

**OFFICE OF THE GOVERNOR**  
**Department of Workers' Claims**  
**(Amendment)**

**120 KAR 1:091. Workers' compensation hospital fee schedule.**

RELATES TO: KRS 216B.105, 342.020, 342.035, 342.315

STATUTORY AUTHORITY: KRS 342.020, 342.035(1), 342.260(1)

CERTIFICATION STATEMENT:

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.035(1) and 342.260(1) require the Commissioner of the Department of Workers' Claims to promulgate administrative regulations to adopt a medical fee schedule for fees, charges and reimbursements under KRS 342.020. KRS 342.020 requires the employer to pay for hospital treatment, including nursing, medical, and surgical supplies and appliances. This administrative regulation establishes hospital fees for services and supplies provided to workers' compensation patients pursuant to KRS 342.020.

**Section 1. Definitions.**

- (1) "Ambulatory surgery center" means a public or private institution that is:
  - (a) Hospital based or freestanding;
  - (b) Operated under the supervision of an organized medical staff; and
  - (c) Established, equipped, and operated primarily for the purpose of treatment of patients by surgery, whose recovery under normal circumstances will not require inpatient care.
- (2) "Hospital" means a facility; surgical center; psychiatric, or other treatment or specialty center that is licensed pursuant to KRS 216B.105 or, if located in another state, is licensed pursuant to the laws of the other state, and shall include a facility that is approved as a rehabilitation agency under the Medicare or Medicaid programs.
- (3) "Hospital-based practitioner" means a provider of medical services who is an employee of the hospital and who is paid by the hospital.
- (4) "Independent practitioner" means a physician or other practitioner who performs services that are covered by the Kentucky Workers' Compensation Medical Fee Schedule for Physicians, incorporated by reference in 803 KAR 25:089, on a contract basis and who is not a regular employee of the hospital.
- (5) "New hospital" means a hospital that has not completed its first fiscal year.

**Section 2. Applicability.** This administrative regulation shall apply to all workers' compensation patient hospital and ambulatory surgery center fees for each hospital and ambulatory surgery center for each compensable service or supply.

**Section 3. Calculation of Hospital's Base and Adjusted Cost-to-charge Ratio; Reimbursement.**

- (1)
  - (a) The commissioner shall calculate cost-to-charge ratios and notify each hospital of its adjusted cost-to-charge ratio on or before February 1 of each calendar year.
  - (b) A hospital's base cost-to-charge ratio shall be based on the latest cost report, or HCFA-2552, which has been supplied to the Cabinet for Health and Family Services, Department of Medicaid Services, pursuant to 907 KAR 1:815 and utilized in 907 KAR 1:820 and 1:825 on file as of October 31 of each calendar year.
  - (c) The base cost-to-charge ratio shall be determined by dividing the net expenses for allocation as reflected on Worksheet A, Column 7, Line 118 plus the costs of hospital-based physicians and nonphysician anesthesiologists reflected on lines 10 and 28 of Worksheet A-8, by the total patient revenues as reflected on line 28 of Worksheet G-2

of the HCFA-2552. The adjusted cost-to-charge ratio shall be determined as established in paragraph (d) of this subsection.

(d)

1. The base cost-to-charge ratio shall be further modified to allow for a return to equity by multiplying the base cost-to-charge ratio by 132 percent except that a hospital with more than 400 licensed acute care beds as shown by the Cabinet for Health and Family Services, Office of Inspector General's website or a hospital that is designated as a Level I trauma center by the American College of Surgeons shall have a return to equity by multiplying its base cost-to-charge ratio by 138 percent.

2. If a hospital's base cost-to-charge ratio falls by ten (10) percent or more of the base for one (1) reporting year, the next year's return to equity shall be reduced from 132 percent to 130 percent or 138 percent to 135 percent as determined by subparagraph 1. of this paragraph.

a. This reduction shall be subject to an appeal pursuant to Section 4 of this administrative regulation.

b. Upon written request of the hospital seeking a waiver and a showing of extraordinary circumstances, the commissioner shall waive the reduction for no more than one (1) consecutive year.

c. The determination of the commissioner shall be made upon the written documents submitted by the requesting hospital.

(e)

1. Except as established in subparagraph 2 of this paragraph, a hospital's adjusted cost-to-charge ratio shall not exceed fifty (50) percent, including the return to equity adjustment.

2. The adjusted cost-to-charge ratio shall not exceed sixty (60) percent for a hospital that:

a. Has more than 400 licensed acute care beds as shown by the Cabinet for Health and Family Services, Office of Inspector General's Web site;

b. Is designated as a Level I trauma center by the American College of Surgeons;

c. Services sixty-five (65) percent or more patients covered and reimbursed by Medicaid or Medicare as reflected in the records of the Cabinet for Health and Family Services, Department of Medicaid Services; or

d. Has a base cost-to-charge ratio of fifty (50) percent or more.

(2)

(a) Except as established in paragraph (b) and (c) of this subsection, the reimbursement to a hospital for services or supplies furnished to an employee that are compensable under KRS 342.020 shall be calculated by multiplying the hospital's charges by its adjusted cost-to-charge ratio after removing any duplicative charges, billing errors, charges for services or supplies not confirmed by the hospital records, and charges for surgical implants and surgical hardware.

(b) If part of a bill for services or supplies is alleged to be noncompensable under KRS 342.020 and that part of the bill is challenged by the timely filing of a medical fee dispute or motion to reopen, the noncontested portion of the bill shall be paid in accordance with paragraph (a) of this subsection.

#### Section 4. Appeal of Assigned Ratio.

(1) A hospital may request a review of its assigned ratio. A written appeal to request a review shall be filed with the commissioner no later than thirty (30) calendar days after the ratio has been assigned and the hospital notified of its proposed cost-to-charge ratio.

(2) The determination of the commissioner shall be made upon the written documents submitted by the requesting hospital.

Section 5. Calculations of New Hospitals, Hospitals that do not file Worksheets A and G-2 of HCFA-2552 and ASC's within the Commonwealth of Kentucky.

(1)

(a) A new hospital shall be assigned a cost-to-charge ratio equal to the average adjusted cost-to-charge ratio of all existing in-state acute care hospitals until it has been in operation for one (1) full fiscal year.

(b) A hospital that does not file Worksheets A and G-2 of HCFA 2552 shall be assigned a cost-to-charge ratio as follows:

1. A psychiatric, rehabilitation, or long-term acute care hospital shall be assigned a cost-to-charge ratio equal to 125 percent of the average adjusted cost-to-charge ratio of all in-state acute care hospitals;

2. An ambulatory surgery center shall be assigned a cost-to-charge ratio equal to:

a. 120 percent of the average adjusted cost-to-charge ratio of all acute care hospitals located in the same county as the ambulatory surgery center;

b. 120 percent of the average adjusted cost-to-charge ratio of all acute care hospitals located in counties contiguous to the county in which the ambulatory surgery center is located, if an acute care hospital is not located in the county of the ambulatory surgery center; or

c. The adjusted cost-to-charge ratio of the base hospital if:

(i) The center is hospital based;

(ii) It is a licensed ambulatory surgery center pursuant to 902 KAR 20:106; and

(iii) It is a Medicare provider based entity;

d. Except as provided in subparagraph c, an ambulatory surgical center's adjusted cost-to-charge ratio shall not exceed fifty (50) percent; and

3. All other hospitals not specifically mentioned in subparagraphs 1 or 2 of this paragraph shall be assigned a cost-to-charge ratio equal to:

a. The average adjusted cost-to-charge ratio of all acute care hospitals located in the same county as the facility; or

b. If there are no hospitals in the county, the average of all acute care hospitals located in contiguous counties.

(2) An assigned cost-to-charge ratio shall remain in full force and effect until a new cost-to-charge ratio is assigned by the commissioner.

(3)

(a) Reimbursement to an ambulatory surgical center for services or supplies furnished to an employee that are compensable under KRS 342.020 shall be calculated by multiplying the ambulatory surgical center's charges by its assigned cost-to-charge ratio after removing any duplicative charges, billing errors, charges for services or supplies not confirmed by ambulatory surgical center records, and charges for surgical implants and surgical hardware.

(b) If part of a bill for services or supplies is alleged to be noncompensable under KRS 342.020 and that part of the bill is challenged by the timely filing of a medical fee dispute or motion to reopen, the noncontested portion of the bill shall be paid in accordance with paragraph (a) of this subsection.

Section 6. Calculation for Hospitals and Ambulatory Surgery Centers Located Outside the Commonwealth of Kentucky.

(1) A hospital or ambulatory surgery center located outside the boundaries of Kentucky shall be deemed to have agreed to be subject to this administrative regulation if it accepts a patient for treatment who is covered under KRS Chapter 342.

(2) The base cost-to-charge ratio for an out-of-state hospital shall be calculated in the same manner as for an in-state hospital, using Worksheets A and G-2 of the HCFA 2552.

(3) An out-of-state ambulatory surgery center having no contiguous Kentucky counties shall be assigned a cost-to-charge ratio equal to 120 percent of the average adjusted cost-to-charge ratio of all existing in-state acute care hospitals.

(4) An out-of-state ambulatory surgery center having one (1) or more contiguous Kentucky counties shall be assigned a cost-to-charge ratio in accordance with Section 5(1)(b)2.b. of this administrative regulation.

(5) An out-of-state ambulatory surgical center's assigned cost-to-charge ratio shall not exceed fifty (50) percent.

Section 7. Reports to be filed by Hospitals. Each bill submitted by a hospital pursuant to this administrative regulation shall be submitted on a statement for services, Form UB-04 (Formerly UB-92), as required by 803 KAR 25:096.

Section 8. Billing and Audit Procedures.

(1) A hospital providing the technical component of a procedure shall bill and be paid for the technical component.

(2)

(a) An independent practitioner providing the professional component shall bill for and be paid for the professional component.

(b) An independent practitioner billing for the professional component shall submit the bill to the insurer on the appropriate statement for services, HCFA 1500, as required by 803 KAR 25:096.

(3) If more than one (1) procedure is performed during a surgical session, an Ambulatory Surgical Center may charge a facility fee for each procedure performed. For the purpose of reimbursement, the total charge for all facility fees shall not exceed 150 percent of the facility fee charged for the primary procedure. A physician may submit charges on form HCFA 1500 using appropriate CPT codes.

Section 9. Miscellaneous.

(1) A new hospital shall file a letter with the commissioner setting forth the start and end of its fiscal year within ninety (90) days of the date it commences operation.

(2)

(a) An independent practitioner who does not receive direct compensation from the contracting hospital shall use the statement for services established by 803 KAR 25:096 if billing for professional services and shall be compensated pursuant to the Kentucky Workers' Compensation Medical Fee Schedule for Physicians, incorporated by reference in 803 KAR 25:089.

(b) An independent practitioner who is directly compensated for services by the contracting hospital shall not bill for the service, but shall be compensated pursuant to the practitioner's agreement with the hospital.

(c) The hospital may bill for the professional component of the service under the Kentucky Workers' Compensation Medical Fee Schedule for Physicians if the independent practitioner is directly compensated for services by the contracting hospital.

(3) A hospital-based practitioner shall not bill for a service he performs in a hospital if the service is regulated by 803 KAR 25:089, but he or she shall receive payment or salary directly from the employing hospital.

(19 Ky.R. 1026; 1396; 1755; eff. 2-2-1993; 21 Ky.R. 1569; 1884; 2130; eff. 2-9-1995; 23 Ky.R. 2619; 2988; eff. 2-10-1997; TAm eff. 8-9-2007; 35 Ky.R. 1907; 2304; 2435; eff. 6-5-2009; 37 Ky.R. 1080; 2005; eff. 3-4-2011; TAm eff. 10-25-2011; 47 Ky.R. 803, 1597; 48 Ky.R. 824; eff. 11-30-2021.)