

## STATEMENT OF EMERGENCY

907 KAR 3:010E

(1) This emergency administrative regulation is being promulgated to alter physician service reimbursement in order to maintain the viability of the Medicaid program and to enhance recipient access to services.

(2) This action must be taken on an emergency basis to ensure the viability of the Medicaid program and to enhance recipient access to services.

(3) This emergency administrative regulation differs from the emergency administrative regulation governing the same subject that was submitted to the Legislative Research Commission on June 30, 2006, in that it implements a new anesthesia reimbursement methodology agreed upon by the Department for Medicaid Services and representatives on behalf of Kentucky's anesthesiologists. The new methodology contains a dollar conversion factor, relative value unit and a time component.

(4) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(5) The ordinary administrative regulation is identical to this emergency administrative regulation.

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Ernie Fletcher  
Governor

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

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Hospitals and Provider Operations

4 (Emergency Amendment)

5 907 KAR 3:010E. Reimbursement for physicians' services.

6 RELATES TO: KRS 205.560

7 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R.  
8 440.50, 447 Subpart B, 42 U.S.C. 1396a, b, c, d, s~~[, EO 2004-726]~~

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
10 Services, Department for Medicaid Services, has responsibility to administer the  
11 Medicaid Program. [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for~~  
12 ~~Health Services and placed the Department for Medicaid Services and the Medicaid~~  
13 ~~Program under the Cabinet for Health and Family Services.] KRS 205.520(3)  
14 authorizes the cabinet, by administrative regulation, to comply with any requirement that  
15 may be imposed, or opportunity presented, by federal law for the provision of medical  
16 assistance to Kentucky's indigent citizenry. This administrative regulation establishes  
17 the method of reimbursement for physicians' services by the Medicaid Program.~~

18 Section 1. Definitions.

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

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

3 (3) "Average wholesale price" or "AWP" means the average wholesale price  
4 published in a nationally-recognized comprehensive drug data file for which the  
5 department has contracted.

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

9 (5) "Department" means the Department for Medicaid Services or its designated  
10 agent.

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

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

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

18 (a) Requires few additional physician resources; or

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

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

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

23 (a) Who temporarily assumes responsibility for the professional practice of a

1 physician participating in the Kentucky Medicaid Program; and

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (19) "Relative value unit" or "RVU" means the Medicare-established value assigned  
4 to a CPT code which takes into consideration the physician's work, practice expense  
5 and liability insurance.

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

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

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

## 13 Section 2. Reimbursement.

14 (1) Reimbursement for a covered service shall be made to:

15 (a) The individual participating physician; or

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

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

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

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

22 (3) If there is not an established fee in the Medicaid Physician Fee Schedule, the  
23 reimbursement shall be forty-five (45) [~~sixty-five~~] percent of the usual and customary

1 billed charge.

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

4 (5) If cost-sharing is required for a service to a recipient, the cost-sharing provisions  
5 established in 907 KAR 1:604 shall apply [~~a recipient is required to make a copayment~~  
6 ~~reimbursement to a participating provider shall be reduced by the amount of the~~  
7 ~~required copayment in accordance with 907 KAR 1:604~~].

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

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

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

- 16 1. The Medicare value assigned to the physician's work; and  
17 2. The dollar conversion factor specified in Section 3~~(2)~~~~[(1)(b)]~~ of this administrative  
18 regulation;

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

- 21 1. The Medicare value assigned to the practice expense involved in the performance  
22 of the procedure; and  
23 2. The dollar conversion factor specified in Section 3~~(2)~~~~[(1)(b)]~~ of this administrative

1 regulation;

2 (d) [~~(e)~~] A bilateral procedure reported by the addition of the two (2) digit modifier fifty  
3 (50) shall be reimbursed at one hundred fifty (150) percent of [~~two (2) times~~] the amount  
4 assigned to the CPT code;

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

8 (f) [~~(e)~~] A procedure performed by a physician acting as a locum tenens for a  
9 Medicaid-participating physician reported by the addition of the two (2) character  
10 modifier Q six (6) shall be reimbursed at the Medicaid Physician Fee Schedule amount  
11 for the applicable CPT code;

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

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

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

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

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

1 laboratory test.

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

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

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

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

8 ~~[(9) Reimbursement for a delivery shall include:~~

9 ~~(a) Admission to the hospital;~~

10 ~~(b) History and physical examination;~~

11 ~~(c) Management of labor;~~

12 ~~(d) Delivery; and~~

13 ~~(e) Postpartum care.]~~

14 Section 3. Reimbursement Methodology.

15 (1)~~[(a)]~~ With the exception of a service specified in subsections (3) through (6) ~~[(2)~~  
16 ~~through (5)]~~ of this section:

17 (a) The rate for a non-anesthesia related ~~[, a fee for a]~~ covered service shall be  
18 established by multiplying RVU ~~[unit]~~ by a dollar conversion factor to obtain the RBRVS  
19 maximum amount specified in the Medicaid Physician Fee Schedule; and

20 (b)1. The flat rate for a covered anesthesia service shall be established by multiplying  
21 the dollar conversion factor (designated as X) by the sum of each specific procedure  
22 code RVU (designated as Y) plus the average amount of time units spent on that  
23 specific procedure (designated as Z). The average time units shall be a static number

1 based upon average time units obtained by the department. The formula for obtaining a  
2 covered anesthesia service's flat rate shall be X multiplied by (Y plus Z).

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

5 (2) [(b)] The dollar conversion factor shall be:

6 (a) [1.] Thirteen (13) dollars and eighty-six (86) cents [Twenty-nine (29) dollars and  
7 ~~two (2) cents~~] for a nondelivery related anesthesia service; or

8 (b) [2.] Twenty-nine (29) dollars and sixty-seven (67) cents for all non-anesthesia  
9 related [other] services.

10 (3) [(2)] For the following services, reimbursement shall be the lesser of:

11 (a) The actual billed charge; [or]

12 (b) A fixed fee of three (3) dollars and thirty (30) cents for [per procedure in  
13 ~~accordance with the following~~]:

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

16 2. Administration of a flu vaccine; or

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

18 1. Vaginal delivery, \$200;

19 2. Cesarean section, \$320;

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

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

23 5. Additional anesthesia for cesarean hysterectomy following neuroxial labor

1 anesthesia shall be twenty-five (25) dollars; or

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

4 ~~(4) [, a three (3) dollar and thirty (30) cent fixed fee per administration;]~~

5 ~~2. For the following obstetrical services:~~

6 ~~a. Vaginal delivery only, \$870;~~

7 ~~b. Vaginal delivery including postpartum care, \$900;~~

8 ~~c. Cesarean delivery only, \$870; and~~

9 ~~d. Cesarean delivery including postpartum care, \$900;~~

10 ~~3. for the following delivery-related anesthesia services:~~

11 ~~a. Vaginal delivery, \$200;~~

12 ~~b. Cesarean section, \$320;~~

13 ~~c. Epidural for a vaginal delivery or cesarean section, \$315; and~~

14 ~~d. Epidural for a planned vaginal delivery terminating in a cesarean section, \$335.]~~

15 ~~(3)] A covered drug specified in 907 KAR 3:005, Section 4(4)(a) through (i) shall be~~  
16 ~~reimbursed at the lesser of the:~~

17 ~~(a) Actual billed charge; or~~

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

19 ~~(5) [(4)] Reimbursement for a covered service provided by a physician assistant shall~~  
20 ~~be:~~

21 ~~(a) Made to the employing physician; or~~

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

1 comprehensive care center.

2 (6) [(5)](a) Except for an item identified in paragraph (b) of this subsection,  
3 reimbursement for a service provided by a physician assistant shall be seventy-five (75)  
4 percent of the amount reimbursable to a physician in accordance with this section and  
5 Section 4 of this administrative regulation.

6 (b) If provided by a physician assistant, an injectable antibiotic, antineoplastic  
7 chemotherapy agent or a contraceptive identified in 907 KAR 3:005, Section 4(4)(a)  
8 through (i), shall be reimbursed at the lesser of the:

9 1. Actual billed charge; or

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

11 Section 4. Reimbursement Limitations.

12 (1)(a) With the exception of chemotherapy administration to a recipient under the age  
13 of nineteen (19) years, reimbursement for an evaluation and management service  
14 representing medical decision making of moderate or high complexity for an established  
15 patient shall be limited to one (1) evaluation and management service of either  
16 moderate complexity or high complexity per recipient, per diagnosis, per twelve (12)  
17 months.

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

22 (2) Reimbursement for an [~~non~~delivery-related] anesthesia service shall include:

23 (a) Preoperative and postoperative visits;

- 1 (b) Administration of the anesthetic;
- 2 (c) Administration of fluids and blood incidental to the anesthesia or surgery;
- 3 (d) Postoperative pain management; [~~and~~]
- 4 (e) Preoperative, intraoperative, and postoperative monitoring services; and
- 5 (f) Insertion of arterial and venous catheters.

6 (3) With the exception of an anesthetic, contrast, or neurolytic solution, administration  
7 of a substance by epidural or spinal injection for the control of chronic pain shall be  
8 limited to three (3) injections per six (6) month period per recipient.

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

- 11 (a) A preoperative service;
- 12 (b) An intraoperative service;
- 13 (c) A postoperative service and follow-up care within:
  - 14 1. Ninety (90) days following the date of major surgery; or
  - 15 2. Ten (10) days following the date of minor surgery; and

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

18 (5) Reimbursement for the application of a cast or splint shall be limited to two (2)  
19 ~~[one (1)]~~ per ninety (90) day period for the same injury or condition.

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

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

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

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

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

4 2. Applied for the same injury or condition.

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

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

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

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

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

17 Section 5. Supplemental Payments.

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

22 (a) Teaching hospital; and

23 (b) Pediatric teaching hospital.

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

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

5 (a) Based on the funding made available through an intergovernmental transfer of  
6 funds for this purpose by a state-supported school of medicine meeting the criteria  
7 established in subsection (1) of this section;

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

9 (c) Made on a quarterly basis.

10 Section 6. Appeal Rights.

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

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

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

907 KAR 3:010E

REVIEWED:

\_\_\_\_\_  
Date

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Glenn Jennings, Commissioner  
Department for Medicaid Services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mike Burnside, Undersecretary  
Administrative and Fiscal Affairs

APPROVED:

\_\_\_\_\_  
Date

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

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:010E

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 revises reimbursement methodology used to set rates for "unlisted codes", reducing payments from 65% of billed charges to 45% of billed charges. Analysis of billed charges on unlisted codes indicates that under resource-based relative value scale (RBRVS) calculations, a fee representing 35% of billed charges would result. The reduced payment is therefore more consistent with fees paid for other types of services. RBRVS is the product of the relative value unit (RVU) and a resource-based dollar conversion factor. This amendment revises reimbursement criteria to allow for payment of a second anesthesia service provided by a single provider to a recipient on the same date of service in order to streamline current procedures which require manual review and override. This amendment revises payment for a bilateral procedure from 200% percent of the rate specified in the Physician's Fee Schedule to 150%. Analysis indicates the revised payment is more compatible with payments made by private insurers for these types of services. With this amendment, the relative value unit conversion factor for anesthesia services is revised allowing for payment of anesthesia by units. The revised anesthesia rate shall not exceed the rate that was in effect on June 1, 2006 by more than twenty (20) percent. This amendment provides for reimbursement of an administration of an influenza

- vaccine for all age groups.
- (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to alter physician reimbursement to maintain the viability of the Medicaid program for anesthesiology services in order to enhance recipient access to these services.
  - (c) How the amendment conforms to the content of the authorizing statutes: This amendment provides for the provision of medically necessary health services to the extent and within the scope of coverage allowed by state and federal law by establishing reimbursement criteria for remuneration of these services.
  - (d) How the amendment will assist in the effective administration of the statutes: This amendment complies with the currently approved Title XIX State Plan and prevents the loss of federal funding which is necessary to provide mandated physician services to Kentucky's Medicaid eligible population.
- (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: Providers will be reimbursed via a methodology rather than having to take action to comply with the amendments.
  - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Anesthesiologists will see a slight increase in reimbursement for anesthesia services, but most physicians will realize a slight decrease in reimbursement for services reported by unlisted procedure codes. However, the reduced payment is more consistent with fees paid for other types of services.
  - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Anesthesiologists will see a slight increase in reimbursement for anesthesia services.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: The Department for Medicaid Services (DMS) is amending this administrative regulation in conjunction with the physician coverage administrative regulation, and estimates that the sum impact of all amendments will result in a budget neutral impact or savings depending upon utilization variables.
  - (b) On a continuing basis: DMS is amending this administrative regulation in conjunction with the physician coverage administrative regulation, and estimates that the sum impact of all amendments will result in a budget

neutral impact or savings depending upon utilization variables.

- (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 3:010E

Contact Person: Stuart Owen or  
Stephanie Brammer-Barnes  
(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. Although most physicians will see a slight decrease in reimbursement for services reported by unlisted procedure codes, a slight increase has been added to the reimbursement for anesthesia services.
  - (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. Although most physicians will see a slight decrease in reimbursement for services reported by unlisted procedure codes, a slight increase has been added to the reimbursement for anesthesia services.
  - (c) How much will it cost to administer this program for the first year? Implementation of this amendment will not result in any additional costs during the first year. DMS is amending this administrative regulation in conjunction with

the physician coverage administrative regulation and estimates that the sum impact of all amendments will result in a budget neutral impact or savings depending upon utilization variables.

- (d) How much will it cost to administer this program for subsequent years? DMS is amending this administrative regulation in conjunction with the physician coverage administrative regulation and estimates that the sum impact of all amendments will result in a budget neutral impact or savings depending upon utilization variables.

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.