CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Hospital and Provider Operations

(Amendment)

907 KAR 3:010. Reimbursement for physicians' services.

RELATES TO: KRS 205.560, 42 C.F.R. 440.50, 447 Subpart B, 42 U.S.C. 1396a, b, c, d, s

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method of reimbursement for physicians' services by the Medicaid Program.

Section 1. Definitions. (1) "Add-on code" or "add-on service" means a service designated by a specific CPT code which may be used in conjunction with another CPT code to denote that an adjunctive service has been performed.

(2) "Assistant surgeon" means a physician who attends and acts as an auxiliary to a physician performing a surgical procedure.

(3) "Average wholesale price" or "AWP" means the average wholesale price pub

lished in a nationally-recognized comprehensive drug data file for which the department has contracted.

(4) "CPT code" means a code used for reporting procedures and services performed by physicians and published annually by the American Medical Association in Current Procedural Terminology.

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

(6) "Established patient" means one who has received professional services from the provider within the past three (3) year period.

(7) "Global period" means the period of time in which related preoperative, intraoperative, and postoperative services and follow-up care for a surgical procedure are customarily provided.

(8) "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:

(a) Requires few additional physician resources; or

(b) Is clinically integral to the performance of the primary procedure.

(9) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(10) "Locum tenens" means a substitute physician:

(a) Who temporarily assumes responsibility for the professional practice of a physician participating in the Kentucky Medicaid Program; and

(b) Whose services are paid under the participating physician's provider number.

(11) "Major surgery" means a surgical procedure assigned a ninety (90) day global period.

(12) "Medicaid Physician Fee Schedule" means a list of current reimbursement rates for physician services established by the department in accordance with Section 3 of this administrative regulation.

(13) "Minor surgery" means a surgical procedure assigned a ten (10) day global period.

(14) "Modifier" means a reporting indicator used in conjunction with a CPT code to denote that a medical service or procedure that has been performed has been altered by a specific circumstance while remaining unchanged in its definition or CPT code.

(15) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one another during the same patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically impossible or improbable use of CPT codes; or

(d) Are described in Current Procedural Terminology as inappropriate coding of procedure combinations.

(16) "Physician assistant" is defined in KRS 311.840(3).

(17) "Physician group practice" means two (2) or more licensed physicians who have enrolled both individually and as a group and share the same Medicaid group provider number.

(18) "Professional component" means the physician service component of a service or procedure that has both a physician service component and a technical component.

(19) "Relative value unit" or "RVU" means the Medicare-established value assigned to a CPT code which takes into consideration the physician’s work, practice expense

and liability insurance.

(20) "Resource-based relative value scale" or "RBRVS" means the product of the relative value unit (RVU) and a resource-based dollar conversion factor.

(21) "Technical component" means the part of a medical procedure performed by a technician, inclusive of all equipment, supplies, and drugs used to perform the procedure.

(22) "Usual and customary charge" means the uniform amount which a physician charges the general public for a specific medical procedure or service.

Section 2. Reimbursement. (1) Reimbursement for a covered service shall be made to:

(a) The individual participating physician; or

(b) A physician group practice enrolled in the Kentucky Medicaid Program.

(2) Except as provided in subsections (3) to (9)[~~(8)~~] of this section, reimbursement for a covered service shall be the lesser of:

(a) The physician's usual and customary charge; or

(b) The amount specified in the Medicaid Physician Fee Schedule established in accordance with Section 3 of this administrative regulation.

(3) If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be forty-five (45) percent of the usual and customary billed charge.

(4) Reimbursement for a service covered under Medicare Part B shall be made in accordance with 907 KAR 1:006, Section 3.

(5) If cost-sharing is required for a service to a recipient, the cost-sharing provisions established in 907 KAR 1:604 shall apply.

(6) Reimbursement for a service denoted by a modifier used in conjunction with a CPT code shall be as follows:

(a) A second anesthesia service provided by a provider to a recipient on the same date of service and reported by the addition of the two (2) digit modifier twenty-three (23) shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable CPT code;

(b) A professional component of a service reported by the addition of the two (2) digit modifier twenty-six (26) shall be reimbursed at the product of:

1. The Medicare value assigned to the physician's work; and

2. The dollar conversion factor specified in Section 3(2) of this administrative regulation;

(c) A technical component of a service reported by the addition of the two (2) letter modifier "TC" shall be reimbursed at the product of:

1. The Medicare value assigned to the practice expense involved in the performance of the procedure; and

2. The dollar conversion factor specified in Section 3(2) of this administrative regulation;

(d) A bilateral procedure reported by the addition of the two (2) digit modifier fifty (50) shall be reimbursed at 150 percent of the amount assigned to the CPT code;

(e) An assistant surgeon procedure reported by the addition of the two (2) digit modifier eighty (80) shall be reimbursed at sixteen (16) percent of the allowable fee for the primary surgeon;

(f) A procedure performed by a physician acting as a locum tenens for a Medicaid-

participating physician reported by the addition of the two (2) character modifier Q six (6) shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable CPT code;

(g) An evaluation and management telehealth consultation service provided by a consulting medical specialist in accordance with 907 KAR 3:170 and reported by the two (2) letter modifier "GT" shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable evaluation and management CPT code; and

(h) A level II National HCPCS modifier designating a location on the body shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable code.

(7) Except for a service specified in paragraphs (a) or (b) of this subsection, a physician laboratory service shall be reimbursed in accordance with 907 KAR 1:029.

(a) Charges for a laboratory test performed by dipstick or reagent strip or tablet in a physician's office shall be included in the office visit charge.

(b) A routine venipuncture procedure shall not be separately reimbursed if submitted with a charge for an office, hospital or emergency room visit or in addition to a laboratory test.

(8) Reimbursement for placement of a central venous, arterial, or subclavian catheter shall be:

(a) Included in the fee for the anesthesia if performed by the anesthesiologist;

(b) Included in the fee for the surgery if performed by the surgeon; or

(c) Included in the fee for an office, hospital or emergency room visit if performed by the same provider.

<u>(9) The department shall reimburse a flat rate of seventy-two (72) dollars per office</u>

12:00 pm on Saturday or anytime Sunday.

Section 3. Reimbursement Methodology. (1) Except for [~~With the exception of~~] a service specified in subsections (3) through (7)[~~(6)~~] of this section:

(a) The rate for a nonanesthesia related covered service shall be established by multiplying RVU by a dollar conversion factor to obtain the RBRVS maximum amount specified in the Medicaid Physician Fee Schedule; and

(b) The flat rate for a covered anesthesia service shall be established by multiplying the dollar conversion factor (designated as X) by the sum of each specific procedure code RVU (designated as Y) plus the actual [~~average~~] amount of time units spent on that specific procedure (designated as Z).

1. [~~The average time units shall be a static number based upon average time units obtained by the department.~~

~~2.~~] The formula for obtaining a covered anesthesia service's flat rate shall be X multiplied by (Y plus Z).

2. [~~3.~~] The flat rate for a covered anesthesia service shall not exceed the rate that was in effect on June 1, 2006 by more than twenty (20) percent.

(2) The dollar conversion factor shall be:

(a) Thirteen (13) dollars and eighty-six (86) cents for a nondelivery related anesthesia service; or

(b) Twenty-nine (29) dollars and sixty-seven (67) cents for all nonanesthesia related services.

(3) For the following services, reimbursement shall be the lesser of:

(a) The actual billed charge;

(b) A fixed fee of three (3) dollars and thirty (30) cents for:

1. Administration of a pediatric vaccine to a Medicaid recipient under the age of twenty-one (21); or

2. Administration of a flu vaccine;

(c) For delivery-related anesthesia services, a fixed rate described as follows:

1. Vaginal delivery, $200;

2. Cesarean section, $320;

3. Neuroxial labor anesthesia for a vaginal delivery or cesarean section, $335;

4. Additional anesthesia for cesarean delivery following neuroxial labor anesthesia for vaginal delivery shall be twenty-five (25) dollars;

5. Additional anesthesia for cesarean hysterectomy following neuroxial labor anesthesia shall be twenty-five (25) dollars; or

(d) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) and over age seventy (70).

(4) Except as established in subsection (5) or (7)(c) of this section, the department shall reimburse for a covered drug or service specified in 907 KAR 3:005, Section 4(4)(a) through (k)[~~(i) shall be reimbursed~~] at the lesser of the:

(a) Actual billed charge; or

(b) Average wholesale price (AWP) minus ten (10) percent.

(5) If a service covered pursuant to 907 KAR 3:005, Section 4(4)(j) is provided to an individual covered under both Medicaid and Medicare and by a physician employed by a community mental health center or other licensed medical professional employed by a

community mental health center, the department shall reimburse for the service at the same rate it reimburses for the service provided to a Medicaid recipient except that the department shall reduce reimbursement by the amount of the third party obligation.

(6)[~~(5)~~] Reimbursement for a covered service provided by a physician assistant shall be:

(a) Made to the employing physician; or

(b) Included in the facility reimbursement if the physician assistant is employed by a primary care center, federally qualified health center, rural health clinic, or comprehensive care center.

(7)(a) [~~(6)(a)~~] Except for an item identified in paragraph (b) or (c) of this subsection, reimbursement for a service provided by a physician assistant shall be seventy-five (75) percent of the amount reimbursable to a physician in accordance with this section and Section 4 of this administrative regulation.

(b) Except as established in paragraph (c) of this subsection, if provided by a physician assistant, an injectable antibiotic, antineoplastic chemotherapy agent or a contraceptive identified in 907 KAR 3:005, Section 4(4)(a) through (k)[~~(i)~~], shall be reimbursed at the lesser of the:

1. Actual billed charge; or

2. Average wholesale price (AWP) of the drug minus ten (10) percent.

(c) If a service covered pursuant to 907 KAR 3:005, Section 4(4)(j) is provided to an individual covered under both Medicaid and Medicare and by a physician assistant employed by a community mental health center or other licensed medical professional employed by a community mental health center, the department shall reimburse for the

service at the same rate it reimburses for the service provided to a Medicaid recipient except that the department shall reduce reimbursement by the amount of the third party obligation.

Section 4. Reimbursement Limitations. (1)(a) With the exception of chemotherapy administration to a recipient under the age of nineteen (19) years, reimbursement for an evaluation and management service with a corresponding CPT code of 99214 or 99215 [~~representing medical decision making of moderate or high complexity for an established patient~~] shall be limited to two (2) [~~one (1) evaluation and management service of either moderate complexity or high complexity~~] per recipient[~~, per diagnosis,~~] per twelve (12) months.

(b) An additional evaluation and management service referenced in paragraph (a) of this subsection shall be covered if prior authorized by the department.

(c) A claim for an evaluation and management service of moderate or high complexity in excess of this limit shall be reimbursed at the Medicaid rate for the evaluation and management service representing medical decision making of low complexity.

(2) Reimbursement for an anesthesia service shall include:

(a) Preoperative and postoperative visits;

(b) Administration of the anesthetic;

(c) Administration of fluids and blood incidental to the anesthesia or surgery;

(d) Postoperative pain management;

(e) Preoperative, intraoperative, and postoperative monitoring services; and

(f) Insertion of arterial and venous catheters.

(3) With the exception of an anesthetic, contrast, or neurolytic solution, administration

of a substance by epidural or spinal injection for the control of chronic pain shall be limited to three (3) injections per six (6) month period per recipient.

(4) If related to the surgery and provided by the physician who performs the surgery, reimbursement for a surgical procedure shall include the following:

(a) A preoperative service;

(b) An intraoperative service;

(c) A postoperative service and follow-up care within:

1. Ninety (90) days following the date of major surgery; or

2. Ten (10) days following the date of minor surgery; and

(d) A preoperative consultation performed within two (2) days of the date of the surgery.

(5) Reimbursement for the application of a cast or splint shall be limited to two (2) per ninety (90) day period for the same injury or condition.

(6) Reimbursement for the application of a cast or splint associated with a surgical procedure shall be considered to include:

(a) A temporary cast or splint, if applied by the same physician who performed the surgical procedure;

(b) The initial cast or splint applied during or following the surgical procedure; and

(c) A replacement cast or splint needed as a result of the surgical procedure if:

1. Provided within ninety (90) days of the procedure by the same physician; and

2. Applied for the same injury or condition.

(7) Multiple surgical procedures performed by a physician during the same operative session shall be reimbursed as follows:

(a) The major procedure, an add-on code, and other CPT codes approved by the department for billing with units shall be reimbursed in accordance with Section 3(1)(a) or (2)(b) of this administrative regulation; and

(b) The additional surgical procedure shall be reimbursed at fifty (50) percent of the amount determined in accordance with Section 3(1)(a) or (2)(b) of this administrative regulation.

(8) When performed concurrently, separate reimbursement shall not be made for a procedure that has been determined by the department to be incidental, integral, or mutually exclusive to another procedure.

(9) Reimbursement shall not be made for the cost of a vaccine that is administered by a physician.

Section 5. Supplemental Payments. (1) In addition to a reimbursement made pursuant to Sections 2 through 4 of this administrative regulation, the department shall make a supplemental payment to a medical school faculty physician employed by a state-supported school of medicine that is part of a university health care system that includes a:

(a) Teaching hospital; and

(b) Pediatric teaching hospital.

(2) A supplemental payment plus other reimbursements made in accordance with this administrative regulation shall not exceed the physician's charge for the service provided and shall be paid directly or indirectly to the medical school.

(3) A supplemental payment made in accordance with this section shall be:

(a) Based on the funding made available through an intergovernmental transfer of

funds for this purpose by a state-supported school of medicine meeting the criteria established in subsection (1) of this section;

(b) Consistent with the requirements of 42 C.F.R. 447.325; and

(c) Made on a quarterly basis.

Section 6. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

907 KAR 3:010

REVIEWED:

Date	Glenn Jennings, Commissioner Department for Medicaid Services

APPROVED:

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

907 KAR 3:010

A public hearing on this administrative regulation shall, if requested, be held on June 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 June 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 July 2, 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 3:010
Cabinet for Health Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the reimbursement criteria for services provided by physicians to Medicaid recipients.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws requiring provision of medical 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 establishes the reimbursement criteria for payment of medically necessary physician services to eligible 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: This amendment establishes reimbursement for physician office visit care beyond typical working hours – extended hour rate is effective Monday through Friday 5:00 pm and weekends; increases evaluation and management service coverage from one (1) per recipient per year to two (2) per recipient per year with additional coverage contingent upon department prior authorization; inserts actual units of time into anesthesiology reimbursement as opposed to an average as was previously used; and establishes reimbursement for administration of a long acting injectable risperidone or an injectable, infused or inhaled drug or biological that is not typically self-administered, not excluded as a noncovered immunization or vaccine and requires special handling, storage, shipping, dosing or information.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure or enhance recipient access to physician care via the department's reimbursement/coverage structure, to promote care delivered in a physician's office versus an emergency room setting and to promote recipient health, safety and welfare by reimbursing for administration of drugs or biologicals requiring special handling or similar.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment establishes reimbursement to promote recipient access to physi-

cian care and to promote recipient health, safety and welfare within the extent and scope authorized by state and federal law by.

(d) How the amendment will assist in the effective administration of the statutes: The amendment establishes reimbursement to promote recipient access to physician care and to promote recipient health, safety and welfare within the extent and scope authorized by state and federal law by.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Reimbursement policies pertaining to covered Medicaid services impacts all physicians enrolled in the Kentucky Medicaid program (approximately 15,000).

(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: Rather than introducing mandates on providers, the amendments favor providers, enabling them to receive a flat rate for providing care beyond normal office hours, for administering certain drugs and biologicals which require special handling or similar, will be reimbursed for actual units of time for anesthesiology and for two, (2) as opposed to one (1) evaluation and management service per recipient per year.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Providers will receive an enhanced reimbursement for care provided beyond normal office hours, will be able to receive reimbursement for two (2) rather than one (1) evaluation and management service per recipient per year, will be reimbursed for administration of drugs or biologicals requiring special handling or similar and will be reimbursed for actual units of anesthesia service time. The amendments enhance provider reimbursement rather than cost providers.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The amendments enhance provider reimbursement rather than cost providers.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The fiscal impact is contingent upon utilization which cannot be accurately predicted at this time; therefore, the impact is indeterminable. The Department for Medicaid Services (DMS) anticipates the enhanced reimbursement will cost money; however, the measures are necessary to enhance recipient access to physician care. Some enhancements, such as reimbursement for extended office hour care, may reduce department costs as recipients may turn to physician offices for care which they may typically seek in an emergency room setting. Additionally, reimbursement for administration of drugs and biologicals requiring special handling may reduce waste of drugs or

biologicals contaminated due to recipient mishandling as well as enhance recipient health, safety and welfare.

(b) On a continuing basis: The fiscal impact is contingent upon utilization which cannot be accurately predicted at this time; therefore, the impact is indeterminable. DMS anticipates the enhanced reimbursement will cost money; however, the measures are necessary to enhance recipient access to physician care. Some enhancements, such as reimbursement for extended office hour care, may reduce department costs as recipients may turn to physician offices for care which they may typically seek in an emergency room setting. Additionally, reimbursement for administration of drugs and biologicals requiring special handling may reduce waste of drugs or biologicals contaminated due to recipient mishandling as well as enhance recipient health, safety and welfare.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue 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 3:010 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 amendment will affect all physicians enrolled in the Medicaid program.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 42 CFR 447 Subpart B.

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? The Department for Medicaid Services (DMS) anticipates the enhanced reimbursement will cost money; however, the measures are necessary to enhance recipient access to physician care. Some enhancements, such as reimbursement for extended office hour care, may reduce department costs as recipients may turn to physician offices for care which they may typically seek in an emergency room setting. Additionally, reimbursement for administration of drugs and biologicals requiring special handling may reduce waste of drugs or biologicals contaminated due to recipient mishandling as well as enhance recipient health, safety and welfare.

(d) How much will it cost to administer this program for subsequent years? The fiscal impact is contingent upon utilization which cannot be accurately predicted at this time; therefore, the impact is indeterminable. DMS anticipates the enhanced reimbursement will cost money; however, the measures are necessary to enhance recipient access to physician care. Some enhancements, such as reimbursement for extended office hour care, may reduce department costs as recipients may turn to physician offices for care which they may typically seek in an emergency room setting. Additionally, reimbursement for administration of drugs and biologicals requiring special handling may reduce waste of drugs or biologicals contaminated due to recipient mishandling as well as enhance recipient health, safety and welfare.

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.