CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amendment)

907 KAR 1:038. Hearing Program coverage provisions and requirements.

RELATES TO: KRS 205.520, 205.622, 205.8451(9), 334.010(4), (9), 334A.020(5), 334A.030, 42 C.F.R. 400.203, [~~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)

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 provisions and requirements regarding the coverage of audiology services and hearing instruments.

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

(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.

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

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

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

(6) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or items.

(7) "Hearing instrument" is defined by KRS 334.010(4).

(8) "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[~~in~~] 42 C.F.R. 438.2.

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

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

(11) "Specialist in hearing instruments" is defined by KRS 334.010(9).

Section 2. General Requirements. (1)(a) For the department to reimburse for a service or item, the service or item shall:

1. Be provided:

a. To a recipient:

(i) Under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21); or

(ii) For evaluation and testing services, not limited by age, by an audiologist, only if the recipient has received a referral from a physician; and

b. By a provider who is:

(i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(ii) Except as provided by paragraph (b) of this subsection, currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(iii) Authorized to provide the service in accordance with this administrative regulation;

2. Be covered in accordance with this administrative regulation;

3. Be medically necessary; and

4. Have a CPT code or HCPCS code that is listed on the most current Department for Medicaid Services Hearing Program Fee Schedule, posted on the department website at: https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(2)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(3) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(4)(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.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(5)(a) An in-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license in accordance with KRS Chapter 334A;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1. of this paragraph to the department; and

3. Annually submit proof of the license referenced in subparagraph 1. of this paragraph to the department.

(b) An out-of-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license to practice audiology in the state in which the audiologist is licensed;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1. of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1. of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of having a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing

Association.

(c) If an audiologist fails to comply with paragraph (a) or (b) of this subsection, as applicable based on if the audiologist is in-state or out-of-state, the:

1. Audiologist shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the audiologist effective with the date the audiologist fails or failed to comply.

(6)(a) An in-state specialist in hearing instruments shall:

1. Maintain a current, unrevoked, and unsuspended license issued by the Kentucky Licensing Board for Specialists in Hearing Instruments;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1. of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1. of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the specialist in hearing instruments by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of having a Certificate of Clinical Competence issued to the specialist in hearing instruments by the American Speech-Language-Hearing Association.

(b) An out-of-state specialist in hearing instruments shall:

1. Maintain a current, unrevoked, and unsuspended license issued by the licensing board with jurisdiction over specialists in hearing instruments in the state in which the license is held;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1. of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1. of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the specialist in hearing instruments by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of having a Certificate of Clinical Competence issued to the specialist in hearing instruments by the American Speech-Language-Hearing Association.

(c) If a specialist in hearing instruments fails to comply with paragraph (a) or (b) of this subsection, as applicable based on if the specialist in hearing instruments is in-state or out-of-state, the:

1. Specialist in hearing instruments shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the specialist in hearing instruments effective with the date the specialist in hearing instruments fails or failed to comply.

Section 3. Audiology Services. (1) Audiology service coverage shall be limited to one (1) complete hearing evaluation per calendar year.

(2) Unless a recipient's health care provider demonstrates, and the department agrees, that an additional hearing instrument evaluation is medically necessary, a hearing instrument evaluation shall:

(a) Include three (3) follow-up visits, which shall be:

1. Within the six (6) month period immediately following the fitting of a hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument; and

(b) Include one (1) additional follow-up visit, which shall be:

1. At least six (6) months following the fitting of the hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument.

(3)(a) A referral by a physician to an audiologist shall be required for an audiology service.

(b) The department shall not cover an audiology service if a referral from a physician to the audiologist was not made.

(c) An office visit with a physician shall not be required prior to the referral to the audiologist for the audiology service.

Section 4. Hearing Instrument Coverage. Hearing instrument benefit coverage shall:

(1) If the benefit is a hearing instrument model, be for a hearing instrument model that is:

(a) Recommended by an audiologist licensed pursuant to KRS 334A.030; and

(b) Available through a Medicaid-participating specialist in hearing instruments; and

(2) Except as provided by Section 5(3) of this administrative regulation, not exceed $800 per ear every thirty-six (36) months.

Section 5. Replacement of a Hearing Instrument. (1) The department shall reimburse for the replacement of a hearing instrument if:

(a) A loss of the hearing instrument necessitates replacement;

(b) Extensive damage has occurred necessitating replacement; or

(c) A medical condition necessitates the replacement of the previously prescribed hearing instrument in order to accommodate a change in hearing loss.

(2) If replacement of a hearing instrument is necessary within twelve (12) months of the original fitting, the replacement hearing instrument shall be fitted upon the signed and dated recommendation from an audiologist.

(3) If replacement of a hearing instrument becomes necessary beyond twelve (12) months from the original fitting:

(a) The recipient shall be examined by a physician with a referral to an audiologist; and

(b) The recipient's hearing loss shall be re-evaluated by an audiologist.

Section 6. Noncovered services. The department shall not reimburse for:

(1) A routine screening of an individual or group of individuals for identification of a hearing problem;

(2) Hearing therapy except as covered through the six (6) month adjustment counseling following the fitting of a hearing instrument;

(3) Lip reading instructions except as covered through the six (6) month adjustment counseling following the fitting of a hearing instrument;

(4) A service for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment;

(5) A telephone call;

(6) A service associated with investigational research; or

(7) A replacement of a hearing instrument for the purpose of incorporating a recent improvement or innovation unless the replacement results in appreciable improvement in the recipient's hearing ability as determined by an audiologist.

Section 7. Equipment. (1) Equipment used in the performance of a test shall meet the current standards and specifications established by the American National Standards Institute.

(2)(a) A provider shall ensure that any audiometer used by the provider or provider's staff shall:

1. Be checked at least once per year to ensure proper functioning; and

2. Function properly.

(b) A provider shall:

1. Maintain proof of calibration and any repair, if any repair occurs; and

2. Make the proof of calibration and repair, if any repair occurs, available for departmental review upon the department's request.

Section 8. 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 9. Appeal Rights. An appeal of a negative action regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

[~~Section 10. Incorporation by Reference. (1) The "Department for Medicaid Services Hearing Program Fee Schedule", December 2013, is incorporated by reference.~~

~~(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. or online at the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm.~~]

907 KAR 1:038

REVIEWED:

_4/12/21_____
Date

Lisa D. Lee, Commissioner
Department for Medicaid Services

APPROVED:

4/12/2021
_____
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 June 28, 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 June 21, 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 June 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: Krista Quarles, Policy Advisor, 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 1:038
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Krista Quarles, (502) 564-6746, CHFSregs@ky.gov

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.
(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 Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.
(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 Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

(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 the administrative regulation will more clearly allow for a recipient to receive testing services from an audiologist. This administrative regulation is also clarified to state that an in-office visit to a physician is not necessary for a referral to an audiologist to occur. Finally, the incorporation by reference section is deleted from this administrative regulation.
(b) The necessity of the amendment to this administrative regulation: The amendments to this administrative regulation are necessary to better accommodate modern audiology practice and ensure testing and evaluation for recipients older than twenty-one (21) years of age.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by ensuring that audiology services are provided with the Medicaid Program.
(d) How the amendment will assist in the effective administration of the statutes: The amendment assists in the effective administration of the statutes by ensuring that audiology services are appropriately delivered within the Medicaid Program.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation:
There are approximately 177 audiologists enrolled with the Medicaid program.

(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 will be required to take no new actions. However, adult hearing testing and referral requirements have been clarified.

(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 by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Additional adult hearing testing may be provided, and some referral practices have been clarified.

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

(a) Initially: DMS does not anticipate additional costs on an initial basis as a result of this amendment.

(b) On a continuing basis: DMS does not anticipate additional costs on a continuing basis as a result of this amendment.

(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 state funds appropriated in the biennium budget.

(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: This administrative regulation neither imposes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is applied in that individuals older than twenty-one (21) are only eligible for certain audiology testing and evaluation services.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 1:038
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Krista Quarles, (502) 564-6746, CHFSregs@ky.gov

(1) Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396d(r)(4), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 441.56, and 45 C.F.R. 147.126.

(2) State compliance standards. KRS 194A.050(1) states, "The secretary shall promulgate, administer, and enforce those administrative regulations necessary to implement programs mandated by federal law, or to qualify for the receipt of federal funds and necessary to cooperate with other state and federal agencies for the proper administration of the cabinet and its programs."

KRS 205.520(3) states: " . . . 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. EPDST hearing coverage must include at least testing and diagnosis and treatment for hearing defects, including hearing aids. Hearing services must also be, "provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition."

Additionally, state Medicaid programs are required to take measures to monitor that services are appropriate. States are required to establish a plan for review of the appropriateness and quality of care and services furnished to Medicaid recipients by appropriate health care professionals. The plan helps protect against overutilization or unnecessary care and to assure that reimbursement is consistent with efficiency, economy and quality of care.

42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to:
". . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services . . . ."

45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

(4) Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

(5) Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The requirements are not stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 1:038
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Krista Quarles, (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 this amendment.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 441.56; KRS 205.520.

(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 will generate no revenue for DMS.
(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 will generate no revenue for DMS.
(c) How much will it cost to administer this program for the first year? DMS does not anticipate additional costs in administering this program in the first year.
(d) How much will it cost to administer this program for subsequent years? DMS does not anticipate additional costs in administering this program in subsequent years.

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: