STATEMENT OF EMERGENCY

907 KAR 1:038E

(1) This emergency administrative regulation is being promulgated to update hearing and vision coverage to current industry practice in order to encourage provider participation and ensure recipient access to necessary care. Specific codes and procedures, consistent with current industry practice, are being covered; procedures previously only covered in physicians' office will be covered in audiologists' offices as well, and lens coverage shall be limited to lenses which are polycarbonate and scratch coated in order to protect recipient safety.

(2) This action must be taken on an emergency basis to protect the health, safety and welfare of recipients by ensuring access to necessary care and to protect recipient safety.

(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.

_____
Ernie Fletcher
Governor

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

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Hospitals and Provider Operations

(Emergency Amendment)

907 KAR 1:038E. Hearing and Vision Program services.

RELATES TO: KRS 205.520, 334.010(4) and (9), 334A.020(5), 334A.030, 42 C.F.R. [~~440.140,~~] 441.30, 447.53, 457.310, 42 U.S.C. 1396a, b, d, 1396r-6

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)[~~, EO 2004-726~~]

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 hearing services and vision [~~program~~] services for which payment shall be made by the Medicaid Program.

Section 1. Definitions. (1) “Audiologist” is defined by KRS 334A.020(5).

(2)"Comprehensive choices" means a benefit plan for an individual who:

(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services;

(b) Receives services through either:

1. A nursing facility in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services;

2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090, Acquired brain injury services;

3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160, Home and community based waiver services; or

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

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

(3)[~~(2)~~] "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(4)[~~(3)~~] "Department" means the Department for Medicaid Services or its designee.

(5)[~~(4)~~] "Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.

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

(a) Is covered pursuant to:

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

2. 42 U.S.C. 1396a(a)(52) and 1396r - 6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

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

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

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

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

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

(7)[~~(6)~~] "Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:

(a) Caretaker relatives who:

1. Receive K-TAP and are deprived due to death, incapacity, or absence;

2. Do not receive K-TAP and are deprived due to death, incapacity, or absence; or

3. Do not receive K-TAP and are deprived due to unemployment;

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

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services; or

2. Receive SSP and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services;

(c) Blind individuals who receive SSI and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services; or

2. SSP, and do not meet nursing facility patient status criteria in accordance with 907

KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services;

(d) Disabled individuals who receive SSI and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services, including children; or

2. SSP, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services;

(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services;

(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services; or

(h) Pregnant women.

(8) “Hearing instrument” is defined by KRS 334.010(4).

(9)[~~(7)~~] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130, Medical necessity and clinically appropriate determination basis.

(10)[~~(8)~~] "Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53

(11)[~~(9)~~] "Optimum choices" means a benefit plan for an individual who:

(a) Meets the intermediate care facility for individuals with mental retardation or a developmental disability patient status criteria established in 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services;

(b) Receives services through either:

1. An intermediate care facility for individuals with mental retardation or a developmental disability in accordance with 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services; or

2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145, Supports for community living services for an individual with mental retardation or a developmental disability; and

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

(12) “Specialist in hearing instruments” is defined by KRS 334.010(9).

Section 2. Hearing Services. (1) All hearing coverage shall be:

(a) Limited to an individual under age twenty-one (21); and

(b) Provided in accordance with the Hearing Program Manual.

(2) Unless a recipient's health care provider demonstrates that services in excess of the following limitations are medically necessary, reimbursement for services provided by an audiologist licensed pursuant to KRS 334A.030[~~a certified audiologist~~] to a recipient shall be limited to:

(a) The following procedures which shall be covered only if a recipient is referred, by a physician, to an audiologist licensed pursuant to KRS 334A.030:

Code	Procedure
92552	Pure Tone audiometry (threshold); air only
92555	Speech audiometry threshold
92556	Speech audiometry threshold; with speech recognition
92557	Comprehensive audiometry eval
92567	Tympanometry
92568	Acoustic reflex testing
92579	Visual reinforcement audiometry
92585	Auditory evoked potentials
92587	Evoked otoacoustic emissions
92588	Complete or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequency)
92541	Spontaneous nystagmus test

92542	Positional nystagmus test
92543	Caloric vestibular test
92544	Optokinetic nystagmus test
92545	Oscillating tracking test
92546	Sinusodial vertical axis rotational testing
92547	Use of vertical electrodes

(b) Complete hearing evaluation;

(c)[~~(b)~~] Hearing instrument [~~aid~~] evaluation;

(d)1.[~~(c)1.~~] Three (3) follow-up visits within the six (6) month period immediately following fitting of a hearing instrument [~~aid~~]; and

2. A follow-up visit shall be related to the proper fit and adjustment of the[that] hearing instrument [~~aid~~]; and

(e)[~~(d)~~] One (1) additional follow-up visit at least six (6) months following the fitting of a hearing instrument [~~aid~~].

(3) Hearing instrument [~~aid~~] benefit coverage shall:

(a) Be for a hearing instrument [~~aid~~] model recommended by an audiologist licensed pursuant to KRS 334A.030[~~a certified audiologist~~] if the model is available through a Medicaid-participating specialist in hearing instruments; [~~hearing aid dealer; and~~]

(b) Not exceed $800 per ear every thirty-six (36) months; and

(c) Be limited to the following procedures:

Code	Procedure

V5010	Assessment for Hearing instrument
V5011	Fitting, Orientation, Checking of Hearing instrument
V5014	Repair, Modification of Hearing Instrument
V5015	Hearing Instrument Repair Professional Fee
V5020	Conformity Evaluation
V5030	Hearing Instrument, Monaural, Body Aid Conduction
V5040	Hearing Instrument, Monaural, Body Worn, Bone Conduction
V5050	Hearing Instrument, Monaural, In the Ear Hearing
V5060	Hearing Instrument, Monaural, Behind the Ear Hearing
V5070	Glasses; Air Conduction
V5080	Glasses; Bone Conduction
V5090	Dispensing Fee, Unspecified Hearing Instrument
V5095	Semi-Implantable Middle Ear Hearing Prosthesis
V5100	Hearing Instrument, Bilateral, Body Worn
V5120	Binaural; Body
V5130	Binaural; In the Ear
V5140	Binaural; Behind the Ear
V5150	Binaural; Glasses
V5160	Dispensing Fee, Binaural
V5170	Hearing Instrument, Cros, In the Ear
V5180	Hearing Instrument, Cros, Behind the Ear
V5190	Hearing Instrument, Cros, Glasses

V5200	Dispensing Fee, Cros
V5210	Hearing Instrument, Bicros, In the Ear
V5220	Hearing Instrument, Bicros, Behind the Ear
V5230	Hearing Instrument, Bicros, Glasses
V5240	Dispensing Fee, Bicros
V5241	Dispensing Fee, Monaural Hearing Instrument, Any Type
V5242	Hearing Instrument, Analog, Monaural, CIC (Completely In the Ear Canal)
V5243	Hearing Instrument, Analog, Monaural, ITC (In the Canal)
V5244	Hearing Instrument, Digitally Programmable Analog, Monaural, CIC
V5245	Hearing Instrument, Digitally Programmable Analog, Monaural, ITC
V5246	Hearing Instrument, Digitally Programmable Analog, Monaural, ITE (In the Ear)
V5247	Hearing Instrument, Digitally Programmable Analog, Monaural, BTE (Behind the Ear)
V5248	Hearing Instrument, Analog, Binaural, CIC
V5249	Hearing Instrument, Analog, Binaural, ITC
V5250	Hearing Instrument, Digitally Programmable Analog, Binaural, CIC
V5251	Hearing Instrument, Digitally Programmable Analog, Binaural, ITC
V5252	Hearing Instrument, Digitally Programmable, Binaural, ITE

V5253	Hearing Instrument, Digitally Programmable, Binaural, BTE
V5254	Hearing Instrument, Digital, Monaural, CIC
V5255	Hearing Instrument, Digital, Monaural, ITC
V5256	Hearing Instrument, Digital, Monaural, ITE
V5257	Hearing Instrument, Digital, Monaural, BTe
V5258	Hearing Instrument, Digital, Binaural, CIC
V5259	Hearing Instrument, Digital, Binaural, ITC
V5260	Hearing Instrument, Digital, Binaural, ITE
V5261	Hearing Instrument, Digital, Binaural, BTE
V5262	Hearing Instrument, Disposable, Any Type, Monaural
V5263	Hearing Instrument, Disposable, Any Type, Binaural
V5264	Ear Mold (One (1) Ear Mold Per Year Per Ear and if Medically Necessary)
V5266	Hearing Instrument Battery (Limit of Four (4) Per Aid When Billed With A New Hearing Instrument Or A Replacement Aid)
V5267	Hearing Instrument Supplies, Accessories
V5299	Hearing Service Miscellaneous (May Be Used to Bill Warranty Replacement Hearing Instruments But Shall be Covered Only if Prior Authorized by the Department)

[.]

Section 3. Vision Program Services. (1) Vision program coverage shall be limited to:

(a) A prescription service;

(b) A repair service made to a frame;

(c) A diagnostic service provided by:

1. An ophthalmologist; or

2. An optometrist to the extent the optometrist is licensed to perform the service.

(2) Eyeglass coverage shall:

(a) Be limited to a recipient who is under age twenty-one (21); and

(b) Not exceed:

1. $200 per year for a recipient in the global choices benefit package; or

2. $400 per year for a recipient in the comprehensive choices, family choices, or optimum choices benefit package.

(3) To be covered:

(a) A service designated as a physical medicine and rehabilitation service CPT code shall require prior authorization if provided to a recipient age twenty-one (21) or over;

(b) A radiology service specified in 907 KAR 3:005, Physicians' Services, Section 5, shall require prior authorization regardless of a recipient's age; [~~and~~]

(c) A service shall be provided in accordance with the Vision Program Manual; and

(d) A lens shall be polycarbonate and scratch coated.

Section 4. Appeal Rights. (1) An appeal of a negative action regarding a Medicaid recipient shall be in accordance with 907 KAR 1:563, Medicaid covered services hearings and appeals.

(2) An appeal of a negative action regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560, Medicaid hearings and appeals regarding eligibility.

(3) An appeal of a negative action regarding a Medicaid provider shall be in accordance with 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions.

Section 5. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "The Vision Program Manual, October 2007[~~2006~~] edition", Department for Medicaid Services; and

(b) "The Hearing Program Manual, October 2007[~~2006~~] edition", Department for Medicaid Services.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:038E

Reviewed:

Date	Shawn M. Crouch, Commissioner Department for Medicaid Services

APPROVED:

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

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:038E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-6204 or Barry Ingram (502) 564-5969

(1) Provide a brief summary of:
   (a) What this administrative regulation does: This administrative regulation establishes the provisions relating to hearing and vision services.
   (b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws that require provision of hearing and vision 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 provides the necessary criteria and denotes the limitations established in KRS 205.560(1) for the provision of medically necessary hearing and vision services to 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: The amendment to hearing coverage specifies covered audiology codes and procedures as well as covered hearing instrument codes and procedures and updates coverage to current industry practice. Via the amendment, services covered are not expanded; however, the department will cover procedures in audiologists' offices which previously were only covered in physicians' offices. Additionally, the amendment mandates that all lenses be polycarbonate and scratch coated; updates the Vision Program Manual by eliminating archaic policy and forms, renders optometric coverage equivalent to physician coverage where appropriate, and categorizes procedural codes.
   (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to clarify audiology and hearing instrument coverage and to alter coverage in order to ensure necessary care for recipients consistent with current industry practice. The amendment to vision coverage is necessary to reduce provider administrative burden and, thereby, encourage provider participation enhancing recipient access to care.
   (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by clarifying audiology and hearing instrument coverage and altering coverage to ensure

necessary care for recipients consistent with current industry practice. Additionally, the amendment reduces provider administrative burden and, thereby, encourages provider participation enhancing recipient access to care.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by clarifying audiology and hearing instrument coverage and altering coverage to ensure necessary care for recipients consistent with industry practice. Additionally, the amendment reduces provider administrative burden and, thereby, encourages provider participation enhancing recipient access to care.

(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 hearing service providers and vision service providers.

(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: Regulated entities are not required to take any action to comply with the amendment.

(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 regulated entities as a result of the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Recipients should benefit as lenses must be polycarbonate (more impact resistant) and scratch coated and should see increased provider participation as a result of the reduction of provider administrative burden.

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

(a) Initially: The Department for Medicaid Services (DMS) projects the amendments to the administrative regulation to be budget neutral.

(b) On a continuing basis: DMS projects the amendments to the administrative regulation to be budget neutral.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of funding to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it

is an amendment: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase any fees.

(9) Tiering: Is tiering applied? Tiering is not applied.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:038E Contact Person: Stuart Owen (502) 564-6204 or Barry Ingram (502) 564-5969)

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? No local government entity is affected; however, the Department for Medicaid Services is affected.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. State laws authorization this action include 194A.030(2), 194A.050(1), 205.520(3). Federal regulations authorization this action include 42 CFR 433.56, 42 CFR 441.10 and 42 USC 1396d(a).

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 any revenue for state or local government.

   (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 amendment is not expected to generate any revenue for state or local government.

   (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services projects the amendment to be budget neutral.

   (d) How much will it cost to administer this program for subsequent years? The DMS projects the amendment to be budget neutral.

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.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:038E

Summary of Material Incorporated by Reference

(1) The “Hearing Program Manual” May 2006 edition is being replaced by the October 2007 edition in order to specify and update covered audiology codes and procedures and covered hearing instrument codes and procedures consistent with current industry practice. The audiology codes and procedures are located on page 16. The hearing instrument codes and procedures are located on pages 20 to 22. The “Hearing Program Manual” contains twenty-six (26) pages.

(2) The “Vision Program Manual” May 2006 edition is being replaced by the October 2007 edition in order to:
(a) Eliminate references to old Medicaid cards. Formerly, cards of different colors were issued to recipients; however, new cards all appear the same;
(b) Revised, page 3.2, medical records requirements to keep the manual consistent with 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation;
(c) Replaced, on page 3.3, references to the MAP 343 and the MAP 344 with references to the MAP 811 as the MAP 811 replaced the MAP 343 and MAP 344;
(d) Replaced, page 4.1, the old HCFA 1500 form with the current CMS 1500 form;
(e) Updated, page 4.2, the list of current procedural terminology (CPT) codes for optometry;
(f) Updated, page 4.3, CPT code 99214 and 99215 limits to render coverage consistent with physicians’ services coverage;
(g) Deleted, page 4.6, old policy regarding number of boys and girls frames which must be kept in stock;
(h) Added, page 4.7, new requirement that all lenses shall be polycarbonate and scratch coated;
(i) Deleted, page 4.10, outdated language referencing “press-on prisms”; and
(j) Replaced, page 4.12, old list of billable CPT codes with reference to three (3) distinct ranges of codes.

The “Vision Program Manual” contains thirty-six (36) pages.

A total of sixty-two (62) pages are incorporated by reference.