

STATEMENT OF EMERGENCY

907 KAR 1:014E

- (1) This emergency administrative regulation is being promulgated to:
- (a) Curtail excessive and inappropriate utilization of care in emergency departments in accordance with KRS 205.8453 and KRS 205.6310; and
 - (b) Establish that the Department for Medicaid Services shall not reimburse for a non-emergency service provided to a lock-in recipient if the service is provided in an emergency department of a hospital or is provided by a hospital which is not the designated hospital for the lock-in recipient.
- (2) This action must be implemented on an emergency basis to ensure the availability of funding necessary for the continued operation of the Medicaid program; thus, protecting the health, welfare and safety of Medicaid recipients.
- (3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.
- (4) The ordinary administrative regulation is identical to this emergency administrative regulation.

Steven L. Beshear
Governor

Janie Miller, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Healthcare Facilities Management

4 (Emergency Amendment)

5 907 KAR 1:014E. Outpatient hospital services.

6 RELATES TO: KRS 205.520, 42 C.F.R. 447.53

7 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560,
8 205.6310, 205.8453,[194.050]

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
10 Services, Department for Medicaid Services, has responsibility to administer the Medi-
11 caid Program. KRS 205.520 empowers the cabinet, by administrative regulation, to
12 comply with any requirement that may be imposed or opportunity presented by federal
13 law for the provision of medical assistance to Kentucky's indigent citizenry. This admin-
14 istrative regulation establishes the provisions relating to outpatient hospital services for
15 which payment shall be made by the medical assistance program on behalf of the cate-
16 gorically needy and medically needy.

17 Section 1. Definitions. (1) "Comprehensive choices" means a benefit plan for an indi-
18 vidual who:

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

20 (b) Receives services through either:

21 1. A nursing facility in accordance with 907 KAR 1:022;

1 2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

2 3. The Home and Community Based Waiver Program in accordance with 907 KAR

3 1:160; or

4 4. The Model Waiver II Program in accordance with 907 KAR 1:595;

5 5. The Acquired Brain Injury Long Term Care Waiver Program in accordance with

6 907 KAR 3:210;

7 6. The Michelle P. Waiver Program in accordance with 907 KAR 1:835; and

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

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

10 (3) "Emergency" means that a condition or situation requires an emergency service

11 pursuant to 42 C.F.R. 447.53.

12 (4) Emergency medical condition" is defined by 42 USC 1395dd(e)(1).

13 (5)[(4)] "Family choices" means a benefit plan for an individual who:

14 (a) Is covered pursuant to:

15 1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u - 1;

16 2. 42 U.S.C. 1396a(a)(52) and 1396r - 6 (excluding children eligible under Part A or

17 E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

18 3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

19 4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

20 5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

21 6. 42 C.F.R. 457.310; and

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

23 (6)[(5)] "Global choices" means the department's default benefit plan, consisting of

1 individuals designated with a package code of A, B, C, D, or E and who are included in
2 one (1) of the following populations:

3 (a) Caretaker relatives who:

- 4 1. Receive K-TAP and are deprived due to death, incapacity, or absence;
- 5 2. Do not receive K-TAP and are deprived due to death, incapacity, or absence; or
- 6 3. Do not receive K-TAP and are deprived due to unemployment;

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

- 8 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
9 1:022; or
- 10 2. Receive SSP and do not meet nursing facility patient status criteria in accordance
11 with 907 KAR 1:022;

12 (c) Blind individuals who receive SSI and:

- 13 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
14 1:022; or
- 15 2. SSP, and do not meet nursing facility patient status criteria in accordance with 907
16 KAR 1:022;

17 (d) Disabled individuals who receive SSI and:

- 18 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
19 1:022, including children; or
- 20 2. SSP, and do not meet nursing facility patient status criteria in accordance with 907
21 KAR 1:022;

22 (e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are
23 eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient

1 status criteria in accordance with 907 KAR 1:022;

2 (f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through"
3 Medicaid benefits, and do not meet nursing facility patient status in accordance with
4 907 KAR 1:022;

5 (g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass
6 through" Medicaid benefits, and do not meet nursing facility patient status in accor-
7 dance with 907 KAR 1:022; or

8 (h) Pregnant women.

9 (7) "Lock-in recipient" means a recipient enrolled in the department's lock-in program
10 pursuant to 907 KAR 1:677.

11 (8)[(6)] "Medical necessity" or "medically necessary" means that a covered benefit is
12 determined to be needed in accordance with 907 KAR 3:130.

13 (9)[(7)] "Nonemergency" means that a condition or situation does not require an
14 emergency service pursuant to 42 C.F.R. 447.53.

15 (10)[(8)] "Optimum choices" means a benefit plan for an individual who:

16 (a) Meets the intermediate care facility for individuals with mental retardation or a de-
17 velopmental disability patient status criteria established in 907 KAR 1:022;

18 (b) Receives services through either:

19 1. An intermediate care facility for individuals with mental retardation or a develop-
20 mental disability patient status criteria established in 907 KAR 1:022; or

21 2. The Supports for Community Living Waiver Program in accordance with 907 KAR
22 1:145; and

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

1 (11) "Recipient" is defined by KRS 205.8451(9).

2 (12)[(9)] "Unlisted procedure or service" means a procedure for which there is not a
3 specific CPT code and which is billed using a CPT code designated for reporting un-
4 listed procedures or services.

5 Section 2. Coverage Criteria. (1) To be covered by the department:

6 (a) The following services shall be prior authorized and meet the requirements estab-
7 lished in paragraph (b) 1, 2 and 3~~and 2~~ of this subsection:

- 8 1. Magnetic resonance imaging (MRI);
- 9 2. Magnetic resonance angiogram (MRA);
- 10 3. Magnetic resonance spectroscopy;
- 11 4. Positron emission tomography (PET);
- 12 5. Cineradiography/videoradiography;
- 13 6. Xeroradiography;
- 14 7. Ultrasound subsequent to second obstetric ultrasound;
- 15 8. Myocardial imaging;
- 16 9. Cardiac blood pool imaging;
- 17 10. Radiopharmaceutical procedures;
- 18 11. Gastric restrictive surgery or gastric bypass surgery;
- 19 12. A procedure that is commonly performed for cosmetic purposes;
- 20 13. A surgical procedure that requires completion of a federal consent form; or
- 21 14. An unlisted procedure or service; and

22 (b) An outpatient hospital service, including those identified in paragraph (a) of this
23 subsection, shall be:

- 1 1. Medically necessary; ~~and~~
- 2 2. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and
- 3 3. For a lock-in recipient, except for a screening to determine if the lock-in recipient
- 4 has an emergency medical condition in accordance with Section 3(2) of this administra-
- 5 tive regulation, only provided by the lock-in recipient's designated hospital pursuant to
- 6 907 KAR 1:677.

7 (2) The prior authorization requirements established in subsection (1) of this section

8 shall not apply to:

9 (a) An emergency service;

10 (b) A radiology procedure if the recipient has a cancer or transplant diagnosis code;

11 or

12 (c) A service provided to a recipient in an observation bed.

13 (3) A referring physician, a physician who wishes to provide a given service, or an

14 advanced registered nurse practitioner may request prior authorization from the de-

15 partment.

16 (4) The following covered hospital outpatient services shall be furnished by or under

17 the supervision of a duly licensed physician, or if applicable, a duly-licensed dentist:

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

19 (b) A therapeutic service, except for occupational therapy, ordered by a physician;

20 (c) An emergency room service provided in an emergency situation as determined by

21 a physician; or

22 (d) A drug, biological, or injection administered in the outpatient hospital setting.

23 ~~(5)~~ (4) A covered hospital outpatient service for maternity care may be provided by:

1 (a) An advanced registered nurse practitioner (ARNP) who has been designated by
2 the Kentucky Board of Nursing as a nurse midwife; or

3 (b) A registered nurse who holds a valid and effective permit to practice nurse midwi-
4 fery issued by the Cabinet for Health and Family Services.

5 (6) The department shall cover:

6 (a) A screening of a lock-in recipient to determine if the lock-in recipient has an
7 emergency medical condition; or

8 (b) An emergency service to a lock-in recipient if the department determines that the
9 lock-in recipient had an emergency medical condition when the service was provided.

10 Section 3. Hospital Outpatient Services Not Covered by the Department. (1) The fol-
11 lowing services shall not be considered a covered hospital outpatient service:

12 (a)[(1)] An item or service that does not meet the requirements established in Section
13 2(1) of this administrative regulation;

14 (b)[(2)] A service for which:

15 1.[(a)] An individual has no obligation to pay; and

16 2.[(b)] No other person has a legal obligation to pay;

17 (c)[(3)] A medical supply or appliance, unless it is incidental to the performance of a
18 procedure or service in the hospital outpatient department and included in the rate of
19 payment established by the Medical Assistance Program for hospital outpatient servic-
20 es;

21 (d)[(4)] A drug, biological, or injection purchased by or dispensed to a patient; or

22 (e)[(5)] A routine physical examination.

23 (f) A nonemergency service, other than a screening in accordance with subsection

- 1 (2) of this section, provided to a lock-in recipient:
2 1. In an emergency department of a hospital; or
3 2. If provided by a hospital which is not the lock-in recipient's designated hospital
4 pursuant to 907 KAR 1:677.

5 Section 4. Therapy Limits. (1) Speech therapy shall be limited to:

6 (a) Ten (10) visits per twelve (12) months for a recipient of the Global Choices bene-
7 fit package;

8 (b) Thirty (30) visits per twelve (12) months for a recipient of the:

9 1. Comprehensive Choices benefit package; or

10 2. Optimum Choices benefit package.

11 (2) Physical therapy shall be limited to:

12 (a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices
13 benefit package;

14 (b) Thirty (30) visits per twelve (12) months for a recipient of the:

15 1. Comprehensive Choices benefit package; or

16 2. Optimum Choices benefit package.

17 (3) The therapy limits established in subsections (1) and (2) of this section shall be
18 over-ridden if the department determines that additional visits beyond the limit are med-
19 ically necessary.

20 (a) To request an override:

21 1. The provider shall telephone or fax the request to the department; and

22 2. The department shall review the request in accordance with the provisions of 907

23 KAR 3:130 and notify the provider of its decision.

1 (b) An appeal of a denial regarding a requested override shall be in accordance with
2 907 KAR 1:563.

3 (4) Except for recipients under age twenty-one (21), prior authorization shall be re-
4 quired for each visit that exceeds the limit established in subsections (1) and (2) of this
5 section.

6 (5) The limits established in subsections (1) and (2) of this section shall not apply to
7 a recipient under twenty-one (21) years of age.

907 KAR 1:014E

REVIEWED:

Date

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:014E

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Jill Hunter (502) 564-5707, Darlene Burgess (502) 564-6511
or Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes Medicaid outpatient hospital service provisions.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid outpatient hospital service provisions.
 - (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 Medicaid outpatient 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 the statutes by establishing Medicaid outpatient 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: DMS is amending outpatient hospital coverage related to lock-in program recipients. The lock-in program is a Medicaid program to curtail excessive and inappropriate utilization of Medicaid services and is established via 907 KAR 1:677. The amendment establishes that DMS will not reimburse for non-emergency services provided to a lock-in recipient in an emergency department of a hospital or if provided by a hospital which is not the lock-in recipient's designated hospital. Additionally, DMS will reimburse for a screening of a lock-in recipient to determine if the individual has an emergency medical condition and will reimburse for emergency services if the lock-in recipient has an emergency medical condition.
 - (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to control excessive Medicaid utilization in accordance with KRS 205.8453 and KRS 205.6310 and to ensure the availability of funding necessary for the continued operation of the Medicaid program; thus, protecting the health, safety, and welfare of Medicaid recipients.
 - (c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 205.8453 and KRS 205.6310 by curtailing excessive Medicaid emergency room utilization.
 - (d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by KRS 205.8453 and KRS 205.6310 by curtailing excessive

Medicaid emergency room utilization.

- (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 hospitals providing outpatient services.
- (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: Outpatient hospitals will have to ensure, when providing care for a lock-in recipient, that they do not provide MRIs, MRAs, PETs and related to the recipient if they are not the designated hospital for that lock-in recipient.
 - (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 the regulated entities.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Outpatient hospitals as a whole may benefit in that Medicaid funds which have been expended due to excessive utilization with lock-in recipients will be reduced; thus, preserving Medicaid funds for appropriate utilization and reimbursement.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) anticipates minimal administrative costs associated with Medicaid Management Information System (MMIS) programming to implement the amendment initially. DMS anticipates reducing expenditures by approximately \$100,000 (federal and state combined) annually by implementing the amendment.
 - (b) On a continuing basis: DMS does not anticipate subsequent year costs related to the amendment and estimates reducing expenditures by approximately \$100,000 (state and federal combined) annually as a result of the amendment.
- (6) 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.
- (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 amendment, including the amendment after comments, does not establish any fees, nor does it directly or indirectly increase any fees

- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment, including the amendment after comments, does not establish or increase any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Critical access outpatient hospital reimbursement differs from other outpatient hospital reimbursement as critical access hospital reimbursement is established in federal regulation. The amendment is applied to lock-in recipients only as they are recipients which have been identified as excessively and/or inappropriately utilizing Medicaid services.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative regulation number: 907 KAR 1:014E

Contact Person: Jill Hunter (502) 564-5707, Darlene Burgess (502) 564-6511 or Stuart Owen (502) 564-4321

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 hospital services including the county and state owned are affected by this amendment. The Department for Medicaid Services will also be affected by the amendment.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030, 194A.050, 205.520, 205.560, 205.6310, 205.8453, 42 USC 1396d(a)(2)(A), 42 CFR 440.20, 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? The amendment is not expected to generate 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 is not expected to generate 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? The Department for Medicaid Services (DMS) anticipates minimal administrative costs associated with Medicaid Management Information System (MMIS) programming to implement the amendment initially. DMS anticipates reducing expenditures by approximately \$100,000 (federal and state combined) annually by implementing the amendment.
 - (d) How much will it cost to administer this program for subsequent years? DMS does not anticipate subsequent year costs related to the amendment and esti-

mates reducing expenditures by approximately \$100,000 (state and federal combined) annually by implementing this amendment.

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.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:014E

Contact Person: Jill Hunter (502) 564-5707, Darlene Burgess (502) 564-6511 or Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. The amendment is not mandated, but 42 USC 1396d(a)(2)(A), 42 CFR 440.20, 42 CFR 440.210 and 42 CFR 440.220 address Medicaid outpatient hospital service requirements.
2. State compliance standards. KRS 205.8453 charges the Cabinet for Health and Family Services and the Department for Medicaid Services with instituting "other measures necessary or useful in controlling fraud and abuse."

KRS 205.6310 states, "The Cabinet for Health and Family Services shall establish a system within the Medical Assistance Program to reduce unnecessary hospital emergency room utilization and costs by redefining and controlling hospital emergency utilization. The cabinet shall establish by promulgation of administrative regulations, pursuant to KRS Chapter 13A, the following:

- (1) Criteria and procedures, at least annually updated, that differentiate children and adults, and which conform to the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. sec. 1395dd), as amended, and any other applicable federal law or regulation for determining if a medical emergency exists;
- (2) Reimbursement rates that provide for nominal reimbursement of emergency room care for care that does not meet the criteria established for a medical emergency;
- (3) Reimbursement, at rates determined by the cabinet, for ancillary services which, based upon the symptoms of the patient, are medically appropriate to determine if a medical emergency exists;
- (4) Except for emergency room services rendered to children under the age of six (6), prohibition of reimbursement at hospital emergency room rates for diagnosis and treatment for a condition that does not meet the criteria established for a medical emergency; and
- (5) The provisions of this section shall apply to any managed care program for Medicaid recipients."

3. Minimum or uniform standards contained in the federal mandate. Outpatient hospital services are required services for the categorically needy. To the extent that outpatient hospital services constitute ambulatory services as defined in a state Medicaid plan, they also are required if the plan covers the medically needy.

Outpatient hospital services are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished to outpatients in an institution licensed or formally approved as a hospital by an officially designated authority for state standard setting. The institution must meet requirements for participation in Medicare and Medicaid as a hospital, and services must be furnished under the direction of a physician or a dentist. A state's Medicaid agency may exclude from the definition of out-

patient hospital services items and services not generally furnished by most hospitals in the state.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This amendment does not impose stricter than federal requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment does not impose stricter than federal requirements.