
4 clinically appropriate determination basis.

5 (10)[(8)] "Nonemergency" means that a condition or situation does not require an
6 emergency service pursuant to 42 C.F.R. 447.53

7 (11)[(9)] "Optimum choices" means a benefit plan for an individual who:

8 (a) Meets the intermediate care facility for individuals with mental retardation or a de-
9 velopmental disability patient status criteria established in 907 KAR 1:022, Nursing facili-
10 ty services and intermediate care facility for individuals with mental retardation or a de-
11 velopmental disability services;

12 (b) Receives services through either:

13 1. An intermediate care facility for individuals with mental retardation or a develop-
14 mental disability in accordance with 907 KAR 1:022, Nursing facility services and inter-
15 mediate care facility for individuals with mental retardation or a developmental disability
16 services; or

17 2. The Supports for Community Living Waiver Program in accordance with 907 KAR
18 1:145, Supports for community living services for an individual with mental retardation or
19 a developmental disability; and

20 (c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.

21 (12) "Specialist in hearing instruments" is defined by KRS 334.010(9).

22 Section 2. Hearing Services. (1) All hearing coverage shall be:

23 (a) Limited to an individual under age twenty-one (21); and

1 (b) Provided in accordance with the Hearing Program Manual.

2 (2) Unless a recipient's health care provider demonstrates that services in excess of
3 the following limitations are medically necessary, reimbursement for services provided
4 by an audiologist licensed pursuant to KRS 334A.030~~[a certified audiologist]~~ to a recipi-
5 ent shall be limited to:

6 (a) The following procedures which shall be covered only if a recipient is referred, by
7 a physician, to an audiologist licensed pursuant to KRS 334A.030:

<u>Code</u>	<u>Procedure</u>
<u>92552</u>	<u>Pure Tone audiometry (threshold); air only</u>
<u>92555</u>	<u>Speech audiometry threshold</u>
<u>92556</u>	<u>Speech audiometry threshold; with speech recognition</u>
<u>92557</u>	<u>Comprehensive audiometry eval</u>
<u>92567</u>	<u>Tympanometry</u>
<u>92568</u>	<u>Acoustic reflex testing</u>
<u>92579</u>	<u>Visual reinforcement audiometry</u>
<u>92585</u>	<u>Auditory evoked potentials</u>
<u>92587</u>	<u>Evoked otoacoustic emissions</u>
<u>92588</u>	<u>Complete or diagnostic evaluation (comparison of transient or distortion product otoacoustic emissions at multiple levels and frequency)</u>
<u>92541</u>	<u>Spontaneous nystagmus test</u>

<u>92542</u>	<u>Positional nystagmus test</u>
<u>92543</u>	<u>Caloric vestibular test</u>
<u>92544</u>	<u>Optokinetic nystagmus test</u>
<u>92545</u>	<u>Oscillating tracking test</u>
<u>92546</u>	<u>Sinusoidal vertical axis rotational testing</u>
<u>92547</u>	<u>Use of vertical electrodes</u>

- 1 **(b)** Complete hearing evaluation;
- 2 **(c)**~~(b)~~ Hearing instrument ~~[aid]~~ evaluation;
- 3 **(d)**~~1.~~~~(c)~~~~1.~~ Three (3) follow-up visits within the six (6) month period immediately fol-
- 4 lowing fitting of a hearing instrument ~~[aid]~~; and
- 5 2. A follow-up visit shall be related to the proper fit and adjustment of the~~[that]~~ hear-
- 6 ing instrument ~~[aid]~~; and
- 7 **(e)**~~(d)~~ One (1) additional follow-up visit at least six (6) months following the fitting of
- 8 a hearing instrument ~~[aid]~~.
- 9 (3) Hearing instrument ~~[aid]~~ benefit coverage shall:
- 10 (a) Be for a hearing instrument ~~[aid]~~ model recommended by an audiologist licensed
- 11 pursuant to KRS 334A.030~~[a certified audiologist]~~ if the model is available through a
- 12 Medicaid-participating specialist in hearing instruments; ~~[hearing aid dealer; and]~~
- 13 (b) Not exceed \$800 per ear every thirty-six (36) months; and
- 14 (c) Be limited to the following procedures:

<u>Code</u>	<u>Procedure</u>
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<u>V5010</u>	<u>Assessment for Hearing instrument</u>
<u>V5011</u>	<u>Fitting, Orientation, Checking of Hearing instrument</u>
<u>V5014</u>	<u>Repair, Modification of Hearing Instrument</u>
<u>V5015</u>	<u>Hearing Instrument Repair Professional Fee</u>
<u>V5020</u>	<u>Conformity Evaluation</u>
<u>V5030</u>	<u>Hearing Instrument, Monaural, Body Aid Conduction</u>
<u>V5040</u>	<u>Hearing Instrument, Monaural, Body Worn, Bone Conduction</u>
<u>V5050</u>	<u>Hearing Instrument, Monaural, In the Ear Hearing</u>
<u>V5060</u>	<u>Hearing Instrument, Monaural, Behind the Ear Hearing</u>
<u>V5070</u>	<u>Glasses; Air Conduction</u>
<u>V5080</u>	<u>Glasses; Bone Conduction</u>
<u>V5090</u>	<u>Dispensing Fee, Unspecified Hearing Instrument</u>
<u>V5095</u>	<u>Semi-Implantable Middle Ear Hearing Prosthesis</u>
<u>V5100</u>	<u>Hearing Instrument, Bilateral, Body Worn</u>
<u>V5120</u>	<u>Binaural; Body</u>
<u>V5130</u>	<u>Binaural; In the Ear</u>
<u>V5140</u>	<u>Binaural; Behind the Ear</u>
<u>V5150</u>	<u>Binaural; Glasses</u>
<u>V5160</u>	<u>Dispensing Fee, Binaural</u>
<u>V5170</u>	<u>Hearing Instrument, Cros, In the Ear</u>
<u>V5180</u>	<u>Hearing Instrument, Cros, Behind the Ear</u>
<u>V5190</u>	<u>Hearing Instrument, Cros, Glasses</u>

<u>V5200</u>	<u>Dispensing Fee, Cros</u>
<u>V5210</u>	<u>Hearing Instrument, Bicos, In the Ear</u>
<u>V5220</u>	<u>Hearing Instrument, Bicos, Behind the Ear</u>
<u>V5230</u>	<u>Hearing Instrument, Bicos, Glasses</u>
<u>V5240</u>	<u>Dispensing Fee, Bicos</u>
<u>V5241</u>	<u>Dispensing Fee, Monaural Hearing Instrument, Any Type</u>
<u>V5242</u>	<u>Hearing Instrument, Analog, Monaural, CIC (Completely In the Ear Canal)</u>
<u>V5243</u>	<u>Hearing Instrument, Analog, Monaural, ITC (In the Canal)</u>
<u>V5244</u>	<u>Hearing Instrument, Digitally Programmable Analog, Monaural, CIC</u>
<u>V5245</u>	<u>Hearing Instrument, Digitally Programmable Analog, Monaural, ITC</u>
<u>V5246</u>	<u>Hearing Instrument, Digitally Programmable Analog, Monaural, ITE (In the Ear)</u>
<u>V5247</u>	<u>Hearing Instrument, Digitally Programmable Analog, Monaural, BTE (Behind the Ear)</u>
<u>V5248</u>	<u>Hearing Instrument, Analog, Binaural, CIC</u>
<u>V5249</u>	<u>Hearing Instrument, Analog, Binaural, ITC</u>
<u>V5250</u>	<u>Hearing Instrument, Digitally Programmable Analog, Binaural, CIC</u>
<u>V5251</u>	<u>Hearing Instrument, Digitally Programmable Analog, Binaural, ITC</u>
<u>V5252</u>	<u>Hearing Instrument, Digitally Programmable, Binaural, ITE</u>

<u>V5253</u>	<u>Hearing Instrument, Digitally Programmable, Binaural, BTE</u>
<u>V5254</u>	<u>Hearing Instrument, Digital, Monaural, CIC</u>
<u>V5255</u>	<u>Hearing Instrument, Digital, Monaural, ITC</u>
<u>V5256</u>	<u>Hearing Instrument, Digital, Monaural, ITE</u>
<u>V5257</u>	<u>Hearing Instrument, Digital, Monaural, BTe</u>
<u>V5258</u>	<u>Hearing Instrument, Digital, Binaural, CIC</u>
<u>V5259</u>	<u>Hearing Instrument, Digital, Binaural, ITC</u>
<u>V5260</u>	<u>Hearing Instrument, Digital, Binaural, ITE</u>
<u>V5261</u>	<u>Hearing Instrument, Digital, Binaural, BTE</u>
<u>V5262</u>	<u>Hearing Instrument, Disposable, Any Type, Monaural</u>
<u>V5263</u>	<u>Hearing Instrument, Disposable, Any Type, Binaural</u>
<u>V5264</u>	<u>Ear Mold (One (1) Ear Mold Per Year Per Ear and if Medically Necessary)</u>
<u>V5266</u>	<u>Hearing Instrument Battery (Limit of Four (4) Per Aid When Billed With A New Hearing Instrument Or A Replacement Aid)</u>
<u>V5267</u>	<u>Hearing Instrument Supplies, Accessories</u>
<u>V5299</u>	<u>Hearing Service Miscellaneous (May Be Used to Bill Warranty Replacement Hearing Instruments But Shall be Covered Only if Prior Authorized by the Department)</u>

1 [-]

2 Section 3. Vision Program Services. (1) Vision program coverage shall be limited to:

3 (a) A prescription service;

1 (b) A repair service made to a frame;

2 (c) A diagnostic service provided by:

3 1. An ophthalmologist; or

4 2. An optometrist to the extent the optometrist is licensed to perform the service.

5 (2) Eyeglass coverage shall:

6 (a) Be limited to a recipient who is under age twenty-one (21); and

7 (b) Not exceed:

8 1. \$200 per year for a recipient in the global choices benefit package; or

9 2. \$400 per year for a recipient in the comprehensive choices, family choices, or op-
10 timum choices benefit package.

11 (3) To be covered:

12 (a) A service designated as a physical medicine and rehabilitation service CPT code
13 shall require prior authorization if provided to a recipient age twenty-one (21) or over;

14 (b) A radiology service specified in 907 KAR 3:005, Physicians' Services, Section 5,
15 shall require prior authorization regardless of a recipient's age; ~~and~~

16 (c) A service shall be provided in accordance with the Vision Program Manual; and

17 (d) A lens shall be polycarbonate and scratch coated.

18 Section 4. Appeal Rights. (1) An appeal of a negative action regarding a Medicaid
19 recipient shall be in accordance with 907 KAR 1:563, Medicaid covered services hear-
20 ings and appeals.

21 (2) An appeal of a negative action regarding Medicaid eligibility of an individual shall
22 be in accordance with 907 KAR 1:560, Medicaid hearings and appeals regarding eligibil-
23 ity.

1 (3) An appeal of a negative action regarding a Medicaid provider shall be in accor-
2 dance with 907 KAR 1:671, Conditions of Medicaid provider participation; withholding
3 overpayments, administrative appeal process, and sanctions.

4 Section 5. Incorporation by Reference. (1) The following material is incorporated by
5 reference:

6 (a) "The Vision Program Manual, October 2007[~~2006~~] edition", Department for Medi-
7 caid Services; and

8 (b) "The Hearing Program Manual, October 2007[~~2006~~] edition", Department for
9 Medicaid Services.

10 (2) This material may be inspected, copied, or obtained, subject to applicable copy-
11 right law, at the Department for Medicaid Services, Cabinet for Health and Family Ser-
12 vices, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m.
13 to 4:30 p.m.

907 KAR 1:038

Reviewed:

Date

Shawn M. Crouch, Commissioner
Department for Medicaid Services

APPROVED:

Date

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

A public hearing on this administrative regulation shall, if requested, be held on January 21, 2008, at 9:00 a.m. in the Cabinet for Health and Family Services Health Services Board Room, Second Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by January 14, 2008, 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 January 31, 2008. 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 1:038

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 the provisions relating to hearing and vision services.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws that require provision of hearing and vision services to Kentucky's indigent citizenry.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation fulfills requirements implemented in KRS 194A.050(1) related to the execution of policies to establish and direct health programs mandated by federal law.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides the necessary criteria and denotes the limitations established in KRS 205.560(1) for the provision of medically necessary hearing and vision services to Medicaid recipients.

- (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 to hearing coverage specifies covered audiology codes and procedures as well as covered hearing instrument codes and procedures and updates coverage to current industry practice. Via the amendment, services covered are not expanded; however, the department will cover procedures in audiologists' offices which previously were only covered in physicians' offices. Additionally, the amendment mandates that all lenses be polycarbonate and scratch coated; updates the Vision Program Manual by eliminating archaic policy and forms, renders optometric coverage equivalent to physician coverage where appropriate, and categorizes procedural codes.
 - (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to clarify audiology and hearing instrument coverage and to alter coverage in order to ensure necessary care for recipients consistent with current industry practice. The amendment to vision coverage is necessary to reduce provider administrative burden and, thereby, encourage provider participation enhancing recipient access to care.
 - (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by clarifying audiology and hearing instrument coverage and altering coverage to ensure

- necessary care for recipients consistent with current industry practice. Additionally, the amendment reduces provider administrative burden and, thereby, encourages provider participation enhancing recipient access to care.
- (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by clarifying audiology and hearing instrument coverage and altering coverage to ensure necessary care for recipients consistent with industry practice. Additionally, the amendment reduces provider administrative burden and, thereby, encourages provider participation enhancing recipient access to care.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This amendment will affect all hearing service providers and vision service providers.
- (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 are not required to take any action to comply with the amendment.
- (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost is imposed on regulated entities as a result of the amendment.
- (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Recipients should benefit as lenses must be polycarbonate (more impact resistant) and scratch coated and should see increased provider participation as a result of the reduction of provider administrative burden.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: The Department for Medicaid Services (DMS) projects the amendments to the administrative regulation to be budget neutral.
- (b) On a continuing basis: DMS projects the amendments to the administrative regulation to be budget neutral.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of funding 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.
- (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: The current fiscal year budget will not need to be adjusted to provide funds for implementing 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 or increase any fees.
- (9) Tiering: Is tiering applied? Tiering is not applied.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:038 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? No local government entity is affected; however, the Department for Medicaid Services is affected.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. State laws authorization this action include 194A.030(2), 194A.050(1), 205.520(3). Federal regulations authorization this action include 42 CFR 433.56, 42 CFR 441.10 and 42 USC 1396d(a).

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? The amendment is not expected to generate any revenue for state or local government.

(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? The amendment is not expected to generate any revenue for state or local government.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services projects the amendment to be budget neutral.

(d) How much will it cost to administer this program for subsequent years? The DMS projects the amendment to be budget neutral.

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 1:038

Summary of Material Incorporated by Reference

(1) The "Hearing Program Manual" May 2006 edition is being replaced by the October 2007 edition in order to specify and update covered audiology codes and procedures and covered hearing instrument codes and procedures consistent with current industry practice. The audiology codes and procedures are located on page 16. The hearing instrument codes and procedures are located on pages 20 to 22. The "Hearing Program Manual" contains twenty-six (26) pages.

(2) The "Vision Program Manual" May 2006 edition is being replaced by the October 2007 edition in order to:

(a) Eliminate references to old Medicaid cards. Formerly, cards of different colors were issued to recipients; however, new cards all appear the same;

(b) Revised, page 3.2, medical records requirements to keep the manual consistent with 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation;

(c) Replaced, on page 3.3, references to the MAP 343 and the MAP 344 with references to the MAP 811 as the MAP 811 replaced the MAP 343 and MAP 344;

(d) Replaced, page 4.1, the old HCFA 1500 form with the current CMS 1500 form;

(e) Updated, page 4.2, the list of current procedural terminology (CPT) codes for optometry;

(f) Updated, page 4.3, CPT code 99214 and 99215 limits to render coverage consistent with physicians' services coverage;

(g) Deleted, page 4.6, old policy regarding number of boys and girls frames which must be kept in stock;

(h) Added, page 4.7, new requirement that all lenses shall be polycarbonate and scratch coated;

(i) Deleted, page 4.10, outdated language referencing "press-on prisms"; and

(j) Replaced, page 4.12, old list of billable CPT codes with reference to three (3) distinct ranges of codes.

The "Vision Program Manual" contains thirty-six (36) pages.

A total of sixty-two (62) pages are incorporated by reference.