

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 1:012. Inpatient hospital services.

6 RELATES TO: KRS 205.520

7 STATUTORY AUTHORITY: KRS 194A.050, 42 CFR 440.10, 42 USC 1396, a, b, d, r-
8 4[, ~~EO 2004-726~~]

9 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004,~~
10 ~~reorganized the Cabinet for Health Services and placed the Department for Medicaid~~
11 ~~Services and the Medicaid Program under the Cabinet for Health and Family Services.]~~

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

18 Section 1. Definitions.

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

20 (2) "Emergency" means a condition or situation which requires an emergency service
21 pursuant to 42 CFR 447.53.

1 (3) "Medical necessity" or "medically necessary" means that a covered benefit is
2 determined to be needed in accordance with 907 KAR 3:130

3 (4) "Non-emergency" means a condition which does not require an emergency service
4 pursuant to 42 CFR 447.53.

5 Section 2. Prior Authorization. To be covered by the department:

6 (1) A non-emergency admission, including an elective admission or a weekend
7 admission among other non-emergency admissions, prior to the admission, shall be
8 determined by the department to be:

9 (a) Medically necessary; and

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

11 (2) An emergency admission, within seventy-two (72) hours of the admission, shall be
12 determined by the department to be :

13 (a) Medically necessary; and

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

15 ~~[(1) To be covered by the department, a nonemergency admission, prior to the~~
16 ~~admission, shall be determined by the department to be:~~

17 ~~(a) Medically necessary; and~~

18 ~~(b) Effective August 1, 2006, clinically appropriate pursuant to the criteria established~~
19 ~~in 907 KAR 3:130.~~

20 ~~(2) The requirements established in subsection (1) of this Section shall not apply to an~~
21 ~~emergency admission.]~~ [Definition. "Medical necessity" or "medically necessary" means
22 that a covered benefit shall be:

23 ~~(1) Provided in accordance with 42 CFR 440.230;~~

1 ~~(2) Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate,~~
2 ~~palliate, or prevent a disease, illness, injury, disability, or other medical condition,~~
3 ~~including pregnancy;~~

4 ~~(3) Clinically appropriate in terms of amount, scope and duration based on generally-~~
5 ~~accepted standards of good medical practice;~~

6 ~~(4) Provided for medical reasons rather than primarily for the convenience of the~~
7 ~~recipient, caregiver, or the provider;~~

8 ~~(5) Provided in the most appropriate location, with regard to generally-accepted~~
9 ~~standards of good medical practice, where the service may for practical purposes be~~
10 ~~safely and effectively provided;~~

11 ~~(6) Needed, if used in reference to an emergency medical service, to evaluate or~~
12 ~~stabilize an emergency medical condition that is found to exist using the prudent~~
13 ~~layperson standard; and~~

14 ~~(7) If applicable, provided in accordance with early and periodic screening, diagnosis,~~
15 ~~and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR Part~~
16 ~~441.~~

17 ~~Section 2. Prior Authorization. A Nonemergency admission shall have prior approval of~~
18 ~~medical necessity by the designated peer review organization in order for the admission~~
19 ~~to be covered under the Medicaid Program. This requirement shall not apply to~~
20 ~~emergency admissions. Weekend stays associated with a Friday or Saturday admission~~
21 ~~for an elective surgical or diagnostic procedure shall not be reimbursed unless an~~
22 ~~emergency exists.]~~

23 Section 3. Covered Admissions.

1 (1) An admission [~~Admissions~~] primarily indicated in the management of acute or
2 chronic illness, injury or impairment, or for maternity care that could not be rendered on
3 an outpatient basis shall be covered.

4 (2) An admission [~~Admissions~~] relating to only observation or diagnostic purposes shall
5 not be covered.

6 (3) Cosmetic surgery shall not be covered except as required for prompt repair of
7 accidental injury or for the improvement of the functioning of a malformed or diseased
8 body member.

9 ~~[(4) Unless an emergency exists, a weekend stay associated with a Friday or Saturday~~
10 ~~admission for an elective surgical or diagnostic procedure shall not be covered by the~~
11 ~~department.~~

12 ~~[(5) In accordance with 907 KAR 1:013, an admission for less than twenty-four (24)~~
13 ~~hours shall not be approved or reimbursed.]~~

14 Section 4. Noncovered Services. Inpatient hospital services not covered shall include:

15 (1) A service which is not medically necessary including [~~to the patient's well-being,~~
16 ~~such as~~] television, telephone or guest meals;

17 (2) Private duty nursing;

18 (3) Supplies, drugs, appliances, or equipment which are furnished to the patient for use
19 outside the hospital unless it would be considered unreasonable or impossible from a
20 medical standpoint to limit the patient's use of the item to the periods during which he is
21 an inpatient;

22 (4) A laboratory test not specifically ordered by a physician and not done on a
23 preadmission basis unless an emergency exists;

1 (5) Private accommodations unless medically necessary and so ordered by the
2 attending physician; or

3 (6) The following listed surgical procedures, except if a life-threatening situation exists,
4 there is another primary purpose for the admission, or the admitting physician certifies a
5 medical necessity requiring admission to a hospital:

6 (a) Biopsy: breast, cervical node, cervix, lesions (skin, subcutaneous, submucous),
7 lymph node (except high axillary excision), or muscle;

8 (b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles,
9 polyps, warts or condylomas, anterior nose bleeds, or cervix;

10 (c) Circumcision;

11 (d) Dilation: dilation and curettage (diagnostic or therapeutic nonobstetrical); dilation or
12 probing of lacrimal duct;

13 (e) Drainage by incision or aspiration: cutaneous, subcutaneous, or joint;

14 (f) Pelvic exam under anesthesia;

15 (g) Excision: bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles),
16 sebaceous cyst, polyps, or subcutaneous fistulas;

17 (h) Extraction: foreign body or teeth;

18 (i) Graft, skin (pinch, splint or full thickness up to defect size three-fourths (3/4) inch
19 diameter);

20 (j) Hymenotomy;

21 (k) Manipulation and reduction with or without x-ray; cast change: dislocations
22 depending upon the joint and indication for procedure or fractures;

23 (l) Meatotomy or urethral dilation, removal calculus and drainage of bladder without

- 1 incision;
- 2 (m) Myringotomy with or without tubes, otoplasty;
- 3 (n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy,
- 4 bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy,
- 5 gastroscopy, hysteroscopy, laryngoscopy, laparoscopy, peritoneoscopy, otoscopy, and
- 6 sigmoidoscopy or procto sidmoidoscopy;
- 7 (o) Removal; IUD, fingernail or toenails;
- 8 (p) Tenotomy hand or foot;
- 9 (q) Vasectomy; or
- 10 (r) Z-plasty for relaxation of scar or contracture.

907 KAR 1:012
(Amended after Comments)

REVIEWED:

Date

Glenn Jennings, Commissioner
Department for Medicaid Services

Date

Mike Burnside, Undersecretary
Administrative and Fiscal Affairs

APPROVED:

Date

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

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:012

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 coverage provisions for inpatient hospital care.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions for inpatient hospital care.
 - (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 inpatient hospital care coverage 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 the authorizing statutes by establishing inpatient hospital care coverage 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 establishes the utilization of clinical criteria by the department to determine the appropriateness of any given service. The amended after comments regulation removes from the original amendment Section 3(4) and (5), which would have exempted from Medicaid coverage: 1) a hospital admission for less than 24 hours; or 2) a weekend stay associated with a Friday or Saturday admission for an elective surgical or diagnostic procedure that is not considered an emergency.
 - (b) The necessity of the amendment to this administrative regulation: The amendment to this administrative regulation and amended after comments regulation are necessary to ensure appropriateness of care and to maintain the viability of the Medicaid program.
 - (c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation and amended after comments regulation conform to the content of the authorizing statutes by establishing the use of clinical criteria to determine the appropriateness of care.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation and amended after comments regulation assist in the effective administration of the statutes by establishing the use of clinical criteria to determine the appropriateness of care.

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect all inpatient hospital service providers participating in the

Kentucky Medicaid Program.

- (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: To comply with this administrative regulation, inpatient hospital providers will be reimbursed for nonemergency admissions only if such admissions are determined, prior to admission, to be medically necessary and clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (c): No costs are required of regulated entities for compliance with this amendment and amended after comments regulation.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The amendment to this administrative regulation and amended after comments regulation establishes the use of criteria by the Department for Medicaid Services to determine the clinical appropriateness of any given care as well as clarify services requiring prior authorization.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) anticipates a one (1) percent reduction in expenditures for any given procedure for which the clinically appropriate criteria is the prior authorization tool.
 - (b) On a continuing basis: DMS anticipates a one (1) percent reduction in expenditures for any given procedure for which the clinically appropriate criteria is the prior authorization tool.
- (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? (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 1:012

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? This administrative regulation and amended after comments regulation will affect all inpatient hospital service providers participating in the Kentucky Medicaid Program.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.
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? DMS anticipates a one (1) percent reduction in expenditures for any given procedure for which the clinically appropriate criteria is the prior authorization tool.
 - (d) How much will it cost to administer this program for subsequent years? DMS anticipates a one (1) percent reduction in expenditures for any given procedure for which the clinically appropriate criteria is the prior authorization tool.

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.