CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amendment)

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

RELATES TO: KRS 205.560, 205.565, 210.370-210.485, 311.840, 42 C.F.R. 400.203, Part 414, 438.2, 440.50, 447.10, 447.200-447.205, 447.325, 42 U.S.C. 1395m, 1395w-4, 1395x(t)(1), 1396a, 1396b, 1396c, 1396d, 1396s

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

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

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

(2) "Anesthesia under medical direction" means a service that is:

(a) Directed by an anesthesiologist;

(b) Delivered by an appropriate and qualified anesthesia provider, including a certified

registered nurse anesthetist; and

(c) Provided concurrently to no more than four (4) patients by the anesthesiologist.

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

(4)[~~(3)~~] "Community mental health center" means a facility that meets the community mental health center requirements established in 902 KAR 20:091.

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

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

(7)[~~(6)~~] "Direct physician contact" means that the billing physician is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(8)[~~(7)~~] "Drug" means the definition of "drugs" pursuant to 42 U.S.C. 1395x(t)(1).

(9)[~~(8)~~] "Federal financial participation" is defined by 42 C.F.R. 400.203.

(10)[~~(9)~~] "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.

(11)[~~(10)~~] "Healthcare common procedure coding system" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or items.

(12)[~~(11)~~] "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.

(13)[~~(12)~~] "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(14)[~~(13)~~] "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.

(15)[~~(14)~~] "Major surgery" means a surgical procedure assigned a ninety (90) day global period.

(16)[~~(15)~~] "Managed care organization" means an entity for which the department has contracted to serve as a managed care organization as defined by 42 C.F.R. 438.2.

(17)[~~(16)~~] "Medicaid Physician Fee Schedule" means a list, located at https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx[~~http://chfs.ky.gov/dms~~], that:

(a) Contains the current reimbursement rates for physician services established by the department in accordance with this administrative regulation; and

(b) Is updated at least quarterly to coincide with the quarterly updates made by the Centers for Medicare and Medicaid Services as required by 42 U.S.C. 1395m and 1395w-4 and 42 C.F.R. Part 414.

[~~(17) "Medical direction" means a service provided:~~

~~(a) Under direct orders from a physician who is:~~

~~1. Not physically present with the recipient during the provision of the service; and~~

~~2. Communicating with the service provider during the provision of the service; or~~

~~(b) Based on a set of written instructions from a physician who is not physically present with~~

~~the recipient during the provision of the service.~~]

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

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

(20) "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.

(21) "Pediatric teaching hospital" is defined by KRS 205.565(1).

(22) "Physician administered drug" or "PAD" means any rebateable covered outpatient[~~out-patient~~] 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.

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

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

(25) "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 provider number.

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

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

(28) "State university teaching hospital" means:

(a) A hospital that is owned or operated by a Kentucky state-supported university with a medical school; or

(b) A hospital:

1. In which three (3) or more departments or major divisions of the University of Kentucky or University of Louisville medical school are physically located and that are used as the primary (greater than fifty (50) percent) medical teaching facility for the medical students at the University of Kentucky or the University of Louisville; and

2. That does not possess only a residency program or rotation agreement.

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

(30) "Usual and customary charge" means the uniform amount that a physician charges the general public in the majority of cases for a specific medical procedure or service.

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

(a) The individual participating physician who provided the covered service; or

(b) The physician:

1. In a provider group enrolled in the Kentucky Medicaid Program; and

2. Who provided the covered service.

(2) Except as provided in subsection (3) of this section and Sections 3 through 11[~~10~~] of this administrative regulation, reimbursement for a covered service shall be the lesser of:

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

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

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

Section 3. Rates Established Using a Relative Value Unit and a Dollar Conversion Factor.

(1) Except for a service specified in Sections 4 through 10[~~9~~] of this administrative regulation:

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

(b) The rate for a covered anesthesia service shall be established by multiplying the dollar conversion factor (designated as X) by the sum of each specific procedure code RVU (designated as Y) plus the number of units spent on that specific procedure (designated as Z). A unit shall equal a fifteen (15) minute increment of time.

(2) The dollar conversion factor shall be:

(a) Fifteen (15) dollars and twenty (20) cents for a nondelivery related anesthesia service; or

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

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

Section 5. Services with a Modifier. Reimbursement for a service denoted by a modifier used in conjunction with a CPT code shall be as established in this section.

(1) A service reported with a two (2) digit modifier of "51" shall be reimbursed at fifty (50) percent of the fee listed on the Medicaid Physician Fee Schedule for the service.

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

(a) The Medicare value assigned to the physician's work; and

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

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

(a) The Medicare value assigned to the practice expense involved in the performance of the procedure; and

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

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

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

(6) A procedure performed by a physician acting as a locum tenens physician for a Medicaid-participating physician reported by the addition of the two (2) character modifier "Q6" shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable CPT code.

(7) An evaluation and management telehealth consultation service provided by a telehealth

provider or telehealth practitioner in accordance with 907 KAR 3:170 and reported by the appropriate[~~two (2)~~] letter modifier, as applicable,[~~"GT"~~] shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable evaluation and management CPT code.

(8) A level II national healthcare common procedure coding system modifier designating a location on the body shall be reimbursed at the Medicaid Physician Fee Schedule amount for the applicable code.

Section 6. Laboratory, Venipuncture, and Catheter. (1) Except for a service specified in paragraph (a) or (b) of this subsection, a physician laboratory service shall be reimbursed in accordance with 907 KAR 1:028.

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

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

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

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

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

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

(3) A laboratory test performed with microscopy shall be reimbursed separately from an evaluation and management CPT code.

Section 7. Delivery-Related Anesthesia, Anesthesia Add-On Services, and Oral Surgery-Related Anesthesia[~~, and Anesthesia Under Medical Direction~~]. (1) The department shall reimburse as follows for the following delivery-related anesthesia services:

(a) For a vaginal delivery, the lesser of:

1. $215; or

2. The actual billed charge;

(b) For a cesarean section, the lesser of:

1. $335; or

2. The actual billed charge;

(c) For neuroxial labor anesthesia for a vaginal delivery or cesarean section, the lesser of:

1. $350; or

2. The actual billed charge;

(d) For an additional anesthesia for cesarean delivery following neuroxial labor anesthesia for vaginal delivery, the lesser of:

1. Twenty-five (25) dollars; or

2. The actual billed charge; or

(e) For an additional anesthesia for cesarean hysterectomy following neuroxial labor anesthesia, the lesser of:

1. Twenty-five (25) dollars; or

2. The actual billed charge.

(2) For an anesthesia add-on service provided to a recipient under the age of one (1) year or over the age of seventy (70) years, the department shall reimburse the lesser of:

(a) Twenty-five (25) dollars; or

(b) The actual billed charge.

(3) For deep sedation or general anesthesia relating to oral surgery performed by an oral surgeon, the department shall reimburse the lesser of:

(a) $150; or

(b) The actual billed charge.

[~~(4) The department shall not reimburse for an anesthesia service if the claim for the service is submitted with a modifier indicating that a service of medical direction was performed.~~]

Section 8. Anesthesia Under Medical Direction. (1) An anesthesia under medical direction service that complies with this section shall be eligible for reimbursement.

(2) An anesthesiologist performing anesthesia under medical direction, regardless of the type of anesthesia provided, shall personally document performing each element described in subsection (3) of this section.

(3) An anesthesia under medical direction service shall meet the requirements established in paragraphs (a) through (i) of this subsection.

(a) The anesthesiologist shall perform a face-to-face examination and evaluation, by telehealth if appropriate pursuant to 907 KAR 3:170, prior to the anesthetic session. The examination and evaluation shall indicate the body system or area examined and the anesthesiologist's findings.

(b) The anesthesiologist shall personally decide on the appropriate anesthetic for the procedure and shall document that decision.

(c) The anesthesiologist shall personally participate in person for the most demanding procedures in the treatment plan developed pursuant to this section. This personal participation shall include that the anesthesiologist be in the room and participating in the service if induction and emergence are part of the anesthesia service provided.

(d) Any services not provided by the anesthesiologist shall be conducted by a qualified individual.

(e) A qualified individual providing services pursuant to this section shall document and sign their delivery of the service. Any signature shall also include the qualified individual's licensure or certification.

(f) The anesthesiologist shall monitor the course of anesthesia administration at frequent intervals during the course of treatment.

(g) The anesthesiologist shall:

1. Remain physically present for all key and critical portions of the procedure; and

2. Be immediately available for immediate diagnosis and treatment of an emergency.

(h)1. The following services may be performed on another patient or case by an anesthesiologist while complying with paragraph (g) of this subsection:

a. Addressing an emergency of short duration in the immediate area;

b. Administering an epidural or caudal anesthetic to ease labor pain;

c. Periodically, but not continuously, monitoring an obstetrical patient;

d. Receiving patients entering an operating suite for surgery;

e. Assessing or discharging patients in the recovery room; or

f. Managing scheduling matters.

2. A service performed in subparagraph 1. of this paragraph shall not be anesthesia under medical direction if:

a. The anesthesiologist leaves the immediate area of the operating suite for longer than a short amount of time;

b. The anesthesiologist is not available to respond to the immediate needs of surgical patients, for example, if the anesthesiologist devotes extensive time to an emergency case; or

c. The anesthesiologist's services to the anesthesia patients are supervisory in nature.

(i) The anesthesiologist shall perform and document all appropriate and necessary post-anesthesia care as indicated. Compliance with this paragraph shall include documentation that transfer was done safely to another level of care.

Section 9. Vaccines. (1) The department shall reimburse administration of a:

(a) Pediatric vaccine to a recipient under the age of nineteen (19) years; or

(b) Flu vaccine to a recipient of any age.

(2)(a) The department shall reimburse for the cost of a vaccine administered to a recipient under nineteen (19) years of age, in addition to administration of the vaccine, for a vaccine that is:

1. Administered to the recipient by a physician; and

2. Not available free through the Vaccines for Children Program in accordance with 42 U.S.C. 1396s.

(b) The department shall not reimburse for the cost of a vaccine if the vaccine is available free through the Vaccines for Children Program in accordance with 42 U.S.C. 1396s.

Section 10[~~9~~]. Physician Assistant. Reimbursement for a service provided by a physician assistant shall be seventy-five (75) percent of the amount reimbursable to a physician in accordance with this administrative regulation.

Section 11[~~10~~]. Reimbursement Limits and Related Requirements. (1)(a) Except for chemotherapy administration to a recipient under the age of nineteen (19) years, reimbursement for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per provider per calendar year.

(b) A claim for an evaluation and management service with a corresponding CPT code of 99214 or 99215 submitted in excess of the limit established in paragraph (a) of this subsection

shall be reimbursed as an evaluation and management service with a corresponding CPT code of 99213.

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

(2) Reimbursement for an anesthesia service shall include:

(a) Preoperative and postoperative visits;

(b) Administration of the anesthetic;

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

(d) Postoperative pain management until discharge from the recovery area;

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

(f) Insertion of arterial and venous catheters.

(3) With the exception of an anesthetic, contrast, or neurolytic solution, administration of a substance to a recipient by epidural or spinal injection for the control of chronic pain shall be limited to three (3):

(a) Injections per date of service; and

(b) Dates of service per six (6) month period.

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

(a) A preoperative service;

(b) An intraoperative service; and

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

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

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

(5) Reimbursement for the application of a cast or splint shall be in accordance with 907 KAR 1:104, Section 3(4).

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

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

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

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

(8) The department shall not reimburse for an evaluation and management CPT code unless:

(a) Direct physician contact occurred during the visit; or

(b) Direct physician contact is not required in accordance with 907 KAR 3:005, Section 3(2).

Section 12[~~11~~]. Other Provider Preventable Conditions. In accordance with 907 KAR 14:005, the department shall not reimburse for other provider preventable conditions.

Section 13[~~12~~]. Supplemental Payments. (1) In addition to a reimbursement made pursuant to Sections 2 through 11[~~10~~] of this administrative regulation, the department shall make a supplemental payment to a medical school faculty physician:

(a) Who:

1. Is licensed to practice medicine or osteopathy in Kentucky;

2. Is enrolled in the Kentucky Medicaid program in accordance with 907 KAR 1:672;

3. Is participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671;

4. Is employed by a state university teaching hospital, a pediatric teaching hospital, or a state university school of medicine that is part of a university health care system; and

5. Agrees to assign his or her Medicaid reimbursement, in accordance with 42 C.F.R. 447.10, to the state university entity with whom the physician is employed; and

(b) For services provided:

1. Directly by the medical school faculty physician; or

2. By a resident working under the supervision of the medical school faculty physician.

(2) A supplemental payment plus other reimbursements made in accordance with this administrative regulation shall:

(a) Not exceed the physician's charge for the service provided; and

(b) Be paid directly or indirectly to the medical school.

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

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

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

(c) Made on a quarterly basis.

Section 14[~~13~~]. The department shall reimburse for physician administered drugs in accordance with 907 KAR 23:020.

Section 15[~~14~~]. Not Applicable to Managed Care Organizations. (1) A managed care

organization may elect to reimburse the same amount for physician services as the department does.

(2) A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for a physician service reimbursed by the department via this administrative regulation.

Section 16[~~15~~]. Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

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

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

Section 17[~~16~~]. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

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

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

907 KAR 3:010

REVIEWED:

January 6, 2021
Date

Lisa D. Lee, Commissioner
Department for Medicaid Services

APPROVED:

2/8/2021
Date

DocuSigned by:
Eric Friedlander
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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 3:010
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 reimbursement requirements for physician services.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to implement the department's reimbursement for physician services.
(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 reimbursement policies for physician services provided within Kentucky Medicaid.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing reimbursement policies for physician 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 to this administrative regulation allow for anesthesia to be reimbursed when provided under medical direction in certain circumstances. A new section describes elements that must be present and documented in each anesthesia under medical direction case. These requirements include that the anesthesiologist perform a face-to-face examination, personally decide on the appropriate anesthetic, and personally participate in-person for the most demanding procedures in the treatment plan. The amendments also require that anesthesia under medical direction services not conducted by the anesthesiologist be conducted by a qualified individual who shall also sign and document their participation. Finally the anesthesiologist is required to frequently monitor the medical direction services in-person, and provide appropriate post-anesthesia care.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to allow for anesthesia under medical direction care to become a reimbursable service in Kentucky Medicaid.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment allows for anesthesia under medical direction to become a reimbursable service.
(d) How the amendment will assist in the effective administration of the statutes: The amendment allows for a new service to be reimbursed and delivered in Kentucky Medicaid.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Anesthesia providers wishing 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. Anesthesia providers will need to comply and document compliance with the new requirements.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Providers should not experience any additional costs in complying with this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). 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: The Department for Medicaid Services (DMS) anticipates no additional costs to implement this administrative regulation.

(b) On a continuing basis: The Department for Medicaid Services (DMS) anticipates no additional 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: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds from 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: Neither an increase in fees nor funding will be necessary to implement the amendment.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendments to this administrative regulation neither establish nor increase any fees.

(9) Tiering: Is tiering applied? No. Tiering was not applied as the policies apply equally to the regulated entities.

# FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 3:010
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

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.

# FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 3:010
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 (DMS) will be affected by the amendment to this administrative regulation.

2. Identify each state 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? DMS does not expect this administrative regulation 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? DMS does not expect this administrative regulation to generate 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 (DMS) anticipates no additional costs as a result of this administrative regulation.
   (d) How much will it cost to administer this program for subsequent years? The Department for Medicaid Services (DMS) anticipates no additional costs as a result of this administrative regulation.

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: ____