CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Healthcare Policy
(Amendment)

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

RELATES TO: KRS 205.560, 205.565, 210.370-210.485, 311.840, 42 C.F.R. 400.203, Part 414, 415.110, 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

CERTIFICATION STATEMENT:

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

Section 1. Definitions.

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

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

(a) Directed by an anesthesiologist;

(b) Delivered by an appropriate and qualified anesthesia provider, including a certified registered nurse anesthetist; and

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

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

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

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

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

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

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

(10) "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) "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) "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) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.
(14) "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) "Major surgery" means a surgical procedure assigned a ninety (90) day global period.
(16) "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) "Medicaid Physician Fee Schedule" means a list, located at https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx, 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 annually~~[quarterly]~~ to include~~[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.
(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 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 at least one licensed physician~~[a group of at least two (2) individually licensed physicians]~~ who:
(a) Is ~~[Are]~~ enrolled with the Medicaid program individually and as a group; and
(b) Share the same Medicaid group provider number, if more than one physician is in the group.
(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 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 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 letter modifier, as applicable, 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.

(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 neuraxial[~~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 neuraxial[~~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 neuraxial[~~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.

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 those Medicare requirements existed at the time of the applicable claim submission. This is a link to the Medicare Claims Processing Manual, Chapter 12, as it existed in July 2021: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

(2) A reimbursement shall not be made for an anesthesiologist assistant or a student registered nurse anesthetist unless those provider types are:

(a) Otherwise eligible for licensure or certification;

(b) Appropriately enrolled with the department; and

(c) If applicable, a managed care organization.

Section 9. Vaccines.

(1) The department shall reimburse administration of a:

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

(b) Department approved vaccines; or

(c) [~~(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 administered [~~isadministered~~] to a recipient by a provider.

(b) For those providers who are enrolled in the Vaccines for Children Program, the department shall not reimburse for the cost of a vaccine if the vaccine is readily available at the provider's facility and free through the Vaccines for Children Program in accordance with 42 U.S.C. 1396s[~~,~~] and 907 KAR 1:680.

Section 10. 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. Reimbursement Limits and Related Requirements.

(1) 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.

(2) 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.

(3) 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.

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

(5) 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.

(6) If 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.

(7) 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. Other Provider Preventable Conditions. In accordance with 907 KAR 14:005, the department shall not reimburse for other provider preventable conditions.

Section 13. Supplemental Payments.

(1) In addition to a reimbursement made pursuant to Sections 2 through 11 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 an annual basis.

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

Section 15. 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. 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. 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.

LISA D. LEE, Commissioner
STEVEN J. STACK, MD, MBA, Secretary

APPROVED BY AGENCY: October 6, 2025

FILED WITH LRC: January 7, 2026 at 12:30 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on March 23, 2026, 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 16, 2026, 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 through March 31, 2026. 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, KY 40621; Phone: 502-564-7476; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Jonathan Scott and Krista Quarles

Subject Headings:Medicaid, Health and Medical Services, Physicians and Practitioners

(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 establish reimbursement requirements 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 requirements for physician services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes:
This administrative regulation assists with the effective administration of the statutes by establishing reimbursement requirements 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 amendment changes this administrative regulation by updating the timeline for the updates to the Physician Fee Schedule to align with the annual updates made by the Centers for Medicare and Medicaid Services, update the definition of a provider group, and update the vaccinations eligible for reimbursement by the provider.

(b) The necessity of the amendment to this administrative regulation:
This amendment to this administrative regulation is necessary to update DMS policy relating to the updated timeline for the Physician Fee Schedule updates, provider groups, and reimbursement eligibility for vaccinations.

(c) How the amendment conforms to the content of the authorizing statutes:
This amendment conforms to the content of the authorizing statutes by ensuring adequate services and physician networks are available to Medicaid recipients.

(d) How the amendment will assist in the effective administration of the statutes:
This amendment will assist in the effective administration of the statutes by addressing the services provided by providers and physicians within the Medicaid program.

(3) Does this administrative regulation or amendment implement legislation from the previous five years?No.

(4) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:
There are more than 73,000 providers in the Medicaid program.

(5) Provide an analysis of how the entities identified in question (4) 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 (4) will have to take to comply with this administrative regulation or amendment:

There are no actions that will need to be taken for entities to comply.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (4):

There will be no additional costs to entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (4):

Providers will have clarity on the reimbursable vaccinations available to Medicaid recipients.

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

(a) Initially:

There are no costs to implement this administrative regulation.

(b) On a continuing basis:

There are no ongoing costs to implement this administrative regulation.

(7) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation or this amendment:

Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(8) 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:

An increase in fees or funding is not necessary to implement the amendments to this admin

(9) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees:

This administrative regulation does not establish or increase any fees.

(10) TIERING: Is tiering applied?

Tiering is not applied in this administrative regulation because the administration regulation applies equally to all individuals and entities regulated by it.

FISCAL IMPACT STATEMENT

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

(2) Identify the promulgating agency and any other affected state units, parts, or divisions:
Cabinet for Health and Family Services, Department for Medicaid Services

(a) Estimate the following for the first year:

Expenditures:N/A

Revenues:N/A

Cost Savings:N/A

(b) How will expenditures, revenues, or cost savings differ in subsequent years?
There are no anticipated changes in subsequent years.

(3) Identify affected local entities (for example: cities, counties, fire departments, school districts):
None identified

(a) Estimate the following for the first year:

Expenditures:N/A

Revenues:N/A

Cost Savings:N/A

(b) How will expenditures, revenues, or cost savings differ in subsequent years?
N/A

(4) Identify additional regulated entities not listed in questions (2) or (3):
None identified.

(a) Estimate the following for the first year:

Expenditures:N/A

Revenues:N/A

Cost Savings:N/A

(b) How will expenditures, revenues, or cost savings differ in subsequent years?
There are no anticipated changes in subsequent years.

(5) Provide a narrative to explain the:

(a) Fiscal impact of this administrative regulation:
DMS does not anticipate additional costs, expenditures, or revenues as a result of the amendments to this administrative regulation.

(b) Methodology and resources used to determine the fiscal impact:
Departmental assessment of utilization patterns, nongovernmental payer experiences with evaluation and management services reimbursement, and anticipated improved treatment outcomes from appropriate utilization of utilization and management services.

(6) Explain:

(a) Whether this administrative regulation will have an overall negative or adverse major economic impact to the entities identified in questions (2) - (4). ($500,000 or more, in aggregate)

The administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities.

(b) The methodology and resources used to reach this conclusion:

Departmental assessment of reimbursement associated with evaluation and management services.

FEDERAL MANDATE ANALYSIS COMPARISON

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

(2) State compliance standards.
KRS 194A.030(2) requires the Department for Medicaid Services to "serve as the single state agency in the commonwealth to administer Title XIX of the Federal Social Security Act".

(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