

Handout - ACA Secs. 1302 & 1311

One Hundred Eleventh Congress  
of the  
United States of America

AT THE SECOND SESSION

*Begun and held at the City of Washington on Tuesday,  
the fifth day of January, two thousand and ten*

An Act

Entitled The Patient Protection and Affordable Care Act.

*Be it enacted by the Senate and House of Representatives of  
the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) **SHORT TITLE.**—This Act may be cited as the “Patient Protection and Affordable Care Act”.

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

**TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS**

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

“PART A—INDIVIDUAL AND GROUP MARKET REFORMS

“SUBPART II—IMPROVING COVERAGE

“Sec. 2711. No lifetime or annual limits.

“Sec. 2712. Prohibition on rescissions.

“Sec. 2713. Coverage of preventive health services.

“Sec. 2714. Extension of dependent coverage.

“Sec. 2715. Development and utilization of uniform explanation of coverage

documents and standardized definitions.

“Sec. 2716. Prohibition of discrimination based on salary.

“Sec. 2717. Ensuring the quality of care.

“Sec. 2718. Bringing down the cost of health care coverage.

“Sec. 2719. Appeals process.

Sec. 1002. Health insurance consumer information.

Sec. 1003. Ensuring that consumers get value for their dollars.

Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-

existing condition.

Sec. 1102. Reinsurance for early retirees.

Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.

Sec. 1104. Administrative simplification.

Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

**PART I—HEALTH INSURANCE MARKET REFORMS**

Sec. 1201. Amendment to the Public Health Service Act.

“SUBPART I—GENERAL REFORM

“Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.

“Sec. 2701. Fair health insurance premiums.

“Sec. 2702. Guaranteed availability of coverage.

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322 or a community health insurance option under section 1323, unless specifically provided for otherwise.

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term “health plan” means health insurance coverage and a group health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term “health plan” shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term by section 2791(a) of the Public Health Service Act.

#### SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan

for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) **RULE OF CONSTRUCTION.**—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) **REQUIREMENTS RELATING TO COST-SHARING.**—

(1) **ANNUAL LIMITATION ON COST-SHARING.**—

(A) **2014.**—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) **2015 AND LATER.**—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) IN GENERAL.—An Exchange may not make available any health plan that is not a qualified health plan.

(ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J).

(3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).

(B) STATES MAY REQUIRE ADDITIONAL BENEFITS.—

(i) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).

(ii) STATE MUST ASSUME COST.—*[Replaced by section 10104(e)(1)]* A State shall make payments—

(I) to an individual enrolled in a qualified health plan offered in such State; or

(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).

(4) FUNCTIONS.—An Exchange shall, at a minimum—

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;

(F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program

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1. Tests how to administer a health care service, item, or drug for the treatment of cancer;
2. Tests responses to a health care service, item, or drug for the treatment of cancer;
3. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer;  
or
4. Studies new uses of health care services, items, or drugs for the treatment of cancer;

Benefits do not, however, include the following:

- The healthcare service, item, or investigational drug that is the subject of the cancer clinical trial;
- Any treatment modality outside the usual and customary standard of care required to administer or support the healthcare service, item, or investigational drug that is the subject of the cancer clinical trial;
- Any healthcare service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient;
- An investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the cancer clinical trial;
- Any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any new patient; or
- Any services, items, or drugs that are eligible for reimbursement by a person other than the insurer, including the sponsor of the clinical trial.

## Congenital Defects and Birth Abnormalities

Covered Services include coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

## Dental Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

### Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and

treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

### **Other Dental Services**

Benefits are provided for anesthesia and Hospital or facility charges for services performed in a Hospital and Ambulatory Surgical Facility. These services must be in connection with dental procedures for Dependents below the age of nine years, Members with serious mental or physical conditions, and Members with significant behavioral problems. Also, the admitting Physician or dentist must certify that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. Benefits are not provided for routine dental care.

If the above paragraph does not apply to a Member, the only other dental expenses that are Covered Services are facility charges for Outpatient services for the removal of teeth or for other dental processes. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

### **Diabetic Equipment, Education and Supplies**

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.**

Diabetes Self Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a certified, registered, or licensed Health Care Professional with expertise in diabetes, as deemed necessary by a health care Provider.

- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

### **Physical Medicine and Rehabilitation Services**

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

### **Vision Services**

Benefits are available for medical and surgical treatment of injuries and/or diseases affecting the eye. Routine vision exams required by federal law are covered under the "Preventive Care" benefit. Benefits for other Covered Services are based on the setting in which services are received.

Benefits are not available for glasses and contact lenses except as described in the "Prosthetics" benefit.

Additional Covered Services include:

- Determination of refraction,
- Routine Ophthalmological examination including refraction for new and established patients, and
- A visual functional screening for visual acuity.

These additional services are not part of the "Preventive Care" benefit and will be based on the setting which services are received. No additional ophthalmological services are covered, except as described above.

Handout - KCHIP Dental/Vision Benefits Regs

**907 KAR 1:026. Dental services.**

RELATES TO: KRS 205.520, 205.8451, 42 U.S.C. 1396a-d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a-d, Pub.L. 109-171

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the 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 for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to dental services.

**Section 1. Definitions.** (1) "Comprehensive orthodontic" means a medically necessary dental service for treatment of a dentofacial malocclusion which requires the application of braces for correction.

(2) "Current Dental Terminology" or "CDT" means a publication by the American Dental Association of codes used to report dental procedures or services.

(3) "Debridement" means a procedure that is performed:

(a) For removing thick or dense deposits on the teeth which is required if tooth structures are so deeply covered with plaque and calculus that a dentist or staff cannot check for decay, infections, or gum disease; and

(b) Separately from a regular cleaning and is usually a preliminary or first treatment when an individual has developed very heavy plaque or calculus.

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

(5) "Direct practitioner contact" means the billing dentist or oral surgeon is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(6) "Disabling malocclusion" means that a patient has a condition that meets the criteria established in Section 13(7) of this administrative regulation.

(7) "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:

(a) Requires little additional practitioner resources; or

(b) Is clinically integral to the performance of the primary procedure.

(8) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(10) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one 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 CDT codes; or

(d) Are described in CDT as inappropriate coding of procedure combinations.

(11) "Other licensed medical professional" means a health care provider other than a dentist who has been approved to practice a medical specialty by the appropriate licensure board.

(12) "Prepayment review" or "PPR" means a departmental review of a claim to determine if the requirements of this administrative regulation have been met prior to authorizing payment.

(13) "Prior authorization" or "PA" means approval which a provider shall obtain from the department before being reimbursed for a covered service.

(14) "Provider" is defined in KRS 205.8451(7).

(15) "Recipient" is defined in KRS 205.8451(9).

(16) "Resident" is defined in 42 C.F.R. 415.152.

(17) "Timely filing" means receipt of a claim by Medicaid:

(a) Within twelve (12) months of the date the service was provided;

(b) Within twelve (12) months of the date retroactive eligibility was established; or

(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.

**Section 2. Conditions of Participation.** (1) A participating provider shall be licensed as a provider in the state in which the practice is

located.

(2) A participating provider shall comply with the terms and conditions established in the following administrative regulations:

- (a) 907 KAR 1:005;
- (b) 907 KAR 1:671; and
- (c) 907 KAR 1:672.

(3) A participating provider shall comply with the requirements to maintain the confidentiality of personal medical records pursuant to 42 U.S.C. 1320d and 45 C.F.R. Parts 160 and 164.

(4) A participating provider shall have the freedom to choose whether to accept an eligible Medicaid recipient and shall notify the recipient of the decision prior to the delivery of service. If the provider accepts the recipient, the provider:

(a) Shall bill Medicaid rather than the recipient for a covered service;

(b) May bill the recipient for a service not covered by Kentucky Medicaid, if the provider informed the recipient of noncoverage prior to providing the service; and

(c) Shall not bill the recipient for a service that is denied by the department for:

- 1. Being:
  - a. Incidental;
  - b. Integral; or
  - c. Mutually exclusive;
- 2. Incorrect billing procedures, including incorrect bundling of procedures;
- 3. Failure to obtain prior authorization for the service; or
- 4. Failure to meet timely filing requirements.

**Section 3. Record Maintenance.** (1) A provider shall maintain comprehensive legible medical records which substantiate the services billed.

(2) A medical record shall be signed by the provider and dated to reflect the date of service.

(3) An X-ray shall be of diagnostic quality and shall include the:

- (a) Recipient's name;
- (b) Service date; and
- (c) Provider's name.

(4) A treatment regimen shall be documented to include:

- (a) Diagnosis;
- (b) Treatment plan;
- (c) Treatment and follow-up; and
- (d) Medical necessity.

(5) Medical records, including x-rays, shall be maintained in accordance with 907 KAR 1:672, Section 4(3) and (4).

**Section 4. General Coverage Requirements.** (1) A covered service shall be:

- (a) Medically necessary;
- (b) Except as provided in subsection (2) of this section, furnished to a recipient through direct practitioner contact; and
- (c) Unless a recipient's provider demonstrates that dental services in excess of the following service limitations are medically necessary, limited to:

- 1. Two (2) prophylaxis per twelve (12) month period for a recipient under age twenty-one (21);
- 2. One (1) dental visit per month per provider for a recipient age twenty-one (21) years and over; and
- 3. One (1) prophylaxis per twelve (12) month period for a recipient age twenty-one (21) years and over.

(2) A covered service provided by an individual who meets the definition of other licensed medical professional shall be covered if the:

- (a) Individual is employed by the supervising oral surgeon, dentist, or dental group;
- (b) Individual is licensed in the state of practice; and

(c) Supervising provider has direct practitioner contact with the recipient, except for a service provided by a dental hygienist if the dental hygienist provides the service under general supervision of a practitioner in accordance with KRS 313.310.

(3)(a) A medical resident may provide services if provided under the direction of a program participating teaching physician in accordance

with 42 C.F.R. 415.170, 415.172, and 415.174.

(b) A dental resident, student, or dental hygiene student may provide services under the direction of a program participating provider in or affiliated with an American Dental Association accredited institution.

(4) Coverage shall be limited to services identified in 907 KAR 1:626, Section 3, in the following CDT categories:

- (a) Diagnostic;
- (b) Preventive;
- (c) Restorative;
- (d) Endodontics;
- (e) Periodontics;
- (f) Removable prosthodontics;
- (g) Maxillofacial prosthetics;
- (h) Oral and maxillofacial surgery;
- (i) Orthodontics; or
- (j) Adjunctive general services.

**Section 5. Diagnostic Service Coverage Limitations.** (1)(a) Except as provided in paragraph (b) of this subsection, coverage for a comprehensive oral evaluation shall be limited to one (1) per twelve (12) month period, per recipient, per provider.

(b) The department shall cover a second comprehensive oral evaluation if the evaluation is provided in conjunction with a prophylaxis to an individual under twenty-one (21) years of age.

(c) A comprehensive oral evaluation shall not be covered in conjunction with the following:

- 1. A limited oral evaluation for trauma related injuries;
- 2. Space maintainers;
- 3. Root canal therapy;
- 4. Denture relining;
- 5. Transitional appliances;
- 6. A prosthodontic service;
- 7. Temporomandibular joint therapy;
- 8. An orthodontic service;
- 9. Palliative treatment; or
- 10. A hospital call.

(2)(a) Coverage for a limited oral evaluation shall:

- 1. Be limited to a trauma related injury or acute infection;
- 2. Be limited to one (1) per date of service, per recipient, per provider; and
- 3. Require a prepayment review.

(b) A limited oral evaluation shall not be covered in conjunction with another service except for:

- 1. A periapical x-ray;
- 2. Bitewing x-rays;
- 3. A panoramic x-ray;
- 4. Resin, anterior;
- 5. A simple or surgical extraction;
- 6. Surgical removal of a residual tooth root;
- 7. Removal of a foreign body;
- 8. Suture of a recent small wound;
- 9. Intravenous sedation; or
- 10. Incision and drainage of infection.

(3)(a) Except as provided in paragraph (b) of this subsection, the following limitations shall apply to coverage of a radiograph service:

- 1. Bitewing x-rays shall be limited to four (4) per twelve (12) month period, per recipient, per provider;
- 2. Periapical x-rays shall be limited to fourteen (14) per twelve (12) month period, per recipient, per provider;
- 3. An intraoral complete x-ray series shall be limited to one (1) per twelve (12) month period, per recipient, per provider;

4. Periapical and bitewing x-rays shall not be covered in the same twelve (12) month period as an intraoral complete x-ray series per recipient, per provider;

5. A panoramic film shall:

a. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider; and

b. Require prior authorization in accordance with Section 15(2) and (3) of this administrative regulation for a recipient under age six (6);

6. A cephalometric film shall be limited to one (1) per twenty-four (24) month period, per recipient, per provider; or

7. Cephalometric and panoramic x-rays shall not be covered in conjunction with a comprehensive orthodontic consultation.

(b) The limits established in paragraph (a) of this subsection shall not apply to:

1. An x-ray necessary for a root canal or oral surgical procedure; or

2. An x-ray that exceeds the established service limitations and is determined by the department to be medically necessary.

**Section 6. Preventive Service Coverage Limitations.** (1)(a) Coverage of a prophylaxis shall be limited to:

1. For an individual twenty-one (21) years of age and over, one (1) per twelve (12) month period, per recipient; and

2. For an individual under twenty-one (21) years of age, two (2) per twelve (12) month period, per recipient.

(b) A prophylaxis shall not be covered in conjunction with periodontal scaling or root planing.

(2)(a) Coverage of a sealant shall be limited to:

1. A recipient age five (5) through twenty (20) years;

2. Each six (6) and twelve (12) year molar once every four (4) years with a lifetime limit of three (3) sealants per tooth, per recipient; and

3. An occlusal surface that is noncarious.

(b) A sealant shall not be covered in conjunction with a restorative procedure for the same tooth on the same date of service.

(3)(a) Coverage of a space maintainer shall:

1. Be limited to a recipient under age twenty-one (21); and

2. Require the following:

a. Fabrication;

b. Insertion;

c. Follow-up visits;

d. Adjustments; and

e. Documentation in the recipient's medical record to:

(i) Substantiate the use for maintenance of existing intertooth space; and

(ii) Support the diagnosis and a plan of treatment that includes follow-up visits.

(b) The date of service for a space maintainer shall be considered to be the date the appliance is placed on the recipient.

(c) Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination thereof shall not exceed two (2) per twelve (12) month period, per recipient.

**Section 7. Restorative Service Coverage Limitations.** (1) A four (4) or more surface resin-based anterior composite procedure shall not be covered if performed for the purpose of cosmetic bonding or veneering.

(2) Coverage of a prefabricated crown shall be:

(a) Limited to a recipient under age twenty-one (21); and

(b) Inclusive of any procedure performed for restoration of the same tooth.

(3) Coverage of a pin retention procedure shall be limited to:

(a) A permanent molar;

(b) One (1) per tooth, per date of service, per recipient; and

(c) Two (2) per permanent molar, per recipient.

(4) Coverage of a restorative procedure performed in conjunction with a pin retention procedure shall be limited to one (1) of the following:

(a) An amalgam, three (3) or more surfaces;

(b) A permanent prefabricated resin crown; or

(c) A prefabricated stainless steel crown.

**Section 8. Endodontic Service Coverage Limitations.** (1) Coverage of the following endodontic procedures shall be limited to a recipient

under age twenty-one (21):

- (a) A pulp cap direct;
  - (b) Therapeutic pulpotomy; or
  - (c) Root canal therapy.
- (2) A therapeutic pulpotomy shall not be covered if performed in conjunction with root canal therapy.
- (3)(a) Coverage of root canal therapy shall require:
- 1. Treatment of the entire tooth;
  - 2. Completion of the therapy; and
  - 3. An x-ray taken before and after completion of the therapy.
- (b) The following root canal therapy shall not be covered:
- 1. The Sargenti method of root canal treatment; or
  - 2. A root canal on one (1) root of a molar.

**Section 9. Periodontic Service Coverage Limitations.** (1) Coverage of a gingivectomy or gingivoplasty procedure shall require prepayment review and shall be limited to:

- (a) A recipient with gingival overgrowth due to a:
  - 1. Congenital condition;
  - 2. Hereditary condition; or
  - 3. Drug-induced condition; and
- (b) One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period.
  - 1. Coverage of a quadrant procedure shall require a minimum of a three (3) tooth area within the same quadrant.
  - 2. Coverage of a per-tooth procedure shall be limited to no more than two (2) teeth within the same quadrant.
- (2) Coverage of a gingivectomy or gingivoplasty procedure shall require documentation in the recipient's medical record that includes:
  - (a) Pocket-depth measurements;
  - (b) A history of nonsurgical services; and
  - (c) Prognosis.
- (3) Coverage for a periodontal scaling and root planing procedure shall:
  - (a) Not exceed one (1) per quadrant, per twelve (12) months, per recipient, per provider;
  - (b) Require prior authorization in accordance with Section 15(2) and (4) of this administrative regulation; and
  - (c) Require documentation to include:
    - 1. A periapical film or bitewing x-ray; and
    - 2. Periodontal charting of preoperative pocket depths.
- (4) Coverage of a quadrant procedure shall require a minimum of a three (3) tooth area within the same quadrant.
- (5) Periodontal scaling and root planing shall not be covered if performed in conjunction with dental prophylaxis.
- (6)(a) A full mouth debridement shall only be covered for a pregnant woman.
- (b) Only one (1) full mouth debridement per pregnancy shall be covered.

**Section 10. Prosthodontic Service Coverage Limitations.** (1) A removable prosthodontic or denture repair shall be limited to a recipient under age twenty-one (21).

- (2) A denture repair in the following categories shall not exceed three (3) repairs per twelve (12) month period, per recipient:
  - (a) Repair resin denture base; or
  - (b) Repair cast framework.
- (3) Coverage for the following services shall not exceed one (1) per twelve (12) month period, per recipient:
  - (a) Replacement of a broken tooth on a denture;
  - (b) Laboratory relining of:
    - 1. Maxillary dentures; or
    - 2. Mandibular dentures;
  - (c) An interim maxillary partial denture; or
  - (d) An interim mandibular partial denture.

- (4) An interim maxillary or mandibular partial denture shall be limited to use:
- (a) During a transition period from a primary dentition to a permanent dentition;
  - (b) For space maintenance or space management; or
  - (c) As interceptive or preventive orthodontics.

**Section 11. Maxillofacial Prosthetic Service Coverage Limitations.** The following services shall be covered if provided by a board certified prosthodontist:

- (1) A nasal prosthesis;
- (2) An auricular prosthesis;
- (3) A facial prosthesis;
- (4) A mandibular resection prosthesis;
- (5) A pediatric speech aid;
- (6) An adult speech aid;
- (7) A palatal augmentation prosthesis;
- (8) A palatal lift prosthesis;
- (9) An oral surgical splint; or
- (10) An unspecified maxillofacial prosthetic.

**Section 12. Oral and Maxillofacial Service Coverage Limitations.** (1) The simple use of a dental elevator shall not constitute a surgical extraction.

- (2) Root removal shall not be covered on the same date of service as the extraction of the same tooth.
- (3) Coverage of surgical access of an unerupted tooth shall:
  - (a) Be limited to exposure of the tooth for orthodontic treatment; and
  - (b) Require prepayment review.
- (4) Coverage of alveoplasty shall:
  - (a) Be limited to one (1) per quadrant, per lifetime, per recipient; and
  - (b) Require a minimum of a three (3) tooth area within the same quadrant.
- (5) An occlusal orthotic device shall:
  - (a) Be covered for temporomandibular joint therapy;
  - (b) Require prior authorization in accordance with Section 15(2) and (5) of this administrative regulation;
  - (c) Be limited to a recipient under age twenty-one (21); and
  - (d) Be limited to one (1) per lifetime, per recipient.
- (6) Frenulectomy shall be limited to one (1) per date of service.
- (7) Coverage shall be limited to one (1) per lifetime, per recipient, for removal of the following:
  - (a) Torus palatinus (maxillary arch);
  - (b) Torus mandibularis (lower left quadrant); or
  - (c) Torus mandibularis (lower right quadrant).
- (8) Except as specified in subsection (9) of this section, a service provided by an oral surgeon shall be covered in accordance with 907 KAR 3:005.
- (9) If performed by an oral surgeon, coverage of a service identified in CDT shall be limited to:
  - (a) Extractions;
  - (b) Impactions; and
  - (c) Surgical access of an unerupted tooth.

**Section 13. Orthodontic Service Coverage Limitations.** (1) Coverage of an orthodontic service shall:

- (a) Be limited to a recipient under age twenty-one (21); and
- (b) Require prior authorization.
- (2) The combination of space maintainers and appliance therapy shall be limited to two (2) per twelve (12) month period, per recipient.
- (3) Space maintainers and appliance therapy shall not be covered in conjunction with comprehensive orthodontics.

- (4) The department shall only cover new orthodontic brackets or appliances.
- (5) An appliance for minor tooth guidance shall not be covered for the control of harmful habits.
- (6) In addition to the limitations specified in subsection (1) of this section, a comprehensive orthodontic service shall:
- (a) Require a referral by a dentist; and
  - (b) Be limited to:
    1. The correction of a disabling malocclusion; or
    2. Transitional or full permanent dentition unless for treatment of a cleft palate or severe facial anomaly.
  - (7) A disabling malocclusion shall exist if a patient:
    - (a) Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors;
    - (b) Has a true anterior open bite that does not include:
      1. One (1) or two (2) teeth slightly out of occlusion; or
      2. Where the incisors have not fully erupted;
    - (c) Demonstrates a significant antero-posterior discrepancy (Class II or III malocclusion that is comparable to at least one (1) full tooth Class II or III, dental or skeletal);
    - (d) Has an anterior crossbite that involves:
      1. More than two (2) teeth in crossbite;
      2. Obvious gingival stripping; or
      3. Recession related to the crossbite;
    - (e) Demonstrates handicapping posterior transverse discrepancies which:
      1. May include several teeth, one (1) of which shall be a molar; and
      2. Is handicapping in a function fashion as follows:
        - a. Functional shift;
        - b. Facial asymmetry;
        - c. Complete buccal or lingual crossbite; or
        - d. Speech concern;
    - (f) Has a significant posterior open bite that does not involve:
      1. Partially erupted teeth; or
      2. One (1) or two (2) teeth slightly out of occlusion;
    - (g) Except for third molars, has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention;
    - (h) Has extreme overjet in excess of eight (8) to nine (9) millimeters and one (1) of the skeletal conditions specified in paragraphs (a) through (g) of this subsection;
    - (i) Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures, and does not include simple loss of teeth with no other affects;
    - (j) Has a congenital or developmental disorder giving rise to a handicapping malocclusion;
    - (k) Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach; or
    - (l) Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation.

(8) Coverage of comprehensive orthodontic treatment shall not be inclusive of orthognathic surgery.

(9) If comprehensive orthodontic treatment is discontinued prior to completion, the provider shall submit to the department:

    - (a) A referral form, if applicable; and
    - (b) A letter detailing:
      1. Treatment provided, including dates of service;
      2. Current treatment status of the patient; and
      3. Charges for the treatment provided.

(10) Remaining portions of comprehensive orthodontic treatment may be authorized for prorated coverage upon submission of the prior authorization requirements specified in Section 15(2) and (7) of this administrative regulation if treatment:

    - (a) Is transferred to another provider; or
    - (b) Began prior to Medicaid eligibility.

**Section 14. Adjunctive General Service Coverage Limitations.** (1)(a) Coverage of palliative treatment for dental pain shall be limited to one

(1) per date of service, per recipient, per provider.

(b) Palliative treatment for dental pain shall not be covered in conjunction with another service except radiographs.

(2)(a) Coverage of a hospital call shall be limited to one (1) per date of service, per recipient, per provider.

(b) A hospital call shall not be covered in conjunction with:

1. Limited oral evaluation;
2. Comprehensive oral evaluation; or
3. Treatment of dental pain.

(3)(a) Coverage of intravenous sedation shall be limited to a recipient under age twenty-one (21).

(b) Intravenous sedation shall not be covered for local anesthesia or nitrous oxide.

**Section 15. Prior Authorization.** (1) Prior authorization shall be required for the following:

(a) A panoramic film for a recipient under age six (6);

(b) Periodontal scaling and root planing;

(c) An occlusal orthotic device;

(d) A preorthodontic treatment visit;

(e) Removable appliance therapy;

(f) Fixed appliance therapy; or

(g) A comprehensive orthodontic service.

(2) A provider shall request prior authorization by submitting the following information to the department:

(a) A MAP-9, Prior Authorization for Health Services;

(b) Additional forms or information as specified in subsections (3) through (7) of this section; and

(c) Additional information required to establish medical necessity if requested by the department.

(3) A request for prior authorization of a panoramic film shall include a letter of medical necessity.

(4) A request for prior authorization of periodontal scaling and root planing shall include periodontal charting of preoperative pocket depths.

(5) A request for prior authorization of an occlusal orthotic device shall include a MAP 306, Temporomandibular Joint (TMJ) Assessment

Form.

(6) A request for prior authorization of removable and fixed appliance therapy shall include:

(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;

(b) Panoramic film or intraoral complete series; and

(c) Dental models.

(7) A request for prior authorization for comprehensive orthodontic services shall include:

(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;

(b) A MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement;

(c) Cephalometric x-rays with tracing;

(d) A panoramic x-ray;

(e) Intraoral and extraoral facial frontal and profile pictures;

(f) Occluded and trimmed dental models;

(g) An oral surgeon's pretreatment work up notes if orthognathic surgery is required;

(h) After six (6) monthly visits are completed, but not later than twelve (12) months after the banding date of service:

1. A MAP 559, Six (6) Month Orthodontic Progress Report; and

2. An additional MAP 9, Prior Authorization for Health Services; and

(i) Within three (3) months following completion of the comprehensive orthodontic treatment:

1. Beginning and final records; and

2. A MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission.

(8) Upon receipt and review of the materials required in subsection (7)(a) through (g) of this section, the department may request a second opinion from another provider regarding the proposed comprehensive orthodontic treatment.

(9) If a service that requires prior authorization is provided before the prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.

(10) Prior authorization shall not be a guarantee of recipient eligibility. Eligibility verification shall be the responsibility of the provider.

(11) Upon review and determination by the department that removing prior authorization shall be in the best interest of Medicaid recipients, the prior authorization requirement for a specific covered benefit shall be discontinued, at which time the covered benefit shall be available to all recipients without prior authorization.

**Section 16. 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.

**Section 17. Incorporation by Reference.** (1) The following material is incorporated by reference:

- (a) "MAP 9, Prior Authorization for Health Services", December 1995 edition;
- (b) "MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement", December 1995 edition;
- (c) "MAP 306, Temporomandibular Joint (TMJ) Assessment Form", December 1995 edition;
- (d) "MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form", March 2001 edition;
- (e) "MAP 559, Six (6) Month Orthodontic Progress Report", December 1995 edition; and
- (f) "MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission", December 1995 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR 1:026, 5-6-86; Am. 14 Ky.R. 663; eff. 11-6-87; 16 Ky.R. 267; eff. 9-20-89; 21 Ky.R. 139; 930; eff. 8-17-94; 23 Ky.R. 3450; 3782; eff. 4-16-97; 25 Ky.R. 654; 1379; eff. 11-18-98; 30 Ky.R. 1630; 1939; eff. 2-16-2004; 33 Ky.R. 582; 1371; 1552; eff. 1-5-2007; 35 Ky.R. 436; 841; eff. 10-31-2008.)

**907 KAR 1:038. Hearing and Vision Program services.**

RELATES TO: KRS 205.520, 334.010(4), (9), 334A.020(5), 334A.030, 42 C.F.R. 441.30, 447.53, 457.310, 42 U.S.C. 1396a, b, d, 1396r-6  
 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the hearing services and vision services for which payment shall be made by the Medicaid Program.

Section 1. Definitions. (1) "Audiologist" is defined by KRS 334A.020(5).

(2) "Comprehensive choices" means a benefit plan for an individual who:

(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. A nursing facility in accordance with 907 KAR 1:022;
2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;
3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or
4. The Model Waiver II Program in accordance with 907 KAR 1:595; and

(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.

(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 designee.

(5) "Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.

(6) "Family choices" means a benefit plan for an individual who:

(a) Is covered pursuant to:

1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;
2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);
3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);
4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);
5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or
6. 42 C.F.R. 457.310; and

(b) Has a designated package code of 2, 3, 4, or 5.

(7) "Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:

(a) Caretaker relatives who:

1. Receive K-TAP benefits and are deprived due to death, incapacity, or absence;
2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or
3. Do not receive K-TAP benefits and are deprived due to unemployment;

(b) Individuals aged sixty-five (65) and over who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or
2. Receive SSP benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(c) Blind individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or
2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(d) Disabled individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or
2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do

not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(h) Pregnant women; or

(i) Medicaid works individuals.

(8) "Hearing instrument" is defined by KRS 334.010(4).

(9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(10) "Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53

(11) "Optimum choices" means a benefit plan for an individual who:

(a) Meets the intermediate care facility for individuals with mental retardation or a developmental disability patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. An intermediate care facility for individuals with mental retardation or a developmental disability in accordance with 907 KAR 1:022; or

2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and

(c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.

(12) "Specialist in hearing instruments" is defined by KRS 334.010(9).

**Section 2. Hearing Services.** (1) All hearing coverage shall be:

(a) Limited to an individual under age twenty-one (21); and

(b) Provided in accordance with the Hearing Program Manual.

(2) Unless a recipient's health care provider demonstrates that services in excess of the limitations established in this subsection are medically necessary, reimbursement for services provided by an audiologist licensed pursuant to KRS 334A.030 to a recipient shall be limited to:

(a) The following procedures which shall be covered only if a recipient is referred by a physician to an audiologist licensed pursuant to KRS 334A.030:

Code	Procedure
92552	Pure Tone audiometry (threshold); air only
92555	Speech audiometry threshold
92556	Speech audiometry threshold; with speech recognition
92557	Comprehensive audiometry evaluation
92567	Tympanometry
92568	Acoustic reflex testing
92579	Visual reinforcement audiometry
92585	Auditory evoked potentials
92587	Evoked otoacoustic emissions
92588	Complete or diagnostic evaluation (comparison of transient or distortion product otoacoustic emissions at multiple levels and frequency)
92541	Spontaneous nystagmus test
92542	Positional nystagmus test
92543	Caloric vestibular test
92544	Optokinetic nystagmus test
92545	Oscillating tracking test

92546	Sinusoidal vertical axis rotational testing
92547	Use of vertical electrodes

- (b) Complete hearing evaluation;
- (c) Hearing instrument evaluation;
- (d) Three (3) follow-up visits that shall be:
  1. Within the six (6) month period immediately following fitting of a hearing instrument; and
  2. Related to the proper fit and adjustment of the hearing instrument; and
- (e) One (1) additional follow-up visit that is:
  1. At least six (6) months following the fitting of the hearing instrument; and
  2. Related to the proper fit and adjustment of the hearing instrument.
- (3) Hearing instrument benefit coverage shall:
  - (a) Be for a hearing instrument model that is:
    1. Recommended by an audiologist licensed pursuant to KRS 334A.030;
    2. Available through a Medicaid-participating specialist in hearing instruments;
  - (b) Not exceed \$800 per ear every thirty-six (36) months; and
  - (c) Be limited to the following procedures:

Code	Procedure
V5010	Assessment for Hearing instrument
V5011	Fitting, Orientation, Checking of Hearing instrument
V5014	Repair, Modification of Hearing Instrument
V5015	Hearing Instrument Repair Professional Fee
V5020	Conformity Evaluation
V5030	Hearing Instrument, Monaural, Body Aid Conduction
V5040	Hearing Instrument, Monaural, Body Worn, Bone Conduction
V5050	Hearing Instrument, Monaural, In the Ear Hearing
V5060	Hearing Instrument, Monaural, Behind the Ear Hearing
V5070	Glasses; Air Conduction
V5080	Glasses; Bone Conduction
V5090	Dispensing Fee, Unspecified Hearing Instrument
V5095	Semi-Implantable Middle Ear Hearing Prosthesis
V5100	Hearing Instrument, Bilateral, Body Worn
V5120	Binaural; Body
V5130	Binaural; In the Ear
V5140	Binaural; Behind the Ear
V5150	Binaural; Glasses
V5160	Dispensing Fee, Binaural
V5170	Hearing Instrument, Cros, In the Ear
V5180	Hearing Instrument, Cros, Behind the Ear
V5190	Hearing Instrument, Cros, Glasses

V5200	Dispensing Fee, Cros
V5210	Hearing Instrument, Bicos, In the Ear
V5220	Hearing Instrument, Bicos, Behind the Ear
V5230	Hearing Instrument, Bicos, Glasses
V5240	Dispensing Fee, Bicos
V5241	Dispensing Fee, Monaural Hearing Instrument, Any Type
V5242	Hearing Instrument, Analog, Monaural, CIC (Completely In the Ear Canal)
V5243	Hearing Instrument, Analog, Monaural, ITC (In the Canal)
V5244	Hearing Instrument, Digitally Programmable Analog, Monaural, CIC
V5245	Hearing Instrument, Digitally Programmable Analog, Monaural, ITC
V5246	Hearing Instrument, Digitally Programmable Analog, Monaural, ITE (In the Ear)
V5247	Hearing Instrument, Digitally Programmable Analog, Monaural, BTE (Behind the Ear)
V5248	Hearing Instrument, Analog, Binaural, CIC
V5249	Hearing Instrument, Analog, Binaural, ITC
V5250	Hearing Instrument, Digitally Programmable Analog, Binaural, CIC
V5251	Hearing Instrument, Digitally Programmable Analog, Binaural, ITC
V5252	Hearing Instrument, Digitally Programmable, Binaural, ITE
V5253	Hearing Instrument, Digitally Programmable, Binaural, BTE
V5254	Hearing Instrument, Digital, Monaural, CIC
V5255	Hearing Instrument, Digital, Monaural, ITC
V5256	Hearing Instrument, Digital, Monaural, ITE
V5257	Hearing Instrument, Digital, Monaural, BTE
V5258	Hearing Instrument, Digital, Binaural, CIC
V5259	Hearing Instrument, Digital, Binaural, ITC
V5260	Hearing Instrument, Digital, Binaural, ITE
V5261	Hearing Instrument, Digital, Binaural, BTE
V5262	Hearing Instrument, Disposable, Any Type, Monaural
V5263	Hearing Instrument, Disposable, Any Type, Binaural
V5264	Ear Mold (One (1) Ear Mold Per Year Per Ear and if Medically Necessary)
V5266	Hearing Instrument Battery (Limit of Four (4) Per Instrument When Billed With A New Hearing Instrument Or A Replacement Instrument)

V5267	Hearing Instrument Supplies, Accessories
V5299	Hearing Service Miscellaneous (May Be Used to Bill Warranty Replacement Hearing Instruments But Shall be Covered Only if Prior Authorized by the Department)

Section 3. Vision Program Services. (1) Vision program coverage shall be limited to:

(a) A prescription service;

(b) A repair service made to a frame;

(c) A diagnostic service provided by:

1. An ophthalmologist; or

2. An optometrist to the extent the optometrist is licensed to perform the service.

(2) Eyeglass coverage shall:

(a) Be limited to a recipient who is under age twenty-one (21); and

(b) Not exceed:

1. \$200 per year for a recipient in the global choices benefit package; or

2. \$400 per year for a recipient in the comprehensive choices, family choices, or optimum choices benefit package.

(3) To be covered:

(a) A service designated as a physical medicine and rehabilitation service CPT code shall require prior authorization if provided to a recipient age twenty-one (21) or over;

(b) A radiology service specified in 907 KAR 3:005, Section 5, shall require prior authorization regardless of a recipient's age;

(c) A service shall be provided in accordance with the Vision Program Manual; and

(d) A lens shall be polycarbonate and scratch coated.

Section 4. Appeal Rights. (1) An appeal of a negative action regarding a Medicaid recipient shall be in accordance with 907 KAR 1:563.

(2) An appeal of a negative action regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.

Section 5. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "The Vision Program Manual", October 2007 edition, Department for Medicaid Services; and

(b) "The Hearing Program Manual", October 2007 edition, Department for Medicaid Services.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR 1:038, 6-10-86; Am. 18 Ky.R. 1625; eff. 1-10-92; 20 Ky.R. 1714; eff. 2-2-94; 23 Ky.R. 4009; 24 Ky.R. 119; eff. 6-18-97; 25 Ky.R. 1254; 1660; eff. 1-19-99; 28 Ky.R. 944; 1404; eff. 12-19-2001; 33 Ky.R. 594; 1377; 1560; eff. 1-5-07; 34 Ky.R. 1820; 2110; eff. 4-4-08.)

Handout - 45 CRK 155.1065  
Stand Alone Ditch Plans

§156.275 of this subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.

**§155.1050 Establishment of Exchange network adequacy standards.**

(a) An Exchange must ensure that the provider network of each QHP meets the standards specified in §156.230 of this subtitle, except for multi-State plans.

(b) The U.S. Office of Personnel Management will ensure compliance with the standards specified in §156.230 of this subtitle for multi-State plans.

(c) A QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under §156.235(c) of this subtitle.

**§155.1055 Service area of a QHP.**

The Exchange must have a process to establish or evaluate the service areas of QHPs to ensure such service areas meet the following minimum criteria:

(a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.

(b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

**§155.1065 Stand-alone dental plans.**

(a) General requirements. The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange, if—

(1) The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and

(2) The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act; and

(3) The plan and issuer of such plan meets QHP certification standards, including §155.1020(c), except for any certification requirement that cannot be met because the plan covers only the benefits described in paragraph (a)(2) of this section.

(b) Offering options. The Exchange may allow the dental plan to be offered –

(1) As a stand-alone dental plan; or

(2) In conjunction with a QHP.

(c) Sufficient capacity. An Exchange must consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage.

(d) QHP Certification standards. If a plan described in paragraph (a) of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.

#### **§155.1075 Recertification of QHPs.**

(a) Recertification process. Except with respect to multi-State plans and CO-OP QHPs, an Exchange must establish a process for recertification of QHPs that, at a minimum, includes a review of the general certification criteria as outlined in §155.1000(c). Upon determining the recertification status of a QHP, the Exchange must notify the QHP issuer.