LABOR CABINET

Department of Workers' Claims

(Amended After Comments)

803 KAR 25:091. 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)

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, rehabilitative, 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 such 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.

(6) "Surgical hardware" means any object that provides internal fixation but is not intended to replace or alter the part of an internal body organ and is not intended to replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. Surgical hardware can be removed after a healing period."

(7) "Surgical implant" means any single-use item/object/device which replaces all or part of an internal body organ, or replaces all or part of the function of a permanently inoperative or malfunctioning internal body organ.

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 anesthetists 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 set forth 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 provided 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 provided 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 total 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.

(c) Charges for surgical implants and surgical hardware shall be reimbursed at invoice cost plus fifteen (15) percent. Invoice cost shall not include shipping, handling, and taxes. Shipping, handling and taxes shall be reimbursed at the amount paid for those charges listed on the invoice. [The hospital shall provide a copy of the invoice and shall certify the actual cost of the item or items.]

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.

(c) Charges for surgical implants and surgical hardware shall be reimbursed at invoice cost plus fifteen (15) percent. Invoice cost shall not include shipping, handling, and taxes. Shipping, handling and taxes shall be reimbursed at the amount paid for those charges [listed on the invoice]. [The ambulatory service center shall provide a copy of the invoice and shall certify the actual cost of the item or items.]

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) When more than one (1) procedure is performed during a surgical session, an [Ambulatory Surgical Center] may charge a facility fee for each procedure performed; however, for the purpose of reimbursement, the total charge for all facility fees shall not exceed one hundred fifty percent (150%) of the facility fee charged for the primary procedure. [only one]
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 defined 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 shall receive payment or salary directly from the employing hospital.

[Section 10. Incorporation by Reference. (1) The following material is incorporated by reference:}
(a) Form UB-04, 10-23-06; and

(b) HCFA-1500, 12-90.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Workers' Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.]
This is to certify the commissioner has reviewed and recommended this administrative regulation prior to its adoption, as required by KRS 342.260, 342.270 and 342.285.

Robert L. Swisher, Commissioner
Department of Workers' Claims

1/14/21

Date
REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation No.: 803 KAR 25:091

Contact person: B. Dale Hamblin, Jr.

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation sets the fee schedule for hospitals, ambulatory surgical centers, and other specified facilities.

(b) The necessity of this administrative regulation: Pursuant to KRS 342.035, the commissioner is required to promulgate an administrative regulation regarding fee schedules.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation sets the fee schedule for hospitals, ambulatory surgical centers, and other specified facilities.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It is imperative to have fee schedules to control the medical costs of the workers' compensation system. Injured employees should receive quality medical care and hospitals and ambulatory surgical centers should be appropriately reimbursed.

(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 clarifies the definition of "hospital" to include certain out-of-state facilities and rehabilitation agencies, defines "surgical hardware" and "surgical implants," establishes the method by which the cost of surgical implants will be reimbursed, and clarifies the calculation and use of a cost-to-charge ratio for ambulatory service centers.
(b) The necessity of the amendment to this administrative regulation: 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. The amendments to this administrative regulation clarifies fees for services and supplies provided to workers' compensation patients pursuant to KRS 342.020.

(c) How the amendment conforms to the content of the authorizing statutes: The schedule of fees has been appropriately updated to insure that medical fees are fair, current, and reasonable for similar treatment in the same community for general health insurance payments.

(d) How the amendment will assist in the effective administration of the statutes: The schedule of fees assists the workers' compensation program by updating fees for hospitals and other facilities to insure injured employees get qualified and appropriate medical treatment.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All hospitals and ambulatory surgery centers providing services to injured workers pursuant to KRS Chapter 342, injured employees, insurance carriers, self-insurance groups, and self-insured employers and employers, third party administrators.

(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: Insurance carriers, self-
insured groups, self-insured employers, third party administrators, and medical providers, hospitals and other facilities must calculate the charge for surgical implants in a manner different from other charges.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There should be no or minimal additional cost to comply with the amendments to this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Medical providers will receive fair, current, and reasonable fees for services provided to injured workers. Injured workers will be treated in appropriate medical facilities. Insurance carriers, self-insured groups, and self-insured employers will reimburse the cost of surgical implant hardware at an appropriate rate.

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

(a) Initially: There is no additional cost to the administrative body to implement these amendments.

(b) On a continuing basis: There are no continuing costs.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department of Workers' Claims normal budget is the source of funding.

(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: No increase in fees or funding to implement this administrative regulation.
(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation sets forth a current schedule of fees to be paid to hospitals and other facilities. Fees have been updated to be fair, current, and reasonable for similar treatment in the same community as paid by health insurers.

(9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied, because the updated fee schedule applies to all parties equally.
FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation No. 803 KAR 25:091

Contact Person: B. Dale Hamblin, Jr.

Phone number: (502) 782-4404

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 of Workers' Claims and all parts of government with employees

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 342.020, 342.035, 342.260(1)

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. As an employer, there may be some increased costs for medical services. It is impossible to estimate without knowing what medical services will be needed by injured workers.

   (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? No revenue will be generated.

   (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? None.

   (c) How much will it cost to administer this program for the first year? There will be no new administrative costs
(d) How much will it cost to administer this program for subsequent years? There will be no new administrative costs.

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:

There is no fiscal impact on state or local government because the fee schedule governs the cost of medical services between medical treatment providers and payment obligors.
STATEMENT OF CONSIDERATION
RELATING to 803 KAR 25:091

Labor Cabinet, Department of Workers’ Claims
(Amended After Comments)

I. The public hearing on 803 KAR 25:091, scheduled for November 24, 2020, at 1:00 p.m., to be held by videoconference by the Department of Workers’ Claims, 657 Chamberlin Avenue, Frankfort, Kentucky, was held by Commissioner Robert L. Swisher. Two (2) public comments were made at the hearing. Eight (8) written comments were received during the public comment period.

II. The following persons were noted as attendees or offered comment:
(a) Lyzette Galloway, CEO, Owensboro Ambulatory Surgical Facility, LTD
(b) Stephanie Perna, RN, MSN, CASC, Director of Operations, Surgical Care Affiliates
(c) Mary Colvin, VP of Claims, Kentucky Employers Mutual Insurance
(d) Tiffany Brock, CEO, Premier Surgery Center of Louisville
(e) Vicki Burns, CASC, Chief Executive Officer, Louisville, SC, Ltd
(f) Kim Handshoe, CEO, Lexington Surgery Center, Ltd
(g) Heather C. Wright, Chief Executive Officer, The Pain treatment Center, Inc dba Stone Road surgery Center
(h) William Prentice, CEO, Ambulatory Surgery Center Association
(i) Eric Riley, Chief Administrative Officer, Lexington Clinic
(j) Ashley Karathanasis, MBA, CASC, Administrator, Outpatient Surgery Centers, Lexington Clinic
(k) Russ Ranallo, Vice President of Finance, Owensboro Health
(l) Nancy Galvagni, President and CEO, Kentucky Hospital Association
III. The following persons from the administrative body were present at the hearing or responded to comments:

(1) Robert L. Swisher, Commissioner, Department of Workers' Claims
(2) B. Dale Hamblin, Jr., Assistant General Counsel, Workers' Claims Legal Division
(3) Scott Wilhoit, Special Assistant to the Commissioner, Department of Workers' Claims
(4) Robert Walker, Deputy Commissioner, Department of Workers' Claims

IV Summary of Comments and Responses

(1) SUBJECT MATTER: An ASC may charge only one facility fee per surgical session.

(a) Comment: Stephanie Perna - The regulation limits Ambulatory Surgical Centers to one facility fee per surgical session. Facility fees cover the cost of drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, nursing services, technician and related services, diagnostic or therapeutic services, administrative, recordkeeping and housekeeping services, and the operating surgeon's supervision of the services provided by an anesthetist. When the number of procedures increase during a surgical session, costs increase as well. Allowing only one facility fee per surgical session will make workers' compensation cases cost prohibitive.

The following made a similar comment:
1. Lyzette Galloway, CEO, Owensboro Ambulatory Surgical Facility, LTD
2. Tiffany Brock, CEO, Premier Surgery Center of Louisville
3. Vicki Burns, CASC, Chief Executive Officer, Louisville, SC, Ltd
4. Kim Handshoe, CEO, Lexington Surgery Center, Ltd
5. Heather C. Wright, Chief Executive Officer, The Pain treatment Center, Inc dba Stone Road surgery Center
6. William Prentice, CEO, Ambulatory Surgery Center Association
7. Eric Riley, Chief Administrative Officer, Lexington Clinic
8. Ashley Karathanasis, MBA, CASC, Administrator, Outpatient Surgery Centers, Lexington Clinic
9. Russ Ranallo, Vice President of Finance, Owensboro Health
10. Nancy Galvagni, President and CEO, Kentucky Hospital Association

(b) Response: The administrative regulation was revised to allow an Ambulatory Surgical Center to charge a facility fee for each procedure performed; however, for the purpose of reimbursement, the total charge for all facility fees cannot exceed one hundred fifty percent (150%) of the facility fee charged for the primary procedure.

(2) SUBJECT MATTER: Charges for surgical implants and surgical hardware shall be reimbursed at invoice cost plus fifteen (15) percent. The hospital shall provide a copy of the invoice and shall certify the actual cost of the item or items.
(a) **Comment:** Nancy Galvagni — The comment stated that producing a paper invoice for surgical implants will be an administrative hardship and cost prohibitive; reimbursement at cost plus fifteen (15) percent was insufficient to cover the cost of producing a paper copy of surgical implant and hardware invoices connected with one surgical session.

1. Russ Ranallo made a similar comment.

(b) The administrative regulation was amended to remove the requirement that an invoice be produced.

3. **SUBJECT MATTER:** Surgical implants and surgical hardware are reimbursed at invoice cost plus fifteen (15) percent.

(a) **Comment:** Nancy Galvagni — The comment states the administrative burden to obtain an invoice used during each visit will result in additional work from multiple departments. Hospitals will have to implement systems to flag claims with implants for manual processing, which will greatly increase costs. The proposal deviates from how commercial insurers reimburse for surgical implants, which will impose a different payment and administrative process for workers’ compensation claims which is not present among other health insurers. The KHA estimates the change in methodology “will reduce hospital payments statewide by $3+ million a year.”

1. Russ Ranallo made a similar comment.

(b) **Response:** No amendment was made as a result of this comment.

4. **SUBJECT MATTER:** The administrative regulation exceeds statutory authority.

(a) **Comment:** Nancy Galvagni — The comment opines that KRS 342.035 requires the commissioner to adopt a schedule of fees that must be in line with and mirror payment made for the same services by commercial insurers. This administrative regulation exceeds its statutory authority because it imposes a different payment and administrative process not present among other health insurers by requiring surgical implants to be reimbursed at cost plus 15 percent. The statute requires fees to “be in line with and mirror payment made for the same services by commercial insurers.”

1. Russ Ranallo made a similar comment.

(b) **Response:** The Department disagrees that the administrative regulation exceeds its statutory authority. KRS 342.035 (1) provides (in part) “[p]eriodically, the commissioner shall promulgate administrative regulations to adopt a schedule of fees for the purpose of ensuring that all fees, charges, and reimbursements under KRS 342.020 and this section shall be fair, current, and reasonable and shall be limited to such charges as are fair, current, and reasonable for similar treatment of injured persons in the same community for like services, where treatment is paid for by general health insurers. In determining what fees are reasonable, the commissioner may also consider the increased security of payment afforded by this chapter.” The statute does not require the charges or payment process be the same as those used by general health insurers; rather, the emphasis is to ensure the fee charged does not exceed the fee imposed on general health insurers which is why the statute goes on to state the commissioner may take into account “the increased security of payment afforded by this chapter.” The implication is that the fee imposed under the workers’ compensation system may be less than that imposed and paid by general health insurers.
because of the increased assurance that payment will be made. No amendment was made in response to this comment.

(5) SUBJECT MATTER: Definitions of surgical implants and surgical hardware.

(a) Comment: Russ Ranallo – The comment states the definitions of surgical implants and surgical hardware are “not defined well in the proposal” and that “carriers will use the ambiguity to dispute whether an item needs an invoice based upon their interpretation which will lead to denials, appeals and additional administrative expenses for the provider and significant delays in payment.”

(b) Response: The department disagrees with the assertion that the definitions are vague. As such, no amendment was made as a result of this comment.

(6) SUBJECT MATTER: Reimbursement for surgical implants.

(a) Comment: Mary Colvin – The comment agreed with the definitions of surgical hardware and surgical implant added to the administrative regulation and that payment at cost plus fifteen (15) percent for these items was fair.

(b) Response: No revision was made as a consequence of this comment.

(7) SUBJECT MATTER: Facility fees for ambulatory service centers

(a) Comment: Mary Colvin – The comment stated that limiting ASCs to one facility fee will reduce duplication of charges.

(b) Response: No revision was made as a consequence of this comment.

(8) SUBJECT MATTER: Provider based billing.

(a) Comment: Mary Colvin – There is the potential for duplication of services where a hospital uses an independent contractor, who independently bills for services under the Kentucky Workers’ Compensation Medical Fee Schedule for Physicians.

(b) Response: No revision was made as a consequence of this comment because this issue is best addressed through the revision of the Kentucky Workers’ Compensation Medical Fee Schedule for Physicians.

(9) SUBJECT MATTER: Definition of rehabilitation facility.

(a) Comment: Mary Colvin – The comment suggested the definition of rehabilitation facility be amended to require a rehabilitation facility be approved as a Comprehensive Outpatient Rehabilitation Facility or Hospital under the Medicare or Medicaid programs.

(b) Response: No revision was made as a consequence of this comment. If there is confusion regarding whether a facility is qualified to be reimbursed in a particular manner, clarification may be sought from the facility.

SUMMARY OF STATEMENT OF CONSIDERATION AND ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY
The public hearing on this administrative regulation was held as scheduled. In addition, written comments were received. The Department of Workers' Claims responded to the comments and amends the administrative regulation as follows:

Page 5
Section 3. Calculation of Hospital's Base and Adjusted Cost-to-Charge Ratio; Reimbursement.
Line 5

After "... reimbursed at the amount" insert "paid" and after "for those charges" insert ".;" and delete "listed on the invoice. The hospital shall provide a copy of the invoice and shall certify the actual cost of the item or items".

Page 7
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.
Line 12

After "... reimbursed at the amount" insert "paid" and after "for those charges" insert ".;" and delete "listed on the invoice. The hospital shall provide a copy of the invoice and shall certify the actual cost of the item or items".

Page 8
Section 8. Billing and Audit Procedures.
Line 16

After "(3)" insert "When more than one (1) procedure is performed during a surgical session, an"

Delete "an"

After "Ambulatory Surgical Center may charge" insert "a facility fee for each procedure performed; however, for the purpose of reimbursement, the total charge for all facility fees shall not exceed one hundred fifty percent 150% of the facility fee charged for the primary procedure."

Delete "only one facility fee for one surgical session even though the surgical session may involve multiple procedures and CPT codes; more than one facility charge shall constitute a duplicate charge."

Insert "A"
Delete "The" before "physician may submit charges on form HCFA 1500 using appropriate CPT codes.".