CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amendment)

907 KAR 3:005. Coverage of physicians' services.

RELATES TO: KRS 205.510, 205.520, 205.560, 205.622, 205.8451, 311.840-311.862, 314.011, 369.101-369.120, 42 C.F.R. 400.203, 413.75(b), 415.174, 415.184, 431.17, 438.2, 440.40(b), 440.50, 441.20, 441.200-441.208, 441.250-441.259, 447.26, 455.410, Part 493, 45 C.F.R. Parts 160, 164, 42 U.S.C. 1320 - 1320d-8, 1396a(a)(19), (30), 1396r-8(a)

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

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 to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program coverage provisions and requirements relating to physicians' services.

Section 1. Definitions. (1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(2) "Behavioral health practitioner under supervision" means an individual who is:

(a)1. A licensed psychological associate;

2. A licensed professional counselor associate;

3. A certified social worker;

4. A marriage and family therapy associate;

5. A licensed professional art therapist associate;

6. A licensed assistant behavior analyst;

7. A licensed clinical alcohol and drug counselor associate;

8. A certified psychologist; or

9. A certified alcohol and drug counselor; and

(b) Employed by or under contract with the same billing provider as the billing supervisor.

(3) "Common practice" means an arrangement through which a physician assistant administers health care services under the supervision of a physician via a supervisory relationship that has been approved by the Kentucky Board of Medical Licensure.

(4) "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.

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

(6) "Designated controlled substance provider" means the provider designated as a lock-in recipient’s controlled substance prescriber:

(a) Pursuant to 907 KAR 1:677, if the recipient is not an enrollee; or

(b) As established by the managed care organization in which the lock-in recipient is enrolled, if the lock-in recipient is an enrollee.

(7) "Designated primary care provider" means the provider designated as a lock-in recipient’s primary care provider:

(a) Pursuant to 907 KAR 1:677, if the recipient is not an enrollee; or

(b) As established by the managed care organization in which the lock-in recipient is enrolled, if the lock-in recipient is an enrollee.

(8) "Direct physician contact" means that the billing physician is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(9) "Early and periodic screening and diagnosis and treatment" or "EPSDT" is defined by 42 C.F.R. 440.40(b).

(10) "Emergency care" means:

(a) Covered inpatient or outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; or

(b) Emergency ambulance transport.

(11) "Enrollee" means a recipient who is enrolled with a managed care organization.

(12) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(13) "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.

(14) "Graduate medical education program" or "GME program" means:

(a) A residency program approved by:

1. The Accreditation Council for Graduate Medical Education of the American Medical Association;

2. The Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;

3. The Commission on Dental Accreditation of the American Dental Association; or

4. The Council on Podiatric Medicine Education of the American Podiatric Medical Associa-

tion; or

(b) An approved medical residency program as defined by 42 C.F.R. 413.75(b).

(15) "Incidental" means that a medical procedure:

(a) Is performed at the same time as a primary procedure; and

(b)1. Requires little additional resources; or

2. Is clinically integral to the performance of the primary procedure.

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

(17) "Lock-in recipient" means:

(a) A recipient enrolled in the lock-in program in accordance with 907 KAR 1:677; or

(b) An enrollee enrolled in a managed care organization's lock-in program pursuant to 907 KAR 17:020, Section 6[~~8~~].

(18) "Locum tenens APRN" means an APRN:

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

(b) Whose services are billed under the APRN's provider number.

(19) "Locum tenens physician" 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.

(20) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined by 42 C.F.R. 438.2.

(21) "Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient as a Medicaid-participating provider in accordance with:

1. 907 KAR 1:671; and

2. 907 KAR 1:672;

(b) The Medicaid Program is the payer for the service; and

(c) The recipient is not liable for payment to the provider for the service other than any cost sharing obligation owed by the recipient to the provider.

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

(23) "Medical resident" means:

(a) An individual who participates in an approved graduate medical education (GME) program in medicine or osteopathy; or

(b) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, including:

1. An individual with a:

a. Temporary license;

b. Resident training license; or

c. Restricted license; or

2. An unlicensed graduate of a foreign medical school.

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

(a) Are not reasonably performed in conjunction with each other 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.

(25) "Non-Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient;

(b) The Medicaid Program is not the payer for the service; and

(c) The recipient is liable for payment to the provider for the service.

(26) "Other licensed medical professional" means a health care provider:

(a) Other than a physician, physician assistant, advanced practice registered nurse, certified registered nurse anesthetist, nurse midwife, or registered nurse; and

(b) Who has been approved to practice a medical specialty by the appropriate licensure board.

(27) "Other provider preventable condition" is defined by 42 C.F.R. 447.26(b).

(28) "Physician administered drug" or "PAD" means any rebateable covered outpatient drug that is:

(a) Provided or administered to a Medicaid recipient;

(b) Billed by a provider other than a pharmacy provider through the medical benefit, including a provider that is a physician office or another outpatient clinical setting; and

(c) An injectable or non-injectable drug furnished incident to provider services that are billed separately to Medicaid.

(29) "Physician assistant" is defined by KRS 311.840(3).

(30) "Podiatrist" is defined by KRS 205.510(12).

(31) "Provider group" means a group of at least two (2) individually licensed physicians who:

(a) Are enrolled with the Medicaid Program individually and as a group; and

(b) Share the same Medicaid group provider number.

(32) "Rebateable" means a drug for which the drug manufacturer has entered into and has in effect a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(33) "Recipient" is defined by KRS 205.8451(9).

(34) "Screening" means the evaluation of a recipient by a physician to determine:

(a) If a disease or medical condition is present; and

(b) If further evaluation, diagnostic testing, or treatment is needed.

(35) "Supervising physician" is defined by KRS 311.840(4).

(36) "Supervision" is defined by KRS 311.840(6).

(37) "Timely filing" means receipt of a Medicaid claim by the department:

(a) Within twelve (12) months of the date the service was provided;

(b) Within twelve (12) months of the date retroactive eligibility was established; or

(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.

(38) "Unlisted procedure or service" means a procedure or service:

(a) For which there is not a specific CPT code; and

(b) That is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Conditions of Participation. (1)(a) A participating physician shall:

1. Be licensed as a physician in the state in which the medical practice is located;

2. Comply with the:

a. Terms and conditions established in 907 KAR 1:005, 907 KAR 1:671, and 907 KAR 1:672; and

b. Requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d

to 1320d-8 and 45 C.F.R. Parts 160 and 164;

3. Have the freedom to choose whether to provide services to a recipient; and

4. Notify the recipient referenced in paragraph (b) of this subsection of the provider's decision to accept or not accept the recipient on a Medicaid basis prior to providing any service to the recipient.

(b) A provider may provide a service to a recipient on a non-Medicaid basis:

1. If the recipient agrees to receive the service on a non-Medicaid basis before the service begins; and

2. The service is not a Medicaid-covered service.

(c)1. If a provider renders a Medicaid-covered service to a recipient, regardless of if the service is billed through the provider's Medicaid provider number or any other entity including a non-Medicaid provider, the recipient shall not be billed for the service.

2. The department shall terminate from Medicaid Program participation a provider who participates in an arrangement in which an entity bills a recipient for a Medicaid-covered service rendered by the provider.

(2) If a provider agrees to provide services to a recipient, the provider:

(a) Shall bill the department rather than the recipient for a covered service;

(b) May bill the recipient for a service not covered by Medicaid if the physician informed the recipient of noncoverage prior to providing the service; and

(c) Shall not bill the recipient for a service that is denied by the department on the basis of:

1. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;

2. Incorrect billing procedures, including incorrect bundling of services;

3. Failure to obtain prior authorization for the service; or

4. Failure to meet timely filing requirements.

(3)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(4)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record within seventy-two (72) hours from the date that the individual provided the service.

(5)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(6) A provider shall comply with 45 C.F.R. Part 164.

Section 3. Covered Services. (1) To be covered by the department, a service shall be:

(a) Medically necessary;

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;

(c) Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and

(d) Eligible for reimbursement as a physician service.

(2) Direct physician contact between the billing physician and recipient shall not be required for:

(a) A service provided by a:

1. Medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;

2. Locum tenens physician who provides direct physician contact;

3. Physician assistant in accordance with Section 7 of this administrative regulation; or

4. Locum tenens APRN who provides direct APRN contact;

(b) A radiology service, imaging service, in office lab, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;

(c) The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;

(d) A sleep disorder service; or

(e) A telehealth consultation provided in accordance with 907 KAR 3:170.

(3) A service provided by an other licensed medical professional shall be covered if the other licensed medical professional is:

(a) Employed by the supervising physician; and

(b) Licensed in the state of practice.

(4) A sleep disorder service shall be covered if performed in:

(a) A hospital; or

(b) A sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the:

1. American Sleep Disorders Association; or

2. American Academy of Sleep Medicine.

Section 4. Service Limitations. (1) A covered service provided to a lock-in recipient shall be limited to a service provided by the lock-in recipient's designated primary care provider or designated controlled substance provider unless:

(a) The service represents emergency care; or

(b) The lock-in recipient has been referred to the provider by the lock-in recipient's designated primary care provider.

(2) An EPSDT screening service shall be covered in accordance with 907 KAR 11:034.

(3) A laboratory procedure performed in a physician's office shall be limited to a procedure for which the physician has been certified in accordance with 42 C.F.R. Part 493.

(4) A drug listed on the Physician Administered Drug List shall be covered in accordance with 907 KAR 23:010.

(5) A service allowed in accordance with 42 C.F.R. 441, Subpart E (441.200 to 441.208) or Subpart F (441.250 to 441.259 and the Appendix to Subpart F), shall be covered within the scope and limitations of 42 C.F.R. 441, Subpart E and Subpart F.

(6)(a) Except as provided in paragraph (b) of this subsection, coverage for a service designated as a psychiatry service CPT code and provided by a physician shall be limited to four (4) services, per physician, per recipient, per twelve (12) months.

(b) Coverage for a service designated as a psychiatry service CPT code that is provided by a

board certified or board eligible psychiatrist or by an advanced practice registered nurse with a specialty in psychiatry shall not be subject to the limits established in paragraph (a) of this subsection.

(7) Coverage for an evaluation and management service shall be limited to one (1) per physician, per recipient, per date of service.

(8) Coverage for a fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(9) An anesthesia service shall be covered if:

(a) Administered by:

1. An anesthesiologist who remains in attendance throughout the procedure; or

2. An individual who:

a. Is licensed in Kentucky to practice anesthesia;

b. Is licensed in Kentucky within his or her scope of practice; and

c. Remains in attendance throughout the procedure;

(b) Medically necessary; and

(c) Not provided as part of an all-inclusive CPT code.

(10) The following shall not be covered:

(a) An acupuncture service;

(b) An autopsy;

(c) A cast or splint application in excess of the limits established in 907 KAR 3:010;

(d) Except for therapeutic bandage lenses, contact lenses;

(e) A hysterectomy performed for the purpose of sterilization;

(f) Lasik surgery;

(g) Paternity testing;

(h) A procedure performed for cosmetic purposes only;

(i) A procedure performed to promote or improve fertility;

(j) Radial keratotomy;

(k) A thermogram;

(l) An experimental service that is not in accordance with current standards of medical practice;

(m) A service that does not meet the requirements established in Section 3(1) of this administrative regulation; or

(n) [~~Medical direction of an anesthesia service; or~~

~~(o)~~] Medical assistance for an other provider preventable condition in accordance with 907 KAR 14:005.

(11)(a) In accordance with 42 C.F.R. 455.410, to prescribe medication, order a service for a recipient, or refer a recipient for a service, a provider shall be currently enrolled and participating in the Medicaid program.

(b) The department shall not reimburse for a:

1. Prescription prescribed by a provider that is not currently:

a. Participating in the Medicaid program pursuant to 907 KAR 1:671; and

b. Enrolled in the Medicaid program pursuant to 907 KAR 1:672; or

2. Service:

a. Ordered by a provider that is not currently:

(i) Participating in the Medicaid program pursuant to 907 KAR 1:671; and

(ii) Enrolled in the Medicaid program pursuant to 907 KAR 1:672; or

b. Referred by a provider that is not currently:

(i) Participating in the Medicaid program pursuant to 907 KAR 1:671; and

(ii) Enrolled in the Medicaid program pursuant to 907 KAR 1:672.

Section 5. Prior Authorization Requirements for Recipients Who are Not Enrolled with a Managed Care Organization. (1) Except as provided by subsection (3) of this section, the following procedures for a recipient who is not enrolled with a managed care organization shall require prior authorization by the department:

(a) Magnetic resonance imaging;

(b) Magnetic resonance angiogram;

(c) Magnetic resonance spectroscopy;

(d) Positron emission tomography;

(e) Cineradiography or videoradiography;

(f) Xeroradiography;

(g) Ultrasound subsequent to second obstetric ultrasound;

(h) Myocardial imaging;

(i) Cardiac blood pool imaging;

(j) Radiopharmaceutical procedures;

(k) Gastric restrictive surgery or gastric bypass surgery;

(l) A procedure that is commonly performed for cosmetic purposes;

(m) A surgical procedure that requires completion of a federal consent form;

(n) An organ transplant in accordance with 907 KAR 1:350; or

(o) A covered unlisted procedure or service.

(2)(a) Prior authorization by the department shall not be a guarantee of recipient eligibility.

(b) Eligibility verification shall be the responsibility of the provider.

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

(a) An emergency service;

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

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

(4) A referring physician, a physician who wishes to provide a given service, a podiatrist, a chiropractor, or an advanced practice registered nurse:

(a) May request prior authorization from the department; and

(b) If requesting prior authorization, shall request prior authorization by:

1. Mailing or faxing:

a. A written request to the department with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation; and

b. If applicable, any required federal consent forms; or

2. Submitting a request via the department's web-based portal with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation.

Section 6. Therapy Service Limits. (1) Speech-language pathology services shall be limited to twenty (20) service visits per recipient per calendar year, except as established in subsection (4) of this section.

(2) Physical therapy services shall be limited to twenty (20) service visits per recipient per calendar year, except as established in subsection (4) of this section.

(3) Occupational therapy services shall be limited to twenty (20) service visits per recipient per calendar year, except as established in subsection (4) of this section.

(4) A service in excess of the limits established in subsection (1), (2), or (3) of this section shall be:

(a) Prior authorized in accordance with subsection (5) of this section if the recipient is not enrolled with a managed care organization; and

(b) Approved if the additional service is determined to be medically necessary by:

1. The department, if the recipient is not enrolled with a managed care organization; or

2. The managed care organization in which the enrollee is enrolled, if the recipient is an enrollee.

(5) Prior authorization by the department shall be required for each service visit that exceeds the limit established in subsection (1), (2), or (3) of this section for a recipient who is not enrolled with a managed care organization.

Section 7. Physician Assistant Services. (1) Except for a service limitation specified in subsection (2) or (3) of this section, a service provided by a physician assistant in common practice with a Medicaid-enrolled physician shall be covered if:

(a) The service meets the requirements established in Section 3(1) of this administrative regulation;

(b) The service is within the legal scope of certification of the physician assistant;

(c) The service is approved in the contractual supervisory relationship between the physician assistant, their supervising physician, and the Kentucky Board of Medical Licensure; and

(d) The physician assistant complies with:

1. KRS 311.840 to 311.862; and

2. If applicable, Section 2(1)(b) of this administrative regulation.

(2) A same service performed by a physician and either a physician assistant or an APRN on the same day within a common practice shall be considered as one (1) covered service.

(3) The following physician assistant services shall not be covered:

(a) A physician noncovered service specified in Section 4(10) of this administrative regulation;

(b) An anesthesia service;

(c) An obstetrical delivery service; or

(d) A service provided in assistance of surgery.

Section 8. Behavioral Health Services Covered Pursuant to 907 KAR 15:010. The requirements and provisions established in 907 KAR 15:010 for a service covered pursuant to this administrative regulation and 907 KAR 15:010 shall apply if the service is provided by:

(1) A physician who is the billing provider;

(2) A provider group that is the billing provider; or

(3) A behavioral health practitioner under supervision who works for a:

(a) Physician who is the billing provider; or

(b) Provider group that is the billing provider.

Section 9. Duplication of Service Prohibited. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech-language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the same service provided to the same recipient during the same time period via the

physicians' services program.

Section 10. Third Party Liability. A provider shall comply with KRS 205.622.

Section 11. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 12. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 13. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 14. Appeal Rights. An appeal of a department decision regarding:

(1) A Medicaid recipient who is not enrolled with a managed care organization based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563; or

(2) An enrollee based upon an application of this administrative regulation shall be in accordance with 907 KAR 17:010.

907 KAR 3:005

REVIEWED:

January 6, 2021
Date

Lisa D. Lee, Commissioner
Department for Medicaid Services

APPROVED:

DocuSigned by:
Eric Friedlander
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2/8/2021
Date

Eric Friedlander, Secretary
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held on April 26, 2021, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by April 19, 2021, 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. This hearing is open to the public. Any person who attends virtually 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 be heard at the public hearing, you may submit written comments on this proposed administrative regulation until April 30, 2021. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Donna Little, Deputy Executive Director, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; Phone: 502-564-6746; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:005
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements relating to physicians' services.
(b) The necessity of this administrative regulation: 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 to qualify for federal Medicaid funds.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements relating to physicians' services.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements relating to physicians' services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendments change this administrative regulation by incorporating changes made to 907 KAR 3:010 to allow for broader practice of anesthesia under medical direction.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to incorporate changes made to 907 KAR 3:010 relating to broader practice of anesthesia under medical direction. These changes are necessary in order to ensure Medicaid coverage of services to all recipients accessing anesthesia services.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by establishing standards for all Medicaid recipients receiving anesthesia services.
(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the statutes by clearly establishing coverage of anesthesia services.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Any provider of anesthesia services that wants to provide anesthesia under medical direction. Currently there are 1,237 physicians with an anesthesiology specialty enrolled as providers, and 2,350 Nurse Anesthetists enrolled as 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: Providers will need to take no

additional actions to comply with this administrative regulation.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There will be no additional costs.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Certain providers will be able to provide anesthesia under medical direction.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: There are no costs to implement this administrative regulation.
(b) On a continuing basis: There are no ongoing costs to implement this administrative regulation.

(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: Neither an increase in fees nor funding is necessary to implement 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 was not appropriate in this administrative regulation because the administration regulation applies equally to all individuals and entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 3:005
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. 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? The Department for Medicaid Services

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1); 42 U.S.C. 1396a(a)(10)(B)

3. 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 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 revenue for state or local government.
(c) How much will it cost to administer this program for the first year? There are no costs to administer this program.
(d) How much will it cost to administer this program for subsequent years? There are no costs to administer this program.

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: _____

FEDERAL MANDATE ANALYSIS COMPARISON

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1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10)(B)

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid).

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter or different responsibilities than the federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter or different responsibilities than the federal requirements.