

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 1:014. Outpatient hospital services.

6 RELATES TO: KRS 205.520, 42 CFR 447.53

7 STATUTORY AUTHORITY: KRS 194A.050[, ~~EO 2004-726~~]

8 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004,~~

9 ~~reorganized the Cabinet for Health Services and placed the Department for Medicaid~~

10 ~~Services and the Medicaid Program under the Cabinet for Health and Family Services.]~~

11 The Cabinet for Health and Family Services has responsibility to administer the program

12 of Medical Assistance in accordance with Title XIX of the Social Security Act. KRS

13 205.520 empowers the cabinet, by administrative regulation, to comply with any

14 requirement that may be imposed or opportunity presented by federal law for the provision

15 of medical assistance to Kentucky's indigent citizenry. This administrative regulation sets

16 forth the provisions relating to outpatient hospital services for which payment shall be

17 made by the medical assistance program on behalf of [~~in behalf of both~~] the categorically

18 needy and medically needy.

19 Section 1. Definitions.

20 (1) "Comprehensive choices" means comprehensive choices as defined in 907 KAR

21 1:900, Section 1.

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

2 (3)[(2)] "Emergency" means that a condition or situation requires an emergency service
3 pursuant to 42 CFR 447.53.

4 (4) "Family choices" means family choices as defined in 907 KAR 1:900, Section 1.

5 (5) "Global choices" means global choices as defined in 907 KAR 1:900, Section 1.

6 (6) [(3)] "Medical necessity" or "medically necessary" means that a covered benefit is
7 determined to be needed in accordance with 907 KAR 3:130.

8 (7) [(4)] "Non-emergency" means that a condition does not require an emergency
9 service pursuant to 42 CFR 447.53.

10 (8) "Optimum choices" means optimum choices as defined in 907 KAR 1:900, Section
11 1.

12 Section 2. Coverage [Covered] Criteria.

13 (1) To be covered by the department:

14 (a) The following services shall be prior authorized and meet the requirements
15 established in paragraph (b)1. and 2. of this subsection:

16 1. Magnetic resonance imaging (MRI);

17 2. Magnetic resonance angiogram (MRA);

18 3. Magnetic resonance spectroscopy;

19 4. Positron emission tomography (PET);

20 5. Cineradiography/videoradiography;

21 6. Xeroradiography;

22 7. Ultrasound subsequent to second (2nd) obstetric ultrasound;

23 8. Myocardial imaging;

- 1 9. Cardiac blood pool imaging;
- 2 10. Radiopharmaceutical procedures;
- 3 11. Gastric restrictive surgery or gastric bypass surgery;
- 4 12. A procedure that is commonly performed for cosmetic purposes;
- 5 13. A surgical procedure that requires completion of a federal consent form; or
- 6 14. An unlisted procedure or service.
- 7 ~~1. Outpatient surgery (performed in an outpatient hospital setting);~~
- 8 ~~2. Cardiac catheterization;~~
- 9 ~~3. Lithotripsy;~~
- 10 ~~4. Computed tomography (CT) imaging;~~
- 11 ~~5. Computed tomographic angiography (CTA);~~
- 12 ~~6. Computed tomography guidance;~~
- 13 ~~7. Magnetic resonance imaging (MRI);~~
- 14 ~~8. Magnetic resonance angiogram (MRA);~~
- 15 ~~9. Magnetic resonance spectroscopy;~~
- 16 ~~10. Positron emission tomography (PET);~~
- 17 ~~11. Dual energy X-ray absorptiometry (DXA);~~
- 18 ~~12. Radiographic absorptiometry;~~
- 19 ~~13. Cineradiography/videoradiography;~~
- 20 ~~14. Xeroradiography;~~
- 21 ~~15. Ultrasound subsequent to second (2nd) obstetric ultrasound;~~
- 22 ~~16. Unlisted procedure;~~
- 23 ~~17. Myocardial imaging;~~

1 18. Cardiac blood pool imaging;

2 19. Single Photon Emission Computed Tomography (SPECT);

3 20. Sensory nerve conduction test (SNCT);

4 21. Magnetic resonance cholangiopancreatography (MRCP);

5 22. Topographic brain mapping;

6 23. Magnetic source imaging;

7 24. Fluorine eighteen (18) fluorodeoxyglucose (F-eighteen (18) FDG) imaging;

8 25. Electron beam computed tomography (also known as Ultrafast CT, Cine CT); and

9 26. Magnetic Resonance Technology (MRT) General.]

10 (b) An outpatient hospital service, including those [not] identified in paragraph (a) of
11 this subsection shall be:

12 1. Medically necessary; and

13 2. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

14 (2) The prior authorization requirements established in subsection (1) of this section
15 shall not apply to:

16 (a) An emergency service; or

17 (b) A radiology procedure if the member has a cancer or transplant diagnosis code.

18 (3) A referring physician, a physician who wishes to provide a given service, or an
19 advanced registered nurse practitioner may request prior authorization from the
20 department.

21 (4) The [A] following covered hospital outpatient services shall be furnished by or under
22 the supervision of a duly licensed physician, or if applicable, a duly licensed dentist:

23 (a) A diagnostic service ordered by a physician;

- 1 (b) A therapeutic service, except for occupational therapy, ordered by a physician;
- 2 (c) An emergency room service provided in an emergency situation as determined by a
- 3 physician; or
- 4 (d) A drug, biological, or injection administered in the outpatient hospital setting.
- 5 (5) A covered hospital outpatient service for maternity care may be provided by:
- 6 (a) An advanced registered nurse practitioner (ARNP) who has been designated by the
- 7 Kentucky Board of Nursing as a nurse midwife; or
- 8 (b) A registered nurse who holds a valid and effective permit to practice nurse
- 9 midwifery issued by the Cabinet for Health and Family Services.

10 Section 3. Hospital Outpatient Services not Covered by the Department. The following

11 services shall not be considered a covered hospital outpatient service:

- 12 (1) An item or service that does not meet the requirements established in Section 2(1);
- 13 (2) A service for which:
- 14 (a) An individual has no obligation to pay; and
- 15 (b) No other person has a legal obligation to pay;
- 16 (3) A medical supply or appliance, unless it is incident to the performance of a
- 17 procedure or service in the hospital outpatient department and included in the rate of
- 18 payment established by the Medical Assistance Program for hospital outpatient services;
- 19 (4) A drug, biological, or injectable purchased by or dispensed to a patient; or
- 20 (5) A routine physical examination.

21 Section 4. Therapy Limits.

- 22 (1) Speech therapy shall be limited to:
- 23 (a) Ten (10) visits per twelve (12) months for a member of the Global Choices benefit

1 package;

2 (b) Thirty (30) visits per twelve (12) months for a member of the:

3 1. Comprehensive Choices benefit package; or

4 2. Optimum Choices benefit package; and

5 (c) Fifteen (15) visits per twelve (12) months for a member of the Family Choices
6 benefit package.

7 (2) Physical therapy shall be limited to:

8 (a) Fifteen (15) visits per twelve (12) months for a member of the Global Choices
9 benefit package;

10 (b) Thirty (30) visits per twelve (12) months for a member of the:

11 1. Comprehensive Choices benefit package; or

12 2. Optimum Choices benefit package; and

13 (c) Fifteen (15) visits per twelve (12) months for a member of the Family Choices
14 benefit package.

15 (3) The therapy limits established in subsection (1) and (2) of this section shall be soft,
16 meaning that they may be over-ridden if the department determines that additional visits
17 beyond the limit are medically necessary.

18 (4) Except for recipients under age twenty-one (21), prior authorization is required for
19 each visit that exceeds the limit established in subsection (1) and (2) of this section.

20 ~~[Hospital Outpatient Services Covered by the Medical Assistance Program. There are no~~
21 ~~limitations on the number of hospital outpatient visits or services available to program~~
22 ~~recipients.~~

23 ~~(1) Hospital outpatient services to be covered, as listed below, shall be prescribed by,~~

1 ~~or in the case of emergency room services, determined to be medically necessary by a~~
2 ~~duly licensed physician, or if applicable, a duly licensed dentist, for the care and~~
3 ~~treatment indicated in the management of illness, injury, impairment or maternity care, or~~
4 ~~for the purpose of determining the existence of an illness or condition in a patient. The~~
5 ~~services shall be furnished by or under the supervision of a duly licensed physician, or if~~
6 ~~applicable, a duly licensed dentist.~~

7 ~~(a) Diagnostic services as ordered by a physician.~~

8 ~~(b) Therapeutic services as ordered by a physician.~~

9 ~~(c) Emergency room services in emergency situations as determined by a physician.~~

10 ~~(d) Effective with regard to services provided on or after July 1, 1990, drugs,~~
11 ~~biologicals, or injections administered in the outpatient hospital setting.~~

12 ~~(2) Hospital outpatient services for maternity care may be provided by an advanced~~
13 ~~registered nurse practitioner (ARNP) who has been designated by the Kentucky Board of~~
14 ~~Nursing as a nurse midwife or by a registered nurse who holds a valid and effective permit~~
15 ~~to practice nurse midwifery issued by the Cabinet for Human Resources.~~

16 ~~Section 2. Hospital Outpatient Services not Covered by the Medical Assistance~~
17 ~~Program.~~

18 ~~(1) Items and services which are not reasonable and necessary for or related to the~~
19 ~~diagnosis or treatment of illness or injury, impairment or maternity care.~~

20 ~~(2) Services for which the individual has no obligation to pay and for which no other~~
21 ~~person has a legal obligation to provide or to pay.~~

22 ~~(3) Medical supplies and appliances except those incident to the performance of~~
23 ~~services in the hospital outpatient department and which are included in the rate of~~

- 1 ~~payment established by the Kentucky Medical Assistance Program for hospital outpatient~~
- 2 ~~services.~~
- 3 ~~(4) Drugs, biologicals and injectables purchased by or dispensed to a patient.~~
- 4 ~~(5) Routine physical examinations.]~~

907 KAR 1:014
(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 1:014

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 outpatient hospital services.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions for outpatient hospital services.
 - (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 the coverage provisions for outpatient hospital services.
 - (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 statutes by establishing the coverage provisions 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 establishes the use of criteria by the Department to determine the clinical appropriateness of delivered services as well as clarifies services requiring prior authorization. The amended after comments regulation includes in Section 2(1) a revised list of services that require prior authorization. The amended after comments regulation further clarifies that prior authorization is not required for any radiology procedure if the patient has a cancer or transplant diagnosis code. Also, the amended after comments regulation establishes soft limits on speech and physical therapy services.
 - (b) The necessity of the amendment to this administrative regulation: This amendment and amended after comments regulation is necessary to ensure the viability of the Medicaid program and to ensure the appropriateness of care provided to Medicaid recipients.
 - (c) How the amendment conforms to the content of the authorizing statutes: This amendment and amended after comments regulation conform to the content of the authorizing statutes by establishing the use of criteria by the department to determine the clinical appropriateness of delivered services.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment and amended after comments regulation assist in the effective administration of the statutes by establishing the use of criteria by the department to determine the clinical appropriateness of delivered services.

- (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 outpatient 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 and amended after comments regulation, outpatient hospital service providers will be subject to prior authorization requirements for designated procedures. Additionally, in order to be reimbursed, a service provided by an outpatient hospital must be clinically appropriate pursuant to 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 (3): 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): This amendment and amended after comments regulation establish 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: No increase in fees or funding is 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: 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 1:014

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 outpatient 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? 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) 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 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.
 - (c) How much will it cost to administer this program for the first year? 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.

(d) How much will it cost to administer this program for subsequent years? 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.

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.