CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy
(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, 438.20,~~[,,]~~ 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 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 Web site at: https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx. Any fee schedule posted shall comply with all relevant existing rate methodologies utilized by the department and established by state and federal law. As appropriate and relevant, the department shall utilize the Medicaid Physician Fee Schedule established in 907 KAR 3:010 to inform and populate the Hearing Program Fee Schedule.

(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.

LISA D. LEE, Commissioner
ERIC C. FRIEDLANDER, Secretary

APPROVED BY AGENCY: December 19, 2022

FILED WITH LRC: December 29, 2022 at 11:30 a.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on March 27, 2023, 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 March 20, 2023, 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 March 31, 2023. 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 Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-6746; fax 502-564-7091; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Jonathan Scott and Krista Quarles

(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 changes the administrative regulation by removing an age limit of 21 on receiving vision services. This will allow adults to receive vision services within the Medicaid program.

(b) The necessity of the amendment to this administrative regulation:
This amendment is necessary to implement the approval of a state plan amendment.

(c) How the amendment conforms to the content of the authorizing statutes:
The amendment conforms to the content of the authorizing statutes by implementing a state plan amendment.

(d) How the amendment will assist in the effective administration of the statutes:
The amendment assists in the effective administration of the statutes by effectively implementing a state plan amendment.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:
This administrative regulation will impact all adult recipients in the Medicaid program. DMS anticipates that this could be as many as 900,000 individuals. In addition, 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:

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

(a) Initially:

The Department for Medicaid Services (DMS) anticipates an increase of about $0.25 for each adult beneficiary's per member per month capitation (PMPM) managed care organization (MCO) capitation rate. The total state expenditure for this additional benefit should be about $150,000. This expenditure should be balanced against expected savings that could be generated within the Medicaid adult population. Consistent with national trends, DMS expects that Medicaid hearing coverage will decrease the likelihood of dementia, depression, anxiety, and even myocardial infarctions. DMS furthermore expects that up to 16% of Kentucky adults have some degree of hearing loss, and that quality of life and employment opportunities could increase as a result of this additional benefit. This could result in individuals leaving the Medicaid program as a result of receiving full-time employment.

(b) On a continuing basis:

DMS anticipates that additional actuarial analysis of hearing services utilization could reduce the annual PMPM for hearing services or even the overall PMPM. The availability of additional hearing services should be beneficial for the adult population, as this is the third most common chronic condition in the United States. DMS does expect some movement out of the Medicaid program could be expected for adult beneficiaries able to access adequate hearing services. Absent additional information, DMS will continue to anticipate a $0.25 PMPM and an approximately $150,000 annual expenditure in state funds.

(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 no longer applied within this administrative regulation as audiology services are now available to all Medicaid recipients.

FEDERAL MANDATE ANALYSIS COMPARISON

(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

(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?

The Department for Medicaid Services (DMS) anticipates an increase of about $0.25 for each adult beneficiary's per member per month capitation (PMPM) managed care organization (MCO) capitation rate. The total state expenditure for this additional benefit should be about $150,000. This expenditure should be balanced against expected savings that could be generated within the Medicaid adult population. Consistent with national trends, DMS expects that Medicaid hearing coverage will decrease the likelihood of dementia, depression, anxiety, and even myocardial infarctions. DMS furthermore expects that up to 16% of Kentucky adults have some degree of hearing loss, and that quality of life and employment opportunities could increase as a result of this additional benefit. This could result in individuals leaving the Medicaid program as a result of receiving full-time employment.

(d) How much will it cost to administer this program for subsequent years?

DMS anticipates that additional actuarial analysis of hearing services utilization could reduce the annual PMPM for hearing services or even the overall PMPM. The availability of additional hearing services should be beneficial for the adult population, as this is the third most common chronic condition in the United States. DMS does expect some movement out of the Medicaid program could be expected for adult beneficiaries able to access adequate hearing services. Absent additional information, DMS will continue to anticipate a $0.25 PMPM and an approximately $150,000 annual expenditure in state funds.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):No answer provided.

Expenditures (+/-):

Other Explanation:

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year?

DMS does not anticipate that cost savings will be generated for regulated entities as a result of the amendments to this administrative regulation in the first year. This administrative regulation may result in higher reimbursement for regulated entities.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years?

DMS does not anticipate that cost savings will be generated for regulated entities as a result of the amendments to this administrative regulation in subsequent years. This administrative regulation may result in higher reimbursement for regulated entities.

(c) How much will it cost the regulated entities for the first year?

DMS does not anticipate that regulated entities will incur costs as a result of this amendment in the first year.

(d) How much will it cost the regulated entities for subsequent years?

DMS does not anticipate that regulated entities will incur costs as a result of this amendment in subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Cost Savings (+/-):No answer provided.

Expenditures (+/-):No answer provided.

Other Explanation:

No answer provided.

(5) Explain whether this administrative regulation will have a major economic impact, as defined below.

"Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)] The administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities. DMS anticipates that this amendment may result in additional reimbursement for dentists.