

907 KAR 1:102. Advanced practice registered nurse services.

RELATES TO: KRS 205.520, 205.622, 205.8451, 314.011, 369.101 – 369.120, 42 C.F.R. 400.203, 431.17, 438.2, 455.410, 45 C.F.R. Parts 160, 164, 42 U.S.C. 1320d – 1320d-8, 1396r-8

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 provisions relating to advanced practice registered nurse services covered by the Medicaid Program.

Section 1. Definitions.

- (1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).
- (2) "Common practice" means an arrangement through which a physician and an APRN jointly administer health care services.
- (3) "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.
- (4) "Department" means the Department for Medicaid Services or its designated agent.
- (5) "Enrollee" means a recipient who is enrolled with a managed care organization.
- (6) "Face-to-face" means occurring:
 - (a) In person; or
 - (b) If authorized by 907 KAR 3:170, via a real-time, electronic communication that involves two (2) way interactive video and audio communication.
- (7) "Federal financial participation" is defined by 42 C.F.R. 400.203.
- (8) "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.
- (9) "Incidental" means that a medical procedure is:
 - (a) Performed at the same time as a primary procedure; and
 - (b) Clinically integral to the performance of the primary procedure.
- (10) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.
- (11) "Locum tenens APRN" means an APRN:
 - (a) Who temporarily assumes responsibility for the professional practice of an APRN participating in the Kentucky Medicaid Program; and
 - (b) Whose services are billed under the Medicaid participating APRN's provider number.
- (12) "Locum tenens physician" means a substitute physician:
 - (a) Who temporarily assumes responsibility for the professional practice of an APRN participating in the Kentucky Medicaid Program; and
 - (b) Whose services are billed under the Medicaid participating APRN's provider number.
- (13) "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.
- (14) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
- (15) "Mutually exclusive" means that two (2) procedures:

- (a) Are not reasonably performed in conjunction with one (1) another 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.
- (16) "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.
- (17) "Provider" is defined by KRS 205.8451(7).
- (18) "Provider group" means a group of at least two (2) individually licensed APRNs who:
- (a) Are enrolled with the Medicaid Program individually and as a group; and
 - (b) Share the same Medicaid group provider number.
- (19) "Rebateable" means a drug for which the drug manufacturer has entered into and has in effect a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).
- (20) "Recipient" is defined by KRS 205.8451(9).
- (21) "Timely filing" means receipt of a Medicaid claim by the department within:
- (a) Twelve (12) months of the date the service was provided;
 - (b) Twelve (12) months of the date retroactive eligibility was established; or
 - (c) Six (6) months of the Medicare adjudication date if the service was billed to Medicare.

Section 2. Conditions of Participation.

- (1) To participate in the Medicaid program as a provider, an APRN or provider group shall comply with:
- (a) 907 KAR 1:005, 907 KAR 1:671, and 907 KAR 1:672; and
 - (b) The requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.
- (2) A provider:
- (a) Shall bill the:
 - 1. Department rather than the recipient for a covered service; or
 - 2. Managed care organization in which the recipient is enrolled if the recipient is an enrollee;
 - (b) May bill the recipient for a service not covered by Medicaid if the provider informed the recipient of non-coverage prior to providing the service; and
 - (c)
 - 1. Shall not bill the recipient for a service that is denied by the department on the basis of:
 - a. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;
 - b. Incorrect billing procedures including incorrect bundling of services;
 - c. Failure to obtain prior authorization for the service; or
 - d. Failure to meet timely filing requirements; and
 - 2. Shall not bill the enrollee for a service that is denied by the managed care organization in which the recipient is enrolled if the recipient is an enrollee on the basis of:

- a. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;
 - b. Incorrect billing procedures including incorrect bundling of services;
 - c. Failure to obtain prior authorization for the service if prior authorization is required by the managed care organization; or
 - d. Failure to meet timely filing requirements.
- (3)
 - (a) If a provider receives any duplicate payment or overpayment from the department or managed care organization, regardless of reason, the provider shall return the payment to the department or managed care organization that issued the duplicate payment or overpayment.
 - (b) Failure to return a payment to the department or managed care organization 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.
- (4)
 - (a) A provider shall maintain a current health record for each recipient.
 - (b)
 - 1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.
 - 2. The individual who provided the service shall date and sign the health record within seventy-two (72) hours from the date that the individual provided the service.
- (5)
 - (a) Except as established in paragraph (b) or (c) of this subsection, a provider shall maintain a health record regarding a recipient for at least six (6) years from the date of the service or until any audit dispute or issue is resolved beyond six (6) years.
 - (b) After a recipient's death or discharge from services, a provider shall maintain the recipient's record for the longer of the following periods:
 - 1. Six (6) years unless the recipient is a minor; or
 - 2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.
 - (c) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) or (b) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.
- (6) If a provider fails to maintain a health record pursuant to subsection (4) or (5) of this section, the department shall:
 - (a) Not reimburse for any claim associated with the health record; or
 - (b) Recoup from the provider any payment made associated with the health record.
- (7) A provider shall comply with 45 C.F.R. Part 164.
- (8)
 - (a) A service provided by an APRN to a recipient shall be substantiated by a health record signed by the APRN that corresponds to the date and service reported on the claim submitted for payment to the:
 - 1. Department if the claim is for a service to a recipient who is not an enrollee; or
 - 2. Managed care organization in which the recipient is enrolled if the recipient is an enrollee.
 - (b) If rendering services to a recipient in a hospital, an APRN shall document in the health record of the hospitalized recipient that the APRN performed one (1) or more of the following:
 - 1. A personal review of the recipient's medical history;
 - 2. A physical examination;

3. A confirmation or revision of the recipient's diagnosis;
4. A visit with the recipient; or
5. A discharge service for the recipient.

Section 3. APRN Covered Services.

(1)

(a) An APRN covered service shall be:

1. A medically necessary service furnished by an APRN through face-to-face interaction between the APRN and the recipient except as established in paragraph (c) of this subsection; and
2. A service that is:
 - a. Within the legal scope of practice of the APRN as specified in:
 - (i) 201 KAR 20:057; and
 - (ii) 201 KAR 20:059; and
 - b. Eligible for reimbursement by Kentucky Medicaid.

(b) Any service covered pursuant to 907 KAR 3:005 shall be covered under this administrative regulation if it meets the requirements established in paragraph (a) of this subsection.

(c) Face-to-face interaction between the APRN and recipient shall not be required for:

1. A radiology service;
2. An imaging service;
3. A pathology service;
4. An ultrasound study;
5. An echographic study;
6. An electrocardiogram;
7. An electromyogram;
8. An electroencephalogram;
9. A vascular study;
10. A telephone analysis of an emergency medical system or a cardiac pacemaker if provided under APRN direction;
11. A sleep disorder service;
12. A laboratory service; or
13. Any other service that is customarily performed without face-to-face interaction between the APRN and the recipient.

(2) The prescribing of drugs by an APRN shall be in accordance with 907 KAR 23:010.

(3) A covered delivery service provided in a:

(a) Hospital shall include:

1. Admission to the hospital;
2. Admission history;
3. Physical examination;
4. Anesthesia;
5. Management of uncomplicated labor;
6. Vaginal delivery; and
7. Postpartum care; or

(b) Freestanding birth center shall include:

1. Delivery services in accordance with 907 KAR 1:180, Section 3(3); and
2. Postnatal visits in accordance with 907 KAR 1:180, Section 3(4).

(4) An EPSDT screening service shall be covered if provided in compliance with the periodicity schedule established in 907 KAR 11:034.

(5) Behavioral health services established in 907 KAR 15:010 that are provided by an APRN or provider group that is the billing provider for the services shall be:

(a) Provided in accordance with 907 KAR 15:010; and

- (b) Covered in accordance with 907 KAR 15:010.
- (6) A drug listed on the Physician Administered Drug List shall be covered in accordance with 907 KAR 23:010.

Section 4. Service Limitations and Exclusions.

- (1)
 - (a) A limitation on a service provided by a physician in accordance with 907 KAR 3:005 shall apply to services covered under this administrative regulation.
 - (b) A service that is not covered pursuant to 907 KAR 3:005 shall not be covered under this administrative regulation.
- (2) The same service performed by an APRN and a physician on the same day within a common practice shall be considered as one (1) covered service.
- (3)
 - (a) Except as established in paragraph (b) of this subsection, coverage of a psychiatric service provided by an APRN shall be limited to four (4) psychiatric services per APRN, per recipient, per twelve (12) months.
 - (b) A service designated as a psychiatry service CPT code that is provided by an APRN with a specialty in psychiatry shall not be subject to the limit established in paragraph (a) of this subsection.
- (4) The department shall not cover more than one (1) of the following evaluation and management services per recipient per provider per date of service:
 - (a) A consultation service;
 - (b) A critical care service;
 - (c) An emergency department evaluation and management service;
 - (d) A home evaluation and management service;
 - (e) A hospital inpatient evaluation and management service;
 - (f) A nursing facility service;
 - (g) An office or other outpatient evaluation and management service; or
 - (h) A preventive medicine service.
- (5) Except for any cost sharing obligation pursuant to 907 KAR 1:604, a:
 - (a) Recipient shall not be liable for payment of any part of a Medicaid-covered service provided to the recipient; and
 - (b) Provider shall not bill or charge a recipient for any part of a Medicaid-covered service provided to the recipient.
- (6)
 - (a) In accordance with 42 C.F.R. 455.410, to prescribe medication, order a service for a recipient, or refer a recipient for a service, a provider shall be currently enrolled and participating in the Medicaid Program.
 - (b) The department shall not reimburse for a:
 - 1. Prescription prescribed by a provider that is not currently:
 - a. Participating in the Medicaid Program pursuant to 907 KAR 1:671; and
 - b. Enrolled in the Medicaid Program pursuant to 907 KAR 1:672; or
 - 2. Service:
 - a. Ordered by a provider that is not currently:
 - (i) Participating in the Medicaid Program pursuant to 907 KAR 1:671; and
 - (ii) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672; or
 - b. Referred by a provider that is not currently:
 - (i) Participating in the Medicaid Program pursuant to 907 KAR 1:671; and
 - (ii) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672.

Section 5. Prior Authorization Requirements. The prior authorization requirements established in 907 KAR 3:005 shall apply to services provided under this administrative regulation.

Section 6. Locum Tenens. The department shall cover services provided by a locum tenens APRN or locum tenens physician under this administrative regulation:

- (1) If the service meets the requirements established in this administrative regulation; and
- (2) In accordance with:
 - (a) 201 KAR 20:056; and
 - (b) 201 KAR 20:057.

Section 7. Duplication of Service Prohibited.

- (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.
- (2) For example, if a recipient is receiving a speech-language pathology service from a speech-language pathologist enrolled with the Medicaid Program under 907 KAR 8:030, the department shall not reimburse for the same service provided to the same recipient on the same day by another provider enrolled with the Medicaid Program.

Section 8. Third Party Liability. A provider shall comply with KRS 205.622.

Section 9. Use of Electronic Signatures.

- (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.
- (2) A provider that chooses to use electronic signatures shall:
 - (a) Develop and implement a written security policy that shall:
 1. Be adhered to by each of the provider's employees, officers, agents, or contractors;
 2. Identify each electronic signature for which an individual has access; and
 3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;
 - (b) Develop a consent form that shall:
 1. Be completed and executed by each individual using an electronic signature;
 2. Attest to the signature's authenticity; and
 3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and
 - (c) Provide the department, immediately upon request, with:
 1. A copy of the provider's electronic signature policy;
 2. The signed consent form; and
 3. The original filed signature.

Section 10. Auditing Authority. The department or the managed care organization in which an enrollee is enrolled shall have the authority to audit any:

- (1) Claim;
- (2) Health record; or
- (3) Documentation associated with the claim or health record.

Section 11. 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 12. Appeal Rights. An appeal of a department decision regarding:

- (1) A recipient who is not enrolled with a managed care organization based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563; or
- (2) An enrollee based upon an application of this administrative regulation shall be in accordance with 907 KAR 17:010.

(17 Ky.R. 2365; eff. 5-3-1991; Am. 19 Ky.R. 1453; eff. 1-27-1993; 27 Ky.R. 245; 811; eff. 9-11-2000; TAm eff. 4-28-2011; 41 Ky.R. 1920; 2268; 2556; eff. 7-6-2015; 44 Ky.R. 391, 1355; eff. 1-5-2018; Cert eff. 10-21-2024.)