CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

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

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

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) <u>“Anesthesia under medical direction” means a service that is:</u>

<u>(a) Directed by an anesthesiologist;</u>

<u>(b) Delivered by an appropriate and qualified anesthesia provider, including a certified</u>

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. **Medical Direction of Anesthesia and Anesthesia Under Medical Direction Services. (1) A provider or facility performing medical direction shall comply with all Medicare requirements to perform medical direction services located in 42 C.F.R. 415.110 and as found in the Medicare Claims Processing Manual, Chapter 12, Section 50, Paragraph C, as they existed at the time of the applicable claim submission.**

(2) No reimbursement shall be made for an anesthesiologist assistant or a student registered nurse anesthetist unless those provider types are otherwise eligible for licensure or certification and appropriately enrolled with the department and, if applicable, a managed care organization[~~**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:

6/9/2021
Date

DocuSigned by:
Lisa Lee
7CB973D215D941E...
Lisa D. Lee, Commissioner
Department for Medicaid Services

APPROVED:

6/9/2021
Date

DocuSigned by:
Eric Friedlander
0AEA1D6C15D6431...
Eric Friedlander, Secretary
Cabinet for Health and Family Services

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.

The amended after comment version deletes the previously new Section 8, and the new language will require providers to precisely follow the existing Medicare guidelines relating to medical direction care. Because the Medicare guidelines are written for states that allow additional providers or providers under supervision to provide anesthesia services, another subsection clarifies that only providers eligible for licensure in Kentucky can provide anesthesia services under medical direction.

(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: ____

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 3:010.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations

Amended After Comments

I. A public hearing on 907 KAR 3:010 was not requested, and therefore, not held. However, written comments were received during the public comment period.

II. The following individuals submitted comments during the public comment period:

Name and Title	**Agency/Organization/Entity/Other**
Hal Clark, Vice President of Economics and Policy	Kentucky Hospital Association
Russ Ranallo, Vice President of Finance, Technical Advisory Committee Chairman	Owensboro Health Hospital TAC
Regina Fragneto, M.D. President	Kentucky Society of Anesthesiologists
Rebecca Randall, Senior Director of Operations	WellCare Health Plans of Kentucky
Randall D. Moore, DNP, MBA, CRNA, Chief Executive Officer	American Association of Nurse Anesthetists
Libby Milligan, Principal	McCarthy Strategic Solutions, LLC Kentucky Association of Nurse Anesthetists
C. Wright Pinson, MD, MBA	Deputy CEO and Chief Health System Officer Vanderbilt University Medical Center
Kristen Safier, Esq., Senior Counsel, Legal Department	Cincinnati Children's Hospital Medical Center
Harini Chenna, MD	
Carey H Costantini, MD	St. Elizabeth Health Care
Dale Santrock, MS, MD	
Sean T. DeGrande, MD, PhD	Seven Hills Anesthesia, NKY Division
Marina Varbanova M.D., Associate Professor, Associate Program Director	University of Louisville, Department of Anesthesiology
Dan Brannon, DO	Seven Hills Anesthesia
Masroor Alam, MD, Anesthesiologist	Seven Hills Anesthesia
Jiapeng Huang MD, PhD, FASA, FASE, Academic Advisory Dean, Professor & Vice Chairman, Medical Director of Operating Rooms, Professor of Cardiovascular & Thoracic Sur-	Department of Anesthesiology & Perioperative Medicine, University of Louisville. Journal of Cardiothoracic & Vascular Anesthesia Seminars in Cardiothoracic & Vascular An-

gery, Associate Editor, Associate Editor in Chief,	esthesia
Joseph K Hassoun, MD	Seven Hills Anesthesia
Mark Grossman, CEO	Seven Hills Anesthesia
R. Andrew Daniel, MD, Chief of Staff	Frankfort Regional Medical Center
Raymond Sullivan, MD	Seven Hills Anesthesia, St. Elizabeth Division President
Damian Dolan, MD	Seven Hills Anesthesia
Ayesa Hilvano, MD	Seven Hills Anesthesia St Elizabeth Healthcare
Dr. Prashant Nayak, MD	Seven Hills Anesthesia
Joshua E. Hansen, MD	

III. The following individuals from the promulgating agency responded to comments received regarding 907 KAR 3:010

Name and Title	**Agency/Organization/Entity/Other**
Lisa Lee, Commissioner	Department for Medicaid Services, Commissioner's Office
Veronica Judy-Cecil, Senior Deputy Commissioner	Department for Medicaid Services, Commissioner's Office
Leslie Hoffman, Chief Behavioral Health Officer	Department for Medicaid Services, Commissioner's Office
Lee Guice, Director	Department for Medicaid Services, Division of Policy and Operations
Angela Parker, Director	Department for Medicaid Services, Division of Program Quality and Outcomes
Jonathan Scott, Regulatory and Legislative Advisor	Department for Medicaid Services, Commissioner's Office

IV. SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Anesthesiologists face challenges in providing anesthesia care to Medicaid recipients.

(a) Comment: Russ Ranallo, Vice President of Finance, Owensboro Health and Technical Advisory Committee Chairman, Kentucky Medicaid Hospital TAC; Regina Fragneto, M.D., President, Kentucky Society of Anesthesiologists; C. Wright Pinson, MD, MBA Deputy CEO and Chief Health System Officer, Vanderbilt University Medical Center; Harini Chenna, MD; Carey H Costantini, MD, St. Elizabeth Health Care; Dale Santrock, MS, MD; Sean T. DeGrande, MD, PhD, Seven Hills Anesthesia, NKY Division; Marina Varbanova M.D., Associate Professor, Associate Program Director, University of Louisville, Department of Anesthesiology; Dan Brannon, DO, Seven Hills Anesthesia; Masroor Alam, MD, Anesthesiologist, Seven Hills Anesthesia; Jiapeng Huang MD, PhD, FASA, FASE, Academic Advisory Dean, Professor & Vice Chairman, Medical Director of Operating Rooms, Professor of Cardiovascular & Thoracic Surgery, Department of Anesthesiology & Perioperative Medicine, University of Louisville, Associate Editor Journal of Cardiothoracic & Vascular Anesthesia, and Associate Editor in Chief, Seminars in Cardiothoracic & Vascular Anesthesia; Joseph K Hassoun, MD, Seven Hills Anesthesia; Mark Grossman, CEO, Seven Hills Anesthesia; R. Andrew Daniel, MD, Chief of Staff, Frankfort Regional Medical Center; Raymond Sullivan, MD, Seven Hills Anesthesia, St. Elizabeth Division President; Damian Dolan, MD, Seven Hills Anesthesia; Ayesa Hilvano, MD, Seven Hills Anesthesia, St Elizabeth Healthcare; Dr. Prashant Nayak, MD Seven Hills Anesthesia, and Joshua E. Hansen, MD, submitted comments pointing out that several payor sources such as Medicare do allow for reimbursement of claims billed as medical anesthesia. Many Kentucky physicians face "significant challenges providing the highest quality of anesthesia care to Kentucky citizens due to the lack of payment for this service for patients with Medicaid insurance". "As the Medicaid population continues to grow, the situation is becoming unsustainable for some practice groups, particularly those independent practices who see a high volume of Medicaid patients. "
(b) Response: While DMS is primarily making this amendment in order to ensure access to anesthesiology services for Medicaid members and promote appropriate billing, taking steps to allow for broader practice of anesthesia among the Medicaid population is a significant benefit of this amendment. The department will not be amending the regulation in response to the comment.

(2) Subject: Support for allowing anesthesiologists to provide medical direction services within the Kentucky Medicaid program.
(a) Comment: Russ Ranallo, Vice President of Finance, Owensboro Health and Technical Advisory Committee Chairman, Kentucky Medicaid Hospital TAC; Regina Fragneto, M.D., President, Kentucky Society of Anesthesiologists; C. Wright Pinson, MD, MBA Deputy CEO and Chief Health System Officer, Vanderbilt University Medical Center; Harini Chenna, MD; Carey H Costantini, MD, St. Elizabeth Health Care; Dale Santrock, MS, MD; Sean T. DeGrande, MD, PhD, Seven Hills Anesthesia, NKY Division; Marina Varbanova M.D., Associate Professor, Associate Program Director, University of Louisville, Department of Anesthesiology; Dan Brannon, DO, Seven Hills Anesthesia; Masroor Alam, MD, Anesthesiologist, Seven Hills Anesthesia; Jiapeng Huang MD, PhD, FASA, FASE, Academic Advisory Dean, Professor & Vice Chairman, Medical Director of Operating Rooms, Professor of Cardiovascular & Thoracic Surgery, Department of Anesthesiology & Perioperative Medicine, University of Louisville, Associate Editor Journal of Cardiothoracic & Vascular Anesthesia, and Associate Editor in Chief, Seminars in Cardiothoracic & Vascular Anesthesia; Joseph K Hassoun, MD, Seven Hills Anesthesia; Mark Grossman, CEO, Seven Hills Anesthesia; R. Andrew Daniel, MD, Chief of Staff, Frankfort Regional Medical Center; Raymond Sullivan, MD,Seven Hills Anesthesia, St. Elizabeth Division

President; Damian Dolan, MD, Seven Hills Anesthesia; Ayesa Hilvano, MD, Seven Hills Anesthesia, St Elizabeth Healthcare; Dr. Prashant Nayak, MDSeven Hills Anesthesia, and Joshua E. Hansen, MD, submitted comments indicating that meeting the requirements of medical direction will "require an immense amount of time, expertise, and effort by the anesthesiologist". The comments further point to the multiple steps that are required to be performed by the anesthesiologist in order to receive payment.
(b) Response: The department agrees that anesthesiologists will need to comply with multiple steps in order to receive reimbursement for medical direction services. The department will not be amending the administrative regulation in response to the comment.

(3) Subject: Medical direction has contributed significantly to a current very low level of perioperative morbidity and mortality in Northern Kentucky.
(a) Comment: Sean T. DeGrande, MD, PhD, Seven Hills Anesthesia, NKY Division, submitted comments pointing out that utilizing medical direction when possible has contributed significantly to a current very low level of perioperative morbidity and mortality in Northern Kentucky.
(b) Response: While DMS is primarily making this amendment in order to ensure access to anesthesiology services for Medicaid members and to ensure appropriate billing, the department will track how and if the introduction of this service improves outcomes for Medicaid members. Ongoing improved outcomes would be significant in the continued use of this service. The department will not be amending the administrative regulation in response to the comment.

(4) Subject: Request to enhance payment for nurse anesthetists – regardless of whether the nurse anesthetist is medically directed or not - to 100% of the Physician's Fee Schedule Amount.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists; and Randall D. Moore, DNP, MBA, CRNA, Chief Executive Officer, American Association of Nurse Anesthetists submitted comments requesting that nurse anesthetists receive the same reimbursement as anesthesiologists for all anesthesia services. The Kentucky Association of Nurse Anesthetists further indicated that a justification should be made for why medical direction is to be covered if identical payments for anesthesiologists and nurse anesthetists are not included in the administrative regulation.
(b) Response: Because medical direction appears to have been performed in Kentucky for some time, it is difficult to arrive at a reliable fiscal estimate, and DMS continues to estimate no increase or decrease in funding. Furthermore, the KyANA's own comments have indicated that this service has been declining over the previous decade. In any case, DMS anticipates that medical direction services are much different in scope than the entirety of anesthesia services performed throughout the Medicaid program. Payment parity between anesthesiologists and nurse anesthetists, therefore, is likely not cost neutral. While DMS may take this step, it would represent a different and larger fiscal impact than anesthesia under medical direction. The department will not be amending the administrative regulation in response to the comment.

(5) Subject: Request to enhance payment for the QR modifier – paid when a nurse anesthetist is **not** medically directed by a physician – to 100% of the Physician's Fee Schedule Amount instead of 75%.
(a) Comment: Russ Ranallo, Vice President of Finance, Owensboro Health, and Hal Clark Vice President of Economics and Policy, Kentucky Hospital Association, submitted comments requesting that DMS enhance payment for the modifier utilized when a nurse anesthetist provides

anesthesia services without medical direction by an anesthesiologist. The justification for this increase would be to encourage a higher availability of nurse anesthetists in certain areas of the state that do not have a high availability of anesthesia services.
(b) Response: The Department prefers to address exact reimbursement rates via the Physician Fee Schedule to allow for a full rate setting analysis. As a result, the Department has not planned to amend physician or nurse anesthetist reimbursement rates with the amendments for this administrative regulation. The department will not be amending the administrative regulation in response to the comment.

(6) Subject: Reimbursement for personally performed services.

(a) Comment: Russ Ranallo, Vice President of Finance, Owensboro Health, submitted comments arguing that while the total number of medical direction services performed is likely to be small, it is still important to provide reimbursement for all medically necessary services that are performed in person.
(b) Response: The department agrees with the need to provide reimbursement for medical direction in this circumstance, and agrees that the total number of medical direction services performed will likely be small. The department anticipates that the vast majority of nurse anesthetist services will continue to be performed independently. The department will not be amending the regulation in response to the comment.

(7) Subject: Request to allow out-of-state providers to perform anesthesia services.
(a) Comment: C. Wright Pinson, MD, MBA, Vanderbilt University Medical Center; and Kristen Safier, Esq., Senior Counsel, Legal Department, Cincinnati Children's Hospital Medical Center, submitted comments requesting that the regulation be clarified to allow out-of-state providers to perform services.
(b) Response: The regulation allows for facilities to enroll in Kentucky Medicaid and utilize qualified providers. This is the most common scenario for out-of-state providers when anesthesia services are provided. The department will not be amending the regulation in response to the comments.

(8) Subject: Withdraw anesthesia under medical direction changes to 907 KAR 3:005 and 3:010.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists; and Randall D. Moore, DNP, MBA, CRNA, Chief Executive Officer, American Association of Nurse Anesthetists submitted comments requesting that the administrative regulation be withdrawn. The commenters pointed to a few studies arguing that CRNA anesthesia is the lowest cost option and that a reduction in quality of care is difficult to demonstrate.
(b) Response: The impetus for these changes – in addition to strong stakeholder support from state university teaching hospitals and the state anesthesiologist associations – involves improving access to anesthesiology services and promoting correct billing practices when services are provided under medical direction. In order for Kentucky Medicaid recipients to continue to have access to certain out-of-state facilities, the department is electing to more clearly and adequately reimburse for medical direction services. The department will not be amending the administrative regulation in response to the comment.

(9) Subject: Request for additional information regarding out-of-state anesthesia under medical

direction requirements.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists submitted comments relating to the association's understanding that Vanderbilt University Medical Center was "one of the stakeholders strongly leading this initiative" and that an out-of-state facility should simply not bill or track medical direction services in response to Kentucky's regulatory prohibition on anesthesia under medical direction.
(b) Response: While Vanderbilt University Medical Center has commented on this administrative regulation, DMS disagrees that this facility is "strongly leading this initiative". Vanderbilt University Medical Center's comments and interest were relayed to DMS after initial drafting of the amendments to this regulation were complete.

The impetus for these changes – in addition to strong stakeholder support from state university teaching hospitals and the state anesthesiologist associations – involves improving access to anesthesiology services and promoting correct billing practices when services are provided under medical direction. In order for Kentucky Medicaid recipients to continue to have access to certain out-of-state facilities, the department is electing to more clearly and adequately reimburse for medical direction services.

Clarifying this issue, about 1 to 1.1 million people under the age of 18 live in Kentucky. More than 700,000 of those children are covered by Kentucky Medicaid or the Kentucky Children's Health Insurance Program (KCHIP). Pursuing a course of action that continues to prohibit reimbursement for medical direction provided by out-of-state facilities would threaten access for Kentucky Medicaid recipients. Kentucky Medicaid is unwilling to risk loss of access to some of the region's best children's' hospitals for more than two-thirds of Kentucky's children.

In addition, many vulnerable Kentucky adults depend on Medicaid having access to these hospitals. Refusing to amend medical direction billing practices would similarly threaten hospital and surgical access for too many recipients, especially those living in counties that border other states.

(10) Subject: Steady decline in billing for medical direction services.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists submitted comments highlighting Medicare claims data and arguing that this billing model has been in "a steady decline since 2010".
(b) Response: The department acknowledges that this does not appear to involve a substantial percentage of anesthesia claims. However, the expanded authority to bill for medical direction is needed within some practice settings. Furthermore, a recent audit conducted by the department indicated that medical direction services were occurring within Kentucky Medicaid and being billed separately by anesthesia providers. Because this service appears to have been prevalent in Kentucky Medicaid even without the availability of modifiers or regulatory approval, it is possible that these services are being otherwise billed within the Medicare program. The Department believes the change is necessary to ensure appropriate billing for medically directed anesthesiology services.

The department will not be amending this administrative regulation in response to the comment.

(11) Subject: Discussion of 2014 version of 907 KAR 3:005.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the

Kentucky Association of Nurse Anesthetists submitted comments requesting clarification of information contained in a 2014 version of a Statement of Consideration of that administrative regulation that indicated that medical direction of anesthesia services had not been covered previously and arguing that this was due to fiscal reasons. The comments further ask for clarification about what has changed.
(b) Response: The 2014 Statement of Consideration was prepared by and for a completely different staff that was working to implement a fundamentally different Medicaid program and Medicaid population. Furthermore, the department's research indicates that Kentucky Medicaid has not reimbursed for medical direction care for many years, this was not a decision made initially in 2014. In the ensuing seven years, additional research and analysis has been conducted, particularly in relation to how some services similar to medical direction were already occurring within the Medicaid program. Highlighting this, a recent audit conducted by the department indicated that medical direction services were occurring within Kentucky Medicaid and being billed separately by anesthesia providers. Because this service appears to have been prevalent in Kentucky Medicaid even without the availability of modifiers or regulatory approval, it is possible that these services are being otherwise billed within the Medicare program. The department will not be amending the administrative regulation in response to the comment.

(12) Subject: Physician Anesthesia Resident services and medical direction.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists; and Kristen Safier, Esq., Senior Counsel, Legal Department, Cincinnati Children's Hospital Medical Center, submitted comments requesting clarification on how a resident physician will bill for services. The comment also states that it is the understanding of the Kentucky Association of Nurse Anesthetists that there is only rare direct reimbursement of anesthesia services to the resident physician.
(b) Response: Hospitals receive payments for teaching via the Graduate Medical Education (GME) program. DMS anticipates that resident physician anesthesia services can only be billed under the supervising physician. Resident physician billing opportunities was not a major consideration for the department in promulgating this administrative regulation. The department will not be amending this administrative regulation in response to the comments.

(13) Subject: Medical direction and fraudulent billing.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists submitted comments stating that "It is published in the literature, and documented publicly that Medical Direction is the most fraudulently billed anesthesia model (intentionally or unintentionally). VUMC, along with many others, have faced legal questioning and financial hardships related to medical direction billing. It should be known that anesthesia billing is frequently on the Federal Office of Inspector General (OIG) Work Plan for auditing and effects providers, anesthesia groups, and facilities alike. ***KyANA would appreciate clarification on the additional steps that Kentucky Medicaid will take to ensure compliance and prevent fraudulent billing***."
(b) Response: The department would like to emphasize that fraudulent billing is a serious concern and a possibility with any type of Medicaid covered healthcare service. The department is operationalized to investigate fraudulent billing and charged with the ultimate responsibility to ensure that all services are billed appropriately. From the department's perspective, fraudulent

billing can happen for any service.

The department utilizes multiple partners, including Medicaid MCOs, to ensure that services are billed appropriately. Any entity that chooses to bill for anesthesia under medical direction should provide services appropriately and ensure appropriate documentation.

Finally, the department would encourage any provider or association that has evidence of fraudulent billing to submit that information to the department, or any of the other civil and criminal entities that would assist the department in investigating such evidence. The department will not be amending the administrative regulation in response to the comment.

(14) Subject: Medical Direction requirements should mirror Medicare Part B requirements.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists; Randall D. Moore, DNP, MBA, CRNA, Chief Executive Officer, American Association of Nurse Anesthetists; Kristen Safier, Esq., Senior Counsel, Legal Department, Cincinnati Children's Hospital Medical Center; and C. Wright Pinson, MD, MBA, Vanderbilt University Medical Center submitted comments recommending that the requirements in 907 KAR 3:010 exactly mirror the Medicare Part B requirements to assist providers and facilities in complying with a more streamlined set of requirements.
(b) Response: It is the department's belief that the requirements contained in 907 KAR 3:010 currently mirror the Medicare Part B requirements. However, in order to fully accommodate multiple billing scenarios, the department will amend the administrative regulation as follows: The existing language in 907 KAR 3:010 Section 8 will be deleted and replaced with these 2 new subsections, the section will also be retitled:

Medical Direction of Anesthesia and Anesthesia Under Medical Direction Services. (1) A provider or facility performing medical direction shall comply with all Medicare requirements to perform medical direction services located in 42 C.F.R. 415.110 and as found in the Medicare Claims Processing Manual, Chapter 12, Section 50, Paragraph C, as they existed at the time of the applicable claim submission.
(2) No reimbursement shall be made for an anesthesiologist assistant or a student registered nurse anesthetist unless those provider types are otherwise eligible for licensure or certification and appropriately enrolled with the department and, if applicable, a managed care organization.

(15) Subject: Request to remove permissive language in Section 8 of 907 KAR 3:010.
(a) Comment: C. Wright Pinson, MD, MBA, Vanderbilt University Medical Center submitted comments requesting that language relating to a service's eligibility for reimbursement be removed in favor of a mandatory reimbursement at the Physician Fee Schedule's amount.
(b) Response: For a service to be reimbursed, any other relevant requirements, including medical necessity pursuant to 907 KAR 3:130, must be met. As a result, it is most appropriate to draft the administrative regulation to allow for the service to be reimbursed but to make that reimbursement contingent on meeting the other relevant requirements of Title 907 KAR. In addition, the existing Section 8 is being replaced by a more clear directive to follow Medicare claim submission guidelines.

(16) Subject: Introduce student registered nurse anesthetists into the Medicaid Program.
(a) Comment: C. Wright Pinson, MD, MBA, Vanderbilt University Medical Center submitted

comments requesting that student registered nurse anesthetists be allowed to participate.
(b) Response: The department does not have the authority to introduce student registered nurse anesthetists as a provider type. Additional licensure and regulatory authority would be needed from the Kentucky Board of Nursing prior to the introduction of this new provider type. The department will not be amending the administrative regulation in response to the comment.

(17) Subject: Cost to department to implement medical direction.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists submitted comments requesting additional information about how adding a new service would have no cost to Kentucky Medicaid.
(b) Response: The department often adds cost neutral services to the Medicaid program. As the source of health coverage for more than one-third of Kentuckians, the department regularly implements new services and eliminates or constrains existing services. Because the population of Medicaid recipients is so large, utilizing new services can create scenarios where cost efficiencies are realized. Reasons for cost efficiencies can include shifting costs from more expensive services to less expensive services, or to intensify the number of providers available for a specific service and to encourage better outcomes.

More significantly, a recent audit indicates that multiple providers have already been utilizing medical direction and submitting separate claims. As such, by more clearly establishing claim editing within DMS and MCO systems, the department may not see any additional costs. As a result, the department cannot reliably assess a cost increase or decrease for the adding of medical direction services. The department will not be amending the regulation in response to the comment.

(18) Subject: Use of phrase "qualified individual" in referring to eligible anesthesia providers.
(a) Comment: Rebecca Randall, Sr. Director, Operations, Wellcare Health Plans of Kentucky and Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists submitted comments requesting that a definition that refers to eligible providers be modified to explicitly state "a certified registered nurse anesthetist, or qualified anesthesia provider eligible for licensure in Kentucky". The comments further state that CHFS and DMS would not be able to extend authority to provide anesthesia services to additional providers.
(b) Response: The term "appropriate and qualified anesthesia provider" or the requested phrase "a certified registered nurse anesthetist, or qualified anesthesia provider eligible for licensure in Kentucky" are functionally identical. However, DMS wants to ensure that medical anesthesia is billed appropriately based on the governing laws in the state in which the service is provided. As a result, DMS is utilizing the more inclusive language that does not restrict all providers to Kentucky licensure. The department will not be amending the administrative regulation in response to the comment.

(19) Subject: Telehealth and Medical Direction..
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists submitted comments requesting that any allowance of telehealth be removed because of a contention that any telehealth involved in medical direction would only be for the convenience of the provider.
(b) Response: Over the previous year, the COVID-19 pandemic has caused an unprecedented in-

crease in the need for and interest in telehealth services. In reviewing this service, the department felt like this was the most likely place where any kind of a telehealth accommodation could be made. Whether this limited instance is permissible via telehealth will still be subject to federal and licensing board restrictions, as well as medical necessity criteria restrictions. However, going forward, all department telehealth permissions and restrictions will be reflected in 907 KAR 3:170, and it is appropriate to include a reference to that administrative regulation in this place to accommodate any future telehealth expansions in this area. The department will not be amending the administrative regulation in response to the comment.

(20) Subject: Provider nondiscrimination and medical direction.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists; and Randall D. Moore, DNP, MBA, CRNA, Chief Executive Officer, American Association of Nurse Anesthetists submitted comments arguing that the federal nondiscrimination requirement in a recently amended section of the Public Health Service Act requires equal payment for nurse anesthetists and anesthesiologists.
(b) Response: The new provider nondiscrimination requirements have not yet been implemented or clarified by the Centers for Medicare and Medicaid Services. As such, the department will wait for additional federal guidance before implementing any necessary changes. The department will not be amending the administrative regulation in response to the comment.

(21) Subject: Coverage of Medical Direction Modifiers QK and QY.
(a) Comment: Rebecca Randall, Sr. Director, Operations, Wellcare Health Plans of Kentucky submitted comments inquiring as to whether both medical direction of anesthesia will be covered as well as anesthesia under medical direction.
(b) Response: The department's intent is to cover all medical direction services. These services are currently described by the medical direction modifiers QK, QY, and QX. The department will not be amending the administrative regulation in response to the comment.

(22) Subject: Reimbursement of Medical Direction.
(a) Comment: Rebecca Randall, Sr. Director, Operations, Wellcare Health Plans of Kentucky submitted comments noting that "medical direction" was deleted from 907 KAR 3:010 and that the body of the regulation does not address reimbursement for medical direction.
(b) Response: The department has replaced the term "medical direction" with the term "anesthesia under medical direction" in the definition section. The term "medical direction" had been removed entirely from the regulation by the amendments, and could not remain in the regulation due to KRS Chapter 13A requirements. The department will not be amending the administrative regulation in response to the comment.

(23) Subject: Coverage of Anesthesia under Medical Direction (QX).
(a) Comment: Rebecca Randall, Sr. Director, Operations, Wellcare Health Plans of Kentucky submitted comments indicating that anesthesia under medical direction, as described by modifier QX is not addressed in 907 KAR 3:005, but is addressed under 907 KAR 3:010.
(b) Response: The department has removed a prohibition against reimbursement for medical direction in 907 KAR 3:005.

(24) Subject: Amount of reimbursement of anesthesia under medical direction.

(a) Comment: Rebecca Randall, Sr. Director, Operations, Wellcare Health Plans of Kentucky submitted comments requesting that information and methodology relating to reimbursement for anesthesia under medical direction be included in the administrative regulation.
(b) Response: The department prefers to not include exact reimbursement amounts within the bodies of administrative regulations due to the times involved in changing an administrative regulation. The length of time involved in changing reimbursement can be negative for any providers as the published Physician Fee Schedule can change reimbursement amounts more quickly than a regulation can be amended. The department will not be amending the administrative regulation in response to the comment.

(25) Subject: Medical supervision of anesthesia and Anesthesia under Medical Supervision.
(a) Comment: C. Wright Pinson, MD, MBA, Vanderbilt University Medical Center, submitted comments requesting that medical supervision become a covered service within Kentucky Medicaid.
(a) Comment: Rebecca Randall, Sr. Director, Operations, Wellcare Health Plans of Kentucky submitted comments acknowledging that medical supervision of anesthesia is not addressed in either administrative regulation (907 KAR 3:005 and 907 KAR 3:010) and inquiring as to whether these services are covered.
(b) Response: The department is not covering medical supervision of anesthesia or anesthesia under medical supervision at this time. The administrative regulation will not be amended in response to the comment.

(26) Subject: Modifiers relating to Medical Direction.
(a) Comment: Kristen Safier, Esq., Senior Counsel, Legal Department, Cincinnati Children's Hospital Medical Center submitted comments requesting that the appropriate modifiers for medical direction services be included within the administrative regulation.
(b) Response: Except in rare cases – most notably when implementing telehealth legislation – the department prefers to not place specific modifiers within administrative regulation. The administrative regulation promulgation process is too lengthy to adequately capture when medical practice changes to a different type of modifier. The administrative regulation will not be amended in response to the comment.

(27) Subject: Discontinued Procedure.

(a) Comment: Rebecca Randall, Sr. Director, Operations, Wellcare Health Plans of Kentucky submitted comments requesting that DMS recognize and adopt a partial reimbursement for a procedure when the practitioner starts, but terminates due to extenuating circumstances or circumstances that threaten the patient’s well-being. The suggestion is for 50% of the normal reimbursement for such a scenario, and would use Modifier 53 on the claim.

(b) Response: The department does not currently reimburse for discontinued procedures. The department needs to conduct additional analysis, including a more in-depth fiscal analysis, prior to implementing a discontinued procedure reimbursement. Therefore, at this time, the department will not implement a discontinued procedure reimbursement. The department will not be amending the administrative regulation in response to the comment.

(28) Subject: Codes not listed on fee schedule not eligible for reimbursement.

(a) Comment: Rebecca Randall, Sr. Director, Operations, Wellcare Health Plans of Kentucky submitted comments recommending that DMS add a statement to 907 KAR 3:010 that establishes that if a code is not listed on the DMS physician fee schedule that it is ineligible for reimbursement.
(b) Response: The department disagrees that codes listed on a fee schedule are the entirety of services that can be provided within the Medicaid program. Services can be described within administrative regulations and yet not have a corresponding code on a DMS fee schedule. DMS discourages sole reliance on published fee schedules. The department will not be amending the administrative regulation in response to the comment.

(29) Subject: Request to collaborate with Kentucky Association of Nurse Anesthetists prior to changing anesthesia policy.
(a) Comment: Libby Milligan, Principal, McCarthy Strategic Solutions, LLC, on behalf of the Kentucky Association of Nurse Anesthetists stated that "we were not privy to beginning discussions of these regulations, we welcome the opportunity to be a part of the solution."
(b) Response: The impetus for these changes – in addition to strong stakeholder support from state university teaching hospitals and the state anesthesiologist associations – involves improving access to anesthesiology services and promoting correct billing practices when services are provided under medical direction. In order for Kentucky Medicaid recipients to continue to have access to anesthesiology services and to ensure appropriate billing by all facilities, including out-of-state facilities, the department is electing to more clearly and adequately reimburse for medical direction services.

Furthermore, the department does not customarily engage in broad pre-filing access to Medicaid administrative regulations for the provider community. Due to recent statutory changes, the comment period associated with the filing of administrative regulations has more than doubled. Requesting that all stakeholders monitor and participate in the administrative regulation promulgation process established in KRS Chapter 13A is not a method of excluding any provider groups or other stakeholders. Instead, the department is attempting to utilize scarce resources as effectively as possible in order to make needed policy changes. The department has fully considered all comments made by all stakeholders through this Statement of Consideration process. In addition, multiple teleconferences have been held with the Kentucky Association of Nurse Anesthetists in discussing and explaining the need for these changes. The department will not be amending the administrative regulation in response to the comments.

V. SUMMARY OF STATEMENT OF CONSIDERATION AND ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 15:070. This administrative regulation is being amended after comments. DMS is amending the administrative regulations as follows:

Section 8
Page 10

Line 5

After "Section 8.", insert the following:

Medical Direction of Anesthesia and Anesthesia Under Medical Direction Services. (1) A provider or facility performing medical direction shall comply with all Medicare requirements to perform medical direction services located in 42 C.F.R. 415.110 and as found in the Medicare Claims Processing Manual, Chapter 12, Section 50, Paragraph C, as they existed at the time of the applicable claim submission.

(2) No reimbursement shall be made for an anesthesiologist assistant or a student registered nurse anesthetist unless those provider types are otherwise eligible for licensure or certification and appropriately enrolled with the department and, if applicable, a managed care organization

Delete the remaining language in Section 8.